Protective Factors in Muslim Women's Mental Health in the San Francisco Bay Area

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Abstract

Little is known about how religion and spirituality (R/S) operate as protective factors for Muslim women's mental health. In this study, 20 Muslim women, including community members and mental health clinicians, participated in focus groups and individual interviews, respectively, to explore how R/S improve Muslim women's social support, self-esteem, and emotional well-being in the San Francisco Bay Area. Utilizing qualitative methods, the present study provides consistent results that being Muslim has a direct positive effect on self-esteem, emotional health, life satisfaction, meaning, and purpose. Women who participated had a more mixed view of the social support that R/S give them, including mixed feelings about the local community and social pressures. Knowledge of protective factors for mental health among Muslim women may contribute to improving treatment strategies and decreasing culturally based stigma.

Keywords: protective factors, Muslim women, self-esteem, emotional well-being, social support.

Introduction

The study of protective factors (PFs) is useful to developing strength-based solutions to the mental health problems faced by the diverse racial and ethnic communities in the U.S. (Koenig & Shohaib, 2014; Ungar, 2011; Ungar, 2013). The study of PFs receives little attention compared to the study of risk factors generally (Patel & Goodman, 2007), yet knowledge of religion and spirituality (R/S) as PFs can contribute to a better understanding of the strengths of diverse cultural communities and their mental health (Abdullah, 2015; Andermann, 2010; Graham, Bradshaw, & Trew, 2009; Graham, Bradshaw & Trew, 2010; Hodge, Zidan, & Husain, 2016a). One community in need of such strength-based strategies is the Muslim community (Abdullah, 2015; Bjorck & Maslim, 2011; Graham et al., 2009; Graham et al., 2010; Hodge, Zidan, & Husain, 2015; Hodge et al., 2016a). This study explored three PFs that have been linked to R/S social support, self-esteem, and emotional health, in Muslim women in the San Francisco Bay Area in order to contribute to the development of strength-based mental health interventions for the Muslim community.

Understanding how R/S are PFs specifically for Muslim women is important given the issues of sexism, racism, post-colonialism, U.S. imperialism, and the War on Terror that have depicted Islam and Muslim's R/S as liabilities, particularly for Muslim women (Haddad, Smith, & Moore, 2006). The representation of Muslim women by outsiders as being in need of liberation from their religion is well-documented and pervasive in both historical and contemporary sources (Ebrahimji & Suratwala, 2011; Haddad et al., 2006; Moghissi, 1999; Sayeed, 2002; Wadud, 2006). Yet when speaking for themselves, Muslim women cite their religion as a source of support, self-esteem, happiness, and overall well-being (Ebrahimji & Suratwala, 2011). The current study is aimed at filling a section of the gaps in the literature on Muslim women's R/S as PF's with new data on positive psychology regarding R/S in a sample of Muslim women. Positive psychology, a movement that has developed over the last 30 years, is based on a positive view of the human person. According to this view, psychology should not study only the pathologies, weaknesses and problems of the human being to solve human challenges, but the strengths, assets, adaptations, and PFs that make people thrive (Luthar et al., 2000; Seligman & Csikszentmihalyi, 2000). The current study is motivated by a positive psychology approach, given that it aims to reveal how Muslim women's mental health benefits from R/S. The goal of this exploratory study of R/S as PFs is to explore known social and psychological domains that both protect and promote mental health, while simultaneously filling the knowledge gap around the specific sample of Muslim women (Luthar, Cicchetti, & Becker, 2000; Patel & Goodman, 2007).

Literature Review

To develop culturally sensitive interventions for Muslim Americans, the role of R/S in mental health is a central consideration (Amer & Bagasra, 2013; Hodge et al., 2016a; Larson & Larson, 2003; Vieten et al., 2013). In general, the potential for R/S to be used as a tool in psychiatric and mental health healing has not been realized (Hill et al., 2000; Larson & Larson, 2003; Oxhandler & Pargament, 2014; Vieten, et. al., 2013). There have been close ties in the Islamic world between R/S and health, including mental health, for the entire history of Islam (Koenig & Shohaib, 2014), and Muslims' religious beliefs and spiritual practices have long served as a way to improve mental health, and are PFs for health in general (Awaad & Ali, 2015 Awaad & Ali, 2016). PFs are affected by culture, ethnicity, age, and other factors, and it is important to develop culturally sensitive understandings of PFs (Abdullah, 2015; Andermann, 2010; Grothaus, McAullife, & Craigen, 2012; Luthar et al., 2000; Patel & Goodman, 2007; Ungar, 2011; Ungar, 2013) and to be conscious of the social context contributing to the specific adaptation of individuals under stress (Ungar, 2013). R/S among Muslims is thus a crucial area of investigation and understanding the connection between R/S and mental health functions, and how it can be used to improve mental health among Muslims and the delivery of services to Muslims is a central consideration for working with Muslim clients (Al-Krenawi & Graham, 1999).

Higher degrees of R/S, as mentioned above, have been linked to better health outcomes and shown to be PFs in numerous studies (Dolan, Peasgood, & White, 2008; Hodge et al., 2016a; Koenig & Larson, 2001; Koenig & Shohaib, 2014; Larson & Larson, 2003) R/S have been cited as PFs and linked to better mental health and wellness (Dolan et al., 2008; Hodge et al., 2016b). R/S have been linked to lower rates of depression, lower rates of suicide, and lower rates of alcohol and drug abuse (Koenig & Larson, 2001; Larson & Larson, 2003). R/S have also been found to contribute to hope, optimism, purpose and meaning, resulting in less fear and anxiety (Koenig & Larson, 2001) and to contribute to psychological adjustment, particularly among women (Crawford, Handal, & Wiener, 1989).

The connection between R/S and greater mental health among women is well documented (Dailey & Stewart, 2007; Hodge, Moser, & Shafer, 2013). Research on PFs that has focused on gender as a variable has contributed to increasing evidence that gender, like culture, plays a role in determining and defining PFs (Andermann, 2010). Hartman et al., (2009) showed that while PFs are equally important for males and females, boys and girls rely on different individual PFs (p. 249). R/S also have been shown to prevent alcohol and drug use among adolescent females/young adults (Haber, Grant, Jacob, Koenig, & Heath, 2012) as well as among sexual minority women and heterosexual wom-

en (Drabble, Trocki, & Klinger, 2016). One study on the effects of PFs on youth delinquency found that self-esteem had a greater protective effect for females than males (Hartman et al., 2009). Khamis (2014) found that greater income was more likely to lower psychological distress for men while higher levels of education predicted less psychological distress for women. Billing and Moos (1982) identified family support as more important for women for functioning while work support was found to be more important for men. Other studies, including one in Pakistan (Khan, Watson, Naqvi, Jahan, & Chen, 2015), also found variations in PFs that were based on gender, such as greater spirituality among women and thus a greater positive effect. There is also some evidence that social support affects women and men differently (Shumaker & Hill, 1991) and that happiness, mental health, and religiosity have gender-based differences in some populations (Abdel-Khalek, 2006). Race also impacts PFs. In one study on the protective effect of spirituality on African American women, increased spirituality was found to negatively correlate with depression, anxiety and health (Dailey & Stewart, 2007).

Social Support

A variety of well-being constructs have shown the centrality of social support for understanding wellness and mental health. Social support is one of the strongest predictors of life satisfaction and social well-being (SWB) (Diener, 2012), with SWB being defined as a combination of life satisfaction, presence of positive affect and absence of negative affect (Joshani & Afshari, 2011). The contribution of social support to improved mental and physical health outcomes has been established for over 30 years (Cohen & Schneiderman, 1988; Koenig & Larson, 2001; Shumaker et al., 1991). However, the mechanism through which social support improves health and mental health outcomes is less well known. Hypothetically, social support mediates wellness by providing pressure on individuals to engage in healthy behaviors, increasing the availability of resources, buffering stressful life events, motivating people to maintain their well-being, and preventing emotional disorder (Koenig & Larson, 2001; Cohen & Schneiderman, 1988). Social support, however, can also contribute to negative health outcomes, when the individual's supportive network promotes unhealthy behaviors (Cohen & Schneiderman, 1988) or when a caregiver faces increased stress and responsibilities (Shumaker et al., 1991).

The linkage of social support and R/S is also well established. Essentially, R/S contribute to social support (Ellison, Boardman, Williams, & Jackson, 2001; Hovey et al., 2014; Koenig & Larson, 2001), which in turn contributes to diverse outcomes such as decreases in depression symptoms (Commerford & Reznikoff, 1996), improved health outcomes (Al Khandari, 2011), and better coping with mental illness (Smolak et al., 2013). Involvement in religious

activities has been positively related to SWB as well (Dolan et al., 2008; George et al., 2000).

Muslim women and social support.

Because the culture of most Muslim countries is collectivistic, defined as cultures that give the group priority over the individual, researchers have posited that social support is a major factor in life satisfaction for Muslims (Diener et al., 1995). This has been born out in some research and continues to be debated in relationship to other factors determining mental health and well-being such as self-esteem and happiness. Diener et al., (1995) suggest that family support may be an area which is particularly crucial for collectivist cultures, given that the family is the most important grouping in most societies. Families often play a significant role in the lives of Muslim clients, and it is important that clinicians are aware of this fact in their treatment of Muslim clients (Ahmed & Reddy, 2007; Bjorck & Maslim, 2011). Muslim women often see the support for women as wives and mothers as well as the encouragement of education among women as supporting their social selves in healthy ways (Bjorck & Maslim, 2011; Haddad et al., 2006). The Quran emphasizes the importance of family, especially parents (Quran 4:36 & 17:23-24). The Quran also emphasizes the community of Muslims, the importance of the believers being friends with each other, and makes congregational prayer mandatory. As a result, social support is important to Muslims both in the U.S. and in Muslim countries.

