Perceived Discrimination, Its Impact on Health, and the Influence of Identity Among Western Muslims

Arvin Bolouri

Autumn 2022

Oslo Metropolitan University

Faculty of Social Science

Abstract

The purpose of this literature review is to contribute to a better understanding of the role played by perceived ethnic and religious discrimination on health among Muslims living in the West. It is also an important goal to investigate how the moderating role of identity influences this association. Through a search process in relevant electronic databases, I have identified and selected 15 papers which address the confluence of these issues. I use social identity theory and the acculturation model as the theoretical foundations to explore the ways in which perceived discrimination affects health. The findings of this thesis, which are meta-findings from the 15 papers, heavily indicate that perceived discrimination predicts detrimental health outcomes among Muslims in the West, especially in relation to psychological health. In addition, the findings also suggest that the type of discrimination (i.e., individual or group-level) is important, because different types may have unique effects on identification processes and health effects. Moreover, the findings reveal that identity moderates the relationship between experienced discrimination and health outcomes. Specifically, I have found six major thematic clusters of identity that influence this association. These are: self-esteem, ethnic identity, religious identity, national identity, gender, and generation.

Acknowledgements

First of all, I would like to thank my supervisor Kjetil Wathne for his guidance. I would not have been able to complete this thesis without his valuable advice. I also want to thank my family and friends for their support throughout my entire life. Their motivational aid has been invaluable. In addition, I would like to mention that the topic of discrimination on minority groups is something I have always been genuinely interested in, and I am very happy that I have had the opportunity to delve into it and discuss its implications for health outcomes.

Table of Contents

1. Introduction

In the context of this thesis, the term Western world or Western countries involves most of the European countries, the United States of America, New Zealand, Australia and Canada. An increasing number of Muslims are residing in the West. Many of these Muslims are migrants, with their own set of ethnic and religious cultures and norms. Anti-Muslim discourse has also been on the rise, especially since the events of the 9-11 terrorist attacks. This has led to many Muslims experiencing discrimination. This may especially be the case for Muslims with high levels of visibility, who are easily identifiable. Discrimination has been linked to detrimental physical and mental health outcomes. There are different types of discrimination, but the two most common ones are individual-level and group-level discrimination. The term 'perceived' is important in relation to discrimination because what is interpreted as discrimination is influenced by who is being asked. Many immigrants, including Muslims, may have a hard time adapting to a new social environment as a result of perceiving that their ethnic and/or religious cultures are not compatible with that of Westerners'. This may especially be true for second generation Muslims, who might experience the need to negotiate multiple issues pertaining to identity processes, as well as the need to combine feelings of belonging to their ethnic and religious community with those to the host country (i.e., the society to which migrants are moving). Finally, ethnic and religious identity has been shown to be important aspects in the life of many Muslims, while also being linked to perceived discrimination and health.

1.1. Research Focus

The purpose of this thesis is to explore research in the field of perceived ethnic and religious discrimination and its effects on health outcomes among Muslims living in Western countries. It is also an important goal to explore the role of identification and acculturation in the ways discriminatory practices affect health. In specific terms, this is a literature review with a focus on these core concepts. Importantly, I have looked for papers that are relevant to my research questions - the research questions themselves did not emerge from my material. Moreover, I mainly rely on psychological research to contribute answer to the research questions, because many of the empirical studies identified belong in this domain. Through a search process in relevant electronic databases, I have identified and selected 15 research articles, which address the field of research where these issues converge. The main keywords used in combination with each other in this search were: perceived Muslim discrimination, health outcomes and identity. The empirical studies were selected because they all have in

common of exploring the detrimental health effects of perceived discrimination on one or more groups of Western Muslims, most of them also including the moderating influence of identity processes. They also all have in common of using quantitative methodologies.

The findings of this thesis, which are meta-findings from the 15 papers, revolve around the effects of perceived discrimination as a direct negative impact on physical and psychological health outcomes. This association varies as a result of identity. Specifically, I have found six major thematic clusters of identity in these studies which enlighten my research questions, and which I discuss as my findings. These are: gender, generation, self-esteem, ethnic identity, religious identity and national identity. Using this type of information, I am positioned to bring issues surrounding perceived Muslim discrimination to light. This thesis also contributes to the debate concerning whether certain dimensions of social identity are protective or harmful in the association between perceived discrimination and health outcomes. In addition, an understanding of Muslim discriminatory experiences may inform better clinical practice in multi-ethnic and multi-religious societies.

In this thesis, I will explore the following research questions: How does perceived ethnic and religious discrimination affect the health of Western Muslims, and is there a moderating role of identity in this association? It is important to mention that while Muslim identity can be analysed in individual terms, such as: ethnicity, nationality, culture, and religion, none of these labels by themselves appears to capture its essence adequately (Jasperse et al., 2012). After all, many authors have noted that the demarcation between ethnic and religious identity is 'blurred', stating that these identity dimensions are positively intertwined for both first generation and second generation immigrants (e.g., Duderija, 2008; Güngör et al., 2011). In addition, being a part of a social group, such as a religion or ethnic community, has an impact on the health of individuals through their capacity to be internalised as part of a person's social identity (Haslam et al., 2009). Social groups that provide individuals with a sense of meaning, purpose, and belonging (i.e., a positive sense of social identity) tend to have more positive health consequences associated with them. Therefore, in this thesis, I make use of social identity theory and the acculturation model as my main theoretical frameworks in order to better understand the multi-dimensional nature of Muslim identity and its relation to perceived discrimination and health outcomes.

In the following three sections, I provide a background in the field of perceived discrimination, what is known about its effects on health, and the influence of identity. Since

many of the Muslims in the empirical studies are migrants, it is important to first say something about what this entails.

1.2. Migration, Muslims and Conflict

The world is increasingly becoming more globalized. Although there are numerous ways to define globalisation, it can be described as the movement of people, goods, services, and ideas across a widening set of countries (Goldin & Mariathasan, 2014). This global movement affects everyone on the planet, including people in the most remote communities. One of the consequences is that immigration takes place on a larger scale than before. Individuals may migrate for a number of reasons. For instance, some migrate to more economically developed countries in search of a better quality of life; some travel in order to achieve a better education; some for better work opportunities; some migrate because of their families and partners; and some migrate to escape war and persecution (Chan, 2014). This has contributed to the rapid expansion of urbanization, which involves that many people of different ethnic and religious backgrounds, including Muslims, now live in cities and interact with each other on a daily basis.

Western Muslims are a diverse and heterogeneous group with origins in many different countries (Pew Research Center, 2017, 2018). They are also one of the largest immigration groups in the Western world. Specifically, in both Europe and the United States, their population growth is expected to increase significantly in the coming decades. Furthermore, in the early 1990s after the cold war, it has been argued that the West was in need of a new public enemy, and research has shown that Muslims gradually took that place (Fangen, 2021). But the events that really led to widespread and generalizing anti-Muslim discourse were the September 11 and subsequent radical Islamist terrorist attacks. People with anti-Islamic views wish to restrict Muslim immigration and Islamic religious practices. In this context, Islam is considered to be a homogenous and totalitarian ideology that threatens to destroy Western civilization. Specifically, the fact that some Muslims are extremists and perpetrate terrorist acts is generalized to encourage an attitude that Islam in general represents a threat. Furthermore, some extremists believe that Islam is slowly taking hold in European societies and replacing the secular and Christian values present there. According to such theories, Muslims in Europe have a hidden agenda where they will gradually seize political power on the continent. Fears also include that the white population will die out over time and be replaced by Muslims. The 2011 terror attacks in Norway is an example of such fearmongering, where the perceived Islamization of Europe was among several ideological

motives behind the terrorist's bombing of the government quarter in Oslo, and the shootings of young people on the island of Utøya.

Berry, a known acculturation researcher, has argued that immigrants are not as well-respected nor trusted compared to ethnically born individuals in the West (Berry, 1997; Berry et al., 2006). Studies carried out in the last decades, primarily in countries with long and established traditions of immigration (e.g., USA, Canada), have documented the complex and multifaceted struggles and challenges faced by immigrants and their descendants. For these reasons and more, Muslims have become one of the most discriminated against groups in Western countries, as anti-Islam views have gradually become more prominent (Fangen, 2021; Ocampo et al., 2018). For instance, the European Union Agency For Fundamental Rights [FRA] surveyed over 10500 Muslims residing in Europe and found that 39% of them had felt discriminated against as a result of their ethnic and/or religious background, among other grounds (FRA, 2017). Specifically, 17% of the Muslim respondents indicate having experienced discrimination on grounds of religion, which is a marked increase compared with 10% in their previous report (FRA, 2010). Similarly, the Council on American Islamic Relations [CAIR] has reported a 60% increase in discriminatory anti-Muslim incidents in the US since 2016 (CAIR, 2018).

1.3. Perceived Discrimination and Health

Discrimination can be defined as beliefs, attitudes, institutional arrangements, and behaviours that tend to deny equal treatment to individuals or groups based on racial characteristics or group affiliation (Clark et al., 1999). Discrimination may be conveyed in many forms based on ethnicity, race, and religious membership (Brittian et al., 2015; Lee, 2003). In the vast majority of the literature, discrimination has been robustly associated with poor health outcomes for minority groups (e.g., Bhui et al., 2005). Other factors, such as limited language experience, marginalized cultural identity, lack of opportunity to utilize skills and knowledge, trauma experienced prior to migration, and a highly stressful process of adjustment, have also been shown to have adverse health consequences for migrants, including for many Muslims in Western countries (Abbott, 2016; Liddell et al., 2016; Minas et al., 2013). While a vast majority of the literature suggests that minority groups are at higher risk of experiencing discrimination and detrimental health effects, there are some studies that indicate the opposite to be true. According to these studies, stigmatised group members frequently exhibit greater levels of psychological well-being than members of non-stigmatized groups (e.g., Crocker & Major, 1989).

Modern research considers discrimination to be multidimensional, including but not limited to interpersonal (i.e., individual), institutional, and systemic (i.e., group) levels (Jones, 1997; Sarwar, 2020). Interpersonal discrimination occurs between people (e.g., treating another person unfairly due to the social category to which he or she belongs, such as the effects of facing verbal insults on the bus), whereas systemic or institutional discrimination entails societal influences (e.g., repetition of acts and unfavourable decisions toward a target group, such as being excluded by government policies; media representation of minorities in derogatory ways). In the literature of Muslim discrimination, it is common to primarily investigate individual-level discrimination, but group-level discrimination has also been increasingly explored although it has showed inconsistent results. In relation to religious group-level discrimination, which is an important element in this thesis, it is vital to mention that the theory of Islamophobia can be understood as indiscriminate negative attitudes or emotions directed at Islam or Muslims (Bleich, 2011). Discrimination can also be experienced as overt (i.e., explicit) or covert (i.e., implicit) (Sellers & Shelton, 2003). An example of overt discrimination could be name-calling or intimidation, while covert discrimination may occur in more subtle ways, such as not being served in a restaurant, or receiving increased attention from law enforcement.

The term 'perceived' is also important in relation to discrimination. Identity processes, such as having a strong ethnic or religious group identification (i.e., the subjective meaning of one's ethnicity or religion and the feelings that one maintains toward one's ethnic or religious group), are highly relevant to explain an individual's perception of a situation as discriminatory (Operario & Fiske, 2001). Estimates and measures of discrimination rely on people's subjective accounts of whether they have been the targets of prejudice (Deitch et al., 2003). What is interpreted as discrimination is influenced by who is being asked. Not all minority members may perceive a situation as discriminatory. For instance, a stranger may simply be curious and ask complex questions about an individual's religion, without having the intention of discriminating against him/her. However, this may reflect that much discrimination in contemporary society is covert, because openly denigrating minorities is incongruent with strongly advocated values of equality and is (in many Western countries) illegal (e.g., Dovidio, 2001).

1.4. Identity and Adaptation Challenges

It can be difficult for both Muslim and non-Muslim minority groups to acculturate (i.e., adapt) to a new society that has different cultural values than they are used to (Friedman

& Saroglou, 2010). Muslims who have been born and raised in the West may also have difficulty adapting to a Western society as a result of their multiple different identities, such as one's religion or ethnicity. Implicit in the act of discrimination is the devaluing of an aspect of a person's identity (Ellis et al., 2010), which may make the individual feel like they do not belong in the same group as the dominant society members, resulting in detrimental health consequences. One aspect of Muslim identity that has received attention in the West is the hijab, which involves the covering of Muslim women's head and body (Droogsma, 2007). Because of its highly public and visible nature, the hijab makes it so members of the host society can easily identify the wearer as a Muslim (Weinreich, 1983), and therefore increases the complexity of social identity in migrant Muslim women (Ajrouch & Kusow, 2007). For Muslim men, visible attributes are often long beards or kufis. For people with such visible attributes, the stigmatization of these features can provide a cognitive framework from which other people make assumptions about the person (e.g., Jones et al., 1984). The awareness that others judge us because of our visibility may influence our thoughts, feelings, and behaviour (Steele & Aronson, 1995). Importantly, visible minorities are believed to be at greater risk for mental health problems, particularly due to the stress of perceived discrimination linked to visibility (Ajrouch & Kusow, 2007).

Moreover, it is difficult for many Muslims to integrate into a new Western society, especially since the west emphasizes the notion of individualism rather than collectivism which is a central aspect for many countries in Asia (Schwartz et al., 2010). The former concept involves the idea that everyone should be able to manage on their own, independently of others, while the latter entails that people should always stay connected to their families and that there should constantly be made an attempt to increase and/or maintain the social status of the family. Since Muslims' religion and cultural values are different from those of the majority group in a Western society, many of them may experience feeling marginalized in relation to the majority group (Schwartz et al., 2009). Even when Muslims are fully integrated in a new society, and thus have knowledge of languages and cultural traditions between multiple countries, it is often expected of them by the public to be loyal to and identify with only one of the countries: either the country of origin or the country of residence (Maalouf, 2000). This presupposes that there is only one affiliation that really matters, a kind of fundamental truth about each individual, that is determined at birth, never to change thereafter. However, many Muslims disagree with this notion and do not think nor feel this way. Many of these people are second generation immigrants, defined as individuals born to

immigrant parents (Rippy & Newman, 2006). On the other hand, first generation immigrants are described as individuals born in a foreign country and whose parents were also foreign citizens or born in a foreign country (Hashemi et al., 2020).

