When You Are the News: The Health Effects of Contemporary Islamophobia on Muslims in the United States and United Kingdom

By

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I. Introduction

Health research focusing on immigrants generally finds that foreign-born individuals exhibit overall better health than native-born individuals and that the health of immigrants deteriorates with time spent in and acculturation to the host country. This is commonly referred to as the "immigrant health paradox" (Dubaybo & Hammad, 2015). However, both Arab immigrants in the United States and Muslim immigrants in Europe seem to be an exception to the rule. A study found that Arab immigrants had worse self-reported health than U.S. born Arabs, and those that spoke Arabic reported worse health than those that spoke English (Abdulrahima & Baker, 2009); therefore, their results demonstrated the exact opposite of the paradox: the health status of Arab Americans improves with acculturation and with the acquisition of the English language. Similarly, a study on acculturation and mental health among non-Western Muslim immigrants to Europe found that improving mastery of the dominant language in host societies increased their health (Fassaert T, 2011). Additionally, improving mastery of the dominant language affected self-reported health in the United Kingdom (Johnston & Lordan, 2012). Thus, the same exception to the immigrant health paradox is present for Muslims in the United Kingdom and throughout Europe. This mutual finding is important because considering 63 percent of the Muslim population in the U.S. (Lipka, 2017) and slightly over 50 percent of the Muslim population in the U.K. (Office for National Statistics, 2016) are foreign-born, it may be language barriers and discrimination against overtly Muslim populations that affect their health.

In fact, stress due to discrimination is found to have profound effects in producing adverse health outcomes. An under-examined topic is the effect of Islamophobia on health in the U.S. over the past decade and a half. Since the attacks on September 11, 2001 and the beginning

of the U.S. government's "war on terror," Muslims in the United States and abroad have been the targets of unwavering scrutiny, discrimination, and being made to feel like "others." In previous literature, religion has been shown to have effects on health; however, the majority of what has been investigated regarding religion and health has been on positive buffering effects (Williams & Sternthal, 2007) or cultural factors of religious communities (Laird, Amer, Barnett, & Barnes, 2006). I argue that this is not sufficient when studying the Muslim population and health outcomes—because of discrimination toward those following the Islamic faith, and because Islam in America and the United Kingdom has been heavily racialized, a distinctly sociological approach is necessary when studying Muslim population health. Furthermore, I argue that there has been a Judeo-Christian bias in previous literature examining the relationship between religion and health, which further adds to the necessity of investigating the health diminishing effects of Islamophobia. Secondly, while studying intersectionality in health disparities, researchers often limit their focus to the intersection of socioeconomic status or class, gender, and race. I argue that religion should be included in the discussion of intersectionality in health disparities research. This inclusion is necessary because the health effects of discrimination have been shown in Muslims in the United States and the United Kingdom. Thirdly, I argue that due to the profound effects that Islamophobia can have on Muslim population health, more national health data needs to include religion in order to measure this disparity. Lastly, I argue that because Islamophobia affects the health of Muslims, it should be framed as a public health issue.

Both American and British Muslims were negatively impacted by the attacks on 9/11 (Johnston & Lordan, 2012). Additionally, in the United Kingdom, the 2005 London bombings, referred to as 7/7, further stigmatized Muslims as terrorists and extremists. An analysis of Islamophobia and health is especially necessary recently, with the election of President Trump

and the Brexit decision (Haidt, 2016). The campaign for Donald Trump to be President of the United States, as well as the campaign for the United Kingdom to exit the European Union (nicknamed "Brexit") occurred concurrently and amplified Islamophobia in the US and the U.K. President Trump and his administration attempted a Muslim Ban, or the barring of Muslim Syrian refugees (while favoring Christian ones) and people traveling from seven predominantly Muslim countries from entering the United States. This executive order was enacted after President Trump discussed a "complete and total shutdown of Muslims entering the United States" on his campaign trail (Council on American-Islamic Relations, 2017). Furthermore, President Trump discussed the possibility of a Muslim registry during his campaign, which would require all Muslims currently living in the United States to be registered on a federal list. Lastly, President Trump said that "Islam hates us," creating an us-versus-them attitude between Muslims and other Americans (Council on American-Islamic Relations, 2017).

The vote to exit the European Union (EU) in the United Kingdom was also largely based on Islamophobia. Many who campaigned to withdraw membership from the EU did so because they did not want to comply with EU immigration principles, especially those that applied to accepting Muslim immigrants and Syrian refugees. The United Kingdom Independence Party (UKIP), the party that led the Leave campaign, warned that continuing EU membership would force the U.K. to accept large numbers of Muslim refugees, as well as other immigrants. Muslims were framed by the party's leader, Nigel Farage, as a group of people who "do not want to become a part of our culture" (Beauchamp, 2016). Like Donald Trump, Farage cultivated a similar us-versus-them attitude toward Muslims during his campaign.

Both 2016 events led to a resurgence of the political far right (Haidt, 2016) as well as hate crimes against Muslims. In this paper, I refer to hate crimes using the Federal Bureau of

Investigation's definition. For the purposes of collecting statistics, the FBI has defined a hate crime as a "criminal offense against a person or property motivated in whole or in part by an offender's bias against a race, religion, disability, sexual orientation, ethnicity, gender, or gender identity," (Federal Bureau of Investigation, 2017).

Scapegoating immigrants as the problem of society and using xenophobia to push political or public health agendas are not new concepts, and these tactics trickle into perceived discrimination, which ultimately affects health. Throughout this paper, I will be using historical basis, past evidence linking discrimination and health, and current conditions to argue my thesis. I analyze the social construction of being Muslim in the United States and the United Kingdom using the concepts of biological citizenship and orientalism, and I examine how similar instances of otherization have occurred throughout history. I then introduce the previous literature linking discrimination/Islamophobia and adverse health outcomes. Lastly, I showcase how the current political climate produces adverse health outcomes in Muslim populations. Therefore, my thesis is situated in the intersection of sociology, political science, and public health. By using an interdisciplinary approach, I aim to prove that more research should be done on Muslim health disparities.

Because of these gaps in the literature on the association of religion, discrimination, and health, I aim to make a case for more collection of data on this topic in order to properly research this association. Because of the limited availability of data I am able to use, I will be doing so using mixed methods. I am including a literature review as well as an analysis of quantitative data sets and qualitative interview data.

Furthermore, this paper is not only a call to researchers to track and study Muslim population health. I also work to phrase Islamophobia as not simply a social issue, but a public

health issue. This is because Healthy People 2020 describes the goal of public health professionals as "to achieve equal access to health for all and to work toward a society in which all people live long, healthy lives," (García & Sharif, 2016). By showcasing Islamophobia (and its consequences) for what it is (that is, a source of discrimination that physically makes people sick), we can create a space to condemn Islamophobia while meeting the objective goal of a healthier population. Through this framing, condemning Islamophobia becomes the ethical responsibility of public health professionals. This tactic has been previously used by civil rights/Black Lives Matter activists who framed racism as a public health issue (Nelson, 2013; García & Sharif, 2016).

For this paper, I use the definition of Islamophobia according to Laird et al., 2007, "to refer to forms of prejudice, exclusion, and violence toward Muslims that have risen to new levels over the past 20 years." Although I focus on Islamophobia as a source of discrimination, I recognize that Muslims are heterogeneous and intersectional themselves, meaning that for many, the effects of this discrimination are multiplicative: toward multiple attributes of their identity. For example, Muslims in the United Kingdom and the United States are differentiated by race (black, white, Asian, etc.) and ethnicity (South Asian, Arab, West African, etc.), national origin, social class and immigration status, any of which can result in being the target of social bias (Laird, Amer, Barnett, & Barnes, 2006). Islamophobia coexists with and multiplies the effects of the other sources of discrimination Muslims may face.

II. Literature Review

Gaps in Current Literature

There is a profound lack of data on religion and health in general, especially in government data sources. In the United States, neither the National Health Interview Survey

(NHIS) nor census data include religion in their demographic data when taking information about health. This makes research challenging because the NHIS is the principal source of information on the health of the civilian noninstitutionalized population of the United States and is one of the major data collection programs of the National Center for Health Statistics (NCHS) which is part of the Centers for Disease Control and Prevention (CDC) (Centers for Disease Control and Prevention, 2016). Secondly, Gallup Analytics uses religion as a metric instead of a demographic, making it impossible for many users to quantitatively study how religion affects health unless using consumption data. In the United Kingdom, the Health Survey for England (HSE) has information on religion, making it easier for British researchers to study how Islamophobia has affected health in the United Kingdom (Johnston & Lordan, 2012). The only data available for linking Islam and health from most U.S. sources come from geographic areas with high concentrations of Muslims (like Detroit, Michigan) or from individual-level data where last names can be used to infer religion. In order to study the effect of religion on health using census data, many researchers turn to using ancestry from a predominantly Muslim country as a marker of religion. However, considering that as of 2011, one-quarter of US Muslims were black and 37 percent of US Muslims were native born (Lipka, 2017), and considering that people from non-Muslim families with traditionally European last names can also be Muslim, these methods are inadequate in accurately depicting the Muslim population in the United States and United Kingdom.

Secondly, because this paper serves as a critique of current literature and data, I have examined how research has traditionally studied the link between religion and health as well as the link between racism and related discrimination and health disparities. Previous literature has shown a positive relationship between religion and health. David Williams and Michelle

Sternthal examined this relationship and found that there is mounting scientific evidence of a positive association between religious involvement and multiple indicators of health (Williams & Sternthal, 2007). They framed religion as a coping mechanism, acting as a mediating factor by providing both social and spiritual support to people in ill health. The paper recognizes the field's Judeo-Christian bias, stating that to date, the majority of research on spirituality and health has focused on U.S. populations with strong Judeo-Christian religious affiliations. They mention that research on diversity in religious preference and geography is necessary to determine the generalizability of current findings on the association between religion and health. However, they do not mention Islam once in the paper and fail to recognize how religious persecution or discrimination could counter the coping mechanism that religion provides. Although religious communities, including Islamic religious communities, provide extensive social support, religion can also be a basis for discrimination, namely Islamophobia, in the countries mentioned in their paper (the United States and Australia). The paper fails to recognize this by only representing religion as a positive buffer, resulting in improved health outcomes.

Furthermore, much of the current literature on Muslim communities and their adverse health outcomes (such as higher rates of diabetes, breast cancer, BMI, etc.), only focuses on cultural factors influencing the health of Muslims. This is important, as these factors can play a prominent role in reducing health disparities in Muslim communities through cultural interventions and community-based participatory research. However, by ignoring the ways that discrimination affects health, researchers could be missing a large component of what causes disparities in Muslim population health (Padela & Afra, 2015).