Many studies have highlighted the importance of social support to Muslims both in the U.S. and internationally. In their comprehensive review of quantitative studies of social support as a function of R/S among Muslims, Koenig and Shohaib (2014) cite seven studies done on the correlation between R/S among Muslims and their level of perceived or actual social support, with six finding positive correlation between the two variables (p. 200-201) and one study finding no association. In a study of women recruited from a North American Muslim women's magazine, Bjorck and Maslim (2011) found a positive correlation between R/S and social support. In a large study of 1472 adults over the age of 60 years old in Kuwait, high religiosity predicted a high level of social support (Al-Khandari, 2011).

Negative impact of social support.

While most studies demonstrate the positive influences of R/S on social support among Muslim women, negative influences have also been found. Religion has the potential to negatively impact social support through increased guilt, fear and shame (Koenig & Larson, 2001). Additionally, it can cause low-self-esteem when individuals are unable to meet high religious standards for

behavior (Koenig & Larson, 2001). Religion can also produce authoritarianism, dogmatism, rigidity and dependency (Seybold & Hill, 2001). There is also support in the literature for negative social support such as marital conflict or depression in a spouse (Ahn, Kim, Zhang, Ory, & Smith, 2017). However, keeping this in mind, religion, as a whole, in the majority of cases, produces positive effects on social support and functioning (Koenig & Larson, 2001; Seybold & Hill, 2001) and this may be the main cause for R/S's protective effect on mental health (Sherkat & Reed, 1992; Hovey et al., 2014).

Self-Esteem

Self-esteem has been positively correlated with mental health. For example, self-esteem is a good predictor of life satisfaction in measures of SWB (Diener et al., 1995). R/S have also been linked to self-esteem and feelings of mastery (Ellison et al., 2001). However, in collectivist cultures, self-esteem tends to be less predictive of mental health than in individualistic cultures (Diener et al., 1995). Self-esteem has also been linked to R/S, and studies have shown that R/S increase self-esteem (Sherkat & Reed, 1992).

Muslim women and self-esteem.

Textually, Islam validates the existential and ontological value of women in relationship to men and in relationship to God (Barlas, 2002; Haddad et al., 2006; Mohr, 2010; Wadud, 1999; Wadud, 2006). In the work of women writing on Islam, there is a focus on redemptive readings of the Quran that support the rights of women based on women's creation in conjunction with men as opposed to creation stories where women are made from men (Barlas, 2002; Haddad et al., 2006; Mohr, 2010; Wadud, 1999). As a result, many Muslim women view Islam as protective of their sense of self-worth. Additionally, the Islamic concept of *fitra*, or the fundamentally good original nature of the self, contributes to the positive self-concept of many Muslims (Abdullah, 2015, Joshanloo & Daemi, 2016). Other concepts such as the equal designation of men and women as trustees of the earth, or *khalifah* (Wadud, 2006), and the concept that the value of all people, regardless of gender, race, or social status, is based on their piety, or *taqwa* (Wadud, 1999), contribute to the positive view of women both in relationship to men and also ontologically in relationship to God. Many Muslim women also have strongly held beliefs that the early practice of Islam gave women a great deal of honor and respect (Mernissi, 1991).

Koenig and Shohaib (2014), in their review of 15 studies of Muslims found that 11 studies reported significant positive relationships between self-esteem and religiosity (p. 181). In two of the studies that did not find a positive relationship between R/S and self-esteem, there was a connection between negative

self-esteem and perceived discrimination based on R/S (p. 181). Self-esteem has also been correlated with greater religiosity, especially in the face of discrimination (Ghaffari & Çiftçi, 2010). Joshanloo and Afshari (2011), who have studied happiness in a number of large transnational studies, including over 14 different countries, found that among Muslim women in Iran self-esteem positively correlated with life satisfaction. In another study, Joshanloo and Daemi (2015) found that among Iranian undergraduates, self-esteem mediated the relationship between R/S and well-being. In a study of Kuwaiti and American Muslim undergraduates, religiosity was correlated with optimism, self-esteem, and self-rating of mental health in the Kuwaiti sample, and only with mental health and self-esteem in the American sample (Abdel-Khalek & Lester, 2013). Abdel-Khalek (2011), in a study of Muslim Kuwaiti adolescents, found a positive correlation between religiosity, self-esteem, and SWB, while a negative association was found between religiosity and anxiety (Abdel Khalek, 2011).

Often, Muslim women relate their self-esteem to their wearing of the head scarf, also called the veil or *hijab*. Many people outside of Islam view the dress of Muslim women, particularly the hijab, as oppressive and a symbol of Muslim women's domination by and subordination to a patriarchal system (Haddad et al., 2006; Hyder, Parrington, & Husain, 2015; Kakoti, 2012; Yaqoob, 2008). Muslim women who wear the hijab often see it as a sign of empowerment and protection, taking the focus away from their bodies and onto their character, behavior, and speech (Ahmed & Reddy, 2007; Haddad et al., 2006; Hyder et al., 2015; Mussap, 2009; Odems-Young, 2008; Yaqoob, 2008). Many Muslim women cite the impact of hijab on their self-esteem as positive, and comment that the emphasis it places on behavior rather than appearance reduces how much they are objectified by society (Hyder et al., 2015).

Emotional Health

Emotional health and mental health are closely intertwined, and emotional health often serves as the measure of mental health. Mental health is often measured by generalized sense of well-being expressed in the areas of happiness, life-satisfaction, and sense of meaning and purpose (Hodge, Zidan, & Husain, 2016b; OECD, 2013). However, these concepts have different cultural manifestations across national lines, races, and religions, depending on a variety of factors (Diener et al., 1995). Spiritual well-being has also been shown to be a predictor of happiness, and general well-being (Rowold, 2011) and generally R/S equate with greater emotional and mental health (Koenig & Shohaib, 2014). A meta-analysis of 147 studies on the effect of religion on depression also showed a mild association with fewer symptoms (Smith, McCullough, Poll, & Cooper, 2003).

Muslim women and emotional health.

Muslim women's R/S have been found to contribute to their emotional health in the areas of happiness, life satisfaction, and sense of meaning and purpose. Muslim women's emotional mental health benefits from their religion in its emphasis on spiritual connectedness and personal direct relationship to God, unmediated by religious authorities (Ahmed & Reddy, 2007; Haddad et al., 2006; Kakoti, 2012). Prayer can also positively contribute to emotional health among Muslims (Hodge, Zidan, Husain, & Hong, 2015).

Muslim women and happiness.

Among Muslims generally, R/S have been found to positively correlate with less depression (Koenig & Shohaib, 2014; Hodge et al., 2015; Hodge et al., 2016a). However, the question of whether or not happiness correlates more highly with R/S is less well-investigated, and there is some evidence that there is a negative relationship between happiness and religiosity (Lewis & Cruise, 2006). However, the preponderance of evidence indicates that happiness is positively related to religiosity among Muslims, as shown by studies in Kuwait (Abdel-Khalek, 2006) and Algeria (Abdel-Khalek & Naceur, 2007).

Muslim women and life satisfaction.

Studies of Muslim women show an association between R/S and life satisfaction. In a study on Muslim women and their religious support, Bjorck and Maslim (2011) found that religious support correlated with higher life satisfaction (p. 62). Koenig and Shohaib (2014) report that there are 20 quantitative studies that all show a significant positive relationship among Muslims between R/S and well-being as measured by life-satisfaction and happiness. In another study, R/S was shown to have a complex but positive impact on life-satisfaction and subsequent positive mental health outcomes in Muslim women in Australia (Jasperse, Ward, & Jose, 2012). Studies have also shown a positive connection between R/S and life satisfaction among Muslim women in Pakistan (Khan, Watson, Naqvi, Jahan, & Chen, 2015) and Algeria (Abdel-Khalek & Naceur, 2007).

Muslim women and meaning and purpose.

Islam teaches Muslims that everything that happens is for a reason, and that because God is all-powerful, everything that happens is a result of Divine Will. Thus, Islam teaches Muslims to have trust in Allah and be patient in times of distress (Aflakseir, 2012). Islam means surrender, and the religion is based on submission to the Divine Will. As a result, it is predictable that Muslims would

have a strong sense of meaning and purpose at all times in the face of a variety of life events.

Koenig and Shohaib (2014) report that they found three studies that measured meaning and purpose as connected to R/S and that all three found significant positive relationships between the two (p. 177). Studies have also found a connection between R/S and meaning and purpose among Muslim women in Pakistan (Khan, Watson, Naqvi, Jahan, & Chen, 2015). Among Muslim students in England, sense of meaning and purpose derived from R/S was linked to well-being (Aflakseir, 2012).

Methods

Design

This study used a mixed methods approach, however only the qualitative section is reported herein. The qualitative component involved one-on-one interviews with mental health professionals and focus groups with community women. Obtaining information from clinicians was expected to provide insight into the community, as a whole, from the point of view of key informants. The clinicians were expected to have a broad understanding of the Muslim community from their work, and to be able to reflect on how mental health affects Muslim women from the perspective of women who have a strong understanding of mental health. Obtaining information from community women was expected to provide information about a range of perspectives on how R/S exert a protective effect on Muslim women's mental health. The Institutional Review Board of California State University, East Bay approved all study procedures.

Sample

This study took place in the East Bay, South Bay, and North Bay of the San Francisco (S.F.) Bay Area. With roughly 250,000 Muslims, representing 3.5% of the population, the Bay Area has one of the highest concentrations of Muslims in the country (Senzai & Bazian, 2010). Focus groups were held in the local masjids, and a private home in Marin. Interviews with clinicians took place in cafes, parks, and private homes. A convenience sample of 20 women was recruited. There were two subsamples, one of mental health professionals and one of community women. The mental health professionals and community women were recruited with a snowballing approach. For the clinician sample, the main source of recruitment was a Google group for Muslim mental health professionals. To qualify for the study, clinicians had to be 18-65, Muslim, and working in mental health, and have at least a Master's level degree in mental

health or be students in a Master's program. Eight women were recruited for the clinician sample. The researcher recruited community women at masjids and online, announcing the study at community events and distributing flyers, and sending out emails with the flyer to potentially interested community members. Women had to be 18-65, had to have been living in the Bay Area for two years, and had to have been Muslim for five years. Twelve women were recruited.