While second-generation immigrants are often born and raised in the host country and primarily exposed to the host cultural environment during their formative years, there has been a growing concern about the role played by young Muslim generations in violent actions, such as riots and terrorist attacks in the West (Berry & Sabatier, 2010; Fine & Sirin, 2007; Pahl & Way, 2006; Umaña-Taylor, 2016). Indeed, it is often argued that news media discourse commonly associates Muslim people with such acts (e.g., Poole, 2011). This leads to a negative representation of Muslim individuals, which results in the legitimization of discrimination against Muslims. Discrimination is particularly salient during the developmental period of adolescence when youth are becoming more aware of power dynamics within social group structures through their interpersonal interactions with others. Violent actions may also be the result of second generation Muslims' need to negotiate multiple issues pertaining to identity processes, as well as the need to combine feelings of belonging to their ethnic and religious community with those to the host country. Furthermore, for many Muslim adolescents, their experience typically involves being name called, teased, and being excluded from peer groups (e.g., Verkuyten et al., 1997). For these reasons, concerns about the integration and psychological well-being of Muslim youth has also been on the rise (e.g., Berry et al., 2006).

1.5. Thesis Organization

Having introduced my thesis topic, research questions, and methodological approach, I will now present the layout of this paper. I first develop a theoretical framework focused on social identity theory and the acculturation model, and introduce how I use this to contribute to an understanding of perceived discrimination and health outcomes. I then present the literature review process, showing how I draw on 15 empirical studies to address the research questions. In the final section, I provide the main key results recurrent in my set of studies, discuss their implications, and provide some answers for the research questions I have set out to understand more about.

2. Theoretical Framework

While the detrimental implications of discrimination for health are clear, researchers have increasingly begun to examine the psychological processes underlying the relation between perceived discrimination and health outcomes. Two theoretical frameworks can

contribute to explain such an association: social identity theory expounded by Tajfel & Turner (e.g., Tajfel, 1974, 1982; Tajfel & Turner, 1979) and Berry's acculturation model (e.g., Berry, 1997). Research has shown that these two frameworks (among other constructs) are highly interrelated in the sense that they can be used in conjunction to help explain Muslims' discriminatory experiences and the associated negative health effects in Western contexts (e.g., Padilla & Perez, 2003; Chan, 2014; Schwartz et al., 2006). Moreover, among the 15 empirical studies examined, these two theoretical frameworks are commonly used as tools to understand these associations.

2.1. Social Identity Theory

Social identity theory (also known as 'SIT') has been important in explaining intergroup relations, which can help explain the contexts surrounding perceived discrimination. SIT is the basic starting point for many theories and models in the present field, and is important in relation to a lot of the empirical studies, and therefore I believe it is essential to introduce it first before delving into Berry's model of acculturation. Social identity theory (Tajfel, 1974, 1982) claims that people construct identities based on their knowledge of group memberships, and their affiliation to these groups determine in large part who they perceive they are and what actions they commit. In other words, SIT states that people think, feel, and act as members of collective groups. The theory was initially developed to better understand racism, prejudice, and discrimination, and it claimed that group-identification by itself could predict intergroup hostility. Such hostility involves aggressive behaviour or attitudes (e.g., discrimination) directed towards one or more members of an out-group (i.e., groups that an individual does not identify being a part of). These concepts are essential in relation to this thesis, in the sense that many Muslims may perceive to be a part of the same in-group (i.e., a group in which a person identifies being a member of), while experiencing being discriminated against by a majority out-group.

One of the important aspects of SIT involves a categorization process that individuals do on an everyday basis, something which Turner et al. (1987) has made into a related theory. Self-categorization means placing oneself as a member of a social category. For example, an individual might think of themselves to be a student at university, a Muslim in a mosque and a teenager among friends. Thus, self-categorization is a part of a person's self-concept. A self-concept involves how we as individuals perceive ourselves, and is influenced by our previous experiences in life and by the perceived evaluation of others (Rogers, 1959). More specifically, a self-concept is the set of cognitive representations a person holds about who

they are. Moreover, another related dimension is the concept of intersectionality, which involves the examination of race, gender, ethnicity, sexual orientation, and religion, amongst others, and how their combination can empower or oppress an individual's identity (Crenshaw, 1989). For instance, a Muslim that is also black, female and poor may experience more discrimination than someone that only belongs to one of these categories.

It is argued that intergroup conflict (e.g., discriminating against an out-group) makes it more likely for people who are members of opposing groups to behave toward each other as a function of their respective group memberships (e.g., a Muslim), rather than in terms of their individual characteristics (Tajfel & Turner, 1979). This highlights the centrality of group identification, as it shows that dominant society members may collectively perceive followers of Islam to be a threat, which could result in further discrimination against Muslims and negatively influence their health. Therefore, in this thesis, group identification processes (i.e., the in-group and out-group aspects of SIT) will be used to explore the ways in which Muslims identify with ethnic, religious and/or national (i.e., host country) groups, as these are often the three types of groups that they are regularly in contact with (or at least encounter) in Western societies. The concept of intersectionality will also be drawn upon because many Muslims may feel like they belong to multiple vulnerable categories of identity, which could have detrimental health implications.

According to Tajfel (1981), there are at least two main evolutionary reasons as to why humans construct social categories of themselves and other people. The first reason argues that it helps us by not wasting precious cognitive resources. It is easier for humans to automatically categorize people into certain social groups (and thus give them specific characteristics) than to consciously do this process for every person encountered. Additional details and information about the individuals involved are often neglected during this process. While such an automatic way of thinking is fast and effortless, it can in many cases bias our perspective because we tend to jump to conclusions based on limited information (World Bank, 2015). A common implication of this is confirmation bias, which is the tendency to automatically interpret information in ways that support our prior beliefs. People are often not rational when it comes to cognition. In everyday scenarios, we often rely on what we feel about a situation before we make a decision about what to do next. The second reason entails that social categories have a function of identification, where different groups are assigned separate values (Tajfel, 1981). This leads to an easier and faster distinction being made between in-group and out-group members. Specifically, people are able to identify other

individuals' key categories (e.g., gender, race, age) within milliseconds of meeting, and they are especially quickly able to recognize members of their own group (Fiske, 2000). In earlier time periods of human history, it was crucial to understand whom to trust and which other groups to be sceptical of. This was especially the case for groups of people that were perceived to be different from one another. Both of these evolutionary reasons are important in relation to the research questions. Specifically, since many Muslims (especially women) are highly visible, it can be easy for out-groups to automatically identify them as followers of Islam using minimal amounts of information processing.

SIT posits three fundamental assumptions about identity (Tajfel & Turner, 1979), all of which have important implications for this thesis' research questions. First of all, people want to perceive their own group as both different and better than other groups, as a way to maintain and increase their (collective) self-esteem (i.e., people strive to have a positive self-concept in order to feel better about themselves). Specifically, Luhtanen & Crocker (1990, 1992) define collective self-esteem (i.e., CSE) as the component of an individual's identity that stems from the knowledge, value, and emotional significance that the individual attributes to their social group membership. In terms of applicability to Muslims in the West, high levels of self-esteem can be tied to identifying with ethnic, religious and/or national groups. In the literature, CSE has traditionally been considered as protective against negative mental health effects, through the process of in-group identification which encourages in-group solidarity (Tajfel & Turner, 1979). Self-esteem is considered to be an important aspect of mental health in the sense that it contributes to the measure of psychological well-being, which affects quality of life (e.g., Wylie, 1989). In this thesis, the concept of self-esteem will be discussed, as it not only is an essential health variable by itself that several of the empirical studies use, but it is also an important element in understanding group identification processes.

Second, social groups and the members of these groups are assigned positive or negative values by individuals (Tajfel & Turner, 1979). Members of an in-group are usually assigned positive traits, which contributes to their psychological well-being, while out-groups are typically assigned negative ones. This is especially important in relation to this thesis' research questions in the sense that Muslims often perceive themselves to be different and discriminated against by the host country majority group, as a result of their ethnic and religious cultures. Such social identities may negatively affect an individual if society negatively stereotypes (i.e., make broad generalizations) the group with which an individual identifies with. For instance, one negative stereotype is that all Muslims are radical terrorists.

An explanation for these assumptions is that humans tend to prefer things and people that they are familiar with, while fear and be sceptical of the 'unknown'. While positive aspects of the in-group are often attributed to stable and enduring personality traits of the group, for out-groups the same positive aspects are usually attributed to situational and temporary factors (e.g., luck or coincidence).

Third, by way of the process of social comparison, an individual's evaluation of their own group depends on how they perceive their group compared to other groups (Tajfel & Turner, 1979). Humans have an intrinsic need to evaluate their skills and abilities, and the way this is done is by comparing oneself to other people. Members of an in-group will often maximize the perceived differences between themselves and outside groups, minimize the perception of differences between in-group members, and remember more positive information about the in-group and more negative information about the out-groups. If the perceived comparison process is positive (i.e., they perceive their own group to be better than the outside group), then this will often enhance the in-group's self-esteem, resulting in better psychological outcomes. However, the opposite outcome may occur if the perceived comparison is negative. In addition, through the process of social mobility, if an individual is not satisfied with the conditions imposed upon their lives by the membership in social groups or social categories to which they belong, it is possible for them to move into another group which suits them better, as a way to improve their self-esteem (Tajfel & Turner, 1979). If the individual does not have an opportunity to change groups (or be part of another group), it could result in negative attitudes towards out-groups and positive attitudes toward the in-group (Herda, 2018). This is especially important in relation to the research questions, because Muslim migrants (who often do not have the same physical characteristics as Western individuals) may have trouble becoming a part of the majority group. This could further incentivize them to favour members of their own group (i.e., in-group favouritism) and be sceptical of outside influence, which could ultimately result in conflict and prejudice between the two groups, and therefore affect the health of Western Muslims. Thus, the concepts of social mobility and social comparison will also be lightly touched upon in the discussion, because of their relevance to group identification processes and health (i.e., self-esteem).

Frameworks such as the rejection-identification model (Branscombe et al., 1999) suggests that perceived discrimination and rejection lead individuals to intensify their in-group identifications, which in turn protects psychological well-being (e.g., less depression, anxiety and psychosomatic symptoms) and increases life satisfaction and self-esteem (Heim et

al., 2011; Vedder et al., 2007). Alternatively, the rejection-disidentification model posits that discrimination may increase in-group identifications, while also decrease identification with the host national out-group (Jasinskaja-Lahti et al., 2009). Both frameworks can be abbreviated to the RIM and RDM, respectively. While both models have received support, they are constantly receiving important refinements. For instance, Armenta and Hunt (2009) called attention to the importance of distinguishing between personal experiences of discrimination and perceptions of group discrimination. Specifically, they found that personal discrimination (i.e., directed at an individual's appearance and attributes) was associated with lower personal self-esteem, but group discrimination (i.e., directed towards an entire group's appearance and attributes) was related to higher personal self-esteem as it increased in-group identification. This is important in relation to the research questions, in the sense that Muslim communities who experience group discrimination may react differently compared to Muslim individuals who perceive personal discrimination. Therefore, in this thesis, the different types of perceived discrimination (i.e., individual-level and group-level) and their implications in relation to group identification and health effects will be discussed. In addition, both the RIM and RDM will be used to assess perceived discrimination and its relation to group identification and health effects, because these models embody many of the key SIT mechanisms (i.e., perceived discrimination, identification with in-group and out-group, and self-esteem).

2.2. Acculturation Model

While SIT focuses on why and how individuals identify with specific social groups for the purpose of establishing self-esteem, the acculturation model primarily revolves around social interaction between different cultural groups. Since many of the Muslim participants in the empirical studies are considered to be migrants, the acculturation model perfectly complements SIT. This is because migrants, including many Muslims, often come from different ethnic and/or religious cultural backgrounds. The acculturation model can provide insight into the consequences many migrant Muslims face when moving to a new country in the West.

Acculturation is the process of social and psychological adjustment that occurs when immigrants and/or minority groups come into contact with members of another culture (Berry, 1997). There are many factors that influence the different ways in which people acculturate (Padilla & Perez, 2003). These include family structure and function, adherence to religious

beliefs and practices, gender, power relationships between the majority and minority groups, personality characteristics, and age of onset of intergroup contact.

While Berry was not the first to propose an acculturation framework, much of the research on contemporary post-migration identity processes and adaptation outcomes stems from his model of acculturation (Giuliani et al., 2018). Many earlier frameworks were unidimensional and claimed that the more an individual adapts to a new culture, the less contact they will maintain with their heritage culture (Berry, 2005; Padilla & Perez, 2003). In the end, the complete adoption of the new culture was thought to be the ultimate goal of the acculturation process. But this was soon to be refuted. Berry's bidimensional model recognized the importance of multicultural societies, minority individuals and groups, and the fact that individuals have a choice in the matter of how far they are willing to go in the acculturation process. Specifically, Berry held the belief that minority members could reverse their acculturation process to the dominant group and revert to their former cultural heritage. Berry argued that this could happen if immigrants perceive that members of the dominant group have low and stigmatized expectations of them. Thus, the process of acculturation is complicated and not merely the outcome of two cultural groups being in contact with each other.

For many immigrants, like most Muslims, the process of acculturation brings specific challenges that produce greater distress than the normal stressors of everyday living (Ahmad et al., 2005; Berry, 1997, 2006). These include the stress associated with the experience of relocation itself, loss of social support networks, the challenges of sociocultural adaptation, and dealing with a potentially discriminatory host environment. Consequently, studies have shown that immigrants may acculturate to a new society based on a strategy Berry termed marginalization, which involves that individuals do not manage to maintain their origin culture nor incorporate the values of the new host culture, often resulting in maladaptive outcomes (Berry, 2005; Berry et al., 2006; Berry & Sam, 2010). These include psychological distress, lower self-esteem, behavioural problems, and poor school adjustment. Acculturation studies have shown that the stress experienced by immigrants has consistent negative effects on mental health; it is related to greater depression and anxiety, feelings of isolation and exclusion, heightened psychosomatic symptoms, suicidal ideation, and identity confusion (Crockett et al., 2007; Jibeen & Khalid, 2010; Kosic, 2004; Szabo et al., 2017; Yeh, 2003).