Similarly, health disparities research typically does not include religion as a social determinant of health. Most health disparities research focuses on the intersection of race and

socioeconomic status, occasionally also including gender and LGBT status in its analyses. When a religion has been as heavily stigmatized and its members have been as heavily otherized as Islam, researchers must also acknowledge religion in their discussion of intersectionality as a factor contributing to the discrimination people experience.

"Other" Citizens: Nativism, Racism, and Health

I use the term "otherization" to refer to the processes by which societies and groups exclude those whom they want to subordinate. Othering produces narratives and images about a group of people that demonizes or dehumanizes them, providing the justification to treat these others as inferior (Arab American National Museum, 2011). Therefore, otherizing is the act of deeming a person or social group as different or alien. This definition draws from the classic work of Edward Said, who states in *Orientalism* that the process of otherization is affiliated with the representation of Western nations (the Self or Occident) and Eastern nations (Other or Orient) in which the Self is privileged and has upper hand to define, reconstruct the passive, silent and weak Other (Said, 1978). This dichotomy places the West and East in binary opposition (Moosavinia, Niazi, & Ghaforian, 2011), making their coexistence seem unnatural or unattainable, as seen by the demonizing of Muslims currently living in Western countries. In other words, Orientalism is a form of cultural imperialism that has permeated our modern social, political, and academic rhetoric when framing the East by creating a West-versus-East, us-versus-them mentality in order to maintain superiority and oppression over these countries and its associated peoples. Orientalist thinking has emphasized and distorted differences of Arab and other Muslim peoples and cultures as compared to that of Europe and the United States, framing Arabs and Western Muslims as a danger to other Western citizens (Arab American National

Museum, 2011) and in need of correction and surveillance. Since 9/11, many works of literature have deemed Muslims as the "Other" of Western society.

Western Islamophobia paints Muslims as threats to the body politic and Islam as a danger to its citizens. In doing so, it otherizes Muslims from the definition of citizenship itself, and lack of true citizenship has resulted in health disparities in the past (Molina, 2006). History has shown that citizenship based on religion or ethnicity has used the bodies of minorities as a matter of contention. The concept of biological citizenship specifically emphasizes this relationship of the state and the body of the individual or populations within a society. Biological citizenship reveals that health—or lack thereof—of individual citizens can be a site of contention, particularly in the instance of either power over life and death or the obligation of the state to provide the basic foundation for the individual (Foucault, 2004). This relationship of state power, through which human life processes are managed, affects targeted populations by hindering the ability of the individual to realize health and happiness (for example, through government surveillance methods, segregation, legislative stripping of rights, or other means) (Molina, 2006; Kraut, 1994; Roberts, 2004).

Concrete historic examples of the state labeling an entire population as a threat to public health and safety include Irish, Italian, Haitian, German, Chinese, Jewish, and Hispanic immigrants (Kraut, 1994). The labeling of these groups as problem populations and as threats to other citizens (and the national culture at large) allowed for blocking and stripping of their citizenship and basic rights through legislative measures. Americans feared contracting disease from these populations as well as these populations shifting the "American identity." By the last decades of the 19th century, Americans feared the health effects of these immigrant populations to the extent that they moved Congress into action, causing each immigrant to undergo a health

inspection before allowed entrance in the country (Kraut, 1994). There are similar political talks today about requiring Muslim immigrants and refugees to undergo more rigorous vetting processes, which showcases how citizenship can easily be denied in the face of xenophobia and now specifically Islamophobia.

This historical basis provides context for today's otherization of Muslims. Muslims are also framed as a danger to shifting the nation's identity, whether this nation is the United States, the United Kingdom, or other Western nations such as France. Immigration and fertility of Muslims in the West are two substantial examples of this "threat" (Hackett, 2016). Many residing in Western nations, especially in Europe, voice opposition to the number of offspring from Muslim families because they fear a "takeover" of Muslims in the country. This is because Muslim families have more offspring than non-Muslim families in Europe (Westoff & Frejka, 2007). Therefore, because the fertility, reproductive systems, and family planning of Muslim women have been called into question, Muslim bodies are now a site of contention, making them an ideal lens through which to study biological citizenship.

Although there is disagreement about the definition of biological citizenship, I mainly draw from the definition explained by sociologists Nikolas Rose and Carlos Novas. Their definition, which uses the term 'biological citizenship' descriptively, encompasses citizenship projects that have linked their conceptions of citizens to beliefs about the biological existence of human beings, as individuals, as families and lineages, as communities, as population and races, and as a species (Rose & Novas, 2002). Additionally, they characterize this form of biological citizenship as distinctive of contemporary liberal democracies and position it in places such as "Paris, San Francisco, or London" (Pollock, 2015). Western, democratic nations are taking issue with Muslim existence, lineage, and families; therefore, the plight of Muslims in Europe and the

United States fits with this definition of biological citizenship. Hence, because society takes issue with the biological existence and biological functions of the Muslim and the Muslim family, the biological citizenship theory is an accurate way to describe Islamophobia in the West.

Rose and Novas mention that like other dimensions of citizenship, biological citizenship is undergoing transformation and re-territorializing itself along national, local and transnational dimensions. Therefore, citizenship has shaped the ways in which individuals understand themselves and relate themselves to others. By referring to Muslims with rhetoric that suggests they are non-citizens (i.e. un-American or anti-British), it is important to examine on what basis countries and their citizens identify themselves and their culture and how an increase of Muslims is a "threat" to the culture they call their own. This begs the question, what is American culture and what is British culture if they are opposed to Muslim citizens? The answer relates back to Said's concept of orientalism: the framing of Muslim citizens as "other" and as a "threat" in this instance is a resurfacing of the Orient and Occident as a binary, a false dichotomy of peoples that supposedly cannot live together in harmony.

Furthermore, citizenship goes beyond whether one resides in a country—rather, it is a measure of if one receives the benefits of living in a country (Roberts, 2004), including a feeling of belonging and equal treatment. Toward the beginning of the 20th century, W.E.B. Du Bois wrote the essay, "Of Our Spiritual Strivings" included in his classic *The Souls of Black Folk*, describing the process of otherization and how it contributes to one's self-perception. There he famously describes how it feels to be labeled a problem and the sense of double-consciousness that labeling produces—individuals labeled as a problem are constantly looking at themselves through the eyes of others, a phenomenon also described by my interviewees. Arab and Muslim Americans are the newest "problem" of American Society (Bayoumi, 2009)—they are the new

threat to American and British society and the health of their "women and children." Therefore, Muslim bodies are once again a site of contention. Consistent efforts have been made to identify Muslims as the alien other as opposed to true American citizens: in 2006, 39 percent of Americans believed Muslims should carry special identification cards (Bayoumi, 2009)—and with the recent election of Donald Trump, this may become a reality.

Other narratives of Muslims being denied citizenship come from works such as "South Asian Muslim Youth in Post-9/11 America" by Ethnic Studies scholar Sunaina Maira. Maira shows how South Asian immigrant youth suggest that the cultural dimensions of national belonging were part of their everyday experiences of inclusion, exclusion, and engagement with their schools, workplaces, and public spheres. They felt that the scapegoating of all Muslims after 9/11 was a form of collective punishment for the attacks, and this is what led to Muslim Americans being portrayed as "un-American" (Maira, 2009). Additionally, she refers to cultural citizenship as "behaviors, discourses, and practices that give meaning to citizenship as lived experience in the context of an uneven and complex field of structural inequalities and webs of power relations, the quotidian practices of inclusion and exclusion." This statement of exclusion and exclusion relates to Muslims in the U.S. and U.K., showcased through my interview data in the results section of this paper.

Secondly, in "Civil Liberties and the Otherization of Arab and Muslim Americans," Princeton professor and Middle Eastern politics scholar Amaney Jamal describes that the state of civil liberties has deteriorated for all Americans since 9/11, especially in undermining Muslim and Arab Americans' confidence in their own rights and security. This was due to the PATRIOT

Act I and II[1] granting the government significant powers to monitor Americans, even allowing the indefinite detention of "non-citizens" without trial. Considering the right to trial is essential to the value of citizenship in the United States, this was a direct stripping of citizenship and rights of Arabs. Jamal also draws from societal attitudes, which show that 41 percent of the general population would support the detention of "suspicious" Arabs and Muslims without sufficient evidence to prosecute, compared to 12 percent of Arab-Americans, and 49 percent would support increased surveillance, compared to 17 percent of Arab Americans. Jamal states that the reason for people willing to support infringement on the civil liberties of Muslims and Arabs is because they characterize them as "enemy Others," due to the racialization and "otherization" of Arabs and Muslims in mainstream American culture. This us-versus-them attitude was used to begin and continue the Iraq war as well as the current otherization of Muslims in America today (Jamal, 2008). Institutionalized otherization and infringements on civil liberties are also present in Europe, where the Prevent Initiative[2] in the United Kingdom has supported the surveillance of Muslims without sufficient evidence to do so. Furthermore, Muslims constitute as much as 70 to 80 percent of inmates in prisons located on urban peripheries in France, even though they generally constitute only 15 percent of urban populations (Brookings Institution).

[1] USA PATRIOT Act is an Act of Congress that was signed into law by President George W. Bush on October 26, 2001. Its title is an acronym that stands for Uniting and Strengthening America by Providing Appropriate Tools Required to Intercept and Obstruct Terrorism Act of 2001. The law allows law enforcement to use surveillance to catch more crimes of terror, and it was often used to surveil innocent Muslims and their communities (United States Department of Justice, n.d.).

[2] The Prevent Strategy forms one of four strands of the U.K. Government's counter-terrorism strategy, known as CONTEST. The initiative is meant to defend the United Kingdom against threat from both international and domestic terrorism. The Prevent Strategy aims to disrupt extremist organizations from operating within British communities. This strategy, similar to the PATRIOT Act, greatly increased surveillance on Muslim communities (Working Borough Council, 2015).

Immigration, Discrimination, and Assimilation

Muslim immigrants are a lens through which to study how citizenship status affects Muslim health disparities. As mentioned earlier, health research focusing on immigrants generally finds that foreign-born individuals exhibit overall better health than native-born people and that the health of foreign-born people deteriorates with time spent in and acculturation to the host country. With Muslim immigrants to the United States and the United Kingdom, however, this is not the case. Because more assimilation results in better self-reported health for this group, Muslim immigrants experience the opposite of this paradox. Therefore, because the immigrant paradox is not the case for Muslims, discrimination and failures of the healthcare system to meet recent immigrants' needs could be at fault. These failures can include discrimination in the doctor-patient relationship, language barriers, or other significant barriers to care.

An example of discrimination affecting Muslim immigrant health is a 2011 study on perceived discrimination and psychological distress in immigrant populations. The study found that perception of discrimination increased from 1998 to 2007 among the Arab Muslim, Arab non-Muslim, and Haitian groups; however, Muslim Arabs were the only group to experience a significant increase in psychological distress associated with this discrimination (Rousseau, 2011). Therefore, it was distinctly their Muslim identity, in addition to their immigrant identity, that affected their mental health.