Data Collection Procedure

The Principal Investigator conducted all individual interviews and focus groups and audio-recorded them. Applying an exploratory strategy, she probed for additional issues based on the answers given to each open-ended question, with the objective of drawing out diverse conceptualizations and phenomena. Due to the limitations of time, and the exploratory nature of the study, not all women commented on each theme, but they were allowed to elaborate on areas that were of particular interest to them within the broad guidelines of the semi-structured interviews.

Data Analysis

For the qualitative data analysis, the researcher listened to audio-recordings of individual and focus group interviews and took detailed notes in MS Excel and MS Word. Coding involved the following steps: (a) listening to the interviews to note concepts, (b) grouping concepts to develop themes and initial codebook based on the interviews, (c) noting examples (i.e., quotes) for each theme for the interviews, (d) coding the remaining interviews again using the codebook while adding concepts and themes, and (e) reviewing the previously coded interviews again to code for the presence of added themes.

A researcher-as-*bricoleur* approach was employed to design this study. Denzin and Lincoln (2005) describe the process of producing a *bricolage* as a process of adding "different tools, methods, and techniques of representation and interpretation to the puzzle" (p. 4.) The researcher-as-*bricoleur* process is "inherently multi-method in focus" and "reflects an attempt to secure an in-depth understanding of the phenomenon in question" (Denzin and Lincoln, 2005, p.5). In the course of this process, Denzin and Lincoln describe how this process of research is shaped by one's "own personal history, biography, gender, social class, race, and ethnicity" (Denzin & Lincoln, 2005, p. 6). In this sense this researcher was well-suited to this study being a Muslim woman and long-time resident of the San Francisco Bay Area. Some of the dangers of being influenced by the prevailing climate of Islamophobia, or historical colonial-

ism and the perception of Muslims as the Other were automatically avoided through the subjective experience of the researcher as a part of the community which was being investigated. In this sense one of the pieces of the "montage," the "*bricolage*" (Denzin and Lincoln, 2005), were the conscious reflexivity of the researcher as part of the social world being studied, and a partially ethnographic approach (Hammersley & Atkinson, 1983). Another piece of the methodological montage used for this study is grounded theory. The coding approach was heavily influenced by grounded theory in that a very open interview guide was used and emerging data was analyzed inductively over the course of the interviews. While the data analysis acknowledged the subjectivity of the researcher, there was also the assumption of neutrality in the process. The codes and themes that emerged as a result of the data analysis were not forced but were empirically valid (Charmaz, 2006) and intended to develop a theory of R/S as PFs through interviewing, coding, and "piecing together implicit meanings about a category" (Creswell, 2013, p. 88). This process did not however at any point minimize the role of the researcher, and allowed for the researcher to bring her personal experience and knowledge of the subject matter to bear on the analysis (Charmaz, 2006; Creswell, 2013).

Results

Analysis of the qualitative data revealed that religion and spirituality (R/S), as hypothesized, function as protective factors (PFs) for mental health through their positive impact on social support, self-esteem and emotional health. However, for two variables, social support, and self-esteem, R/S also had a negative impact.

Sample Characteristics

Clinicians.

The sample of clinicians was a combination of licensed and unlicensed mental health professionals including Master's in Family Therapy, Master's in Social Work, and Psychology Doctorate degree holders. The clinicians had been practicing from 2 years to 19 years. Ages for clinicians ranged from 24 - 47 and represented a variety of ethnicities: six were South Asian and two were of mixed race. Marital status was varied, including two were single, five were married, and one was divorced. Four of the clinicians were born in the U.S. while four had immigrated to the U.S. at some point.

Focus group participants.

For the focus groups, ages ranged from 29- 64, and participants represented a variety of ethnicities including South Asian, North African, Arab, Latino, and Caucasian. Educational background ranged from “some college” to “doctoral level degree.” Marital status was varied, including eight were married, four each single, divorced, engaged, and separated. Three women were converts, and the other 9 were born Muslim. Women had been in the Bay Area for a variety of lengths of time (three years – life). Two women had been born in the U.S., and all other women had immigrated to the U.S. at some point either in childhood or as an adult.

Findings

Thirty themes were detected across the three investigative domains. For social support, there were 10 positive themes (sense of belonging, values, learning, peer support, family, support for a variety of lifestyles, help in raising children, support for women, social justice, hijab) and two negative themes (lack of support for woman in the masjid, cultural and ethnic divisions). For self-esteem, there were nine themes (essential value as a human being, pride in being Muslim, strong values, caregiving and service, education and learning, stories, prayer, a holistic approach) and two negative themes (judgment, abuse). For emotional health, there were five themes (gratitude, prayer, patience in adversity, social justice, belief in heaven). Two themes outside of the variables came up in the interviews and focus groups (Islamophobia, mental health). Five of the 30 themes stand out as going across variables (values, prayer, hijab, learning, social justice). The themes were largely shared between mental health professionals and focus groups, with 26 themes detected in both focus groups and clinicians; two themes detected only in individual interviews; and two themes detected only in focus groups. The major difference between the focus group women and the clinicians was the fact that the clinicians commented more on the negative mental health effects of R/S. All quotes cited in the qualitative findings use pseudonyms to protect the anonymity of the participants.

Social Support

R/S had positive and negative influences on social support. The data revealed 12 themes regarding social support across individual and focus group participants. The 12 themes included 10 positive themes (sense of belonging, values, learning, peer support, family, support for a variety of lifestyles, help in raising children, support for women, social justice, hijab) and two negative themes (lack of support for woman in the masjid, cultural and ethnic divisions). Each

theme is described, including any sub-themes, and illustrated with quotes from study participants.

Sense of belonging.

The most pervasive theme in the area of social support was the sense of belonging that women expressed in relationship to other Muslims. Nineteen out of 20 of the women expressed that they felt a strong sense of belonging in the community centers and masjids. One focus group (FG) participant said, "I found no matter where I go I can always connect to the Muslims, that I can go to the masjid. I can start to meet people, and that's the first step of making friends and building social supports" (Hasana, September 5, 2016). She explained this was partly because Muslims share the same faith. Another FG participant stated that the connection to other Muslims that she felt had to do with shared values saying, "There is a strong connection just because we are all part of the same faith. So, there's already kind of an organic relationship there because we have similar norms and standards" (Hajar, September 5, 2016). Three women mentioned the sense of belonging when they attended prayer, both Eid prayer and Friday prayer, or prayer with family. Concrete support was another form of social support mentioned by women that contributed to a sense of belonging. Two of the focus group women stated that when they moved to the Bay Area, the masjid provided support for them in getting settled in the community. One woman said her husband had found a job through the masjid.

Support from moral values.

In both the masjid and the greater Muslim community, women reported that values played an important role in how their R/S affected their social support. Eight women (4 clinicians, 4 FG participants) stated that the strong values that they learned and practiced as a result of their R/S were a big component in how their R/S supported them socially in their way of being in the world as individuals. One clinician commented, "Religion is a guiding force in terms of your relationship with the world, an internal relationship to Allah but also an external relationship to the world" (Khadija, August 10, 2016). Another clinician called Islam "a guide to life" (Hafsa, August 25, 2016). They talked about how it helped them to raise their children with strong values, or alternatively for young people, how it inculcated in them a sense of strong values which they found to be supportive and strengthening.

Learning as social support.

Three women (2 clinicians, 1 FG participant) reported on of the main values that supported social support in the community was learning. One clinician

commented, “The Quran is dedicated to those who reason” (Ayesha, August 9, 2016) and talked about how this led to open questioning that she thought supported women in the community.

Positive peer support.

R/S also contributed to perceived peer support. Five women (4 clinicians, 1 FG participant) responded to the question of peer support by saying they felt their R/S were crucial elements in how they or other Muslim women they know connected to peers. They said the reason was the importance of forming bonds with people who understood and shared their values. A clinician stated, women “can go to any place in the community, even if people are less religious than you, we all believe in God. We all believe in certain values. We all share a struggle” (Sonia, August 25, 2016). Several women commented that they see the conflict of Islamic values with societal values as standing in the way of relationships with non-Muslims. One clinician also said Islam “teaches us to be loyal to our friends,” and that Islam gives her guidance in how to have positive relationships with peers citing the example of how the Prophet’s companions are still remembered and respected for their close connection to him (Khadija, August 10, 2016).

Family support: R/S as guidance and hindrance.

The women varied in their response to how important R/S were to their connection to their families. Five women (4 clinicians, 1 FG participant) said that family was very important and central to their R/S and cited reasons such as a religious upbringing, emphasis on helping parents, and the impact of their R/S on their relationship to their children. Several women stated their R/S gave instructions and guidance on how to relate to their families, particularly parents and husbands. Two FG participants talked about how Islam teaches *sabr*, or patience and how this helps them to deal with family in positive ways.

Seven women (3 clinicians, 4 FG participants) said there was also a negative component of the masjids in regard to pressure to conform to a certain type of lifestyle, particularly in response to women that were not married. One clinician stated that single women are “not so supported” and that there is more of a need for this (Hafsa, August 25, 2016). Three of the women (1 clinician, 4 FG participants) who were divorced voiced that it was sometimes difficult to be in the community as a divorced woman, and that there was a stigma attached to being divorced even though it is permissible in Islam. However, two of the divorced women expressed that while being divorced was difficult, their R/S also helped them to cope. One woman said her R/S had given her comfort in hard

times. She quoted a verse in the Quran saying, "Verily with the remembrance of Allah do we find peace and tranquility" (Hajar, September 5, 2016).