However, if the challenges that generate distress are overcome, the negative outcomes can be mitigated. For instance, Berry et al. (2006) found that identification with the ethnic

culture contributes positively to psychological adaptation, while identification with the host culture predicts better sociocultural adaptation. Specifically, more positive adaptation outcomes, such as Berry's strategy of integration (i.e., biculturalism), imply that immigrants are able to navigate between their own heritage culture and the national culture, often resulting in better psychosocial outcomes (Berry, 1997, 2005, 2006). These include greater self-esteem, self-efficacy and life satisfaction. In addition, Berry lists two more types of acculturation strategies that have received mixed findings regarding psychosocial outcomes. These are assimilation (i.e., individuals adopt the cultural norms of the host culture and neglect origin culture) and separation (i.e., individuals reject the host culture in favour of preserving their heritage culture). Furthermore, research suggests that people's acculturation strategies can vary between their private and public lives (Arends-Tóth & van de Vijver, 2004). For instance, individuals may reject the values and norms of the host culture in their private life (e.g., allowing corporal punishment on minors, even though this is against the law), while adapting to the host culture in public (e.g., celebrate host country's national day). In this thesis, the acculturation model, specifically Berry's different acculturative strategies, will be used to help understand the relation between group identification and adaptation outcomes among Muslim migrants.

Moreover, it has been well established that religiosity, as the degree of an individual's involvement and personal significance attached to a belief system (Aflakseir, 2012), has a positive role in the acculturation process and adjustment to the host society, in addition to being associated with better physical and mental health, for immigrant populations (Abu-Rayya & Abu-Rayya, 2009; Harker, 2001; Hackney & Sanders, 2003). For example, religion has been shown to be a main source of social support for migrants, which involves individuals' beliefs about the availability of help provided through their social environment, including friends, family, and significant others. This may be because of religion providing a social system allowing migrants to be a part of a social network made up of people with similar backgrounds, interests, and values (Davis & Kiang, 2016; Merino, 2014; Newman et al., 2018). Moreover, the task of coping with multiple cultural systems of reference is intensified within societies where immigrants experience discrimination and rejection for their religious and/or ethnic affiliations (Brewer, 2010). High levels of perceived discrimination can contribute to explain why a strategy of integration may not be seen as a feasible choice for Muslims living in the West, which forces them to rely on their own group for social support (Fleischmann et al., 2011; Heim et al., 2011).

2.3. Applicability of Theory in Relation to Research Questions

In summary, I will use the social identity theory and the acculturation model to shed light on the complex relationship between perceived discrimination and health outcomes. I do this by using core theoretical concepts in discussing the relationship between perceived discrimination and health. Specifically, the in-group and out-group aspects of SIT will be used to explore the ways in which many Muslims identify with ethnic, religious and/or national groups. The concepts of intersectionality, social mobility, and social comparison will also be touched upon, because of their relevance to group identification and health. In addition, self-esteem will be used, as it not only is an essential health variable by itself, but is also important in understanding group identification processes. Moreover, the different types of perceived discrimination (i.e., individual-level and group-level) and their implications will be discussed. Most of these mechanisms are manifested through the RIM and RDM, and therefore these two models will be used to assess perceived discrimination and its relation to group identification and health outcomes.

Finally, the acculturative model will be used because many of the Muslims in the empirical studies are migrants. The acculturative model, specifically Berry's different acculturative strategies, can contribute to help understand the relation between group identification and adaptation outcomes among Muslim migrants. Despite the mostly positive associations between religious/ethnic factors and identity processes, many Muslims may acculturate to a society based on a maladaptive strategy as a result of perceived discrimination, resulting in negative health outcomes. For instance, Muslims who adopt a strategy of separation (i.e., individuals reject the host culture in favour of preserving their heritage culture) may experience more discrimination from the host country out-group, but may be more resilient to the detrimental effects of this as a result of their identification with their ethnic and/or religious communities.

Without these theoretical foundations, it is hard to understand the indirect processes that shape discriminatory experiences and health outcomes. Specifically, research suggests that social identity theory (i.e., in-groups and out-groups) is essential in understanding the adjustments made as part of the acculturation process (Côté, 2006; Schwartz et al., 2006). For instance, individuals being part of both the national and ethnic groups (i.e., in-groups), and being accepted as being a member by both groups, can provide them with goals, values and beliefs that results in positive adaptation and health outcomes. In other words, we cannot easily discuss Western Muslims' perceived discrimination and its effects on health without

also assessing identity, because this is an important variable that affects the association to a large extent.

Both SIT and the acculturation model have important implications for Western Muslims perceptions of discrimination and health outcomes. While there are many different types of Muslims, as well as individual differences in the degree to which they uphold Islam's values and norms, it is safe to claim that many of them share an experience of belonging to a stigmatized religious and/or ethnic identity. Muslim identities may be considered to have negative implications in some Western contexts where Muslims are considered to be a minority group, often far away from their home countries. If a Muslim minority group in the West perceives themselves as disadvantaged and discriminated against compared to other groups in society, it could result in individuals from this group constructing a negative identity (i.e., having negative self-esteem) about themselves, resulting in maladaptive health outcomes. This may especially be true for Muslims who are expected to adhere to ethnic, religious and national norms and values, which may leave them to be overwhelmed and confused. In addition, negative attitudes towards Muslims may slowly turn into negative stereotypes, which can drastically affect their well-being. This may be the case for girls wearing hijab, who are easily identifiable as Muslim and can therefore be more susceptible to discriminatory experiences.

3. Literature Review

In this thesis, I explore Western Muslims experience with religious and ethnic discrimination, and how such perceptions of discrimination affect their health. I also investigate how the moderating role of identity affects the relationship between perceived discrimination and health outcomes. There is a large body of empirical literature in this field, and the majority of it has been conducted in the United States, but there is an increasing amount of studies appearing in other Western contexts, such as in Europe, New Zealand, Canada and Australia. Through a search process, I identified 15 papers that address the issues surrounding perceived discrimination, its impact on health outcomes, and the influence of identity on Muslims in the West. Therefore, in the following literature review, I will limit myself by briefly presenting 15 empirical studies that contribute to our understanding of these associations. Afterwards, I will explore and discuss common themes that are relevant across the empirical research. These themes are what I call findings in my material, and are tied to different types of identity: self-esteem, gender, generation, ethnic identity, religious identity, and national identity.

All of the empirical studies use psychological and quantitative methods, with the exception of Ellis et al.'s (2010) research which also uses qualitative interviews, a study which was included because of its particular relevance to the research questions. The studies also use similar types of scales to evaluate perceived discrimination, specific health outcomes, and specific types of identity. As an example, Ellis et al. (2010) use an instrument designed to assess cases of perceived discrimination, a Post-traumatic stress disorder (PTSD) scale, a depression scale, and an acculturation scale assessing American and Somali identity. Moreover, because of the large amount of empirical studies to be presented and the complexity of the thesis, I will aggregate the main research samples across the articles. In general, the sample sizes of the empirical studies range from a hundred to several hundred Muslim participants. A majority of the studies that take gender into consideration have an equal mix of men and women. The subjects' ages vary greatly, ranging from young adolescents (10) to elderly (79). Many of the participants across the studies are also split into different types of Muslim categories, mainly either first or second generation Muslims. Lastly, two of the studies (i.e., Rousseau et al., 2011, 2013) also use Haitians as a control group.

It is also important to note that I would likely have gained different insights if I had relied more heavily on qualitative studies. This is because qualitative studies more accurately reflect the subjective experiences of individuals. Nevertheless, if I were to mostly use qualitative research, I believe it would have been more difficult to look at the moderating influence of identity in the association between perceived discrimination and health outcomes, because such studies generally use small sample sizes and are more difficult to interpret.

I used electronic databases to identify relevant articles. These databases included: Google Scholar, PsycINFO and JSTOR. The searches included all studies to date, produced in the English language. The main keywords used in combination with each other were: *Muslim*, *ethnic*, *social identity*, *social identity theory*, *acculturation*, *acculturation model*, *perceived discrimination*, *Western*, *health effects*, *health outcomes*, and *well-being*. This generated a vast number of hits, which I narrowed down by manually picking out articles that were directly relevant to my research questions. Specifically, the articles were initially reviewed for relevance based on their titles and later through reading their respective abstracts. I only included research that explore the association between perceived discrimination and health outcomes, as well as studies that investigated the influence of social identity processes in the association between perceived discrimination and health consequences. While this is not a comprehensive review of the literature in my field of focus, I believe these 15 enlighten on

my research questions and in various ways discuss aspects of how Muslims tangle with these issues.

In addition, a vast majority of studies in the field evaluate psychological health outcomes, often neglecting physical health consequences. This is most likely due to the difficulty of measuring physical health-related changes, such as stress or blood-pressure. Therefore, I only found a few studies that examine physical health. Furthermore, I include studies done on both perceived individual-level discrimination and perceived group-level discrimination. Finally, a couple of the empirical studies (i.e., Ellis et al.'s., 2010; Kira et al., 2010) explore specific groups of Muslims (i.e., Somali Muslim and Iraqi Muslim refugees), which have been included in order to better understand the specific experiences of Islamic subgroups. This is in contrast to the remaining 13 research that more broadly looks at different types of Muslims living in the West. Nevertheless, all of the empirical studies explore similar types of variables, including: perceived discrimination, health outcomes and identity processes. In the following section, I briefly introduce the material I have analysed.

3.1. Presentation of Material Related to Key Variables

I find it useful to present the cluster of 15 empirical studies in relation to their operationalisation of key research variables. Specifically, I split the studies into different segments, and I created and organized each segment's name based on the key variables of the studies. My intention is to bring out the thematic scope of this material. While many of the research variables across the articles overlap with each other (e.g., such as perceived discrimination and health being relevant across all the studies), my overarching goal is to clarify the key distinctions and similarities among the research.

3.1.1. Perceived Discrimination and Health

This segment highlights three studies that explored the relationship between perceived discrimination and health outcomes, with little say on the role played by identity processes.

Rippy & Newman (2006) investigated the effects of perceived discrimination and religiously-based hate crimes on paranoid ideation and general anxiety in Muslim Americans. In this context, hate crimes were defined as criminal actions with the intention to harm or intimidate individuals based on their race, ethnicity, sexual orientation, religion, or minority group status.

Kira et al. (2010) created their own type of perceived discrimination scale (i.e., backlash trauma scale, known as BTS), and measured its relationship with cumulative trauma disorders (CTD), post-traumatic stress disorder (PTSD), and other psychological and physical

health outcomes among Muslim Iraqi refugees living in Wayne County. Backlash, in the context of this study, was defined as intensified reactive acts of discrimination toward one or more minority groups as a response to an act of aggression committed by individuals or groups perceived to be associated with that minority group, such as 9-11 and Muslims.

Rousseau et al. (2011) compared perceived discrimination from 1998 to 2007 among recently arrived Arab (Muslim and non-Muslim) and Haitian immigrants to Montreal. Specifically, they studied the association between perceived discrimination and psychological distress in 1998 and 2007.

3.1.2. Self-esteem

This segment includes three studies that investigated the role played by self-esteem in the relation between perceived discrimination and health consequences. As a reminder, it is important to understand that self-esteem is both an identity process and a health effect.

In a follow-up study, Rousseau et al. (2013) analysed the roles of collective self-esteem (CSE) and religiosity in the relationship between perceived discrimination and psychological distress among recently arrived Arab (Muslim and non-Muslim) and Haitian immigrants to Montreal.

Every & Perry (2014) investigated the effects of perceived interpersonal (individual) and perceived systemic (group) religious discrimination on self-esteem among Muslim Australians.

Ameline et al. (2019) examined the mediating role of Muslim group identification in the association between perceived religious discrimination in the news media, perceived stress and self-esteem.

3.1.3. Gender

This segment contains three studies that looked into the influencing role of gender in the association between perceived discrimination and health outcomes.

Ellis et al. (2010) explored the association between perceived discrimination, social identity, and mental health outcomes among Somali Muslim refugees in the United States. Identity was defined in terms of acculturation and gender.

Jasperse et al. (2012) examined how psychological, behavioural, and visible aspects of identity relates to each other, to perceived discrimination, and to well-being among Muslim women immigrants in New Zealand. In this study, pride, belonging, and centrality (i.e., the amount of time spent thinking about being a group member) were the basis of psychological identity, while behavioural aspects of Muslim identity involved specific prescribed religious

practices (e.g., praying, reading Quran or attending Mosque). For Muslim women, visible identity consisted of wearing the hijab.

Maes et al. (2014) investigated the association between perceived ethnic personal and group discrimination and internalizing (e.g., anxiety & depression) and externalizing (aggressive, violent, delinquent) problem behaviours in Muslim-Dutch immigrant early adolescents. In addition, the moderating role of ethnic, religious, and national group identification were examined in relation to gender.

3.1.4. Ethnic, Religious and National Identity

This segment focuses on six studies that examine the role played by ethnic, religious and national identity in the relationship between perceived discrimination and health effects.

Stuart et al. (2020) studied the relation between social identity, perceived discrimination, and depressive symptoms among British Muslims. The Rejection-Identification and Rejection Disidentification models were used to assess social identity.

Lowe et al. (2019) explored the associations between perceived discrimination, major depression (MD), and generalized anxiety disorder (GAD) symptoms among Muslim American College students, and whether this relationship is moderated by Muslim American identity.

Giuliani et al. (2018) investigated the mediating role of ethnic, national, and religious identity in the association between perceived discrimination and two aspects of psychological well-being (i.e., depression and satisfaction with the migrants decision related to their choice of leaving the country of origin), by comparing first and second generation adult Muslim Italian immigrants.

Hashemi et al. (2020) examined the relative contribution of religious identity, social support, social connectedness (i.e., how close people are to national, ethnic and/or religious communities), and perceived discrimination on the psychological well-being of Middle Eastern Muslim immigrants in Australia.

Stuart & Ward (2018) investigated the effects of religiosity and perceived acculturative stress on the mental health of Muslim immigrant youth in New Zealand. Acculturative stress encompassed two dimensions: discrimination distress caused by perceived religious discrimination and distress caused by cultural transition (i.e., experiences of change that challenge one's understandings about how to live).

Balkaya et al. (2019) examined the mediating roles of Muslim-American adolescents' religious and national group identities in the associations between their perceptions of

individual-level religious discrimination and internalizing (e.g., anxiety & depression) and externalising (e.g., aggressive, violent, delinquent) behaviours. They also assessed the moderating role of their perceptions of group-level discrimination (i.e., Islamophobia) in these mediated associations.

4. Findings

The present thesis contributes to our knowledge of Muslims experiences by making use of 15 empirical studies that examine different types of discriminatory relationships. There were two research questions guiding the thesis: How does perceived ethnic and religious discrimination affect the health of Western Muslims, and is there a moderating role of identity in this association?