Mechanisms through which Islamophobia Affects Health

American and British Muslims' loss of citizenship, increased surveillance, and increased discrimination are not past experiences; rather, they continue today. Hate crimes against Muslims have still not subsided to pre-9/11 levels, both in the United States and the United Kingdom. Arabs and Muslims have been profiled by law enforcement and have faced increased

surveillance and deportation, and Muslims are now routinely discriminated against in their places of employment, housing, healthcare, poll-gathering, and in the media (Bayoumi, 2009). Muslims are interacting with this discrimination at multiple levels, with each layer adding to their amount of perceived discrimination, which in turn affects health.

Health disparities among racial and ethnic groups are influenced by the structural (socially or state-sanctioned), institutional, and interpersonal aspects of a society and its health care systems (Laird, Amer, Barnett, & Barnes, 2006). Through information from my interviews and literature review, it is clear that in order to truly understand the effect of Islamophobia and health, researchers must examine three main levels of interaction: interpersonal interactions (including hate crimes and provider-patient relationships), community-level interactions (such as community stereotyping and surveillance), and societal interactions (person-media or person-state/policy). These three tiers of discrimination are discussed with interview data in the results section below.

However, as mentioned earlier, many texts examining the health of Muslims primarily focus on cultural factors. Kleinman (2006), for example, argues that the illness experience is shaped by cultural factors that govern the way individuals perceive, label, evaluate, and seek help for their ailments within an overarching healthcare system. Although this is partially true, by ignoring the effects of discrimination and social marginalization on discernable differences in health outcomes, we leave out a major cause of health disparities. Health does not exist in a vacuum—being exposed to constant discrimination causes weathering on the bodies of socially marginalized individuals.

The specific mechanisms that cause this are known and well-researched. During a stressful event, there is a rapid response in the body, giving rise to a series of behavioral and

physiological responses to help an individual survive (Johnston & Lordan, 2012). Through this process, the autonomic nervous system, hypothalamic–pituitary–adrenal (HPA) axis, and cardiovascular, metabolic, and immune systems protect the body by responding to internal and external stress (Williams & Mohammed, 2013). Usually, in episodes of stress, this response is protective, as it enhances immune functions, promotes memory, and increases blood pressure and heart rate to activate fight or flight. Therefore, generally, the response passes when the stressor is gone. When the stress is constant, like in the case of prolonged discrimination, the prolonged exposure to the increased and consistent secretion of stress hormones can result in allostatic load (Johnston & Lordan, 2012).

Allostatic load leads to negative health consequences, including less restful stage four sleep, higher resting blood pressure, greater abdominal fat, higher risk for diabetes, coronary artery calcification, fibroids, and breast cancer (Williams & Mohammed, 2013). Similarly, other health consequences of discrimination include greater exposure to community violence, reduced health care seeking, increased perceived provider discrimination, higher rates of substance abuse, and discrimination in employment (which results in greater risk of exposure to job site hazards, injury, and job-related death) (Williams & Mohammed, 2013). This discrimination and abuse can also lead to psychological ailments such as depression or to maladaptive behavioral patterns such as smoking (Padela & Curlin, 2013). Most of these adverse outcomes can be quantitatively measured; however, measuring them is difficult due to the lack of quantitative data available including both religion and health.

Although there is limited available data, there are studies that investigate perceived discrimination of Muslims and health. One study conducted in 2006 showed that discrimination-related stress is associated with adverse psychological symptoms. These findings linked

perceived religious discrimination and subclinical paranoia, an association that could be important in the understanding of the effects that chronic perceived discrimination has upon ethnic and religious minorities who are subjected to discriminatory behavior in their everyday lives. The authors argue that the findings should be beneficial to clinicians who are treating an increasing number of Muslim clients as the population of Muslims in the U.S. grows. They state that clinicians should be aware of the role that perceived discrimination might play in a client's presenting symptoms, especially in the symptoms of social withdrawal, suspicion, or hypervigilance (Rippy & Neuman, 2006).

In the few instances of available quantitative health data, significant results show that discrimination has discernable and alarming effects on the health of Muslims in the United States and the United Kingdom. For example, data from Dearborn, MI, a predominantly Arab-American and Muslim area, shows Arab residents have higher rates of diabetes than any other population in the Detroit area. In a study that addresses breast cancer health disparities among Arab women in the U.S., it was found that seventy percent of Arab American women greater than 40 years of age in the Detroit metropolitan area had received a mammogram compared to 92.6 percent among all women in Michigan (Dubaybo & Hammad, 2015). This could be due to psychosocial factors associated with breast cancer screening among Arab women, including fear of the screening process, fear of negative results, embarrassment and stigmatization, language barriers, lack of knowledge, transportation and economic barriers, fear of inconsiderate/Islamophobic physicians, and cultural and religious barriers (Dubaybo & Hammad, 2015). Additionally, a multiple regression analysis revealed a significant positive association between the religious breast cancer screening barrier and less time in the U.S., identifying as Muslim, and being from Yemen (Dubaybo & Hammad, 2015). This was primarily due to

stigmatization in their community as well as fear of discrimination at the doctor's office. It was also found that Dearborn residents had high stress, depression, and anxiety rates due to post-September 11 backlash and discrimination, and they had higher mortality rates due to violent hate crimes (Laird, Amer, Barnett, & Barnes, 2006).

Being perceived to be Muslim or Arab in the post-September 11 America has also correlated with poor birth outcomes, specifically low birth weight in infants and premature birth. Because of limited data, a study examining how being Muslim/Arab post-September 11 affected adverse birth outcomes from expectant mothers was done by seeking out Arabic-sounding last names in birth certificates. The birth certificate data showed that the estimated effect of being an Arab-named mother on birth weight of the baby, compared to being a non-Hispanic white mother, was insignificant pre-September 11 and significant post-September 11 (Lauderdale, 2006). Therefore, the relative risk for poor birth outcomes in the six months following September 11 were significantly elevated for Arabic-named women and not so for any other ethnic groups in the state. This means that stress and fear of Arabic-named expectant mothers had a direct effect on the health of their newborn babies.

Other studies produced similar results in the United Kingdom. Using data from the Health Survey for England (HSE), a study in London found that the health of Muslim Pakistanis and Bangladeshis significantly worsened relative to non-Muslim Indians between 1999 and 2004 using objective measures of health such as BMI, blood pressure, and cholesterol, as well as subjective measures such as self-reported health (Johnston & Lordan, 2012). They used difference-in-difference methods to calculate the effect of discrimination on health by comparing changes in the health of Muslims living in England before and after the recent upsurge in terrorism post 9/11, with changes in the health of the similar non-Muslim population. This

change over time carries significant importance due to the increased discrimination of Muslims in the United Kingdom after September 11, 2001. The objective and subjective health of their Muslims participants declined over the course of the study. They argue that exogenous changes in the perception of Muslims by the general population in the U.K. during this time resulted in increased levels of perceived discrimination. Therefore, through applying this difference-in-differences analysis, they found that the increased discrimination caused the relative health of Muslims to deteriorate in the United Kingdom.

Another study analyzed the effect of discrimination on 16 to 25-year-old Muslim men. They found a 9 to 11 percent relative decrease in employment for this group post-September 11th, 2001 and a 10 percent decrease post the 2005 London underground bombings (Rabby & Rogers, 2011). As mentioned earlier, employment discrimination can have a significant effect on health, as it pressures people to find employment at more dangerous job sites. This results in greater risk of exposure to job site hazards, injury, and job-related death (Williams and Mohammed, 2009). Furthermore, data from the United Kingdom shows that cancer fatality is higher in the Bangladeshi Muslim community of East London than any other ethnic group or religious community (Vrinton, Wardle, & Marlow, 2016), and they also have the highest rate of depression among all other ethnicities (Loue & Sajatovic, 2008).

Quantitative studies like these that showcase the discernable changes in Muslim population health prove that discrimination has affected the health of Muslims in the United States and the United Kingdom. Furthermore, I use these studies to argue that a wider range of data linking religion and health in the United States is necessary to understand the mechanisms that cause these disparities and to research how to cease them.

III. Data and Methods

My pilot work was informed by my experiences in London, U.K. and Dearborn, MI. Out of the many residents of Tower Hamlets and Newham in East London that I interviewed for pilot data, almost all of them were Muslim, had diabetes, and struggled with language barriers and with seeking health care. Because I have recently seen the disparities that exist within these two communities and because of the elimination of language barrier in the literature from these locations, I decided to use the United States and the United Kingdom instead of other appropriate Western nations, such as France or Australia, to frame my study. Therefore, I chose interviewees from these locations due to convenience. Treating the two cases comparatively is meant to show that the experience being Muslim in the Western world, even from two different countries (and continents), is generalizable.

I used mixed methods and an interdisciplinary approach to form this thesis. My first method used was an interdisciplinary literature review. By using databases EBSCO Host and PubMed Central, I found relevant literature by drawing upon primarily the disciplines of public health and American Studies. I used search terms "Muslim health," "religion and health," "biological citizenship," "Islamophobia and health," "Muslim health in the United States and United Kingdom," "discrimination and health," "mental health in Muslim communities," "Muslim health disparities," "Islam in media," "otherization," "Muslim community-based participatory research," "Muslims and stigma," "Muslim fertility in Europe," and "intersectionality and health." I searched for a multitude of sources, including books as well as articles in peer-reviewed journals.

Secondly, I used qualitative interview data. My participants include Muslims from the United Kingdom and the United States. These participants are community members, university students,

Center for American Islamic Relations representatives, American Muslim Affairs Council officials, and Muslim healthcare providers, and Muslim public health officials. Each interview recording was numbered and each interviewee was de-identified. I assigned each participant a pseudonym in order to keep them anonymous in my study. Additionally, in order to gain interviewees, I used snowball sampling: I asked each participant if they had other interviewees to suggest to me, which is how I was able to contact my future participants. The interview questions encompassed four main themes: instances of discrimination, feeling like a valued American citizen, relationship with the media, and perception of health disparities in their Muslim community (See Appendix 1). The interviews were conducted spanning from November 2016 to February 2017.

Lastly, I used quantitative methods to analyze current data. The data I used to analyze my hypothesis that Islamophobia affects health comes from the Detroit Arab American Study (DAAS) conducted in 2003. The Detroit Arab American Study is one of the few American surveys focusing on discrimination and health of Arab Americans and Muslims, and I chose it because it asked a set of targeted questions regarding perceived discrimination, health, and religion. I have chosen to focus on Detroit because of the availability of data—there are no nationwide quantitative sources of health data that include religion in the dataset. Secondly, Detroit is an ideal place to study because it harbors the highest density Muslim community in the United States, Dearborn. Thirdly, the data only includes Arab-Americans living in Detroit; therefore, the confounding variable of race is accounted for in the data. Lastly, the data contain a wide range of respondent information surrounding their experiences since the September 11 attacks including social trust, perception of discrimination, frequency of religious participation, level of political activism, and community needs. The dataset also contains demographic

information such as educational attainment, religion, language used at home, ethnicity and nationality, year of immigration (if any), and veteran status. The sample was drawn from the three-county Detroit metropolitan area.