There were mixed responses on the impact of R/S on being single. One clinician who had never been married was very vocal in her criticism of the pressure within the community to be married and the difficulty of being single (Sonia, August 25, 2016). However, another woman (Sakhina) who was single said she felt that Muslim family and friends were supportive of Muslim women being single and that for her personally, since both her sisters were single, it felt normal to be single.

There was a range of responses on the impact of the religion on raising children. Two women commented that their children had experienced challenges growing up and that they felt marginalized by the community as mothers. A third FG participant (Saida) stated that the masjid had helped her in raising her son through a Sunday school group. A FG participant (Zubaida) commented that when she gave birth and had to have a C-section, the support from other women was critical in her recovery because they brought her food and she didn't have to cook.

Problems with social support in the community.

Five women (4 clinicians, 1 FG participant) criticized local community centers and masjids for being less friendly and supportive of women than men. Two women (1 clinician, 1 FG participant) commented that while they were growing up, there were unequal educational opportunities for girls and boys, and this negatively impacted their ability to learn to practice their R/S. However, they both commented that in recent years, this had been changing and one of them (Amina) said that she had become a Sunday school teacher to respond to this need. Several women commented that many community centers had smaller and worse spaces for women and that this posed a problem for them especially when they wanted to attend prayers and events with their children.

Several women (2 clinicians, 3 FG participants) gave a contradictory viewpoint to the criticism of women's spaces and stated that they felt that they were accepted and supported as women by the community and that the smaller prayer spaces for the women made sense, as community prayer is not obligatory for women. One clinician stated that masjids have a lot of spaces for women, including opportunities to volunteer, offer encouragement for civic engagement, and women's *halaqas* (Arabic: religious study groups.) One clinician (Sakhina) talked about how she had organized women's groups for years and how much women had enjoyed participating in these groups. She commented that it would strengthen the community if there were more spaces outside the masjid for Muslim women to meet.

Additionally, one woman was vocal in expressing that the West's treatment of women was worse than the treatment of women in Islam and questioned the portrayal of Western feminism as a solution to women's problems. She stated, "The 1970s was about women's liberation but the women's liberation we got from the West was a joke" (Maha, March 13, 2016). She also said that her resistance to feminism has alienated her from some people in society. She stated, "I balk at so many things, particularly the view of women in the West, which I find very unfortunate, and very repressive in a different way, and very dangerous. Then I can be viewed as a very conservative person with backward ideas" (Maha, March 13, 2017). Overall, the comments on the impact of R/S on being a woman in social settings were mixed.

Ten women (4 clinicians, 6 FG participants) criticized the community centers and masjids for being very ethnically separated and for the negative impact of culture, both on the expression of the religion and the role of culture in dividing the community. One FG participant stated she thought it was an important area of needed growth for the community. She said, "I've been over 35 years in America and every community that I've gone to every single community that I've gone to, Pakistanis stick there, and Afghans stick there, Indians stick there. So, you know, we like to say we're integrated but you know we're not" (Jamila, September 9, 2016). There were contradictory statements to this though including a woman who is Cuban-American, a convert, and a FG participant who stated, "I went to the masjid in Concord and I studied the Quran. I started with a group of people from very different places. They have people from Afghanistan people, from Pakistan people, from Egypt, the teacher was from Egypt, and I felt so welcomed" (Karima, September 9, 2016). Several women commented that these cultural divisions as well as cultural interpretations were not part of the religion of Islam and that it was a universal problem among all religions. One FG participant said, there is "one Islam and many cultures, and there are some interpretations that have made religions, all of them, very strange" (Maha, March 13, 2016). Like the responses on the impact of R/S on the participants as women, the responses about the impact of culture and race on R/S were mixed.

Social justice and social support.

When asked about social support some women (2 clinicians, 3 FG participants) emphasized the importance of social justice. One FG participant (Maha) tied the Islamic emphasis on social justice into many of the already mentioned themes, including her relationship to the masjids and community centers, her relationship to peers, the importance of values, and her decision to wear the hijab. She talked about the importance of giving to the masjid as a response to the teachings of social justice. Concerning values and peers she said, "Islam stress-

es social justice. Some religions encourage people to be charitable, but they don't make it a part of your everyday life. When we interact with other people, you are more aware that you are doing it" (Maha, March 13, 2016). She stated that the example of the Prophet framed her entire relationship to the world by making fundamental principles of justice and fairness central. She stated, "We learn from the example of the Prophet, *sallahu alayhi wa sallim* (Arabic: peace be upon him,) what would he do? Get along and be just. It's pretty darn simple. It's like, who would Jesus bomb?" (Maha, March 13, 2016).

Hijab and social justice.

The emphasis on social justice and resulting political engagement tied into many themes, one of which was the hijab. Two FG participants said they had put on hijab as a response to the political situation and that this had been a recent response for many Muslim women. On hijab, one FG participant commented, "No one wore hijab 30 years ago" (Maha, March 13, 2016). She said the decision to wear hijab for her was very political. She stated, "9-11 happened, I went, 'Oh My God.' People give hijab way too much importance or not enough. After 9-11 I was inspired to wear it. It's political. No, nobody is forcing me. You come visit my household; you'll see who rules this show. (Everyone started laughing)" (Maha, March 13, 2016). She said immediately before she started wearing it all the time, she put on hijab and people said she looked like a Muslim, and this made her think she should wear it all the time to be more assertive about her identity. Another FG participant (Jamila) also stated she had put on hijab recently due to a desire to be visibly Muslim in her community in response to Islamophobia, particularly in her children's school district.

Hijab and social support.

Seventeen of the 20 women wore hijab with two clinicians reporting not wearing it and one FG participant reported sometimes wearing it. Most of the ten women (2clinicians, 8FG) who commented on wearing hijab stated it contributed to beneficial social support. The women who commented that hijab improved their social support said it contributed to other women saying *salaam* (Arabic: peace, the traditional greeting) to them in the community and made it easy for other Muslim women to identify them and reach out to them. A FG participant said, "Especially around, wearing hijab just walking around town, or something, you might be someplace you never been and you may see a stranger and they may give you salaam. You're like, 'Oh there's Muslims here. People value me'" (Hasana, September 5, 2016). One clinician (Sonia) stated that beneficial social support helped to deal with the pressure of wearing a hijab in the current political climate. Another woman (Amina) who wears the

hijab said that she had been wearing a hijab for 20 years, and the current political climate had made it much more difficult to be visibly Muslim. One clinician who does not wear a hijab said she had stopped wearing the hijab in part due to Islamophobia making it too much of a burden. The one FG participant that did not wear hijab all the time said, “One day I was in Costco, and someone asked me is someone forcing you to wear hijab” and asked her if she was OK (Nabila, March 13, 2017). She said her response was,

It’s my wish. One day I’ll go to Costco with the hijab. One day I will not go to Costco with my hijab. It’s my preference or how I feel on that day . . . it’s different for me. Some people chose to wear it all the time but I do it occasionally. I want to have the privilege of being whoever you want to be and I don’t want to be perceived as a stereotype . . . I want to be free. Wear it. That is my freedom. Don’t wear it. That is also my freedom (Nabila, March 13, 2017).

Self-Esteem

Women unanimously reported that being Muslim supported their self-esteem and that it was for a variety of reasons. These included the belief that they were created by God, the virtues of modesty, and other strong ethical values that went along with being a Muslim, including service to others, and learning. Several of the themes that came up in the topic of self-esteem overlapped with the themes that came up with social support including the importance of strong values, prayer, learning, and hijab. There were a total of 10 themes for self-esteem. These included eight positive themes (essential value as a human being, pride in being Muslim, strong values, caregiving and service, education and learning, stories, prayer, a holistic approach) and two negative themes (judgment, abuse).

The essential value of the human being.

Nine women (5 clinicians, 4 FG participants) commented that they felt either them themselves, or Muslim women generally, felt self-esteem due to the essential value of being human in relationship to a good God and Creator. One clinician (Ayesha) talked about how in Islam there is the belief that people are all born in right relationship to God, that the fundamental nature of people, or *fitra*, is seen as good. One FG participant said, “With religion, Allah created everybody and everybody has worth whether we recognize it or not” (Hasana, September 5, 2016). Several women explained that they felt self-esteem because they believed God loves them or forgives them.

Pride in being Muslim.

Two of the clinicians stated they believed Muslim women have a pride in themselves as Muslim, and the focus groups all reflected this sentiment at one point or another. One clinician said, "I mean Allah had the Angels bow to Adam. We don't want to take it to the extreme and be prideful. But there's I think a lot of underlying value of the human being in Islam" (Ayesha, August 9, 2016). Another clinician said,

Our religion is such a big part of our identity, especially nowadays with everyone that is going on in the news and you know in the world with politics more women, especially in the Bay Area, are proud to wear it on their sleeve, that hey, we're Muslim. Look at me. Come talk to me. Especially in the Bay Area there are a lot of women who wear full on *niqab* (Arabic: the full veil that only shows the eyes) and they have no hesitation about it . . . They're proud to do it. They love when people stop them like in the shopping centers and want to talk to them and stuff like that. For women, our religion increases their self-awareness and their self-esteem (Fatima, August 16, 2017).

Both clinicians and FG participants talked about how their identity is primarily as Muslims. In the past, they said, they had been Afghani, or women, or Americans. With the increase in Islamophobia, and the negative images of Islam and Muslims in the media, they had responded by identifying more with themselves as Muslims.

Strong values.

Five women (4 clinicians, 1 FG participant) talked about the importance of values for either themselves or for Muslim women in fostering self-esteem. Three women (2 clinicians, 1 FG participant) specifically mentioned the importance of the value of chastity. They talked about how in the broader society women link their self-esteem and their self-respect to men and said they feel that Islam protects women from that behavior. One clinician said, "A lot of girls get stuck on getting attention from a man and they forgo their self-respect to do that. Our religion teaches us to hold off on that" (Sakhina, January 10, 2017). One FG participant stated that she gets self-esteem from the value of speaking up for the values religion gives her.