4.1. Discrimination and Health

The overall findings across the material strongly support a negative relationship between perceived discrimination and health outcomes. Specifically, a vast majority of the empirical studies indicate that perceived ethnic and/or religious discrimination have large detrimental implications for Western Muslims' psychological health. This includes: depressive symptoms, anxiety, psychological distress, reduced psychological well-being, stress, paranoid ideation, post-traumatic stress disorder (PTSD), cumulative trauma disorders (CTD), internalizing and externalizing symptoms, and changes in self-esteem levels. In addition, while most of the studies focus on mental health, discriminatory experiences also has an impact on Muslims' physical health. Specifically, backlash trauma (i.e., intensified reactive acts of discrimination) had severe negative effects on neurological, blood pressure related, respiratory, and digestive disorders (Kira et al., 2010). It is important to note that some of the listed negative psychological outcomes also have an impact on physical health, especially in combination with each other. For instance, individuals who report discrimination often have higher levels of stress (Sellers & Shelton, 2003). High amounts of stress could result in these people experiencing increased levels of anxiety. Anxiety symptoms include physical symptoms such as: increased muscle tension and heart rate, difficulty concentrating, excessive sweating and shaking, among others (Endler et al., 1991).

My material underscores that Muslims in the West experience different types of discrimination. For instance, Ellis et al. (2010) found that 72% of the Muslim Somali participants stated that they had experienced at least one act of discrimination (e.g., such as having others act as though they are 'better than you', treated with less courtesy or being insulted, among others). Rippy & Newman (2006) showed that 55% of the Muslim American

participants reported being victim of an incident of hate crime violence or discrimination at some time in their life, the most common form of discrimination experienced being verbal harassment. Rousseau et al. (2011) indicated that, regardless of a participant's cultural or religious group, perceived discrimination significantly increased from 1998 to 2007 for both Muslims and Haitians, but surprisingly, this had more detrimental health consequences (i.e., psychological distress) for Haitians than for Muslims. In their follow up study, Rousseau et al. (2013) found that, in comparison to their Arab-Muslim and non-Muslim counterparts, Haitian participants reported more frequent and extensive discrimination experiences. This indicates that Muslims are not the only minority group that is vulnerable to discriminatory experiences.

In other words, many Western Muslims perceive discrimination which leads to detrimental health outcomes. Therefore, my material supports much of the literature in the field of perceived discrimination and its negative effects on health.

4.2. Generational Differences in Health Effects

In general, these types of detrimental health outcomes seem to apply for both first-generation and second-generation Muslims, but perhaps more so for the latter group. For instance, Rippy & Newman's (2006) study showed that second-generation Muslims experienced more group discrimination than first-generation and convert Muslims. In addition, Giuliani et al. (2018) found that, for second generation Muslim immigrants, perceived discrimination was directly associated with lower psychological well-being (i.e., more depression and lower satisfaction with the migration decision). In contrast, among first generation Muslim immigrants, discrimination was directly correlated only with one aspect of psychological well-being (i.e., lower satisfaction with migration decision). Stuart et al. (2020) revealed that second generation Muslims had significantly higher levels of perceived Islamophobia, personal discrimination and depressive symptoms. These findings indicate that second generation Muslims may have a harder time integrating into a new society as a result of their dual identities.

4.3. Influence of Gender on Identity in Health and Discrimination

With the exception of Rippy & Newman's (2006) study, boys seem to experience less discrimination than girls, because they can dress in ways that don't identify them as Muslim (Ellis et al., 2010; Jasperse et al., 2012). On the other hand, more religious discrimination is directed towards visible girls, such as those wearing a headscarf. While girls are reported to experience increased levels of anxiety and depressive symptoms (e.g., Rousseau et al., 2011, 2013), it is also argued that they have stronger resilience as a result of being more connected

to their ethnic and religious groups, and therefore receive stronger social support. Specifically, many of the studies found that a strong ethnic identity, religious identity and/or national identity were associated with better adaptation outcomes, greater life satisfaction, and fewer psychological symptoms. For instance, Balkaya et al. (2019) found that adolescents who had a strong sense of belonging to both their religious and mainstream American cultural groups were less likely to report internalizing and externalizing symptoms. In another example, Ameline et al. (2019) showed that the more Muslims perceive discrimination, the more they will identify with their Muslim in-group and the less they will perceive stress.

In contrast, Maes et al. (2014) found that while girls' ethnic group identification had a protective role in the relation between perceived discrimination and internalizing problems, religious group identification had a sensitizing effect on the association between perceived discrimination and internalizing and externalising problem behaviours. In other words, for girls who strongly identified with their religious group, the association between perceived discrimination and internalizing and externalizing problem behaviours were stronger than for girls who weakly identified with their religious group. However, the authors themselves admit that religious identification by itself does not imply that it is a direct risk factor for internalizing or externalizing problems. After all, their results also show that higher levels of religious identification was directly associated with lower levels of externalizing problems.

Moreover, girls who engage in their ethnic and religious groups less frequently may be more susceptible to discrimination, often resulting in maladaptive psychosocial outcomes such as heightened anxiety or feelings of being unsafe in the host country (Ellis et al., 2010). Specifically, girls who choose not to wear the headscarf or in other ways disassociate themselves from their ethnic or religious groups may be at risk of discrimination or harassment from members of their own in-groups.

In short, girls seem to experience more discrimination than boys as a result of being more visible. However, girls also seem to have stronger resilience against the detrimental health effects of discrimination as a result of being more connected to their ethnic and religious communities. In addition, girls who engage in their ethnic and religious groups less frequently may be more susceptible to discrimination, particularly from members of their own in-group.

4.4. The Harmful Role of Identity

While many of the empirical studies report that Muslim identification with ethnic, religious, and even national groups act as protective barriers to the detrimental effects of

perceived discrimination, not all of the research conclude that social identities are associated with more favourable health outcomes. Indeed, some of the studies have come to the opposite conclusion. Stuart et al. (2020) found that Muslim identity (but not national identity) was weakly associated with greater depressive symptoms. Stuart & Ward (2018) suggested that religious practices exacerbated the negative effects of perceived discrimination on well-being for those engaged in high levels of such religious activities. In addition, high levels of religious practices also exacerbated the detrimental effects of perceived religious discrimination distress on depression. Lowe et al. (2019) stated that the most severe anxiety symptoms (but not depressive symptoms) were observed in participants reporting a strong Muslim American identity and high levels of perceived discrimination. In other words, having a strong Muslim American identity exacerbated the relationship between perceived discrimination and anxiety symptoms.

Hashemi et al. (2020) showed that having a strong religious identity was related to higher perceived discrimination, which in turn resulted in lower psychological well-being. In the same study, it was also stated that the experience of discrimination did not make Muslim migrants turn to their ethnic group for protection and support as a way to increase their psychological well-being, even though social support by itself was found to have a large positive effect on this health outcome. Kira et al. (2010) showed that one of the 6 trauma sub types, the collective identity trauma factor (i.e., discrimination related to one or more aspects of one's identity), was highly correlated with backlash trauma (BTS) and a strong predictor of both PTSD and cumulative trauma disorders. This is because BTS and collective identity trauma are similar in the sense that the former is a part of the latter (i.e., backlash trauma is one of the collective identity traumas).

In essence, some of my material underscores that social identities (particularly religious identity) can have maladaptive implications in the association between perceived discrimination and health outcomes.

4.5. The Complexity of Identity

Yet, other studies show more complicated identity relationships. For example, Stuart & Ward (2018) concluded that religious identity acts as a protective barrier against the detrimental effects of perceived religious discrimination on depression. However, greater religious identity was also associated with an increased susceptibility to the detrimental impact of cultural transition distress (i.e., experiences of change that challenge one's understandings about how to live) on depression. Jasperse et al. (2012) found that

psychological Muslim identity (i.e., centrality, pride and belongingness) was associated with an increased susceptibility to the detrimental impact of perceived religious discrimination on psychological well-being. However, the behavioural component of Muslim identity (i.e., high levels of engagement in Islamic practices) was revealed to buffer this effect. Specifically, while Muslims may experience more discrimination as a result of their religious identity, religious practices may serve as a coping resource in times of stress. Both of these studies suggest that identity serves as both a negative and positive influence in the association between perceived discrimination and health outcomes.

Giuliani et al. (2018) found that high levels of perceived discrimination among second generation (but not first generation) Muslim immigrants was linked to weaker national identification and greater religious identification. In this context, national identification was linked to higher levels of satisfaction regarding their migration decision, while religious identification was associated with lower levels of satisfaction. In addition, their study failed to confirm the buffering role played by ethnic and religious identity on well-being among both first and second generation Muslim immigrants. Specifically, no significant association was found between ethnic identity and well-being for either first or second generation immigrants. Unlike previous studies suggesting that religiosity is positively related to well-being, it was here found that religious identity (including measures of identification with Islam and engagement with practices) did not have a positive impact on well-being. Rather, a negative link between religious identity and satisfaction with migration was found among both Muslim generations: that is, the more important the religious dimension was for them, the more dissatisfied they were with their choice to leave their country of origin and to live in another context. Balkaya et al. (2019) found that at low levels of perceived group discrimination (i.e., Islamophobia), individual-level religious discrimination was associated with lower levels of identification with the national group and more internalizing and externalizing problems among Muslim-Americans. However, at higher levels of perceived group discrimination, individual-level discrimination was linked to greater identification with the national group and less internalizing and externalizing health problems. Muslim identity (unlike national American identity) did not mediate the associations between individual-level religious discrimination and adjustment outcomes. In other words, when Muslims perceived that their group was not as discriminated against, and when individually targeted by discriminatory acts, they did not identify with the national group and experienced worse health outcomes. But when they perceived that their group was greatly discriminated against, and when

individually targeted by discrimination, they identified with the national group and experienced better health outcomes. Both of these studies indicate that ethnic and religious identity had a harmful effect in the association between perceived discrimination and health. This is in contrast to national identity, which was found to have a surprisingly positive influence in this relationship.

Another key variable explored in the literature review is the role played by self-esteem, because of its relationship with not only health outcomes, but also to SIT. Every & Perry (2014) found that both perceived interpersonal discrimination and perceived group discrimination significantly predicted self-esteem among Muslims. Specifically, interpersonal discrimination was associated with lower self-esteem (i.e., less in-group identification), while group discrimination was related to an increase in self-esteem (i.e., more in-group identification). Surprisingly, Ameline et al. (2019) found that neither perceived discrimination nor group identification was found to be associated with self-esteem. Rousseau et al. (2013) found that CSE (i.e., collective self-esteem) buffers the negative effects of discrimination on psychological distress. Specifically, Participants who reported higher levels of discrimination along with higher levels of CSE reported fewer anxiety and depression symptoms compared to participants who reported higher discrimination levels along with lower CSE levels. However, the observed interaction effect between discrimination and CSE suggests that repeated exposure to discrimination negatively impacts perception of the in-group (i.e., negatively affects the CSE), which may be a risk factor for mental health problems. Nevertheless, such detrimental associations between religiosity, CSE and psychological distress stands in contrast to previous research, the majority of which suggests that CSE (or self-esteem) and religiosity are protective against psychological health problems. These empirical studies indicate that self-esteem is a complex variable and difficult to interpret, but is helpful when used in conjunction with SIT, which will be discussed later.

In summary, this section highlights several studies that draws attention to the fact that identity is multifaceted and complex, and therefore can have both positive and negative links in the relationship between perceived discrimination and health outcomes. Moreover, the overall findings indicate that perceived discrimination affects Western Muslims in maladaptive ways, and that there are different dimensions of identity moderating this association, including: Gender, generation, self-esteem, ethnic identity, religious identity and national identity. While there are a few contradictions among the empirical studies, it is clear that these dimensions of identity can be discussed.

5. Discussion

There are a number of reasons as to why some of the empirical studies have shown contrasting results. In general, the main reasons seem to be technical research limitations, such as different sample sizes, variations in participants' age, statistical constraints (e.g., different types of analyses may yield different results), correlational limits (i.e., many of the studies are correlational in nature, and correlation is not causation), small time frames to work on and finish the project (e.g., most of the studies are cross-sectional), and differences in perception of discrimination among the participants, all of which may have affected the research results to some degree. In addition, a vast majority of the examined studies are quantitative in nature, neglecting qualitative strengths such as a deeper exploration of the individuals true subjective experience of discrimination. For instance, what does it mean when a Muslim individual chooses to identify with his/her origin culture instead of the host culture, and what is the motivation behind this? Such questions may be better suited for qualitative interviews, which focus on Muslims' personal stories. Moreover, many of the studies use scales in their methodologies (e.g., perceived discrimination scale, religiosity scale, etc). One particular weakness with these types of scales is that they refer only to a specific point in time, which may stand in contrast to the development of identity processes which evolve over a broader time period. Also, many of the studies used scales that asked the participants to rate how much they perceive to identify as a Muslim. This is noteworthy because it may be hard to establish what a 'Muslim' is. In general, because this thesis explored Western Muslims, to be or not to be a Muslim is a subjective choice. Definitions of being a Muslim may be completely different between unique groups of people.

The findings highlight the fact that no single group of Muslims are alike, and therefore one cannot generalize the results from one sample to the entire population of the country in question, let alone all of the West. For instance, Rippy & Newman (2006) state that the likely reason that anxiety was not related to perceived discrimination in their particular study was, among other things, due to the population itself (i.e., maybe Muslim Americans, unlike other groups, don't show this specific association). In another example, Rousseau et al. (2011) suggest that although Muslim Arabs report less psychological distress than non-Muslim Arabs and Haitians in the 2007 sample, this relative advantage has decreased since 9-11. An explanation for this may be that despite the rapid decline of discrimination associated with Islamophobia in the months following 9-11, the general levels of fear against Muslims have not concurrently declined.

It is also important to note that two papers used specific proxy populations to assess Muslim ethnicity. These two were Somali American and Iraqi American refugees. Somali American, Iraqi American and Muslim Americans are distinct, although overlapping, populations (Lowe et al., 2019). While the vast majority of these participants identified as Muslims, some of them did not do so, which could have slightly affected the results in these studies. However, even in these studies, discrimination associated with being a Muslim was particularly salient. For instance, having a Muslim name, wearing a headscarf, or otherwise being identified as a Muslim placed Somalis at risk of being harassed, teased, or treated poorly (Ellis et al., 2010). In addition, it is worth mentioning that while refugees and immigrants/migrants are similar, they are not the same. Refugees are usually forced to move to another country, while immigrants/migrants move by choice and due to promise of better life opportunities. However, I do not believe that this particular difference had an impact on my research questions, because many people who discriminate cannot easily distinguish between a Muslim migrant and a Muslim refugee.