To analyze this data, I first ran descriptive statistics to find the distribution of survey participants in each religious category. The demographic question of religion asks, "Looking at the categories on that page, which best describes your religion?" and survey respondents can choose between Christian, Jewish, Muslim, Atheist, Other, or None. Although the dataset provided the opportunity to differentiate between types of Islamic faith (e.g. Sunni, Shiites, etc.), I chose not to do so because even though the attackers were labeled as Sunni, evidence suggests that the media and most American residents (Jamal, 2008) and British residents treat Muslims as a homogeneous group (Johnston & Lordan, 2012). Following my recoding of religion, I chose to focus on questions of discrimination, otherization and feeling American, happiness, health, depression, anxiety, and access to health insurance.

Next, I performed a series of analyses to produce results from the data. After computing a frequency distribution of the religions of the respondents, I recoded the religion variable into three categories: Muslim, Christian, and other. However, the lack of sample size of the "other" group produced insignificant results—therefore, I eliminated the "other" group and focused solely on Muslims and Christians in the respondent group. Because the data I used was categorical, I used mainly cross tabulations to analyze my data. For nominal data, I used Pearson Chi-Square, Phi, and Cramer's V to calculate association and significance. For ordinal data, I used Gamma to calculate association and significance. To correlate instances of abuse, happiness, and health, I conducted cross tabulations. I conducted a cross tabulation of whether respondents had experienced abuse, threatening words or gestures, physical attack, vandalism or

destruction of property, or loss of employment due to their race, ethnicity, or religion in the last two years with feelings of worthless, depression, and extreme nervousness. I conducted a cross tabulation of happiness and health as well as a multivariate regression of religion and health. Lastly, in order to link religion and health while controlling for confounding variables, I conducted a multivariate regression.

IV. Results

Qualitative Results

Interpersonal Interactions

Interpersonal interactions include the overt instances of discrimination that Muslim individuals face. This encompasses hate crimes and other instances of interpersonal abuse as well as abuse in the doctor-patient relationship.

In 2001, hate crimes against Muslims in the United States increased by 1700 percent (Bayoumi, 2009), and Muslims are still five times more likely to experience a hate crime since before September 11 (Federal Bureau of Investigation, 2016). Hate crimes against people of Middle Eastern origin or descent increased from 354 attacks in 2000 to 1501 attacks in 2001 (Ibish, 2003). This increase in Arabs/Muslims experiencing hate crimes is particularly concerning, considering the overall amount of hate crime incidents in the United States has been following a steady decline since 2011 (Federal Bureau of Investigation, 2016). In the U.K., A survey of British Muslims in 2002 indicated that 82.6 percent of respondents felt an increase in racism and 76.3 percent felt an increase in discriminatory experiences (Sheridan, 2006). Importantly, the level of harassment against Muslims increased across time, rather than reverting back to pre-2001 levels (Johnston & Lordan, 2012).

The FBI also cataloged a total of 5,818 hate crimes in 2015—the start of President Donald Trump's campaign—a rise of about 6 percent over the previous year. These hate crimes included assaults, bombings, threats, and property destruction. Out of all victims, Muslim Americans experienced the largest number of attacks. There were 257 reports of assaults, attacks on mosques and other hate crimes against Muslims in 2015, an increase of approximately 67 percent from 2014. This number is the highest total of hate crimes against Muslims since 2001, when more than 480 attacks occurred in the aftermath of September 11 (Lightblau, 2016). Donald Trump winning the presidential election in 2016 caused another surge in hate crimes against Muslims (American Civil Liberties Union, 2016). Hate crimes result in added fear and stress among the targeted populations, making them an accurate lens through which to examine perceived discrimination.

Similarly, the Muslim Council of Britain, a group of mosques in the United Kingdom, compiled a dossier of 100 hate crimes the weekend after the Brexit vote alone. Sixty-five percent of victims in the cases it recorded involved women and of those, 75 percent were clearly identifiable as Muslim (for example, due to their headscarves or veils, also called *hijab*). Tell MAMA, the United Kingdom's hate crime reporting organization, reported that women were more likely to be attacked or abused while traveling on public transport to town and city centers or when shopping (Muslim Council of Britain, 2016).

This alarming increase of hate crimes in both the U.K. and U.S. is reflected in the interview data. Every American Muslim that I interviewed said "yes" when I asked if they had experienced any type of abuse based on their being perceived by others as Muslim. Farah has been called a "disgusting Muzzy" repeatedly and her dad was fired from his job due to his religion. Sarah had only one incident of discrimination when she was walking to her car and a

man in a pickup truck drove by and yelled “terrorist.” Rashed spoke about his father, who was shaken by an experience of walking into a grocery store different from where he usually shops and receiving dirty looks from everyone in the store until he walked out. Dania mentioned that the Islamophobic comments she received began when she started wearing hijab in grade school. Lastly, Maya disclosed that in high school, verbal abuse was a daily occurrence. People would yell things such as, “Watch out! She has a bomb!" "Muslims are a disgrace (to America), 9/11 was their fault," "That's a pretty dress, for a terrorist," "Do you build bombs in your basement?" and worst of all, "I think there should be another holocaust, but with Muslims."

Maya also added that she is forced to face the reality that hate crimes against Muslims are the highest since post-9/11, thanks to President Trump enabling racists with the hateful rhetoric he has been spreading. This is her new reality.

Because every interviewee had experienced a direct instance of abuse, the interviews in this section showcased how widespread instances of interpersonal discrimination are in the British and American Muslim experience.

Health-seeking Behaviors

Health-promoting behaviors are also affected by perceived discrimination. One study examined the effects of discrimination on constraints of leisure activity in American Muslims. Najila, an interviewee from the study, stated that it is difficult for her to exercise daily because in her experience, people looked at her strangely, questioned her about Islam, and shouted slurs at her while she was exercising. Walking daily was prescribed to her because of her diabetes, and she was not able to fulfill her prescription due to Islamophobia (Livengood & Stodolska, 2004).

The authors of this study also stated that there was a lack of desire found in multiple study participants to engage in out-of-home activities. This was due to their anxiety and their fears of the physical dangers of leaving the home. One of my interviewees, Maya, disclosed that after President Trump's election, she was called multiple slurs and threatened while leaving her home to go for a run. She exercises daily, she is an avid runner, and usually runs to and from the gym; however, since the election, she has either stayed home or had to wait for a companion to come with her because she feared another threatening incident. Another interviewee, Noora, who resides in East London, informed me that she constantly worries about her daughter. Although they live in East London, her daughter exits the enclave for school daily, and Noora fears that when leaving their community, her daughter will encounter Islamophobic people who can and will hurt her. When Noora travels on the tube alone, she finds that she is constantly aware of her surroundings because she is visibly Muslim by her hijab. She feels compelled to smile and wave at strangers, hoping that she can combat the stereotypes of Islam that the media has presented while also ensuring her safety when leaving her home.

These interviews showcase that Muslims, especially those who wear hijab, are continuously aware of how they are perceived by others; that is, they experience the double consciousness feeling described by DuBois in *The Souls of Black Folk*. Because of their past experiences, these participants were cognizant of how Islamophobia affects their everyday lives.

Not only are positive health behaviors hindered by Islamophobia, but maladaptive ones are affected by it, as well. Because discrimination and abuse may lead to psychological ailments such as depression, Islamophobia can also lead to higher levels of smoking in Muslim populations (Padela & Curlin, 2013). One participant, Farah, stated that she started smoking to cope with the Islamophobia she faced. She described that after she organized a protest against

Islamophobia, she received hundreds of comments and messages both online and in person calling her a "muzzy" and sending her death threats. "The threats triggered my depression and anxiety. I remember smoking almost daily to cope with the stress. I had never been a smoker before, but it was one of the only things that could calm me down when I was surrounded by so much stress from the threats."

The Doctor-Patient Relationship

Furthermore, interpersonal interactions that shape health-seeking behaviors of Muslims include the patient-provider relationship and fear of abuse while outside the house or community. Perceived provider discrimination has a direct effect on self-reported health status. Additionally, because minorities perceive more provider discrimination, they are more likely to delay health seeking. In turn, this delay is associated with poor health outcomes. Furthermore, fear of a negative experience with their healthcare provider may result in a Muslim patient choosing to go to the doctor less often. In the worst cases, healthcare providers have refused medical care to those belonging to the Islamic faith (Lee & Ayers, 2009). These findings enrich the understanding of how health disparities in the Muslim community are created and sustained and provide a concrete mechanism on how to reduce them (Lee & Ayers, 2009).

Pew Research Center analyzed how Islamic attitudes toward medicine influence Muslims' engagement with the U.S. health system and found that although Islam itself encourages Muslims to seek care, certain factors, including inequity, conflict and health outcomes for refugees, and physician attitudes towards Muslims, can produce adverse health outcomes (Lipka, 2017). For example, Muslim immigrants who participated in the study did not feel their experiences with local health care providers were comfortable or beneficial due to discriminatory practices by physicians (Inhorn & Serour, 2011). Furthermore, another study with

Muslim Americans found that one-third of its subjects perceived they were discriminated against in the healthcare setting. Education was negatively correlated with perceived discrimination in the health care, and women who wear Muslim clothing reported more anti-Muslim discrimination than those who did not (Marin, 2013). Women who wear the hijab said their healthcare providers often presumed they were ignorant and had abusive husbands, and at times even refused them medical care (Padela & Curlin, 2013).

Additionally, 63 percent of the Muslim-American population is foreign-born (Lipka, 2017). Therefore, language barriers are a pressing issue in the doctor-patient interaction. Farah disclosed that her grandparents do not speak English, so she has to accompany them to the hospital. “Every time I accompany them to the hospital, I see how they are treated like trash because they cannot respond or complain.”

Rashed spoke about language barriers as well. He stated, “Many Muslims in America are foreign born and experience a language barrier. Insurance won’t pay for a translator most of the time and a lot of hospitals have stopped providing them because they don’t have the money. And in some places, they say children are no longer allowed in doctors’ appointments, which makes things even worse because their children are usually their translators since they can’t pay for one on their own.”

Dania’s experiences of language barriers illustrate how hospital policy can directly affect the lives of immigrants, like immigrant Muslims. When she was five years old, she was the only one in her family that could speak English, making her the one chosen to accompany her parents to their doctor’s appointments. Later, her mom became an interpreter at the general hospital: she interpreted for many different women, and the amount of work she had to endure because of how necessary of a resource she was for the Kurdish community was immense. Dania mentioned that

now, because of new hospital policies, it is the responsibility of the patient to bring their own translator. Public hospitals do not provide this service anymore, and insurance only pays for translation services part of the time. This made it more difficult for her community to attend doctor's appointments, as there was no affordable option to actually understand what their provider was telling them.