I want to do the right thing, I believe in God, I want to uphold those values, I have stronger courage I have confidence, that is self-esteem, I might

have temporarily . . . other people might not like me because I am open-mouthed, but I feel that I am doing things because of the underlying values (Saida, September 9, 2016).

Care-giving and service.

Seven women (1 clinician, 6 FG participants) responded to the question of how R/S relate to self-esteem by talking about caring for the sick, or caring for others generally. One FG participant stated,

To increase my self-esteem, I volunteered in a hospital, in a nursing home. When you volunteer, you get something, a feeling of gratitude. Your life is not as bad as you think. You are walking out of this nursing home. Praise be to God you can walk out. Yeah, I could go to therapy, but to go visit sick people was more productive for me. 70,000 angels may be praying for me. It gives you that positive feeling that I don't think that therapy ever . . . (Amina, September 9, 2016).

Another FG participant stated,

It comes to the same idea as the Prophet, peace be upon him. He purposely said, "I came to serve. I am not a king." I think it was in relationship to how much things he had in his house and it's described that he was very humble. And so, in that same idea how Islam teaches us to be humble, teaches us to serve others. In my case I asked my mother to come and live with me. And she was living in New York and she was living in . . . Compared to the conditions she could live with me it was not as good as the ones that she could have. And so, I beg her to come to California, and she did, and so I felt that that was you know in my religion I learned that the doors for *Jannah* (Arabic: heaven) is at the feet of your mother. And so, having her in my house was actually bringing the doors of *Jannah* closer to me . . . so I do it because I am getting rewarded by Allah. When we use servant here in America people feel that you are less but I feel that I am not less. It makes me feel strong and big . . . (Karima, September 9, 2016).

One FG participant stated, "When you are able to come out of the me zone, that is for me when I able to serve more and able to do more. That is the self-esteem" (Uzma, March 13, 2017). She said Islam teaches us "how to give your helping hand to another" and how this is important to her self-esteem and for other people's self-esteem (Uzma, March 13, 2017). Another FG participant stated, "You give out of your good deeds. You give out of your time you get out of your caring. If you have time to go meet old people you go do that because

this is all part of Islam. I feel that's relating to self-esteem" (Zahra, September 9, 2016).

Education and learning.

Five women (2 clinicians, 3 FG participants) talked about the importance of the Islamic emphasis on education and learning and how this supports their self-esteem. One woman stated that her parents taught her that Islam teaches for people to "learn from cradle to grave" and that this supports her in making a positive contribution to the world, and therefore her self-esteem (Jamila, September 9, 2016). One clinician commented that, "God is like nothing else. You cannot know what God is" As a result she said, "There's an intellectual inquisitive allowance in Islam" and that "the ability to grow and ask questions builds self-esteem" (Ayesha, August 9, 2016). She made the connection that the total transcendence and unknowability of God in Islam precludes any final answers and "opens the door" to individual exploration of truth (Ayesha, August 9, 2016). One clinician said, "Islam is education . . . I am Muslim by studying. Anything you study, when you work on yourself, is Islam" (Sakhina, January 10, 2017).

Stories.

Three women (1 clinician, 2 FG participants) brought up the importance of stories from their R/S as contributing factors to self-esteem. One FG mentioned the story of Prophet Yusuf (Joseph) and how he was imprisoned in spite of the fact that he had done nothing wrong. She said that knowing "you can come up" encourages people when they feel low self-esteem (Nabila, March 13, 2017). Another FG participant talked about how she gets encouragement from the *seerah*, the stories of the life of the Prophet.

Prayer.

Another woman said prayer, or *salaat*, improves self-esteem. She said, "You are getting purified. You are purifying your soul and your heart feels brighter and your mind is also focused" (Nabila, March 13, 2017). She stated that this gives her self-esteem.

Holistic view of Islam.

Two clinicians commented on how a holistic view of Islam supports self-esteem. One clinician (Sakhina) talked about how she sees what you eat, exercise, and how you spend your time as an important part of self-esteem. She

talked about how a lot of people tend to disconnect R/S from the rest of their lives while she sees Islam as connecting to all areas of life. She mentioned that she has a holistic view of prayer and described her prayer life as including her self-care and her work.

Negative impact of R/S on self-esteem.

As mentioned above, the clinicians talked more about some of the negative impact of R/S on Muslim women. Two clinicians and one FG participant (Sonia, Maryam, Maha) commented on the problem of being judged. Each of them mentioned this in connection to being judged for not wearing the hijab and related how upset they were that other women had felt marginalized for this reason. Other ways they mentioned being judged were by being outside of the mainstream, or not following all the rules of the religion. One clinician (Maryam) talked about the impact of culture on patriarchy and said a lot of the immigrant community carries cultural beliefs about Islam and particularly about women that are not Islamic. She believes these cultural biases contribute to low self-esteem and/or oppressive practices, but said that she felt this was a larger problem in human society.

Emotional Health

Women reported unanimously that their emotional health was positively impacted by their R/S. All the women reported their level of happiness, life satisfaction, and sense of meaning and purpose were improved as a result of being Muslim. However, three of the clinicians commented that they felt that this was not the case for all women in the community and that they had seen how a fear of being judged had led to religious guilt, or self-criticism that was detrimental to women's emotional health. In total, there were five themes in response to the questions of emotional health (gratitude, prayer, patience in adversity, social justice, belief in heaven).

Prayer.

In response to the question of happiness, ten women (5 clinicians, 5 FG participants) responded that prayer helped them be happier. One clinician commented that she said that she knew people who had been suicidal, and they didn't kill themselves because the religion prohibits it. Other participants also said Islam had helped them when they were severely depressed not to commit suicide or to pull out of depression. Another FG participant talked about how telling God her problems made her feel like someone would help her. She said,

"I can't be with my family sometimes. I can only sit there and talk to God and when you keep sitting and crying, you feel that you have told another person and they are going to take care of it" (Hina, March 13, 2017). One clinician (Sakhina) said the prayer puts people in synchrony because of the physical elements of the prayer.

Gratitude.

Additionally, nine women cited gratitude as being a source of happiness. The women mostly combined their answers on life satisfaction with their answers on happiness or their answers on meaning and purpose. The women generally reported high degrees of life satisfaction, saying that this was directly related to their R/S. The nine women (5 clinicians, 4 FG participants) who commented more extensively on life satisfaction cited gratitude as the main reason for their satisfaction with life. One clinician said, "Islam is about gratitude. It's about appreciating what we have" (Sakhina, January 10, 2017). One FG participant said, "With submission comes gratitude" after saying that submission to God is the central truth of her life that gives her happiness, life satisfaction, and meaning and purpose (Hina, March 13, 2017).

Patience in adversity.

Fifteen women (6 clinicians, 9 FG participants) commented that their R/S gave them patience in adversity in some way. They reported this mainly in response to the question on meaning and purpose, but their answers also crossed over into the areas of life satisfaction and happiness. Two women stated that their R/S were based on the belief that Islam means to submit to God and that this submission teaches them acceptance of everything that happens. One FG participant said, "You don't have to have anything to see the beauty of the universe. You practice acceptance . . . a terrible situation has occurred but I'm just going to submit" (Maha, March 13, 2017). Another FG participant said, "Acceptance comes from submission" (Zahra, September 9, 2016). Two women reported that their belief that there is a reason for everything gives them patience. One woman said, "Allah tests those who He loves. He keeps me through everything" (Hajar, September 5, 2016). Other women (2 clinicians, 2 FG participants) also said that they believe that God tests people and that accepting that is part of their R/S. The concept that everything is God's will was commented on by some women as well. Another clinician said, "When things don't go my way I say this is my destiny" (Khadija, August 10, 2016). One FG participant said, "No matter how much I want to control things, He is the ultimate controller" (Zahra, September 9, 2016).

Social justice and meaning and purpose.

Four of the women (3 clinicians, 1 FG participants) commented that they feel that their R/S give them a political sense of meaning and purpose and discussed their commitment to Islam, service, and social justice as major motivators in life. One FG participant said, “Let’s try to be more helpful and help others and then we will be more happy” (Rashida, March 13, 2017).

Belief in heaven.

Some of the women (2 clinicians, 1 FG participants) commented that the belief in heaven gave them a sense of meaning and purpose. One woman commented, “Nobody wants to die, but this is not a final destination” and talked about how her R/S made her see her goal as the next life, not this life (Nabila, March 13, 2017).

Other Themes

There were two themes that stood out that did not really fit into any of the categories, or in some way impacted all of them, Islamophobia and the status of mental health services and care in the community. While these themes were not specifically brought up by the interview questions many women commented on them. In particular, the women wanted to take time to make recommendations which the interviews allowed.

Islamophobia.

Six women (4 clinicians, 2 FG participants) commented on Islamophobia and said it has had a significant impact on their mental health or the health of women in the community. One of the clinicians said that her identity as an American was invalidated because she was a Muslim. She said, “It bothers me when people think I’m not an American. They’re entitled to be American and Christian, but I’m not entitled to be American and Muslim” (Khadija, August 10, 2016). One of the FG participants (Karima) stated that she lost all her friends when she became Muslim. Another FG participant said, “If I was Christian I would have it much easier, because of Islamophobia. I have been wearing hijab for 20 years, but there is definitely this post-terrorism stress disorder” (Amina, September 9, 2016).

Mental health among Muslims in the Bay Area.

Because of the relationship of the topic to mental health generally, several women commented on the status of mental health in the Bay Area Muslim

community and the global Muslim community. Seven women (3 clinicians, 4 FG participants) stated that stigma was an issue. One woman said, "I'm sure if I had a mental health issue, I'd be shunned. There are some educated and some very uneducated, just like anywhere else" (Jamila, September 9, 2016). One FG participant said, "People are afraid to talk across the board in all communities" when the discussion turned to mental and social health (Maha, March 13, 2017). Two women said that the lack of incorporation of Western approaches to mental health was causing damage to Muslims in the community who were experiencing mental health crisis. One FG participant (Hajar) said that some people consider mental illness to be caused by *jinn* (Arabic: spirits) and *shaitan* (Arabic: devils) and, as a result, believe that reciting *Quran* or prayers is the solution to mental health problems. She criticized this saying, "When someone has a broken leg you don't take them to the masjid. You take them to the hospital" (Hajar, September 5, 2016). Several women (3 clinicians, 6 FG participants) said there is a huge need for more mental health services in the community. Another FG participant (Zubaida) said of mental health services at her masjid, "We are not getting anything right now" (Zubaida, March 13, 2017).