5.1. The Moderating Role of Identity

There is general consensus on the moderating role of identity in the association between perceived discrimination and health outcomes. For instance, Rousseau et al. (2011) first suggested that discrimination targeting valued collective identities, such as one's religion, may reinforce group cohesion within minority groups, which has a protective function. A few years later, Rousseau et al. (2013) found an interaction effect between collective self-esteem and discrimination, whereby CSE buffers the negative effects of discrimination on psychological distress. In addition, Kira et al. (2010) show that collective identity trauma (i.e., identity-related discrimination) was a strong predictor of both PTSD and CTD. In another example, Ellis et al. (2010) conclude that social identity moderated the association between discrimination and mental health (i.e., the intersection of gender and acculturation shaped the experience of discrimination).

However, not all of the identity models explored have received uniform support. For instance, while both the rejection-identification (RIM) and the rejection-disidentification (RDM) models have received strong support in the literature, the general findings from the empirical studies examined in this thesis have been mixed. I want to reemphasize that the RIM suggests that perceived discrimination lead individuals to intensify their in-group identifications, which in turn protects and increases psychological well-being. On the other

hand, the RDM posits that discrimination may increase in-group identifications, while also decrease identification with the host national out-group.

Consistent with the RIM, Stuart & Ward (2018) found that personal discrimination distress was associated with lower levels of depression for Muslims who strongly identified with their religion. However, the opposite effect was found for the interaction between religious identity and cultural transition stress (i.e., experiences of change that challenge one's understandings about how to live). Partly in line with the model, Stuart et al. (2020) found that perceived group discrimination (but not personal discrimination) was associated with stronger in-group religious identity, but surprisingly this was not related to less depressive symptoms. In contrast to the RIM, Balkaya et al. (2019) conclude that neither Muslim-American adolescents' experience of individual-level nor group-level discrimination were related to their Muslim in-group identity. However, a higher sense of belonging to the Muslim in-group was related to less externalising problems.

It is important to mention that the RIM is related to SIT, in the sense that the latter theory posits that people want to perceive their own group as better than other groups as a way to maintain and increase their self-esteem (i.e., people strive to have a positive self-concept in order to feel better about themselves). If the perceived comparison process between one's own group and outside groups is positive (i.e., they perceive their own group to be better than the outside group), then this will often enhance the group's self-esteem and in-group identification, resulting in better psychological outcomes. Every & Perry (2014) found important results in their study on the relationship between self-esteem and perceived prejudice: While group level discrimination lead to an increase in self-esteem (i.e., more in-group identification), interpersonal discrimination resulted in lower self-esteem (i.e., less in-group identification), which supports and contradicts the RIM at the same time. In line with the RIM, Rousseau et al. (2013) found that self-esteem buffers the negative effects of perceived discrimination on psychological distress. Surprisingly, Ameline et al. (2019) found a lack of significant relationship between perceived discrimination, group identification and self-esteem, which stands in contrast to much of the literature in the field. One particular problem with self-esteem is that it is a positive variable, and it is stated that these are generally harder to find effect-sizes (i.e., relationship strength) for than negative variables, such as depression, which may contribute to explain the study's lack of significant relationships. Moreover, Wiley et al. (2013) suggest that a potential reason for the lack of association between perceived discrimination and group identification may be that first-

generation immigrants do not want to identify more strongly with their in-group when they face discrimination from the mainstream culture in order to avoid further prejudice and potential persecution. Nonetheless, there is evidence that both group and individual forms of perceived discrimination is associated with a stronger in-group identity in other studies, confirming the centrality of the RIM (e.g., Branscombe et al., 1999; Spencer-Rodgers & Collins, 2006).

Consistent with the RDM, Stuart et al. (2020) found that perceived personal discrimination was related to weaker host national identity. Balkaya et al. (2019) found similar results, which consequently also lowered the Muslims' psychological adjustment. These findings might imply that when discrimination is personal, the desire to become part of the higher status group is reduced. Specifically, in line with SIT, individuals may distance themselves from a group to protect their self-esteem if the discriminatory experience is attributed to personal deservingness (e.g., Major et al., 2003). In contrast to the RDM, group discrimination was associated with a stronger host national identity in both studies. In Balkaya et al.'s (2019) study, stronger national identity also resulted in better health outcomes (i.e., less internalizing and externalizing problem behaviours). While it may be difficult to pinpoint why exactly group discrimination operates in this way, some researchers argue that it is because of differences in perceived compatibility of identities (Hutchison et al., 2014). This makes it so perceived group discrimination will result in stronger host country identification. Specifically, in Stuart et al.'s (2020) study, the dual identity situation of British Muslims may suggest that in the face of discrimination towards one possible identity position, the less threatened position (i.e., the British identity) is taken on in order to cope with identity threat. In relation to the research questions, this means that identity has a protective function in the association between perceived discrimination and health outcomes, among Western Muslims.

Nonetheless, other research has concluded that both perceived personal and group discrimination results in weaker host national identity, affirming the validity of the RDM (e.g., Verkuyten, 2007). While the findings regarding the RIM and RDM are mixed, one thing remains clear: The type of discrimination (i.e., individual vs group-level) is important, because the distinctions between different forms may have unique effects on group identification and health outcomes. Specifically, both perceived individual-level and perceived group-discrimination can influence the degree to which (Muslim) individuals identity with their ethnic, religious and/or national group, which results in varying health outcomes. This highlights the complexity of the experiences we are trying to capture under a

single umbrella term of 'discrimination' (Every & Perry, 2014). This is also important in relation to the research questions because it shows that identity is not the only moderating variable in the relationship between perceived discrimination and health.

Balkaya et al. (2019) also points out that different types of discrimination can be linked, and should not always be evaluated separately. As previously stated, their study found that at low levels of perceived group discrimination (i.e., Islamophobia), individual-level religious discrimination was associated with lower levels of identification with the host country group and more internalizing and externalizing problems among Muslim-Americans. However, at higher levels of perceived group discrimination, individual-level discrimination was linked to greater identification with the host country group and less internalizing and externalizing problems. This indicates that the impact of perceptions of discrimination in interpersonal interactions can depend on one's perceptions of group discrimination. In other words, group-level discrimination may serve as a moderator of the relation between individual-level discrimination and group identity, in the sense that individuals may either blame themselves for discrimination or dismiss their individual perceptions of discrimination and shift responsibility to those who discriminate against them, likely as a way to protect their self-esteem. This Moderation seems to depend on the individuals personal perceptions of discrimination relative to the discrimination their in-group faces (e.g., Crocker & Major, 1989; Hatzenbuehler, 2016).

Moreover, Berry's (1997, 2005, 2006) acculturation model is also relevant to many of the findings in this thesis. Specifically, his strategies of acculturation may contribute to explain the relationship between ethnic, religious and/or national identity processes and health outcomes. To reemphasize, the strategies are as follows: Marginalisation (i.e., neither identifying with origin culture nor new host culture), integration (i.e., identifying with both cultures), assimilation (i.e., identifying with host culture and neglect origin culture), and separation (i.e., identifying with heritage culture and neglect host culture). However, using this model to interpret the findings, the implications seem to be mixed. First of all, Berry's strategy of integration was related to better psychosocial outcomes in his studies, which some of the empirical studies do support. For instance, Balkaya et al. (2019) found that Muslims who had a strong sense of belonging to their religious and/or mainstream American cultural groups were less likely to report internalizing and externalizing symptoms. However, Lowe et al. (2019) state that the most severe anxiety symptoms were observed in participants reporting a strong Muslim American identity, which stands in contrast to Berry's integration strategy.

Furthermore, the strategy of marginalization is not suitable to explore in this thesis, because in all of the empirical studies outlined the Muslim participants identified with at least one of the groups (i.e., ethnic, religious and/or national groups).

In addition, similarly to the acculturation literature, there are mixed findings in the empirical studies regarding the health effects of assimilation and separation. For instance, Stuart et al. (2020) found that Muslim identity (but not national identity) was weakly associated with greater depressive symptoms, which suggest that assimilation may be the better acculturative outcome. Similarly, Giuliani et al. (2018) found that national identification was linked to higher levels of satisfaction regarding Muslims' migration decision, while religious identification was associated with lower levels of satisfaction. Balkaya et al. (2019) also found support for national identification to be related to better health outcomes. Nonetheless, many of the studies found that ethnic and/or religious identification had a protective effect on the association between perceived discrimination and health (e.g., Ellis et al., 2010; Ameline et al., 2019; Stuart & Ward., 2018; Jasperse et al., 2012), which suggest that the acculturative strategy of separation (or at the very least the aspect of holding onto one's heritage cultural values) may also have positive effects on health outcomes. Therefore, in terms of optimal health outcomes it may not be clear as to whether immigrants should assimilate into a new society, separate and retain their cultures, or integrate and do both.

Ethnicity and visible religiosity appears to be powerful agents when it comes to people distinguishing between in-groups and out-groups. As SIT states, this is likely because the visual differences between groups is immediately apparent, and requires a minimal amount of information processing for most humans. Chan (2014) argues that it is not surprising that absolute assimilation was traditionally seen as the ultimate end point of acculturation - in many western countries, efforts are continuously being made in order to 'integrate' immigrants into the mainstream society, including Muslim groups. Those who are visibly perceived to be a part of an out-group and refuse to adapt to the new host national culture may be put at a disadvantage compared to the majority group, especially in terms of discrimination and maladaptive health outcomes. Fortunately, diversity is increasingly becoming recognized as a positive element in society, and Berry's framework has replaced the old acculturation model of absolute assimilation. Specifically, minority members are free to revert to their former heritage cultures, if they perceive that this will suit them better, which aligns with SIT's concept of social mobility (i.e., people will move to groups that they perceive to be

better, as a way to boost their self-esteem). According to SIT, it also does not matter as to which group should be perceived as the in-group and which group to be perceived as the out-group, since they both serve the same function as contributors of identity and self-esteem. In terms of Muslim identity in the West, this indicates that as long as Muslims identify with either the ethnic, religious or host national group, they will benefit from better health.

Lastly, it is also important to mention that while identity-related variables (e.g., ethnicity, religion, nationality, generation, and gender) are valuable in explaining perceived discrimination and its relation to health, they are certainly not the only key factors that have an influence on this relationship. In line with the concept of intersectionality, other variables such as immigrant status, poverty, and colour of skin, may also increase discriminatory acts towards Muslims living in the West. In addition, research suggests that regardless of which specific variable that is contributing to discrimination, the frequency of perceived discriminatory acts is predictive of detrimental health effects (Kessler et al., 1999). In other words, individuals who are of multiple disadvantaged statuses are likely at increased risk for discrimination and health problems. In contrast, there are other potential protective factors besides ethnic, religious and national identity that contribute to alleviate or buffer the negative effects of perceived discrimination, such as employment, social support, and social connectedness (Rousseau et al., 2011; Hashemi et al., 2020). For instance, Hashemi et al. (2020) found support for the mediating role of social support on the association between religious identity and psychological well-being among Muslim migrants. Specifically, a stronger sense of religious identity lead to more social support, which ultimately resulted in better psychological well-being. It has been argued that the feeling of being cared for and supported by others often helps migrants to cope with stressful, postmigration events and plays a significant role in the promotion of positive psychological functioning (e.g., Newman et al., 2018). An explanation for this, based on SIT, is that individuals tend to support groups that embody the salient aspects of their social identities because it builds self-esteem and maintains a positive self-identity (Tajfel & Turner, 1979; Lopez et al., 2011). Thus, more research is required to explore other factors that may moderate the relationship between perceived discrimination and health outcomes.

5.1.1. Gender

According to SIT, an individual's evaluation of their own group depends on how they perceive their group compared to other groups (Tajfel & Turner, 1979). Specifically, as individuals become increasingly identified with a particular social group, they become more

likely to view this group in a positive light, which in turn contributes to their psychological well-being. This could potentially be an answer as to how the girls in many of the studies examined are resilient to the detrimental health effects of perceived discrimination. Many of them may have a particularly high level of positive in-group evaluation (i.e., many of them value and feel a part of their ethnic and religious groups greatly), which protects them from out-group discrimination. For example, the complex personal, cultural, religious, and political symbolism underpinning the choice to wear hijab may act to diminish the negative consequences of being a visible Muslim in Western societies (Jasperse et al., 2012). This may especially be true for young girls who, in comparison to young boys, are cognitively more mature and therefore more involved in processes of identity development (Meeus et al., 2014). Specifically, girls may be seen as responsible for holding the traditions of the culture of origin and passing them along to the next generation (e.g., Sua´rez-Orozco et al., 2006), which can result in girls being allowed less flexibility to explore their host culture identities and thus develop stronger connections to their heritage cultures (Ketner et al., 2004). Thus, while wearing the headscarf can easily identify girls as members of Islam, and make them more likely to be discriminated against, it can also make some girls feel a sense of pride and belonging to their ethnic and religious groups, which acts as a protective barrier in the association between perceived discrimination and health.

However, not all results showed that ethnic and religious groups were protective for girls. Specifically, there may be explanations as to why some Muslim girls who engage in their ethnic and religious groups less frequently may be more susceptible to discrimination from their own in-group, often resulting in maladaptive psychosocial outcomes. In terms of the acculturation model, gender can play a salient role in shaping acculturation experiences (Ellis et al., 2010). Specifically, individuals who accept and adopt aspects of the receiving host culture (i.e., assimilate or integrate) may be criticized and ostracized by more traditionalist members of their ethnic culture or religious community (Schwartz et al., 2006). This may create an identity conflict, whereby the individual is forced to choose between the two identities, resulting in psychological distress.

In contrast, since Muslim boys are not told what they have to wear at any given time in most contexts, they experience less discrimination. Perhaps this is because boys are able to construct their social identities in relation to the host country's culture, while at the same time manage to not offend their ethnic or religious groups, resulting in more positive health outcomes. However, this does not necessarily mean that boys have an easier time than girls in

every context. For instance, Rippy & Newman (2006) found an association between perceived religious discrimination and subclinical paranoid ideation (but not for anxiety) among Muslim American males (but not females). However, this gender difference may be due in large part to the contextual impact of the fear, suspicion and anger against Muslim men in the aftermath of the 9-11 terrorist attacks. Specifically, these results suggest that for Muslim boys, the greater the perception of a discriminatory and hostile environment, the greater the amount of suspicion, mistrust, and wariness they will experience. All in all, the experience of discrimination is different for Muslim boys and girls, and there are different consequences for the ways in which they encounter discrimination (i.e., buffering vs sensitizing role) and the ways in which this affects them based on their connection to their religious, ethnic and/or national groups.