Another interviewee, Noora, who works for a public health organization in London, spoke about her view that the healthcare system harbors injustice. "It's not fair. If you can advocate, you should. Many providers do not understand cultural background. They do not respect people's views because they treat elderly like babies, opening them up and changing them. When we, Muslim women, go to a hospital we request female nurses and doctors, but in this society, they do not understand this. They say that if you need some medical intervention, you do not have to be the same gender. Our community members should know that they have a choice to ask, and some are not given that choice. So, females do not go for breast exams and pap smears because of this."

Dania spoke about refugees having a tough time navigating healthcare once resettled in the United States. She works for a refugee resettlement agency, and many refugees arrive in the United States with an already unfavorable view of institutions, including hospitals, because of the oppressive regimes they endured through institutions in their home countries. This deters them from healthcare seeking. Other issues. such as language barriers, Islamophobia, and lack of cultural understanding they endure from providers in the United States, only work to further deter refugees from seeking health resources.

Sarah, who works in a hospital, gave more of a unique perspective. Her siblings are both healthcare professionals, and she disclosed that both have experienced discrimination

from patients or from colleagues in the hospital. Her brother, a doctor, could never receive a promotion in the hospital and was consistently not referred to patients from other doctors when he lived in the Southern United States. However, once he moved to San Francisco, he no longer experienced this problem. Her brother has seen patients who would smile at his face, make jokes, and the moment he left the room, they would say "that damn terrorist." Her sister, who wears the hijab, had numerous patients refuse to see her because of her faith. Therefore, although Muslim patients are discriminated against in the doctor-patient relationships, many Muslim doctors combat discrimination in the hospital, as well.

Overall, the issues encompassing Muslim experiences with their providers (and Muslim providers' experiences with their patients) showcase that the healthcare sphere is a microcosm of the discrimination faced in everyday life. Muslims experience a vast amount of interpersonal interactions with abuse, and the patient-provider relationship, like other relationships, is no different. This discrimination in the healthcare sphere does, however, have a direct impact on health behaviors and is the reason why many Muslims, especially Muslim immigrants, avoid accessing preventative services (Lee & Ayers, 2009).

Community-Level Interactions

Community-wide Discrimination

For the purposes of this paper, I use the word "community" to refer to a gathering of Muslims within a specific geographic location that belong to an Islamic center or a multitude of Islamic centers. Some of these communities and Islamic centers are grouped by ethnicity and some are not. Therefore, Muslims living in rural areas without Muslim neighbors or an Islamic center they regularly attend may not be part of an Islamic community, whereas most Muslims living in a major metropolitan area would have a community. "The community" is a common

phrase used by Muslims to describe the people that attend their Islamic center or the people within their ethnic group that are Muslim. These communities are often smaller, as there are often community gatherings on religious and cultural holidays as well as close ties and support between community members. Muslim communities will traditionally have an Imam, religious scholars, and members of various different disciplines and backgrounds (Nimer, 2002).

The ways in which a community can be affected by Islamophobia are many, especially through community surveillance, community-level discrimination, and stigmatization of the community. Increased and discriminatory surveillance, such as the New York Police Department's surveillance methods, have resulted in added stress and adverse health outcomes among Muslims. The NYPD's program of surveillance of Islamic communities in the United States is the only surveillance program based on religious identity, and it includes community leaders, mosques, student associations, organizations, businesses, and individuals (American Civil Liberties Union). These surveillance techniques had adverse outcomes—Muslim charities were shut down, and when students realized they had been watched for years and were still watched, they reported repeated panic attacks, pervasive apprehension, and trouble concentrating in classes (Theoharis, 2008).

Communities can also face discrimination through vandalizing of local Islamic centers. Mosques in Atlanta have recently been advised to install security cameras, keep the door locked with an electronic keypad during prayer times, and use armed security. One of my informants, Dania disclosed that as a community across the state of Tennessee, her community had multiple attacks:

> We had the incident at Murfreesboro Mosque[3] as well as the Anti-Sharia Bill that was proposed by the senator from Murfreesboro who took it upon himself to promise his constituents that he would rid the state of Muslims. My community fought against the bill and got it condensed to the National Terrorism Bill—but it still passed and he bragged about it. That was in 2011. It has only gotten worse since then. Now, the same efforts continue in counties. There is talk of changing our textbooks to make jihad the 6th pillar of Islam. Just being Muslim and living our everyday is enough of a stressor. And then on top of that, to combat this outside pressure of dehumanizing us—we don't have the resources to do that. Our community does not have the resources to combat these policies against us. And this stress affects us, our parents, and our community leaders.

Rashed described the good and the bad of living in a community. His community has both buffering and negative effects. He also mentioned the Murfreesboro mosque, and that it was vandalized multiple times by phrases such as "get out of my country," as well as set on fire, but he countered that with his experience at Islamic Center of Nashville after the 2016 election, where people drew on the sidewalks with encouraging words. He feels that Nashville has felt more of the better than the worse effects of living in a community. Farah also described buffering effects and negative effects of her community. She feels that a tight-knit community lends itself to gossip and stigma for seeking mental health resources. But in terms of health care, she said it is positive because it offers social support as well as connections to get translators in doctor's offices.

[3] In 2010, there were multiple incidences of arson, vandalism, and gunshots at the construction site of the Murfreesboro Mosque in Tennessee. As the mosque was undergoing a renovation, vandalizers set fire to construction materials while campaigning congressmen promised constituents they were against the mosque's expansion (Brown, 2010).

In East London, the Islamic community is heavily stigmatized. I use Goffman's definition of stigma "to refer to bodily signs designed to expose something unusual and bad about the moral status of the signifier" (Goffman, 1963). The East London Islamic community's adverse health outcomes, such as congenital disorders and high rates of diabetes, are often reduced to genetics: a tendency for Pakistani Muslims to participate in consanguineous marriage or to hold more weight, respectively (Laird, Amer, Barnett, & Barnes, 2006). This community is also stigmatized as harboring extremism. Because of this stigmatization, community-based nonprofit organizations in the area feel pressure from funding sources to implement initiatives surrounding surveillance and counter-terrorism instead of simply public health initiatives or counseling services. One specific initiative, called Prevent, is a government website through which teachers have been trained to look at signs of radicalization in children. Noora was outraged—how would children be radicalized? And she believes this showcases how paranoid the government and the public are of the East London Muslim community. This website was especially shocking to her because she has never met anyone who was "radicalized."

Noora also said this visibility of their community means that people often stereotype people from there, but it also adds a visible barrier between them and other boroughs of London. She often feels scared for her daughter to leave her community, as she knows people in their community know that she is not a threat, but when she goes to other boroughs, she will likely be the only hijabi in the tube and likely to experience more discriminatory attitudes.

Many communities feel pressure to combat the stereotypes with which they are labeled. Shazia said that some of the people in her community say that it is their duty to make themselves appear good, and that each of them is representing other Muslims whether they like it or not. Noora said she always makes sure to smile at strangers on the tube and tells her daughter to, as

well. She believes that as a Muslim, she and her community members have to be polite and cannot act out, or else others will think all Muslims are like that. Furthermore, Dania mentioned that at her local Islamic center they had Boy Scouts and Girl Scouts and now that she is older, she has realized that their badges were meant to make the people around them more comfortable about them being Muslims. They learned things like how to be very understanding when someone does not say your name right, how to compromise on shaking the opposite gender's hand, as well as other activities meant to ease the discomfort of people around them. She has a problem with this now. She wonders, why did she have to go so far out of her way to make people recognize her as human?

Therefore, community-wide discrimination made participants' communities feel a need to overcompensate to combat stereotypes. Community leaders urged members to constantly be on their best behavior, once again employing the sense of double consciousness caused by feeling like the society's problem, described by Du Bois and Bayoumi. This encouragement from leaders made community members feel as if they were required to view themselves through the eyes of non-community members in hopes of reducing future discrimination against the Islamic community as a whole.

Community-Based Participatory Research

Some Muslims have used the community to their advantage. Although Islamic communities can warrant discrimination against community members due to their visibility, some organizations use the community as an asset rather than a burden or a buffer. They urge that although living in a Muslim community can have both adverse and buffering effects on health, it can also be used as a tool to combat health disparities. This is primarily using the method of CBPR, or community-based participatory research. This method has been attempted

in the American Somali Refugee community (Johnson, Ali, & Shipp, 2009), as well as in Southern Michigan (Padela & Killawi, 2013). It has also been implemented in many boroughs of East London by my interviewee, Noora, and her organization.

Noora believes that social determinants of health can greatly impact people's lives. She has seen how women, especially Muslim women, have been treated by their own family, husband, or in-laws and how they are feeling depression because of it. These women did not know who to talk to about their depression, especially postpartum depression, since they felt they could not talk to their family or community because of stigmatization and they could not talk to healthcare professionals/counselors because the language barrier was too difficult to overcome.

She recognized there was a need in the community for people to provide services and fight for others in the healthcare sphere, so she joined the organization that now serves the area by helping people with discrimination in healthcare and with community health efforts. Now, she says, they have successfully reduced disparities in access, language barriers, and cultural health issues for Muslims (such as domestic violence, female genital mutilation, etc.). They have also helped the community by advising residents, partnering with hospitals, and partnering with community and religious organizations in their boroughs. They did this by empowering people in the local communities—they designated certain members of the community to become health guides. Additionally, the people who work for her organization are community members themselves, who help provide translation services as well as create buy-in from the community. They get funding from the National Health Service, as well as local authorities and primary care clinics. Furthermore, they partner with mosques in the area, such as the East London Mosque, to help augment the health of Muslims in their community.

For example, their organization implemented a tobacco cessation project through the local mosques. They used hadith, or sayings of the Prophet, to educate people about the harms of smoking. Additionally, they asked the Imam to warn against consuming intoxicating substances that can have adverse effects on health. Through this initiative, the NHS realized that they need to use the community's own understanding and religious sayings to make people more aware to care about themselves and their bodies. By saying "even in religion it says to keep healthy, they can increase positive health habits." Lastly, they offered women-only community health classes. Public health in the area realized that in order to make people healthy, they have to make it engrained in the cultural and religious background and they have to ensure there is equal access to health resources.

Her organization has also focused on awareness, especially about breast cancer and sexual health. Community members did not know how to communicate with their doctors, doctors did not understand or support them, and they did not know the signs and symptoms of certain cancers in the community. Additionally, this was a cultural issue—many Muslim women would ignore signs of cancer because they had more proximal stressors, like getting their children to school.