Several of the women (2 clinicians, 1 FG participant) also commented on the growth of mental health in the Bay Area over the last ten years in response to community needs. One clinician stated that the field of mental health "is exploding" including services and knowledge of mental health (Ayesha, August 9, 2016). She said she feels there is a natural connection between Islam and mental health due to the rigorous questioning that has always been a part of the intellectual tradition of Islam and the openness of a lot of Muslims to psychology. She said of the focus on mental health, "I also just think it's very fitting for the Muslim community because I think that most of the Muslims I meet are kind of bright and psychologically minded anyhow. So, there's not a lack or shortcoming of openness to it and awareness of it especially in the Bay Area" (Ayesha, August 9, 2016). Both clinicians commented on the recent opening of centers dedicated to Muslim mental health, run by Muslims for Muslims.

Discussion

The study's hypothesis that R/S are protective factors because of their impact on social support, self-esteem, and emotional health was confirmed even though a few negative impacts were also found with regard to social support and self-esteem. The diversity and uniqueness of the set of themes suggest a need for culturally sensitive intervention strategies that account for the complex and subtle nature of R/S as a protective factor. Culturally competent practice also highlights the need to tailor interventions to each individual. Given that there are almost two million Muslims in the U.S., there is no "one-size fits

all” approach to Muslim clients (Graham et al., 2010). However, the unanimous response of the study participants that their R/S supported their mental health confirms the importance of gaining understanding of the impact of R/S and exploring how such knowledge can be incorporated to promote culturally competent social work and mental health services.

Findings

Social Support

While the quantitative data was inconclusive, the qualitative data showed strong connections between R/S and the increase in PFs among the study sample. With regard to social support, this study suggests that community support based on R/S is a critical piece of how Muslim women can strengthen their mental and emotional health. With these findings in mind, social workers should consider encouraging Muslim women to access these community based strengths (Hodge, 2005; Graham et al., 2010). For instance, if women are trying to build on their R/S and they attend a masjid or community center that they find unwelcoming, it can be recommended that they try another place given that there are significant differences between organizations. Not all Muslims, particularly recent immigrants, may be aware of the variety of options (Hodge, 2005).

Even with the potential benefits derived from community support, social workers should be prepared to support their clients if they encounter some of the problems that study participants described, including challenges with being a woman in the masjid, cultural and ethnic divisions and idiosyncrasies, and the stigma and lack of information about Western approaches to mental health. The women in the study gave many recommendations on how to best approach these challenges. Women’s advisory boards, more women teachers, and improved spaces for women in the masjids were just some of these suggestions. Women also asked for greater education and support to their local imams and community leaders in order to facilitate both the exchange of information between Muslims and the greater community and more effective intra-community support. Overall, findings point to the importance of building connections between mental health professionals and religious organizations in the community as a key component in supporting Muslim clients to access resources in the community that they can utilize to their advantage (Graham et al., 2009). Many of these changes are already being implemented in the Bay Area in a variety of ways, and have already been identified as needs in larger studies such as the one conducted by Senzai and Bazian (2010) and in other literature (Canda & Furman, 2009).

Self-Esteem

The finding that suggest that R/S are associated with high levels of self-esteem for Muslim women provides modest support for previous research. Combined with the knowledge that self-esteem is positively correlated with mental health, this information could lead to a number of interventions. Cognitive behavioral therapy (CBT) has been shown to improve mental health through improving self-talk and ways of perceiving the world. Spiritually informed CBT is an approach that modifies traditional CBT in culturally sensitive ways to utilize the strong positive messages of R/S in reframing cognitions of the self. Modifying CBT to fit with Islamic worldviews has been found to have positive outcomes for treating depression, anxiety, and psychosis (Hodge & Nadir, 2008). In order help clients formulate positive cognitions necessary for spiritual CBT it is important that clinicians familiarize themselves with the basics of the religion. This approach requires a commitment on the part of the clinician to have a genuine understanding of Islamic beliefs and tenets so that the intervention is not superficial and therefore ineffective (Hodge & Nadir, 2008; Rahiem & Hamada, 2012). In order to do this, clinicians could talk with a local imam (Hodge & Nadir, 2008) or attend classes or events at local masjids. It is also significant to note that in a study of Muslim social workers El-Amin (2009) found that 10 of 15 Muslim social workers in the study believed it to be inappropriate to broach the topic of spirituality with their clients unless it was "client-directed" or "client-initiated." This finding indicates the importance of being tactful and sensitive to client needs when dealing with the topic of R/S.

Emotional Health

The main findings on emotional health also suggest the importance of culturally informed interventions, including the findings that R/S enhance participants' sense of patience in face of adversity, and the importance of gratitude and prayer. Mental health professionals should consider supporting clients to access their R/S as a tool to cultivate emotional health, happiness, life satisfaction and a sense of meaning and purpose. The participants' responses highlight the possibility that religious coping with spiritual distress can lead to greater levels of well-being (Canda & Furman, 2009). The findings suggest that prayer might also help with maintaining emotional health through reducing stress and elevating mood. As an intervention, clinicians can discuss prayer with clients, and ask them how and if they are already using prayer. This also suggests the importance for organizations and individual clinicians to make a safe space for Muslim clients to say their five daily prayers. Many settings, especially low-income settings such as homeless shelters or mental health rehabilitation

centers, do not provide this space, especially when clients do not have a private room.

The importance of R/S to social support, self-esteem, and emotional health indicates that creating an environment which reflects spiritual competence could contribute to the well-being of Muslim clients (Rahiem & Hamada, 2012). Spiritually competent work can be defined as work that supports clients' ability to access their R/S as therapeutic tools and as valuable cultural capital. Just as a basic understanding of Islam is central to using spiritually modified CBT, understanding Islam is vital for having a positive therapeutic relationship with Muslim clients, both at the individual level and the agency level.

Negative mental health outcomes due to discrimination and negative stereotypes in the U.S. have increased in the current climate of hostility to Muslims (Hodge et al, 2015). In spite of all the negative stereotypes of the impact of Islam on Muslim women, this study showed a relationship between factors that support good mental health and R/S among Muslim women. This finding should encourage providers who do not already understand the positive elements of Islam to reject negative Islamophobic depictions of the religion, have an open mind about what it means to be Muslim, and to encourage Muslim clients to practice their religion (Graham et al., 2009). This may require self-reflection, journaling, and discussion of inclusivity to work through the societally imposed stereotypes of what Islam is and who Muslims are (Canda & Furman, 2009).

Limitations

The most predominant limitation that is frequently a part of qualitative research is that samples are often convenience samples, the small size of samples, and the fact that samples are often non-representative. These limitations were all present in this study. Thus, findings must be regarded situationally rather than globally. Another significant limitation of this study is the fact that due to the design of the study the findings are all merely perceptions of how R/S are PFs, and do not further elucidate the ongoing question of whether R/S function as moderating or mediating PFs (Fabricatore et al, 2004; Szymanski & Obiri, 2011). Resolving this will require more complex studies that investigate this question more fully. Another important question is if R/S are in fact PFs at all or if confounding factors in this study are responsible for the beneficial effects attributed to R/S by the participants. Additionally, this would likely be best done with quantitative methods that are not engaged in the current report.

Implications for Promoting Respect and Inclusion of Muslim Culture

The findings in this and other studies of R/S as protective factors for mental health point to the importance of support for the R/S of Muslim women from

non-Muslim men and women (Abdullah, 2015; Rahiem & Hamada, 2012). The evidence that Muslim women, when asked, describe the many positive benefits of Islam on their lives contradicts the historical and current use of Muslim women's oppression as a justification for anti-Muslim laws, policies, and attitudes (Ebrahimji & Suratwala, 2011; Haddad et al., 2006). Muslim women are precariously situated between their oppression by the non-Muslim Islamophobic West and the patriarchal oppression experienced by women in Islam, an oppression that is present in every culture and religion on the planet (Abdullah, 2015; Haddad et al., 2006). It is essential to respect Muslim women's right to exist as individuals, separate from the constant demand to denounce terrorism. The overall process and agenda of confronting anti-Muslim narratives is incumbent upon all responsible members of the community, a part of strengthening our society and our nurturing our shared values as Americans (Senzai & Bazian, 2010).

The current study suggests the potential value of further research on the protective effects of R/S on Muslim women's mental health, and mental health in general. Further research could focus on how R/S promote mental health in a variety of areas, including contributing to beneficial social support, improving self-esteem through positive reinforcement of self-worth, and supporting emotional health. Studies focusing on women who practice Islam from a variety of backgrounds, educational levels, economic levels, and levels of acculturation are crucial for increasing our knowledge of how R/S buffers from risk and functions as a PF.