5.1.2. Second Generation Muslims

There are mixed findings in the literature regarding the differences of discrimination perceived by first and second generation Muslims. The studies explored in this thesis suggest that second generation Muslims perceive and are more vulnerable to discriminatory experiences and its negative health effects compared to the first generation (Rippy & Newman, 2006; Giuliani et al., 2018), but why is this the case? One potential reason is that they have more opportunities to interact in socialization contexts, such as in school and workplaces (Kaduvettoor-Davidson & Inman, 2013). Specifically, second generation Muslims often spend their formative years within host countries, where they are a religious and/or ethnic minority. Higher linguistic competences among the second generation are likely to facilitate and increase opportunities for interaction within the host society and make them more aware of and affected by discrimination.

In addition, first generation Muslims have a stronger connection to their ethnic cultural group compared to the second generation, which has been shown to buffer the detrimental effects of perceived discrimination. In contrast, second generation youth have to engage in a dual identity developmental process, which results in conflicts between external (i.e., out-group) and family (i.e., in-group) pressures, making them more susceptible to perceptions of discriminatory experiences (Stuart et al., 2010). Lastly, Liu & Suyemoto (2016) suggest that whereas first generation Muslim adults attribute discrimination experiences to their status as an immigrant, the second generation tend to consider themselves as members of the host society, and thus perceive discrimination as a result of their distinctiveness linked to ethnicity and/or religiosity. However, it is important to note that there are other studies in the literature

that indicate that children born to immigrant parents have higher levels of acculturation and lower levels of perceived discrimination (e.g., Kohatsu et al., 2000), which stands in contrast to the findings in this thesis. For instance, Stevens et al. (2004) suggest that second generation Muslims are more willing to combine loyalty to their cultural heritage and host society values compared to their adult counterparts, which often leads to better adaptive outcomes.

5.2. Muslims, Discrimination and Health

As was established in the initial section of the thesis, research has shown that negative attitudes toward Muslims have increased substantially throughout recent decades and that the widespread hostility towards Muslims is shared by both majority and minority non-Muslim groups in the West. For instance, visible Muslim expressions might be assumed by the host population as a cultural and/or political statement made on behalf of Muslims to protest against rising Islamophobia, to advocate Islamic values or to show adherence to an Islamic identity, leading to more prejudice against the Muslim population (Droogsma, 2007; Jasperse et al., 2012). In addition, people in different Western countries have their own individual perceptions of Muslims. These statements may contribute to explain the reason for some of the mixed findings regarding the moderating influence of religious and ethnic identity on perceived discrimination and health outcomes. Specifically, in diverse countries such as the USA, Muslims may be more likely to experience high levels of discrimination as a result of their ethnic and religious identities, especially post 9-11. Moreover, not every country's culture may be tolerant of Islam and its influence, and no individual context is the same, and therefore there are bound to be differences in perceived discrimination at different places in the world. For instance, a highly visible Muslim individual who does not have any interest in accepting the host country's cultural values may be more susceptive to receive negative attention. As SIT shows, people are often quick to point out and dislike individuals who are different from themselves, and therefore immigrants can easily become the targets of discrimination. In contrast, a less visible Muslim individual who actively tries to blend in the host country environment may receive far less public attention, and therefore reduces the risk of being discriminated against.

It is also evident that immigrants eventually become familiar with the different sets of social rules and norms in the host society over time, but they might choose to adopt or reject these ideas if they are found to be in conflict with their previous beliefs (Chan, 2014). Individuals characterised as 'separated' who highly identify with their ethnic and/or religious group may reject social values that are associated with the out-group, especially when they are

found to be in conflict with the values that are representative of their in-group, as may be said for many Muslim migrants. Therefore, while being able to navigate between one's heritage culture and the host culture (i.e., integration) often does lead to more positive adaptation outcomes, many Muslims may not have the possibility of doing this and may as a result adopt a separation strategy. This could help to explain how discrimination against Muslims occurs. Specifically, Muslims may be perceived by the majority group to not want to take part in their host country culture, which can result in experiences of discrimination.

Based on the empirical studies, identifying with the national group (i.e., adoption of host country culture) generally seems to have a positive role in the association between perceived discrimination and health. A potential reason for this is that national identity, in contrast to religious and ethnic identity, may be more linked to socio-cultural aspects of adjustment such as school and work success as well as successful participation in the host society (e.g., Heim et al., 2011). In other words, when a majority group perceives that Muslims identifies with and adopts their cultural values, they may have a greater sense of respect and approval of them, resulting in better adaptation and health outcomes.

The different findings indicating whether ethnic and/or religious identification has a buffering or sensitizing effect on perceived discrimination and health outcomes highlights the complexity of the topic. Most of the empirical studies suggest that ethnic identification has a protective role in this association. The literature in the field also seems to agree with this statement. For instance, Wong et al. (2003) found strong support for an ethnic identity buffer against the detrimental effects of perceived discrimination. However, while there is evidence that religious and ethnic identities can act as protective factors against the negative effects of perceived discrimination for Muslims, there are also contradictory findings in the literature that indicate these can exacerbate the negative outcomes of stressors on dimensions of psychological well-being (e.g., Downey & Feldman, 1996; Stuart, 2014). Specifically, Friedman & Saroglou (2010) argue that the relationship between religiosity and well-being is complex within Western societies where religiosity plays an important role in the stigmatization of Muslims, such as in Belgium. In contrast to being a member of an ethnic group, being a religious group member is more likely to be perceived as a voluntary choice, for which one more easily can be held responsible for by both oneself and others (Crocker & Major, 1989). Because of this self-responsibility, people are more likely to blame themselves for their stigmatizing condition, which may result in individuals being more vulnerable to low self-esteem, which involves worse health outcomes.

However, that is not to say that being overtly involved with one's religion always results in negative health consequences, despite the risk of facing more discrimination. Specifically, even research that has found religious practices to exacerbate certain types of detrimental effects (e.g., acculturative stress) have ultimately concluded that they do exert a positive influence on mental health in general (Stuart & Ward, 2018). In fact, a majority of the literature indicates that the sense of belonging to a religious group and its importance to self-concept, the association with a religious institution, engagement in religious activities, and belief in a god or higher power provide individuals with a sense of significance, positive emotions, self-esteem, and mental health (e.g., Aflakseir, 2012; Davis & Kiang, 2016). For example, in a cross-cultural comparative study, it was found that Muslim youth's identification with Islam was related to greater life satisfaction, better school adjustment and fewer behavioural problems, and it was found that religious identity was protective against the negative health effects of discrimination (Ward et al., 2010). A suggestion for why this may be the case for Muslims is that Islam is a key aspect in the daily life of many Middle Eastern societies, in the sense that it greatly impacts individuals' thinking, behaviours, and social customs (e.g., Ikizler et al., 2018; Duderija, 2008; Thomas & Sanderson, 2011; Wong et al., 2003). In addition, religious identity fosters opportunities for social interaction between likeminded people and nurtures friendships and social ties through participation and involvement in religious organizations, which in turn results in better mental health outcomes (e.g., Wei et al., 2012). In other words, many Muslims have access to cultural and social resources that contribute to mitigate the detrimental impact of perceived discrimination on their adjustment (Balkaya et al., 2019).

The acculturation model may also help explain why religious and/or ethnic communities have a protective function in the association between perceived discrimination and health effects. As has been stated, the acculturation model can be understood to occur along two dimensions: the degree to which one identifies with one's host culture and the degree to which one identifies with one's culture of origin. Each of these dimensions has implications for the degree to which one experiences discrimination as well as its effects. In relation to the thesis, and despite the positive findings on the role of national identity, Muslims who initially spend more time with individuals from outside their culture of origin may place themselves in settings where they are less protected by their own community and therefore more likely to experience discrimination (Viruell-Fuentes, 2007). In contrast,

Muslims who continuously participate in community activities may surround themselves with other Muslims and thus be less likely to experience discrimination.

While Muslims are one of the most discriminated against groups in the Western world, they are not the only minority group that regularly perceives and is affected by prejudice. In Rousseau et al.'s (2011, 2013) studies, Haitians and Arab Muslims both experienced high levels of perceived discrimination. This might be because Haitians, as a black ethnic minority, have traditionally suffered racial, social, and economic discrimination in Canada, while Arab Muslims have historically been more respected (Rousseau et al., 2013). However, post 9-11, an increasing amount Arab Muslims have been reported being victims of discrimination. This indicates that international discourse on national security after 9-11 may not only have affected Muslims but also other minority groups. This is despite Muslims having received immense amounts of negative media attention (Ameline et al., 2019).

While research has shown that ethnic and religious identity dimensions are strongly intertwined for both first and second generation immigrants (e.g., Duderija, 2008; Güngör et al., 2011), there seem to be contexts where these two can be separated. Specifically, there may be different experiences of perceived religious discrimination based on one's ethnicity. For instance, white American Muslims may experience pure religious discrimination, but this is usually devoid of the influence of ethnicity (Rippy & Newman, 2006). In contrast, minority groups such as Arab or Iraqi American Muslims experience both types of discrimination. This may be because dominant group members in a society (i.e., white Americans) are perceived to be a more valued group, while minority groups (i.e., Muslim Arab immigrants) are perceived to be less valued (e.g., Branscombe, 1998). This can be an explanation as to why some immigrants may choose to deviate from the host country by adopting an acculturative strategy of separation or marginalisation.

On a final note, there are a number of ways that may help prevent discrimination from occurring, or at the very least minimize the detrimental health effects it causes. This has important clinical implications because, as stated in the initial section of the thesis, Muslims are expected to increase in population in both the US and Europe in the coming years, which suggests that more people will experience discrimination and negative health outcomes. The general protective functions of Islamic practices highlight the importance of Muslims being able and encouraged to maintain their cultural and religious identity in their new society of settlement (Jasperse et al., 2012). Specifically, Balkaya et al. (2019) found that a sense of belonging to both the Muslim and the host national group were each associated with less

mental health difficulties, including less anxiety, depression, somatic problems, substance use and violence. After all, Berry (1997) himself state that integration (i.e., immigrants being actively a part of both the heritage culture and the host culture) is the most positive acculturative outcome for an individual's psychological well-being. Thus, policies and programs should encourage the development of multiple social identities by supporting positive intergroup relations. Moreover, the contribution of the news media in the development of discrimination against Muslims is not sufficiently considered (e.g., Poole, 2011). Perceptions of discrimination at the individual-level as well as anti-Muslim public sentiments in the form of Islamophobia may be particularly detrimental for Muslims living in Western cultural contexts because of public attitudes that portray Islamic cultural values as incompatible with those of the host country (e.g., Phalet et al., 2018). The media tends to magnify this supposed incompatibility. This greatly affects Muslims' social identities and mental health adjustment. Thus, another suggestion is the importance to change the public's perception of Muslims through the media, in order to reduce daily discriminatory experiences and to foster a more positive and inclusive sociocultural climate. Specifically, public information campaigns can be developed to correct misconceptions about Muslims, which could promote interfaith and intercultural dialogue, and potentially result in improved health outcomes (Lowe et al., 2019).

5.3. Conclusion

In conclusion, many Western Muslims experience discrimination, and this absolutely does have severe negative health consequences for the individuals affected, especially in relation to psychological health. Moreover, The role of identity has a large influence in the association between perceived discrimination and health. With the use of the SIT and the acculturation model, key identity processes were explored.

In terms of the SIT, the findings show that self-esteem is an important variable in relation to perceived discrimination, identity and health outcomes, generally indicating a positive relationship. Specifically, higher levels of self-esteem is correlated with greater levels of in-group identification, which is further related to improved psychological well-being and protection against the detrimental effects of perceived discrimination. Moreover, while the findings in regard to the RIM and RDM are mixed, it does highlight the notion that the type of discrimination (i.e., individual or group-level) is important. This is because different types of discrimination may have unique effects on group identification and health outcomes.

Regarding the acculturation model, the findings also seem to be mixed. The different types of acculturation strategies (with the exception of marginalization) can all be linked to positive adaptation outcomes depending on the reader's perspective, and thus it is hard to argue that one strategy results in better health than others. However, these findings must be taken with a grain of salt, as much of the acculturation literature points out that integration (i.e., identifying with origin and national groups) is the best adaptive strategy in relation to health.

The studies explored in this thesis seem to indicate that people who are of a different ethnic and/or religious group tend to perceive more discrimination, but being a part of one's cultural in-group (i.e., group-identification) buffers the detrimental impact of discriminatory experiences. Surprisingly, the studies explored also suggest that national identity (i.e., host country identification) has positive effects on the association. In addition, gender is an important identity variable and plays an essential role in the interaction between perceived discrimination and health outcomes. Specifically, girls tend to experience more discrimination than boys as a result of being more visibly identifiable as Muslims (i.e., as a result of having to wear the hijab). Finally, there are clear differences between first and second generation Muslims, which constitutes another important part of Western Muslims' identity, showing that perceived discrimination has more detrimental effects on health and represents a larger obstacle to integration processes for second generation Muslims compared to first generations.

References

Abbott, A. (2016). The Mental-Health Crisis Among Migrants. *Nature*, *538*(7624), 158-160. https://doi.org/10.1038/538158a

Abu-Rayya, H. M., & Abu-Rayya, M. H. (2009). Acculturation, Religious Identity, and Psychological Well-Being Among Palestinians in Israel. *International Journal of Intercultural Relations*, *33*(4), 325-331. http://dx.doi.org/10.1016/j.ijintrel.2009.05.006

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.

Ahmad, F., Shik, A., Vanza, R., Cheung, A. M., George, U., & Stewart, D. E. (2005). Voices of South Asian Women: Immigration and Mental Health. *Women & Health*, *40*(4), 113-130. https://doi.org/10.1300/J013v40n04_07

Ajrouch, K.J., & Kusow, A.M. (2007). Racial and Religious Contexts: Situational Identities Among Lebanese and Somali Muslim Immigrants. *Ethnic and Racial Studies*, *30*, 72-94. https://doi.org/10.1080/01419870601006553

Ameline, A., Ndobo, A., & Roussiau, N. (2019). Psychological Study of Perceived Religious Discrimination and Its Consequences for a Muslim Population. *Religions*, *10*(3), 144. https://doi.org/10.3390/rel10030144

Arends-Tóth, J., & van de Vijver, F. J. R. (2004). Domains and Dimensions in Acculturation: Implicit Theories of Turkish-Dutch. *International Journal of Intercultural Relations*, *28*(1), 19-35. https://doi.org/10.1016/j.ijintrel.2003.09.001

Armenta, B. E., & Hunt, J. S. (2009). Responding to Societal Devaluation: Effects of Perceived Personal and Group Discrimination on the Ethnic Group Identification and

Personal Self-Esteem of Latino/Latina Adolescents. *Group Processes & Intergroup Relations*, *12*(1), 23-39. https://doi.org/10.1177/1368430208098775

Balkaya, M., Cheah, C. S. L., & Tahseen, M. (2019). The Mediating Role of Multiple Group Identities in the Relations Between Religious Discrimination and Muslim-American Adolescents' Adjustment. *Journal of Social Issues*, *75*(2), 538-567. https://doi.org/10.1111/josi.12326

Berry, J. W. (1997). Immigration, Acculturation, and Adaptation. *Applied Psychology*, *46*(1), 5-34. https://doi.org/10.1111/j.1464-0597.1997.tb01087.x

Berry, J. W. (2005). Acculturation: Living Successfully in Two Cultures. *International Journal of Intercultural Relations*, *29*(6), 697-712. https://doi.org/10.1016/j.ijintrel.2005.07.013

Berry, J. W. (2006). Acculturative Stress. In P. Wong & L. Wong (Eds.), *Handbook of Multicultural Perspectives on Stress and Coping* (pp. 287-298). Springer US.