Lastly, Noora's organization has focused many of its efforts around social justice and advocacy against Islamophobia. Participants and staff noticed multiple instances of discrimination occurring in the community adding to their members' stress. Additionally, they noticed discrimination occurring in the doctor-patient relationship, as described above. They were able to intervene because they had staff to advocate for the Muslim patients and they had health educators to help publicize their efforts. Therefore, she believes the key to solving many

problems causing health disparities in Muslim communities is to educate and empower the community and to use their community as an asset rather than a burden.

Societal-Level Interactions

This level of interaction refers to Islamophobic media portrayal and policy changes, both of which affect Muslims' daily lives. Hate crimes are correlated with anti-Muslim rhetoric, which gets reproduced through consistent media attention and policy proposals. Amir Saeed, a professor at University of Sunderland, U.K., conducted a critical literature review using media sources and previous literature to argue that British Muslims are portrayed as an 'alien other' within the media. This misrepresentation can be linked to the development of a 'racism', namely Islamophobia, that has its roots in cultural representations of the 'other'. The media has portrayed Islam with an innate propensity to violence that poses the most serious threat to Western civilization (Saeed, 2007). Therefore, constant exposure to negative media portrayal itself can contribute to the chronic stress and perceived discrimination of Muslims in the United States and the United Kingdom.

Media Representation and Perceived Discrimination

It is important to recognize that this negative media portrayal does not only affect Muslims by contributing to more Islamophobia among the wider population. Rather, Muslims experience Islamophobia and the stress associated with it by being direct consumers of the news media. Every interviewee stated that they feel stressed, angry, or frustrated while watching national news networks. Overall, the interviewees conveyed a negative relationship with the media.

Shazia said that people in the media do not treat them as humans or functional members of society. They only treat Muslims as ticking bombs waiting to go off. Samah echoed this statement, saying that she also has never had a positive relationship with the media and that she often feels frustrated when watching and reading the news.

Farah described herself as the media's buzzword. "Muslims know what it is like to have your identity be a buzzword in the news. To turn on the channel every day to see yourself talked about in the news. They're talking about you because they are talking about Muslims as a whole. So, it's not like you are just interested in current events. Your identity is a current event. You are a current event. You are the news."

Dania had a nuanced perspective to add. She has a two-sided relationship with media—on one side she is a receiver of media and that is harmful. She hates how she sees herself versus how her identity is being portrayed to others. She is a firm believer that the media should simply reflect the culture that is. Instead, it is forcing a separate culture for people to believe something that does not exist, and this puts Muslims in danger. Dania wishes she could just turn it off and turn away from how television news portrays Muslims, but because the stigma that exists about Muslims in mainstream TV culture has permeated news into popular culture, she cannot. However, she is also a community organizer and part of her job is interacting with the media. She connects people in the community with the media to give a story, and that story becomes what someone else is watching and it helps spread the community's narrative. This highlights their stories and separates community members from "All Muslims are this or that." Therefore, she feels that although she cannot paint the media with a wide brush and say they are all horrible, she also cannot ignore the pain the media has caused her and her community.

These feelings transcend even further into everyday life through social media. All participants stated that they felt that they could not escape Islamophobia. From the moment they turned on the news in the morning to the time they scrolled through their Facebook timelines at night, they were constantly seeing Islamophobic articles or topics being discussed. Their identities were an unwavering matter of contention, and what others saw as a simple or interesting debate on social media became a daily stressor for them. Farah described this as "racial battle fatigue" and deleted her Facebook for this reason. Maya disclosed that she is constantly stressed by seeing what people from her high school post on Facebook. She feels compelled to continuously educate friends she made in high school about how what they post on Facebook about her religion is incorrect. If she does not comment back, she cannot stop thinking about it.

Farah disclosed a similar sentiment to Maya by saying, "The media pressure is constant—I can't escape it. Any time I open the news, Facebook, Twitter, or Instagram, I become frustrated all over again. I don't know how to deal with it sometimes—I have fallen into deep spells of depression or anxiety because I cannot escape that the identity I hold closest to me is constantly being attacked everywhere I look. I do not get a break."

The last interviewee, Sarah, also decided to do something about the media portrayal she saw. After the terrorist attacks in Nice, France on Bastille Day in 2016, the media coverage was everywhere, including in her hometown in the United States. This media coverage sparked Islamophobia in France and other Western countries once again. She felt helpless—that there was nothing she could do to combat the stereotype that had been presented in the media. To cope with this feeling, she posted on a Facebook page of her local neighborhood, explaining that Muslims are not terrorists. She offered for those who had never met a Muslim before to meet her

at a local café so she could explain that her religion is not synonymous with terrorism. Thousands of people responded to her request, and she felt compelled to meet with each of them to explain that Islam is peaceful. Because of the overwhelming response, she was featured on the front page of her statewide newspaper. However, she mentioned that although she received hundreds of positive messages, for some reason, she focused on her negative responses and felt compelled to respond to them. This is consistent with the literature: people who are chronic targets of discrimination may be highly vigilant to stigma (Major et al., 2002) and may not be able to simply minimize the discriminatory value of a respective event (Kunst, Tajamal, Sam, & Ulleberg, 2012). Conversely, they are likely to attribute negative treatment to themselves or to external factors (Kunst, Tajamal, Sam, & Ulleberg, 2012).

Even after having a positive experience with social media and print media, Sarah still described her relationship with the media is a negative one. She stated that she can never escape the need to combat what she hears in the news about people who identify with her same religion. Consequently, she lets people cut in front of her in traffic, or she holds the door open for people miles away. The necessity of being extremely polite to combat stereotypes has been engrained into her for as long as she can remember.

Other interviewees echoed this statement. Rashed explained that he always feels the need to combat stereotypes about Muslims and that he is constantly hyper-aware of his surroundings, especially when he is the only brown man or Muslim in the room. Likewise, every interviewee said that they felt hyper-aware post-Brexit or post-2016 presidential election.

Dania specifically mentioned this feeling and described it as a sense of displacement from her surroundings:

> The stress that it causes is just that you are hyperaware of your visibility and displacement as a Muslim, especially in the South, Bible Belt, and in Nashville. Along with that comes a certain sense of visibility of people who are counter your culture. Every time you go get groceries, your faith, your skin color, and your hijab is something you are aware of. When I drive between Knoxville and Nashville, I will not stop to get gas because being a Muslim in those spaces is dangerous. I know what will happen if I stop there. Not all spaces are safe for us at a time like this.

Lastly, Farah said that although she does not wear the hijab, she understands the need to combat stereotypes in order to live her everyday life. At airports, she feels she has to act friendly to combat the stereotypes associated with her name. She always wears her college t-shirt and adds slang to her speech. Although she already has an American accent, she emphasizes her southern twang when she talks to make the people around her believe she is just another American on the flight. She is always careful on planes about how she pronounces her hometown, Atlanta. She said, "I have to say "A'lan'a instead of Atlanta for people not to wonder if I'm foreign when sitting next to me on a plane."

Public Policy and Islamophobia

Lastly, the state itself contributes to Muslims' perceived discrimination. Islamophobic policies have a direct effect on the lives of everyday Muslims, and this is proven through the recent Muslim ban[4] put into action by President Donald Trump. Dania described how Muslims

[4] These interviews were conducted in January and February, when the first of two attempted Muslim bans by the Trump administration were enacted by process of executive order. The first of these bans, present during this interview, made it so that all non-citizens could not enter the United States from Iran, Libya, Somalia, Sudan, Syria and Yemen. This included those who were legal permanent residents and had resided in the US for years who had simply taken a trip to one of these seven countries. Muslim Syrian refugees were also barred entry during this time,

experience added stress from policies meant to harm them and their communities. Shazia stated that she does not feel like a valued citizen when interacting with policies about Muslims. She answered, "These policies make me feel un-American. Do I feel like a valued citizen? Not anymore. Not since President Trump was inaugurated. My whole value as a citizen could be stripped away at any moment. And I know he does not value me as a citizen and neither will his administration."

In conclusion, societal-level interactions, including person-media and person-state interactions, greatly contribute to the overall discrimination Muslims face. Many described feeling like a second-class citizen through policy decisions and like a problem or scapegoat through media portrayal. Therefore, perceived discrimination is the sum of each of these levels of discrimination, with societal-level discrimination being an essential part of this summation.

Citizenship and Feeling American

Many of the participants felt that the Islamophobic policies were a direct attack to their citizenship. Muslims I interviewed have internalized a lack of feeling like they belong in their own countries. Most of the participants said they do not feel truly American or truly British because of the constant media portrayal of Muslims as Anti-American and Anti-British and the legislative pushes that discriminate against Muslims. These feelings of otherization have only been augmented by the current political climate.

As Shazia stated in her interview, the recent Muslim ban was a reminder that their citizenship does not protect them from being treated as second-class or non-citizens. Additionally, Farah stated that she does not feel like a citizen because being a citizen means

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even those who had already been accepted to live in the US (Council on American-Islamic Relations, 2017).

more than just having a passport of your home country. To her, citizenship also means being treated like you belong in the country, and that this country is your home and values you.

Some interviewees concluded that they do not have a country to call home. Both Sarah and Farah disclosed that they did not feel American until realizing that they did not belong in their native countries, either. Both left their native countries as young children, and realized that they do not call it their home when returning on a visit. They had little in common with the citizens of that country, yet their own country, the United States, did not treat them as one of their own. Farah resolved this issue by realizing that she has nowhere to call home. Sarah resolved this issue by relying on the support she gets from friends and coworkers that make her feel valued in America. She continues believing that the Founding Fathers, regardless of how their words are used today, would have wanted her to feel at home in the U.S.

Maya mentioned that even when Muslims are meant to be represented as American, it is often problematic. To illustrate her point, she mentioned the image of the woman in the American flag hijab that has been circulated since President Donald Trump's inauguration. She said, "This picture is supposed to represent someone that is American and Muslim, but why do you have to be hyper-patriotic for people to think that? I shouldn't have to wear an American flag around my head for people to think that I love my country. I do love my country, but not in a way that is blind to its injustices."

Farah had opposite feelings about loving her country. She described how she does not feel she is America's problem. Rather, she is America's scapegoat. "America uses me and my Muslim identity to distract from other issues. I am America's scapegoat. I have never loved America. My dad bought an American flag when I was 6 years old in America after 9/11. Patriotism to me was that flag. A flag put in front of my house to make sure we stayed intact. My

dad is very overtly Muslim and he got fired from his job after 9/11. My grandfather's car got egged [after the attacks]. If this country never loved me, how could I love it?"

This loss of patriotism is consistent with the literature. In a study on how perceived Islamophobia, negative representations in media, and religious discrimination affect Western Muslim identity, discrimination was expected to have direct negative effects on the participants' national identity and engagement. In other words, the various forms of religious stigma were expected to induce a religious identity threat, to which the participants would respond with national disengagement and disidentification (Kunst, Tajamal, Sam, & Ulleberg, 2012).