References

- Abdel-Khalek, A. (2006). Happiness, health, and religiosity: Significant relations. *Mental Health, Religion & Culture*, 9(1), 85-97. <https://doi.org/10.1080/13694670500040625>
- Abdel-Khalek, A. (2011). Religiosity, subjective well-being, self-esteem, and anxiety among Kuwaiti Muslim adolescents. *Mental Health, Religion & Culture*, 14(2), 129-140. <https://doi.org/10.1080/13674670903456463>
- Abdel-Khalek, A. & Lester, D. (2013). Mental health, subjective well-being, and religiosity: Significant associations in Kuwait and USA. *Journal of Muslim Mental Health*, 7(2). <https://doi.org/10.3998/jmmh.10381607.0007.204>
- Abdel-Khalek, A., & Naceur, F. (2007). Religiosity and its association with positive and negative emotions among college students from Algeria. *Mental Health, Religion & Culture*, 10(2), 159-170. <https://doi.org/10.1080/13694670500497197>
- Abdullah, S. (2015). An Islamic perspective for strengths-based social work with Muslim clients. *Journal of Social Work Practice*, 29 (2), 163-172. <https://doi.org/10.1080/02650533.2014.956304>
- Aflakseir, A. (2012). Religiosity, personal meaning, and psychological well-being: A study among Muslim students in England. *Pakistan Journal of Social and Clinical Psychology*, 9(2), 27-31.

- Ahmed, S., & Reddy, L. (2007). Understanding the mental health needs of American Muslims: Recommendations and considerations for practice. *Journal of Multicultural Counseling and Development*, 35(4), 207-218. <https://doi.org/10.1002/j.2161-1912.2007.tb00061.x>
- Ahn, S., Kim, S., Zhang, H., Ory, M., & Smith, M. (2017). Changes in depressive symptoms among older adults with multiple chronic conditions: Role of positive and negative social support. *International Journal of Environmental Research and Public Health*, 14(1), 16. <https://doi.org/10.3390/ijerph14010016>
- Al-Khandari, Y. (2011). Religiosity, social support, and health among the elderly in Kuwait. *Journal of Muslim Mental Health*, 6(1) 81-98. <https://doi.org/10.3998/jmmh.10381607.0006.106>
- Al-Krenawi, A., & Graham, J. (1999). Social work and Koranic mental health healers. *International Social Work*, 42(1), 53-65. <https://doi.org/10.1177/002087289904200106>
- Amer, M., & Bagasra, A. (2013). Psychological research with Muslim Americans in the age of Islamophobia: Trends, challenges, and recommendations. *American Psychologist*, 68(3), 134-144. <https://doi.org/10.1037/a0032167>
- Andermann, L. (2010). Culture and the social construction of gender: Mapping the intersection with mental health. *International Review of Psychiatry*, 22(5), 501-512. <https://doi.org/10.3109/09540261.2010.506184>
- Awaad, R., & Ali, S. (2015). Obsessional disorders in Al-Balkhi's 9th century treatise: Sustenance of the body and soul. *Journal of Affective Disorders*, 180, 185-189. Retrieved from: <http://dx.doi.org.proxylib.csueastbay.edu/10.1016/j.jad.2015.03.003>
- Awaad, R., & Ali, S. (2016). A modern conceptualization of phobia in Al-Balkhi's 9th century treatise: Sustenance of the body and soul. *Journal of Anxiety Disorders*, 37, 89-93. <https://doi.org/10.1016/j.janxdis.2015.11.003>
- Barlas, A. (2002) *Believing women in Islam: Unreading patriarchal interpretations of the Qur'an*. Austin, Texas: University of Texas Press.
- Billings, A., & Moos, R. (1982). Social support and functioning among community and clinical groups: A panel model. *Journal of Behavioral Medicine*, 5, 295-311. <https://doi.org/10.1007/BF00846157>
- Bjorck, J. P. & Maslim, A. A. (2011). The Multi-Faith Religious Support Scale: Validation with a sample of Muslim women. *Journal of Muslim Mental Health*, 6 (1), 62-80. <https://doi.org/10.3998/jmmh.10381607.0006.105>
- Canda, E., Furman, L. (2009). *Spiritual diversity in social work practice: The heart of helping*. Oxford; Oxford University Press.
- Charmaz, K. (2006). *Constructing Grounded Theory; A practical guide through qualitative analysis*. Thousand Oaks, CA: Sage Publications.
- Cohen, S., & Schneiderman, N. (1988). Psychosocial models of the role of social support in the etiology of physical disease. *Health Psychology*, 7(3), 269-297. <https://doi.org/10.1037/0278-6133.7.3.269>
- Commerford, M., & Reznikoff, M. (1996). Relationship of religion and perceived social support to self-esteem and depression in nursing home residents. *Journal of Psychology*, 130(1), 35. <https://doi.org/10.1080/00223980.1996.9914986>
- Crawford, M., Handal, P., & Wiener, R. (1989). The relationship between religion and mental health/distress. *Review of Religious Research*, 31(1), 16-22. <https://doi.org/10.2307/3511020>
- Creswell, J.W. (2013). *Qualitative inquiry and research design: Choosing among five approaches*. Thousand Oaks, CA: Sage Publications.
- Dailey, D. E. & Stewart, A. L. (2007), Psychometric characteristics of the spiritual per-

- spective scale in pregnant African-American women. *Research in Nursing and Health*, 30, 61–71. <https://doi.org/10.1002/nur.20173>
- Denzin, N.K. & Lincoln, Y.S. (2005). *The Sage handbook of qualitative research*, Third Edition. Thousand Oaks, CA: Sage Publications.
- Diener, E. (2012). New findings and future directions for subjective well-being research. *American Psychologist*, 67(8), 590–597. <https://doi.org/10.1037/a0029541>
- Diener, E., Diener, M., & Geen, R. (1995). Cross-cultural correlates of life satisfaction and self-esteem. *Journal of Personality and Social Psychology*, 68(4), 653–663. <https://doi.org/10.1037/0022-3514.68.4.653>
- Dolan, P., Peasgood, T., & White, M. (2008). Do we really know what makes us happy? A review of the economic literature on the factors associated with subjective well-being. *Journal of Economic Psychology*, 29(1), 94–122. <https://doi.org/10.1016/j.joep.2007.09.001>
- Drabble, L., Trocki, K., & Klinger, J. (2016). Religiosity as a protective factor for hazardous drinking and drug use among sexual minority and heterosexual women: Findings from the National Alcohol Survey. *Drug and Alcohol Dependence*, 161, 127–134. <https://doi.org/10.1016/j.drugalcdep.2016.01.022>
- Ebrahimji, M. M. & Suratwala, Z. T. (Eds.). (2011). *I speak for myself*. Ashland OR: White Cloud Press.
- El-Amin, C. (2009). *Personal and professional spirituality: Muslim social workers' perspectives* (Order No. 3366969). ProQuest Dissertations & Theses Global: The Humanities and Social Sciences Collection. (305078746). Retrieved from <http://proxylib.csueastbay.edu/login?url=http://search.proquest.com.proxylib.csueastbay.edu/docview/305078746?accountid=28458>
- Ellison, C., Boardman, J., Williams, D., & Jackson, J. (2001). Religious involvement, stress, and mental health: Findings from the 1995 Detroit area study. *Social Forces*, 80(1), 215–249. <https://doi.org/10.1353/sof.2001.0063>
- Epstein, N. (2011). Anti-Muslim discrimination in post 9/11 America. *Moment*, 36(2), 52.
- Fabricatore, A.N., Handal, P. J., Rubio, D. M., & Gilner, F. H. (2004). Stress, religion, and mental health: Religious coping in mediating and moderating roles. *International Journal for the Psychology of Religion*, 14(2), 91–108. https://doi.org/10.1207/s15327582ijpr1402_2
- George, L. K., Larson, D. B., Koenig, H. G., & McCullough, M. E. (2000). Spirituality and health: What we know, what we need to know. *Journal of Social and Clinical Psychology*, 19, 102–116. <https://doi.org/10.1521/jscp.2000.19.1.102>
- Ghaffari, A., & Çiftçi, A. (2010). Religiosity and self-esteem of Muslim immigrants to the U.S.: The moderating role of perceived discrimination. *International Journal for the Psychology of Religion*, 20(1), 14–25. <https://doi.org/10.1080/10508610903418038>
- Graham, J., Bradshaw, C., & Trew, J. (2009). Adapting social work in working with Muslim clients. *Social Work Education*, 28(5), 544–561. <https://doi.org/10.1080/02615470802400729>
- Graham, J., Bradshaw, C., & Trew, J. (2010). Cultural considerations for social service agencies working with Muslim clients. *Social Work*, 55(4), 337–346. <https://doi.org/10.1093/sw/55.4.337>
- Grothaus, T., McAuliffe, G., & Craigen, L. (2012). Infusing cultural competence and advocacy into strength-based counseling. *Journal of Humanistic Counseling*, 51(1), 51–65. <https://doi.org/10.1002/j.2161-1939.2012.00005.x>
- Haber, J. R., Grant, J. D., Jacob, T., Koenig, L. B., & Heath, A. (2012). Alcohol milestones,