Berry, J. W., & Sabatier, C. (2010). Acculturation, Discrimination, and Adaptation Among Second Generation Immigrant Youth in Montreal and Paris. *International Journal of Intercultural Relations*, *34*(3), 191-207. https://doi.org/10.1016/j.ijintrel.2009.11.007

Berry, J. W., & Sam, D. L. (2010). Acculturation: When Individuals and Groups of Different Cultural Backgrounds Meet. *Perspectives on Psychological Science*, *5*(4), 472-481. https://doi.org/10.1177/1745691610373075

Berry, J. W., Phinney, J. S., Sam, D. L., & Vedder, P. (2006). Immigrant Youth: Acculturation, Identity, and Adaptation. *Applied Psychology*, *55*(3), 303-332. https://doi.org/10.1111/j.1464-0597.2006.00256.x

Bhui, K., Stansfeld, S., McKenzie, K., Karlsen, S., Nazroo, J., & Weich, S. (2005). Racial/Ethnic Discrimination and Common Mental Disorders Among Workers: Findings From the EMPIRIC Study of Ethnic Minority Groups in the United

Kingdom. *American Journal of Public Health, 95*(3), 496-501. https://doi.org/10.2105/AJPH. 2003.033274

Bleich, E. (2011). What is Islamophobia and How Much is There? Theorizing and Measuring an Emerging Comparative Concept. *American Behavioral Scientist, 55*(12), 1581-1600. https://doi.org/10.1177/0002764211409387

Branscombe, N. M., Schmitt, M., & Harvey, R. (1999). Perceiving Pervasive Discrimination Among African Americans: Implications for Group Identification and Well-Being. *Journal of Personality and Social Psychology*, *77*, 135-149. https://doi.org/10.1037/0022-3514.77.1.135

Branscombe, N. R. (1998). Thinking About One's Gender Group's Privileges or Disadvantages: Consequences for Well-Being in Women and Men. *British Journal of Social Psychology*, *37*(2), 167-184. https://doi.org/10.1111/j.2044-8309.1998.tb01163.x

Brewer, M. B. (2010). Social Identity Complexity and Acceptance of Diversity. In R. J. Crisp (Ed.), *The Psychology of Social and Cultural Diversity* (pp. 9-33). https://doi.org/10.1002/9781444325447.ch2

Brittian, A. S., Kim, S. Y., Armenta, B. E., Lee, R. M., Umaña-Taylor, A. J., Schwartz, S. J., Villalta, I. K., Zamboanga, B. L., Weisskirch, R. S., Juang, L. P., Castillo, L. G., & Hudson, M. L. (2015). Do Dimensions of Ethnic Identity Mediate the Association Between Perceived Ethnic Group Discrimination and Depressive Symptoms? *Cultural Diversity and Ethnic Minority Psychology*, *21*(1), 41-53. https://doi.org/10.1037/a0037531

Chan, D. (2014). *Acculturation: A Social Identity Approach* [Master thesis, Lincoln University]. Research@Lincoln Repository.

https://researcharchive.lincoln.ac.nz/bitstream/handle/10182/6370/chan_msocsc.pdf?sequence=3

Clark, R., Anderson, N. B., Clark, V. R., & Williams, D. R. (1999). Racism as a Stressor for African Americans: A Biopsychological Model. *American Psychologist*, *54*(10), 805-816. https://doi.org/10.1037/0003-066X.54.10.805

Côté, J. E. (2006). Acculturation and Identity: The Role of Individualization Theory. *Human Development*, *49*(1), 31-35. https://doi.org/10.1159/000090301

Council on American-Islamic Relations [CAIR]. (2018). *Targeted: 2018 civil rights report*. Retrieved from https://www.cair.com/resources/cair-civil-rights-reports/

Crenshaw, K. W. (1989). Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory, and Antiracist Politics. *University of Chicago Legal Forum*, *1989*, 139-167.

Crocker, J., & Luhtanen, R. (1990). Collective Self-Esteem and Ingroup Bias. *Journal of Personality and Social Psychology*, *58*, 60-67. https://doi.org/10.1037/0022-3514.58.1.60

Crocker, J., & Major, B. (1989). Social Stigma and Self-Esteem: The Self-Protective Properties of Stigma. *Psychological Review*, *96*(4), 608-630. https://doi.org/10.1037/0033-295X.96.4.608

Crockett, L. J., Iturbide, M. I., Torres Stone, R., McGinley, M., Raffaelli, M., & Carlo, G. (2007). Acculturative Stress, Social Support, and Coping: Relations to Psychological Adjustment Among Mexican American College Students. *Cultural Diversity & Ethnic Minority Psychology*, *13*(4), 347-355. https://doi.org/10.1037/1099-9809.13.4.347

Davis, R. F., & Kiang, L. (2016). Religious Identity, Religious Participation, and Psychological Well-Being in Asian American Adolescents. *Journal of Youth and Adolescence*, *45*(3), 532-546. https://doi.org/10.1007/s10964-015-0350-9

Deitch, E. A., Barsky, A., Butz, R. M., Chan, S., Brief, A. P., & Bradley, J. C. (2003) Subtle Yet Significant: The Existence and Impact of Everyday Racial Discrimination in the Workplace. *Human Relations*, *56*(11), 1299-1324. https://doi.org/10.1177/00187267035611002

Dovidio, J. (2001). On the Nature of Contemporary Prejudice: The Third Wave. *The Journal of Social Issues*, *57*(4), 829-849. https://doi.org/10.1111/0022-4537.00244

Downey, G., & Feldman, S. I. (1996). Implications of Rejection Sensitivity for Intimate Relationships. *Journal of Personality and Social Psychology*, *70*(6), 1327-1343. https://doi.org/10.1037/0022-3514.70.6.1327

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

Duderija, A. (2008). Factors Determining Religious Identity Construction Among Western-Born Muslims: Towards a Theoretical Framework. *Journal of Muslim Minority Affairs*, *28*(3), 371-400. https://doi.org/10.1080/13602000802548003

Ellis, B. H., MacDonald, H. Z., Klunk-Gillis, J., Lincoln, A., Strunin, L., & Cabral, H. J. (2010). Discrimination and Mental Health Among Somali Refugee Adolescents: The Role of Acculturation and Gender. *American Journal of Orthopsychiatry*, *80*(4), 564-575. https://doi.org/10.1111/j.1939-0025.2010.01061.x

Endler, N. S., Edwards, J. M., & Vitelli, R. (1991). *Endler Multidimensional Anxiety Scale*. Western Psychological Services.

European Union Agency For Fundamental Rights [FRA]. (2010). *European Union Minorities and Discrimination Survey*. Publications Office of the European Union. https://fra.europa.eu/sites/default/files/fra_uploads/663-fra-2011_eu_midis_en.pdf

European Union Agency For Fundamental Rights [FRA]. (2017). *Second European Union Minorities and Discrimination Survey*. Publications Office of the European Union. https://fra.europa.eu/sites/default/files/fra_uploads/fra-2017-eu-minorities-survey-muslims-selected-findings_en.pdf

Every, D., & Perry, R. (2014). The Relationship Between Perceived Religious Discrimination and Self-Esteem for Muslim Australians. *Australian Journal of Psychology*, *66*(4), 241-248. https://doi.org/10.1111/ajpy.12067

Fangen, K. (2021, July 9). Why Did Muslims Become the New Enemy in Norway and Europe? *Prio Blogs*. https://blogs.prio.org/2021/07/why-did-muslims-become-the-new-enemy-in-norway-and-europe/.

Fine, M., & Sirin, S. R. (2007). Theorizing Hyphenated Selves: Researching Youth Development in and Across Contentious Political Contexts. *Social and Personality Psychology Compass*, *11*(3), 164-38. https://doi.org/10.1111/j.1751-9004.2007.00032.x

Fiske, S. T. (2000). Stereotyping, Prejudice, and Discrimination at the Seam Between the Centuries: Evolution, Culture, Mind, and Brain. *European Journal of Social Psychology*, *30*(3), 299-322. https://doi.org/10.1002/(SICI)1099-0992(200005/06)30:3%3C299::AID-EJSP2%3E3.0.CO;2-F

Fleischmann, F., Phalet, K., & Klein, O. (2011). Religious Identification and Politicization in the Face of Discrimination: Support for Political Islam and Political Action Among the Turkish and Moroccan Second Generation in Europe. *British Journal of Social Psychology*, *50*(4), 628-648. https://doi.org/10.1111/j.2044-8309.2011.02072.x

Friedman, M., & Saroglou, V. (2010). Religiosity, Psychological Acculturation to the Host Culture, Self-esteem and Depressive Symptoms Among Stigmatized and

Nonstigmatized Religious Immigrant Groups in Western Europe. *Basic and Applied Social Psychology*, *32*(2), 185-195. https://doi.org/10.1080/01973531003738387

Giuliani, C., Tagliabue, S., & Regalia, C. (2018). Psychological Well-Being, Multiple Identities, and Discrimination Among First and Second Generation Immigrant Muslims. *Europe's Journal of Psychology*, *14*(1), 66-87. https://doi.org/10.5964/ejop.v14i1.1434

Goldin, I., & Mariathasan, M. (2014). *The Butterfly Defect: How Globalization Creates Systemic Risks, and What to Do About It*. Princeton University Press.

Güngör, D., Fleischmann, F., & Phalet, K. (2011). Religious Identification, Beliefs, and Practices Among Turkish Belgian and Moroccan Belgian Muslims: Intergenerational Continuity and Acculturative Change. *Journal of Cross-Cultural Psychology*, *42*(8), 1356-1374. https://doi.org/10.1177/0022022111412342

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

Harker, K. (2001). Immigrant Generation, Assimilation, and Adolescent Psychological Well-Being. *Social Forces*, *79*(3), 969-1004. https://doi.org/10.1353/sof.2001.0010

Hashemi, N., Marzban, M., Sebar, B., & Harris, N. (2020). Religious Identity and Psychological Well-Being Among Middle-Eastern Migrants in Australia: The Mediating Role of Perceived Social Support, Social Connectedness, and Perceived Discrimination. *Psychology of Religion and Spirituality*, *12*(4), 475-486. https://doi.org/10.1037/rel0000287

Haslam, S. A., Jetten, J., Postmes, T., & Haslam, C. (2009). Social Identity, Health and Well-Being: An Emerging Agenda for Applied Psychology. *Applied Psychology*, *58*, 1-23. https://doi.org/10.1111/j.1464-0597.2008.00379.x

Hatzenbuehler, M. L. (2016). Structural Stigma: Research Evidence and Implications for Psychological Science. *American Psychologist*, *71*(8), 742-751. https://doi.org/10.1037/amp0000068

Heim, D., Hunter, S. C., & Jones, R. (2011). Perceived Discrimination, Identification, Social Capital, and Well-Being: Relationships With Physical Health and Psychological Distress in a U.K. Minority Ethnic Community Sample. *Journal of Cross-Cultural Psychology*, *42*(7), 1145-1164. https://doi.org/10.1177/0022022110383310

Herda, D. (2018). Reactive Ethnicity and Anticipated Discrimination among American Muslims in Southeastern Michigan. *Journal of Muslim Minority Affairs*, *38*(3), 372-391. https://doi.org/10.1080/13602004.2018.1524136

Hutchison, P., Lubna, S. A., Goncalves-Portelinha, I., Kamali, P., & Khan, N. (2014). Group-Based Discrimination, National Identification, and British Muslims' Attitudes Toward Non-Muslims: The Mediating Role of Perceived Identity Incompatibility. *Journal of Applied Social Psychology*, *45*(6), 330-344. https://doi.org/10.1111/jasp. 12299

Ikizler, A. S., & Szymanski, D. M. (2018). Discrimination, Religious and Cultural Factors, and Middle Eastern/Arab Americans' Psychological Distress. *Journal of Clinical Psychology*, *74*(7), 1219-1233. https://doi.org/10.1002/jclp.22584

Jasinskaja-Lahti, I., Liebkind, K., & Solheim, E. (2009). To Identify or Not to Identify?: National Disidentification as an Alternative Reaction to Perceived Ethnic Discrimination. *Applied Psychology*, *58*(1), 105-128. https://doi.org/10.1111/j.1464-0597.2008.00384.x

Jasperse, M., Ward, C., & Jose, P. E. (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

Jibeen, T., & Khalid, R. (2010). Predictors of Psychological Well-Being of Pakistani Immigrants in Toronto, Canada. *International Journal of Intercultural Relations*, *34*(5), 452-464. https://doi.org/10.1016/j.ijintrel.2010.04.010

Jones, E. E., Farina, A., Hastorf, A. H., Markus, H., Miller, D. T., & Scott, R. A. (1984). *Social Stigma: The Psychology of Marked Relationships*. Freeman

Jones, J. (1997). *Prejudice and Racism* (2nd ed.). McGraw Hill.