Dania mentioned that in her community organizing work, she has seen how feeling American overlaps with class. People in the immigrant Muslim community are mainly of two types—those who immigrated as students on visas and have stayed for two to three generations, and refugees who are recent arrivals. She stated that because those in the first group tend to be wealthier, they are able to identify more fully as American because they are shielded from many of the negative effects of being Muslim or being an immigrant Muslim. In contrast, the newest refugee arriving Muslims (the ones she works with at a resettlement agency), or even the recently-arrived or low income community members who are not refugees, often feel that although they are citizens, they do not have direct access to the same rights that other Americans would. For them, identifying as fully American is a way to erase what they come from rather than empowering them, giving them rights, and giving them access to health care. Dania ended with the fact that although many of the community members have citizenship papers, they still do not have access, in every sense of the word.

Health outcomes

According to the current data section of the literature review, as well as my interview with Noora, London Muslims are more likely to suffer from heart disease and diabetes than other Londoners. Noora does not believe this disparity is due to race, or perhaps even only the religion—she believes it may be the culture. For example, a lot of Muslims come from a different environment. Their eating habits are the same as they were in their own country, but they are not exercising like they were in their home country and they are eating more processed food. Other interviewees from London echoed this statement. Therefore, she stated, it is not genetic makeup of their race that is making them have diabetes and heart disease; instead, it is a shift in environment. Additionally, she believes that stress due to discrimination can contribute to this disparity. She stated that tension and discrimination still exist between communities in London; therefore, even if one lives in a predominantly Muslim or a predominantly South Asian community, there is still an issue of discrimination. Lastly, she believes social status and financial status both contribute health disparities in the Muslim population in London.

Farah has also noticed significant disparities in her community. She disclosed that Pakistanis have a high prevalence of high blood pressure, diabetes, arthritis, and other ailments. She believes this is partly due to the food they eat—it is high in fat and oil content. Secondly, she believes it is because of access to care. Her grandmother is not insured, for example. Therefore, she cannot go to the dentist every year or get a yearly doctor checkup. "Her teeth are falling out. She got the cheapest version of a denture because she cannot afford to undergo a procedure to pull and replace teeth."

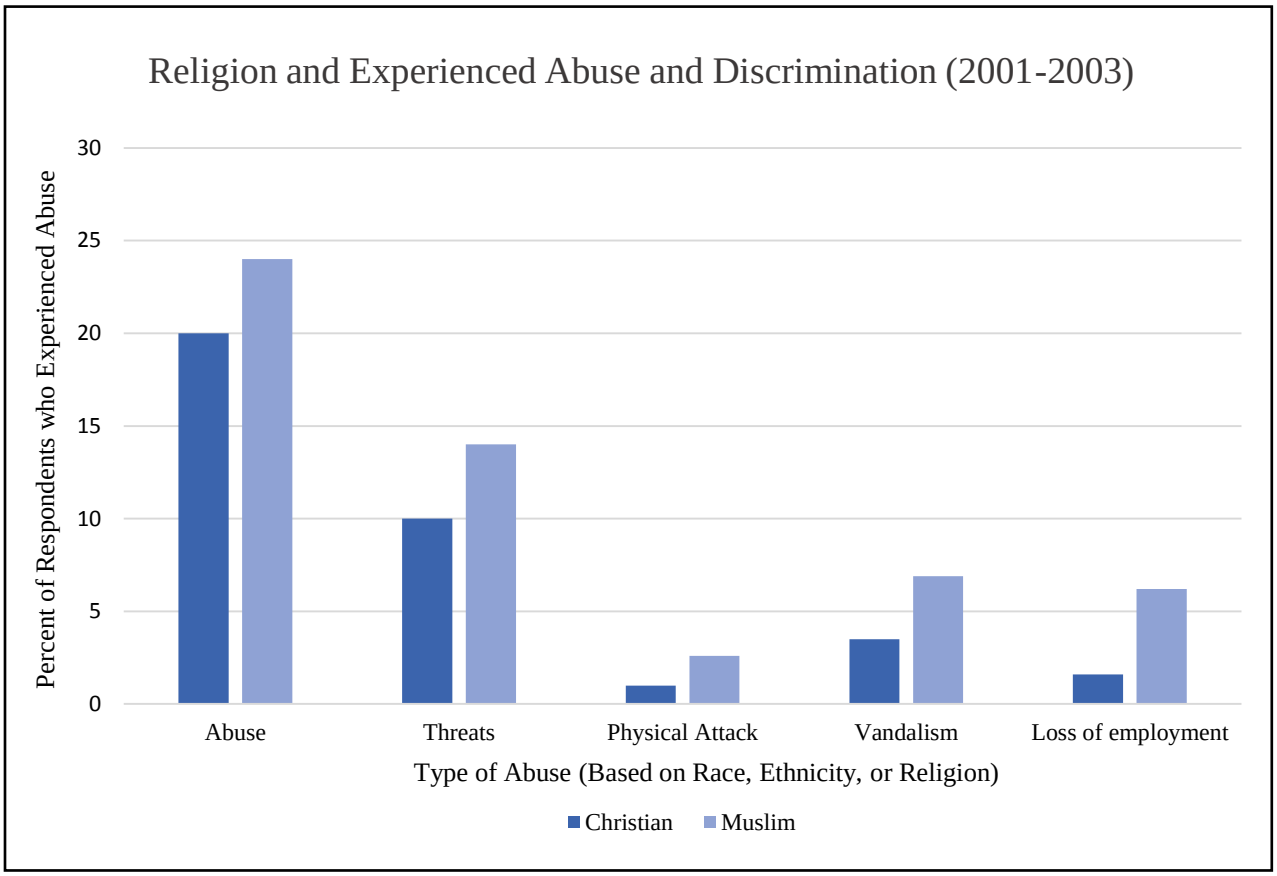
Lastly, Dania has noticed issues with mental health in her community. She attempted to gather more data on Muslim mental health to implement a new community health initiative;

however, this is when she realized that there is no widely available data on the subject. Because religion is not a demographic in most national surveys, it was impossible for her to quantitatively measure rates of depression and/or other mental illness for Muslims in Tennessee. Although she knew how common depression, especially postpartum depression, is in her community, she did not have the means to present this prevalence either to community members or in grant proposals. She was frustrated by the fact that there is no government dataset because religion is not tracked as a demographic, even though she knew that the reason for this lack of information was to avoid discriminatory practices using the collected data.

Quantitative Results

Although I could not analyze national-level data, I was able to analyze results from the Detroit Arab American Study. According to the data, with racial identity and geographic location being the same, Muslims reported higher levels of discrimination than Christians. D21, the question used to assess how different religions experience different levels of discrimination, asked, "In the last two years, have you personally, or anyone in your household, experienced the following due to your race, ethnicity, or religion?" The five categories include verbal abuse, threatening words or gestures, physical attack, vandalism or destruction of property, and loss of employment.

Figure 1. Religion and Experienced Abuse and Discrimination (2001-2003)



This data also showcased that with confounding variables controlled, these higher instances of abuse correlated with higher levels of psychological distress, which could result in adverse mental health outcomes (Padela & Heisler, 2010). As seen in Table 1., the cross tabulations of having experienced an instance of abuse based on race, ethnicity, or religion in the last two years highly correlated with symptoms of anxiety and depression in the last 12 months, with mostly extremely significant results. The Cramer's V shows a moderate association between experiencing abuse in the last two years and feelings of nervousness while the Phi value shows little association. This relationship also had a $p>.05$. However, experience of abuse heavily correlated with feelings of nervousness, worthlessness and depression. With a Phi value of .585, .708, and .724 and a Cramer's V of .414, .501 and .512, respectively, there is a very

strong association between experience of abuse and these three mental health variables. This association was extremely significant, with a $p<.00$.

The survey included multiple questions alluding to depression and anxiety]. This included asking respondents if they felt hopeless, restless, so restless they could not sit still, depressed, worthless, and that everything was an effort. These questions also had five possible answers ranked including all of the time, most of the time, some of the time, almost never, or not at all. For the purposes of my analysis, because many of these variables could produce similar answers, I used only four of the variables. I included two symptoms of anxiety and two symptoms of depression.

Similar results occurred in more specific instances of this abuse. Experiencing threatening words or gestures was highly correlated with feelings of nervousness, worthlessness, and depression, with all $p<.00$. However, feelings of extreme nervousness showed little correlation and insignificant findings ($p>.05$). Experiencing physical attack also highly correlated with feelings of nervousness, worthlessness, and depression. Similarly, experiencing physical attack moderately correlated with extreme nervousness. All four of these associations were highly significant ($p<.05$). Experiencing vandalism and destruction of property was heavily correlated with feelings of nervousness, worthlessness, and depression ($p<.00$) and it was moderately correlated with extreme nervousness ($p>.05$). Lastly, experiencing a loss of employment due to race, ethnicity, or religion strongly correlated with feelings of nervousness, worthlessness, and depression. There was little to no association with extreme nervousness ($p>.05$).

Table 1. Cross Tabulation of Experiences of Abuse based on Race, Ethnicity, or Religion in the Last Two Years with Indicators of Depression and Anxiety

Cross Tabulations	Dependent Variable Y (measure)		
	Phi Value	Cramer's V	P-value
Experienced abuse in the last two years (overall)			
Feeling nervous	0.585	0.414	.000
Feeling so nervous nothing could calm you down	0.147	0.147	0.070
Feeling worthless	.708	.501	.000
Feeling depressed	.724	.512	.000
Experienced threatening words or gestures			
Feeling nervous	0.585	.414	.000
Feeling so nervous nothing could calm you down	.092	.092	.603
Feeling worthless	.707	.500	.000
Feeling depressed	.718	.508	.000
Experienced physical attack			
Feeling nervous	.595	.344	.000
Feeling so nervous nothing could calm you down	.183	.183	.006
Feeling worthless	.709	.409	.000
Feeling depressed	.713	.412	.000
Experienced vandalism or destruction of property			
Feeling nervous	.579	.409	.000
Feeling so nervous nothing could calm you down	.138	.138	.114
Feeling worthless	.711	.502	.000
Feeling depressed	.714	.505	.000
Experienced loss of employment			
Feeling nervous	.590	.341	.000
Feeling so nervous nothing could calm you down	.104	.074	.921
Feeling worthless	.729	.429	.000
Feeling depressed	.719	.415	.000

Furthermore, the data on experienced abuse also yields significant findings in levels of happiness. To assess happiness, I assessed question A4, asking if respondents felt they were very happy, happy, not very happy, or not happy at all. Respondents' level of happiness moderately correlated with overall abuse, threats, physical attack, loss of employment, and vandalism, with highly significant results ($p<.05$). Only the latter category of abuse had a $p>.05$. Happiness also had a strong association with self-reported health, with a Gamma value of .559 ($p<.00$). Therefore, self-reported health was greatly affected by whether a respondent was Muslim.