- risk factors, and religion/spirituality in young adult women. *Journal of Studies on Alcohol and Drugs*, 73(1), 34-43. <https://doi.org/10.15288/jsad.2012.73.34>
- Haddad, Y. Y., Smith, J. I., & Moore, K. M. (2006). *Muslim women in America: The challenge of Islamic identity today*. New York: Oxford University Press. <https://doi.org/10.1093/acprof:oso/9780195177831.001.0001>
- Hammersley, M & Atkinson, P. (1990). *Ethnography; Principles in practice*. New York, NY: Routledge.
- Hartman, J. L., Turner, M. G., Daigle, L. E., Exum, M. L., & Cullen, F. T. (2009). Exploring the gender differences in protective factors: Implications for understanding resiliency. *International Journal of Offender and Comparative Criminology*, 53(3), 249-277. <https://doi.org/10.1177/0306624X08326910>
- Hill, P., Pargament, K., Hood, R., McCullough, J., Swyers, J., Larson, D. B., & Zinnbauer, B. J. (2000). Conceptualizing religion and spirituality: Points of commonality, points of departure. *Journal for the Theory of Social Behavior*, 30(1), 51-77. <https://doi.org/10.1111/1468-5914.00119>
- Hodge, D. (2005). Social work and the house of Islam: Orienting practitioners to the beliefs and values of Muslims in the United States. *Social Work*, 50(2), 162-173. <https://doi.org/10.1093/sw/50.2.162>
- Hodge, D. R., Moser, S. E., & Shafer, M. S. (2013). Spirituality and mental health among homeless mothers. *National Association of Social Workers*, 245-255. <https://doi.org/10.1093/swr/svs034>
- Hodge, D., & Nadir, A. (2008). Moving toward culturally competent practice with Muslims: Modifying cognitive therapy with Islamic tenets. *Social Work*, 53(1), 31-41. <https://doi.org/10.1093/sw/53.1.31>
- Hodge, D. R., Zidan, T., & Husain, A. (2015) Modeling the relationships between discrimination, depression, substance use, and spirituality with Muslims in the U.S. *Social Work Research Advance Access*. <https://doi.org/10.1093/swr/svv025>
- Hodge, D. R., Zidan, T. R., Husain, A., & Hong, P. Y. P. (2015) Correlates of self-rated health among Muslims in the U.S. *Families in Society: The Journal of Contemporary Social Services*, 96(4) 284-291. <https://doi.org/10.1606/1044-3894.2015.96.33>
- Hodge, D., Zidan, T., & Husain, A. (2016a). Depression among Muslims in the U.S.: Examining the role of discrimination and spirituality as risk and protective factors. *Social Work*, 61(1), 45. <https://doi.org/10.1093/sw/swv055>
- Hodge, D., Zidan, T., & Husain, A. (2016b). Developing a model of wellness among Muslims: Examining the role of spirituality. *The British Journal of Social Work*, 46(6), 1671-1689. <https://doi.org/10.1093/bjsw/bcv099>
- Hovey, J., Morales, L., Hurtado, G., & Seligman, L. (2014). Religion-based emotional social support mediates the relationship between intrinsic religiosity and mental health. *Archives of Suicide Research*, 18(40), 376-391. <https://doi.org/10.1080/13811118.2013.833149>
- Hyder, N., Parrington, C., & Hussain, M. (2015). Experiences of hijabi women: Finding a way through the looking glass for Muslim Americans. *Advancing Women in Leadership*, 35, 172-177. <http://advancingwomen.com/awl/awl-wordpress/>
- Jasperse, M., Ward, C., & Jose, P. (2012). Identity, perceived religious discrimination, and psychological well-being in Muslim immigrant women. *Applied Psychology*, 61(2), 250-271. <https://doi.org/10.1111/j.1464-0597.2011.00467.x>
- Joshanloo, M., & Afshari, S. (2011). Big five personality traits and self-esteem as predictors of life satisfaction in Iranian Muslim university students. *Journal of Happiness Studies*, 12(1), 105-113. <https://doi.org/10.1007/s10902-009-9177-y>

- Joshanloo, M., & Daemi, F. (2015). Self-esteem mediates the relationship between spirituality and subjective well-being in Iran. *International Journal of Psychology*, 50(2), 115-120. <https://doi.org/10.1002/ijop.12061>
- Kakoti, S. A. (2012). Arab American women, mental health, and feminism. *Journal of Women and Social Work*, 27(1), 60-70. <https://doi.org/10.1177/0886109912437572>
- Khamis, V. (2014). Gender responses to psychological distress among Palestinians: Risk and PFs. *British Journal of Psychology*, 105(3), 338-351. <https://doi.org/10.1111/bjop.12036>
- Khan, Z., Watson, P., Naqvi, A., Jahan, K., & Chen, Z. (2015). Muslim experiential religiousness in Pakistan: Meaning in life, general well-being and gender differences. *Mental Health, Religion & Culture*, 18(6), 1-10. <https://doi.org/10.1080/13674676.2015.1079602>
- Koenig, H. G., Larson, D. (2001). Religion and mental health: Evidence for an association. *International Review of Psychiatry*, 2001, 13(2), 67-78. <https://doi.org/10.1080/09540260124661>
- Koenig, H. G., & Shohaib, S. A. (2014). *Health and well-being in Islamic societies: Background, research, and applications*. New York, NY: Springer. <https://doi.org/10.1007/978-3-319-05873-3>
- Larson, D., & Larson, S. (2003). Spirituality's potential relevance to physical and emotional health: A brief review of quantitative research. *Journal of Psychology and Theology*, 31(1), 37-51. <https://doi.org/10.1177/009164710303100104>
- Lewis, C., & Cruise, S. (2006). Religion and happiness: Consensus, contradictions, comments and concerns. *Mental Health, Religion & Culture*, 9(3), 213-225. <https://doi.org/10.1080/13694670600615276>
- Luthar, S. S., Cicchetti, D., & Becker, B. (2000). The construct of resilience: A critical evaluation and guidelines for future work. *Child Development*, 71(3), 543-562. <https://doi.org/10.1111/1467-8624.00164>
- Mernissi, F. (1991) *The veil and the male elite: A feminist interpretation of the rights of women in Islam*. New York: Basic Books.
- Moghissi, H. (1999) *Feminism and Islamic fundamentalism*. New York: Zed Books.
- Mohr, S. (2010). Building an Islamic feminism: Contrasting Beauvoir and the work of Amina Wadud. *Journal of Interreligious Dialogue Website*. <http://irdialogue.org/journal/issue03/building-an-islamic-feminism-contrasting-beauvoir-and-the-work-of-amina-wadud-by-sarah-mohr/>
- Mussap, A. J. (2009) Strength of faith and body image in Muslim and non-Muslim women. *Mental Health, Religion, and Culture*, 12(2), 121-127. <https://doi.org/10.1080/13674670802358190>
- Odems-Young, A. (2008) Factors that influence body image representations of black Muslim women. *Social Science and Medicine*, 66(12), 2573-2584. <https://doi.org/10.1016/j.socscimed.2008.02.008>
- Oxhandler, H., & Pargament, K. (2014). Social work practitioners' integration of clients' religion and spirituality in practice: A literature review. *Social Work*, 59(3), 271-279. <https://doi.org/10.1093/sw/swu018>
- Patel, V., & Goodman, A. (2007). Researching protective and promotive factors in mental health. *International Journal of Epidemiology*, 36(4), 703-707. <https://doi.org/10.1093/ije/dym147>
- Rahiem, F. T., & Hamid, H. (2012) "Mental health interview and cultural formulation." Amer, M., & Ahmed, S. (Eds.) *Counseling Muslims: Handbook of mental health issues and interventions*, (Chapter 4). Retrieved from: <http://web.a.ebscohost.com.proxylib.csueastbay.edu/ehost>

- Rowold, J. (2011). Effects of spiritual well-being on subsequent happiness, psychological well-being, and stress. *Journal of Religion and Health*, 50(4), 950-963. <https://doi.org/10.1007/s10943-009-9316-0>
- Sayeed, A. (2002). "Chappals and gym shorts: An Indian Muslim woman in the land of Oz." *Colonize This! Young women of color on today's feminism*. D. Hernandez & B. Rehman (Eds.), Berkeley, CA: Seal Press.
- Seligman, M. P., & Csikszentmihalyi, M. (2000). Positive psychology: An introduction. *American Psychologist*, 55(1), 5-14. <https://doi.org/10.1037/0003-066X.55.1.5>
- Senzai, F., & Bazian, H. (2010). The Bay Area Muslim study: Establishing identity and community. Executive Summary. *Institute for Social Policy and Understanding. One Nation Bay Area*. Retrieved from: https://www.academia.edu/6974419/Bay_Area_Muslim_Study_Executive_Summary
- Seybold, K., & Hill, P. (2001). The role of religion and spirituality in mental and physical health. *Current Directions in Psychological Science*, 10(1), 21-24. <https://doi.org/10.1111/1467-8721.00106>
- Sherkat, D., & Reed, M. (1992). The effects of religion and social support on self-esteem and depression among the suddenly bereaved. *Social Indicators Research*, 26(3), 259-275. <https://doi.org/10.1007/BF00286562>
- Shumaker, S., & Hill, D., (1991). Gender differences in social support and physical health. *Health Psychology*, 10(2), 102-111. <https://doi.org/10.1037/0278-6133.10.2.102>
- Smith, T., McCullough, M., Poll, J., & Cooper, H. (2003). Religiousness and depression: Evidence for a main effect and the moderating influence of stressful life events. *Psychological Bulletin*, 129(4), 614-636. <https://doi.org/10.1037/0033-2909.129.4.614>
- Smolak, A., Gearing, R. E., Alonzo, D., Baldwin, S., Harmon, S., & McHugh, K. (2013). Social support and religion: Mental health service use and treatment of schizophrenia. *Community Mental Health Journal*, 49(4), 444-450. <https://doi.org/10.1007/s10597-012-9536-8>
- Szymanski, M., & Obiri, O. (2011). Do religious coping styles moderate or mediate the external and internalized racism-distress links? *Counseling Psychologist*, 39(3), 438-462. <https://doi.org/10.1177/0011000010378895>
- Ungar, M. (2011). The social ecology of resiliency: Addressing contextual and cultural ambiguity of a nascent construct. *American Journal of Orthopsychiatry*. 81(1), 1-17. <https://doi.org/10.1111/j.1939-0025.2010.01067.x>
- Ungar, M. (2013). Resilience, trauma, context, and culture. *Trauma, Violence, & Abuse*, 14(3), 255-266. <https://doi.org/10.1177/1524838013487805>
- Vieten, C., Scammell, S., Pilato, R., Ammondson, I., Pargament, K., Lukoff, D. (2013). Spiritual and religious competencies for psychologists. *Psychology of Religion and Spirituality*, 5(3), 129-144. <https://doi.org/10.1037/a0032699>
- Wadud, A. (1999). *Qur'an and Woman: Rereading the sacred text from a woman's perspective*. New York: Oxford University Press.
- Wadud, A. (2006) *Inside the Gender Jihad: Women's reform in Islam*. Oxford, England: One World Publications.
- Yaqoob, S. (2008). Muslim women and the war on terror. *Feminist Review*, 88(1), 151-161. <https://doi.org/10.1057/palgrave.fr.9400382>