Table 2. Cross Tabulation of Levels of Happiness with Experiences of Abuse

	Association (Gamma)	
Cross Tabulations	Gamma	P-value
Experienced abuse in the last two years (overall)	-0.206	0.002
Experienced threatening words or gestures	-.211	0.016
Experienced physical attack	-.418	0.048
Experienced vandalism or destruction of property	-.256	0.082
Experienced loss of employment	-.483	0.001

The last table, Table 3., showcases the importance of religion in feeling American. To analyze how otherization affects Muslims and Christians differently, I used survey questions asking about worries for their families (H8), feeling at home in America (H9), and if these sentiments have changed since September 11th (H10). I recoded variables H8 and H9. I included "strongly agree" and "agree" as agreeing with the statement, and "neither agree nor disagree" "disagree" and "strongly disagree" as disagreeing with the statement. In every category, Muslims were more likely to feel otherized by American society ($p<.05$). Muslims were 28.4 percent more likely to worry about the future of their families inside the United States and Christians were 10.7 percent more likely to feel at home in America. Muslims were 10.3 percent more likely to have felt increasingly otherized after September 11.

Table 3. Importance of Religion in Feeling American

	Respondent Answers		
Cross Tabulations	Percent Agree	Percent Disagree	P-value
Since 9/11, I worry more about the future facing me and my family here in the U.S.			
Muslim	68.5	31.5	.000
Christian	40.1	59.9	
I feel at home in America.			
Muslim	90.9	9.1	.005
Christian	80.2	19.8	
Has your feeling on [feeling at home in America] changed since 9/11?			
Muslim	19.2	80.9	.001
Christian	29.5	70.5	

Other findings include self-reported health and health insurance. 25.3 percent of Muslim respondents reported having no health insurance while 10.5 percent of Christians reported having no health insurance. However, I did not include the results from health insurance in the analysis purely because the implementation of the Affordable Care Act has likely greatly affected these numbers.

Approximately 30 percent of Christians in the sample reported excellent health while only 25 percent of Muslims reported the same; however, this finding came with a 10.5 percent chance this outcome was due to chance. Lastly, a multivariate regression between religion and self-reported health to control for other variables showed that much of the variance in the data connecting self-reported health had little to do with income and was mainly due to the confounding variable of happiness. As happiness increased, self-reported health increased.

Discussion

Overall, this analysis showed that experiencing abuse within the last two years (or knowing someone who had experienced abuse in the last two years) due to respondent race, ethnicity, or religion correlated with self-reported health and happiness. With all other factors the same, Muslims were more likely to experience or know someone who had experienced these instances of abuse. Lastly, instances of abuse had significant effects on respondents' feelings of anxiety and depression.

V. Conclusion

Limitations

The main limitation of my quantitative analysis was the lack of data available. In order to find a quantitative dataset with a large sample size of Muslims that also included health, I had to

search 14 years into the past to find the Detroit Arab American Study conducted in 2003. The reason why the United States has such limited quantitative data available on religion and health is because the U.S. Bureau of the Census itself is constitutionally precluded from inquiry into religion (Kosmin & Keysar, 2009). Therefore, other related national datasets, like the National Health Interview Survey (NHIS), do not record religion as a demographic (Centers for Disease Control and Prevention, 2016). Widespread religious data has come from the American Religious Identification Survey, which has been recognized the U.S. Bureau of the Census since 2003. However, this dataset does not include information about health.

A limitation of the interview portion of the study was time. Because I interviewed my participants within the span of November 2016 to February 2017, I had a limited amount of time to gather, record, and transcribe interviews. Although I contacted many more possible interviewees, I was able to interview 8 participants in total for my study. The second limitation of the qualitative portion of my study was language barrier. While I collected pilot data in East London, there was a prominent language barrier between me and many potential interviewees; therefore, my interview data from East London is limited to public health officials and more assimilated immigrants.

Language barrier was also a limitation in my literature review. I compared the United States and the United Kingdom mainly because of the similar health disparities seen in Dearborn, MI as majority-Muslim boroughs in East London such as Tower Hamlets. I also chose this comparison because of simultaneous right-wing campaigns which capitalized on the otherization of Muslims. However, the main reason why I did not include other Western nations was due to both feasibility and language barrier. Including all Western nations would be too broad a scope, although it is arguable that France or Australia could have made great comparisons to the U.S.

due to their Islamophobic policies and societal attitudes. However, comparing the United States to the United Kingdom eliminated the problem of language barrier with the literature.

My last limitation for my qualitative section was that I was not able to study rural Muslims who do not have a community. It could be possible that these Muslims suffer most from discrimination, as they have no community buffering effect and interact with non-community members often. However, I did not find any literature on this subject nor was my sampling wide enough to find interviewees from such areas.

Implications

Past researchers have measured religion and health through specialized access to individual health data and using last names to target individuals. Because analyses like these have produced statistically significant data, and because such analyses exclude a large amount of American and British Muslim populations (approximately 25 percent of Muslims in the U.S. are Black, and many other Muslims do not have an Arabic last name (Lipka, 2017)), it is crucial that there is another method of collecting health data on Muslims in the United States. The Census, as well as its affiliated national data, is bound by constitutionality not to include religion in its analyses. In the recent political climate, in which President Trump wants to create a national Muslim registry, recording more government data on Muslims is even more complicated—government surveillance systems should not be able to use this demographic health data to target and increase surveillance on Muslims. Therefore, although individual-level nationally representative data would be extremely useful to researchers studying health disparities, Muslim Americans must be assured that their data is being de-identified and not used to create said registry.

The Health Survey for England (HSE), the United Kingdom's version of the American Community Survey, actually asks respondents questions about religion as well as measurements of health (Johnston & Lordan, 2012). This has allowed researchers to quantitatively track health disparities faced by Muslim populations in the United Kingdom, whereas researchers in the United States are forced to rely on other, less representative measures. The United Kingdom's version is partially completed by a nurse and includes both subjective and objective health data, whereas the American Community Survey includes subjective health data (but not objective health data or religion). However, the American Community Survey, as it is a branch of the U.S. Census, cannot take data on religion: the only religion data is in a separate dataset that does not include health.

Therefore, since a question on religion cannot be added to the United States Census or the American Community Survey, and because Islamophobic hate crime incidents are once again on the rise, I argue that other nationally representative data should be compiled and is necessary to the research and cessation of Muslim health disparities. This data could be separate from government data (therefore, privately owned) and de-identified, similar to the data from the Detroit Arab American Study. In the meantime, surveys like DAAS should be routinely done to monitor health disparities of Muslim populations, especially since the latest version of DAAS was conducted in 2003. Future surveys should include a measure of religiosity within the Islamic religious spectrum in order to assess if attachment to Muslim religious identity can affect internalization of discrimination and if there are significant buffering effects of using the Islamic faith to cope with stress due to discrimination.

This data is essential for community health efforts, as well. Community-based participatory research, a method of reducing health disparities that has been attempted in

multiple Muslim communities in America and the United Kingdom, can be better funded with national-level data (or at least data from prominent Muslim communities). This is showcased by Dania's interview, in which she stated that she wanted to do community health initiatives surrounding mental health, especially postpartum depression, but there was no data on the subject she could utilize in a grant proposal. She specifically mentioned national survey data as the source she needed to use, and she was not able to do so because the data was simply unavailable.

The second implication is that healthcare providers need to be aware of the effect Islamophobia could be having on their Muslim patients. Providers must be aware of their religious competence and biases while also able to understand that it is possible that symptoms and health outcomes of their Muslim patients could be due to the discrimination they face in their everyday lives. Furthermore, cultural competency training seminars for healthcare providers must include religion in their modules, and providers must understand the ways in which feared discrimination in the doctor-patient relationship can affect their patients' healthcare seeking. Healthcare spheres should be open to cooperating with patients to find doctors that fit their own gender in order to ensure patient comfort and continued healthcare seeking.

Thirdly, it is imperative that health disparities researchers include religion in their measures of intersectionality and begin considering religion as a basis of discrimination causing adverse health outcomes. Most health disparities research focuses on race, SES, gender, and occasionally LGBT status. When a religion has been as heavily racialized and stigmatized as Islam, religion also should be included in intersectional analyses. This can be as simple as mentioning religious background as one of many factors that can affect health or as complicated as controlling for religion in quantitative studies assessing the effect of, for example, racial and

ethnic health disparities in London. Furthermore, there needs to be more research surrounding social marginalization and lack of citizenship that many American Muslims experience which exposes them to the health-diminishing effects of racism.

An additional implication is that Islamophobic policies and media representations must cease and be condemned. Lawmakers, whether United States Congressmen or British Members of Parliament, must understand that their discriminatory policies against Muslims are making their constituents sick. Negative and incorrect media portrayal that groups all Muslims as terrorists must also cease, as it also contributes to perceived discrimination, making Muslims sick.

Lastly, this paper is more than a call to researchers to track and study Muslim health disparities: it also works to phrase Islamophobia as not only a social issue, but a public health issue. I call upon public health organizations and professionals to conduct this collection of data and research because understanding the issue of Muslim health disparities is essential to the eradication of the oppressive structures that cause them. Since the goal of public health professionals is to achieve equal health for all and since Healthy People 2020 describes public health professionals as working toward "a society in which all people live long, healthy lives," it is the intellectual and ethical responsibility of public health workers to value and intervene in how discrimination and racism affect health (García & Sharif, 2016). Therefore, by framing Islamophobia as a public health issue, we can create a space to condemn Islamophobic ideology and actions against British and American Muslims while meeting the objective goal of improving population health.

Appendix 1. Interview Questions

Health

1. What are some of your main concerns of community health in your area?
2. What are the major disparities that you see?
3. Do you see discrimination, Islamophobia, or lack of understanding in the patient-provider relationship?
4. Have there been any efforts to change this through training modules or advocacy?
5. Is there a language barrier between patients and their providers and how do you all help with that?

Community

6. Does your community experience Islamophobia?
7. Have you seen stress due to the discrimination people in your community face?
8. Have community members taken it upon themselves to combat stereotypes?
9. Does segregation contribute to the health disparities in your community? How so?
10. How have you seen communities or cultural factors contribute to adverse health outcomes?
11. Would you say that community relationships and/or religious beliefs have served as a buffer?

Personal experiences and attitudes

12. What has been your experience with discrimination?
13. Living in such a heavily populated Muslim area, do you still experience discrimination due to islamophobia? OR Have you ever experienced interpersonal discrimination?
14. How do you feel when you leave your community?
15. What has been your relationship with the television media and the way they represent Islam?
16. What has been your experience with social media?
17. Do you feel a pressure to perform differently in public in order to combat stereotypes perpetuated by the media?
18. How has the recent Brexit/Trump vote affected your day-to-day life?
19. Have there been Islamophobic policies targeting your community?
20. Have you ever advocated against Islamophobia?

Conclusion

21. How do you think interventions can be strategized based on religion?
22. Do you have any advice for who I can contact next?

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