Kaduvettoor-Davidson, A., & Inman, A. G. (2013). South Asian Americans: Perceived Discrimination, Stress, and Well-Being. *Asian American Journal of Psychology*, *4*(3), 155-165. https://doi.org/10.1037/a0030634

Kessler, R. C., Mickelson, K. D., & Williams, D. R. (1999). The Prevalence, Distribution, and Mental Health Correlates of Perceived Discrimination in the United States. *Journal of Health and Social Behaviour*, *40*(3), 208-230. https://doi.org/10.2307/2676349

Ketner, S. L., Buitelaar, M. W., & Bosma, H. A. (2004). Identity Strategies Among Adolescent Girls of Moroccan Descent in the Netherlands. *Identity: An International Journal of Theory and Research*, *4*(2), 145-169. https://doi.org/10.1207/s1532706xid0402_3

Kira, I. A., Lewandowski, L., Templin, T., Ramaswamy, V., Ozkan, B., & Mohanesh, J. (2010). The Effects of Perceived Discrimination and Backlash on Iraqi Refugees' Mental and Physical Health. *Journal of Muslim Mental Health*, *5*(1), 59-81. https://doi.org/10.1080/15564901003622110

Kohatsu, E. L., Dulay, M., Lam, C., Concepcion, W., Perez, P., Lopez, C., & Euler, J. (2000). Using Racial Identity Theory to Explore Racial Mistrust and Interracial Contact Among Asian Americans. *Journal of Counseling & Development*, *78*(3), 334-342. https://doi.org/10.1002/j.1556-6676.2000.tb01915.x

Kosic, A. (2004). Acculturation Strategies, Coping Process and Acculturative Stress. *Scandinavian Journal of Psychology*, *45*(4), 269-78. https://doi.org/10.1111/j.1467-9450.2004.00405.x

Lee, R. M. (2003). Do Ethnic Identity and Other-Group Orientation Protect Against Discrimination for Asian Americans? *Journal of Counseling Psychology*, *50*(2), 133-141. https://doi.org/10.1037/0022-0167.50.2.133

Liddell, B. J., Nickerson, A., Sartor, L., Ivancic, L., & Bryant, R. A. (2016). The Generational Gap: Mental Disorder Prevalence and Disability Amongst First and Second Generation Immigrants in Australia. *Journal of Psychiatric Research*, *83*, 103-111. http://dx.doi.org/10.1016/j.jpsychires.2016.08.011

Liu, C. M., & Suyemoto, K. L. (2016). The Effects of Racism-Related Stress on Asian Americans: Anxiety and Depression Among Different Generational Statuses. *Asian American Journal of Psychology*, *7*(2), 137-146. https://doi.org/10.1037/aap0000046

Lopez, A. B., Huynh, V. W., & Fuligni, A. J. (2011). A Longitudinal Study of Religious Identity and Participation During Adolescence. *Child Development*, *82*(4), 1297-1309. https://doi.org/10.1111/j.1467-8624.2011.01609.x

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

Luhtanen, R., & Crocker, J. (1992). A Collective Self-Esteem Scale: Self-Evaluation of One's Social Identity. *Personality and Social Psychology Bulletin*, *18*(3), 302-318. https://doi.org/10.1177/0146167292183006

Maalouf, A. (2000). Introduction (B. Bray, Trans.). *In the Name of Identity: Violence and the Need to Belong*. (pp. 1-5). Arcade Publishing.

Maes, M., Stevens, G. W. J. M., & Verkuyten, M. (2014). Perceived Ethnic Discrimination and Problem Behaviours in Muslim Immigrant Early Adolescents: Moderating Effects of Ethnic, Religious, and National Group Identification. *The Journal of Early Adolescence*, *34*(7), 940-966. https://doi.org/10.1177/0272431613514629

Major, B., Kaiser, C. R., & McCoy, S. K. (2003). It's Not My Fault: When and Why Attributions to Prejudice Protect Self-Esteem. *Personality and Social Psychology Bulletin*, *29*(6), 772-781. https://doi.org/10.1177/0146167203029006009

Meeus, W., van de Schoot, R., Keijsers, L., Schwartz, S. J., & Branje, S. (2014). On the Progression and Stability of Adolescent Identity Formation: A Five-Wave Longitudinal "Study in Early-To-Middle and Middle-To-Late Adolescence": Erratum. *Child Development*, *85*(3), 1320. https://doi.org/10.1111/cdev.12256

Merino, S. M. (2014). Social Support and the Religious Dimensions of Close Ties. *Journal for the Scientific Study of Religion*, *53*(3), 595-612. https://doi.org/10.1111/jssr.12134

Minas, H., Kakuma, R., Too, L. S., Vayani, H., Orapeleng, S., Prasad-Ildes, R., Turner, G., Procter, N., & Oehm, D. (2013). Mental Health Research and Evaluation in Multicultural Australia: Developing a Culture of Inclusion. *International Journal of Mental Health Systems*, *7*, 23. https://doi.org/10.1186/1752-4458-7-23

Newman, A., Nielsen, I., Smyth, R., & Hirst, G. (2018). Mediating Role of Psychological Capital in the Relationship Between Social Support and Wellbeing of Refugees. *International Migration*, *56*, 117-132. http://dx.doi.org/10.1111/imig.12415

Ocampo, A. X., Dana, K., & Barreto, M. A. (2018). The American Muslim Voter: Community Belonging and Political Participation. *Social Science Research*, *72*, 84-99. https://doi.org/10.1016/j.ssresearch.2018.02.002

Operario, D. & Fiske, S. T. (2001). Ethnic Identity Moderates Perceptions of Prejudice: Judgements of Personal Versus Group Discrimination and Subtle Versus Blatant Bias.

Personality and Social Psychology Bulletin, *27*, 550-61. https://doi.org/10.1177/0146167201275004

Padilla, A. M., & Perez, W. (2003). Acculturation, Social Identity, and Social Cognition: A New Perspective. *Hispanic Journal of Behavioral Sciences*, *25*(1), 35-55. https://doi.org/10.1177/0739986303251694

Pahl, K., & Way, N. (2006). Longitudinal Trajectories of Ethnic Identity Among Urban Black and Latino Adolescents. *Child Development*, *77*(5), 1403-1415. https://doi.org/10.1111/j.1467-8624.2006.00943.x

Pew Research Center. (2017, November 29). *Europe's Growing Muslim Population*. https://www.pewforum.org/2017/11/29/europes-growing-muslim-population/

Pew Research Center. (2018, January 3). *New Estimates Show U.S. Muslim Population Continues to Grow*. https://www.pewresearch.org/fact-tank/2018/01/03/new-estimates-show-u-s-muslim-population-continues-to-grow/

Phalet, K., Fleischmann, F., & Hillekens, J. (2018). Religious Identity and Acculturation of Immigrant Minority Youth: Toward a Contextual and Developmental Approach. *European Psychologist*, *23*(1), 32-43. https://doi.org/10.1027/1016-9040/a000309

Poole, E. (2011). Change and Continuity in the Representation of British Muslims Before and After 9/11: The UK Context. *Global Media Journal*, *4*(2), 49-62.

Rippy, A. E., & Newman, E. (2006). Perceived Religious Discrimination and Its Relationship to Anxiety and Paranoia Among Muslim Americans. *Journal of Muslim Mental Health, 1(1),* 5-20. https://doi.org/10.1080/15564900600654351

Rogers, C. R. (1959). A theory of Therapy, Personality, and Interpersonal Relationships: As Developed in the Client-Centered Framework. In S. Koch (Ed.), *Psychology: A Study of a Science*. (Vol. 3, pp. 184-256). McGraw-Hill.

Rousseau, C., Hassan, G., & Moreau, N. (2013). Ethnic and Religious Discrimination: The Multifaceted Role of Religiosity and Collective Self-Esteem. *Transcultural Psychiatry*, *50*(4), 475-492. https://doi.org/10.1177/1363461513495586

Rousseau, C., Hassan, G., Moreau, N., & Thombs, B. D. (2011). Perceived Discrimination and Its Association With Psychological Distress Among Newly Arrived Immigrants Before and After September 11, 2001. *American Journal of Public Health*, *101*(5), 909-915. https://doi.org/10.2105/AJPH.2009.173062

Sarwar, M. (2020). *Examining the Associations Between Perceived Discrimination and Psychological Distress in a Muslim American Sample* [Doctoral dissertation, Texas Tech University]. ThinkTech. https://ttu-ir.tdl.org/bitstream/handle/2346/86494/SARWAR-DISSERTATION-2020.pdf?sequence=1&isAllowed=y

Schwartz, S. J., Dunkel, C. S., & Waterman, A. S. (2009). Terrorism: An Identity Theory Perspective. *Studies in Conflict & Terrorism*, *32*(6), 537-559. https://doi.org/10.1080/10576100902888453

Schwartz, S. J., Montgomery, M. J., & Briones, E. (2006). The Role of Identity in Acculturation Among Immigrant People: Theoretical Propositions, Empirical Questions, and Applied Recommendations. *Human Development*, *49*(1), 1-30. https://doi.org/10.1159/000090300

Schwartz, S. J., Unger, J. B., Zamboanga, B. L., & Szapocznik, J. (2010). Rethinking the Concept of Acculturation: Implications for Theory and Research. *American Psychologist*, *65*(4), 237-251. https://doi.org/10.1037/a0019330

Sellers, R. M. & Shelton, J. N. (2003). The Role of Racial Identity in Perceived Racial Discrimination. *Journal of Personality and Social Psychology*, *84*(5), 1079-92. https://doi.org/10.1037/0022-3514.84.5.1079

Spencer-Rodgers, J., & Collins, N. L. (2006). Risk and Resilience: Dual Effects of Perceptions of Group Disadvantage Among Latinos. *Journal of Experimental Social Psychology*, *42*(6), 729-737. https://doi.org/10.1016/j.jesp.2005.10.009

Steele, C. M., & Aronson, J. (1995). Stereotype Threat and the Intellectual Test Performance of African Americans. *Journal of Personality and Social Psychology*, *69*(5), 797-811. https://doi.org/10.1037/0022-3514.69.5.797

Stevens, G. W. J. M., Pels, T. V. M., Vollebergh, W. A. M., & Crijnen, A. A. M. (2004). Patterns of Psychological Acculturation in Adult and Adolescent Moroccan Immigrants Living in the Netherlands. *Journal of Cross-Cultural Psychology*, *35*(6), 689-704. https://doi.org/10.1177/0022022104270111

Stuart, J. (2014). A Qualitative Analysis of Muslim Young Adults' Adaptation Experiences in New Zealand. *The Journal of Muslim Mental Health*, *8*(2), 21-46. https://doi.org/10.3998/jmmh.10381607.0008.203

Stuart, J., & Ward, C. (2018). The Relationships Between Religiosity, Stress, and Mental Health for Muslim Immigrant Youth. *Mental Health, Religion & Culture*, *21*(3), 246-261. https://doi.org/10.1080/13674676.2018.1462781

Stuart, J., Robinson, L., & Ward, C. (2020). Rejection Identification or Disidentification? The Association of Discrimination on Depressive Symptoms via Religious and National Identity Among British Muslims. *International Journal of Intercultural Relations*, *77*, 38-45. https://doi.org/10.1016/j.ijintrel.2020.05.003

Stuart, J., Ward, C., & Adam, Z. (2010). Current Issues in the Development and Acculturation of Muslim Youth in New Zealand. *Bulletin of International Society for Studying Behavioral Development*, *2*(58), 9-13.

Suárez-Orozco, C., Todorova, I., & Qin, D. B. (2006). The Well-Being of Immigrant Adolescents: A Longitudinal Perspective on Risk and Protective Factors. In F. A.

Villarruel & T. Luster (Eds.), *The Crisis in Youth Mental Health: Critical Issues and Effective Programs*, Vol. 2. *Disorders in Adolescence* (pp. 53-83). Praeger Publishers/Greenwood Publishing Group.

Szabo, A., English, A. S., Zhijia, Z., Jose, P., Ward, C., & Jianhong, M. (2017). Is the Utility of Secondary Coping a Function of Ethnicity or the Context of Reception? A Longitudinal Study Across Western and Eastern Cultures. *Journal of Cross-Cultural Psychology*, *48*(8), 1230-1246. https://doi.org/10.1177/0022022117719158

Tajfel, H. (1974). Social Identity and Intergroup Behaviour. *Social Science Information*, *13*(2), 65-93. https://doi.org/10.1177/053901847401300204

Tajfel, H. (1981). *Human Groups and Social Categories: Studies in Social Psychology*. Cambridge University Press.

Tajfel, H. (1982). *Social Identity and Intergroup Relations*. Cambridge University Press.

Tajfel, H., & Turner, J. C. (1979). An Integrative Theory of Intergroup Conflict. In W. G. Austin., & S. Worchel (Eds.), *The Social Psychology of Intergroup Relations*. (pp. 33-37). Brooks/Cole.

Thomas, P., & Sanderson, P. (2011). Unwilling Citizens? Muslim Young People and National Identity. *Sociology*, *45*(6), 1028-1044. https://doi.org/10.1177/0038038511416161

Turner, J. C., Hogg, M. A., Oakes, P. J., Reicher, S. D., & Wetherell, M. S. (1987). *Rediscovering the Social Group: A Self-categorization Theory*. Basil Blackwell.

Umaña-Taylor, A. J. (2016). A Post-racial Society in Which Ethnic-Racial Discrimination Still Exists and Has Significant Consequences for Youths' Adjustment. *Current Directions in Psychological Science*, *25*(2), 111-118. https://doi.org/10.1177/0963721415627858

Vedder, P., Sam, D. L., & Liebkind, K. (2007). The Acculturation and Adaptation of Turkish Adolescents in North-Western Europe. *Applied Developmental Science*, *11*(3), 126-136. https://doi.org/10.1080/10888690701454617

Verkuyten, M. (2007). Religious Group Identification and Inter-Religious Relations: A Study Among Turkish-Dutch Muslims. *Group Processes & Intergroup Relations*, *10*(3), 341-357. https://doi.org/10.1177/1368430207078695

Verkuyten, M., Kinket, B., & Wielen, C. V. D. (1997). Preadolescents' Understanding of Ethnic Discrimination. *The Journal of Genetic Psychology: Research and Theory on Human Development*, *158*(1), 97-112. https://doi.org/10.1080/00221329709596655

Viruell-Fuentes, E. A. (2007). Beyond Acculturation: Immigration, Discrimination, and Health Research Among Mexicans in the United States. *Social Science & Medicine*, *65*(7), 1524-1535. https://doi.org/10.1016/j.socscimed.2007.05.010

Ward, C., Adam, Z., & Stuart, J. (2010). *Psychological and Socio-Cultural Adaptation of Asian Muslim Youth* [Conference presentation]. Paper presented at The Fourth International Asian Health and Wellbeing Conference: An Holistic Approach to Asian Health. Auckland, New Zealand.

Wei, M., Wang, K. T., Heppner, P. P., & Du, Y. (2012). Ethnic and Mainstream Social Connectedness, Perceived Racial Discrimination, and Posttraumatic Stress Symptoms. *Journal of Counseling Psychology*, *59*(3), 486-493. https://doi.org/10.1037/a0028000

Weinreich, P. (1983). Psychodynamics of Personal and Social Identity. In A. Jacobson-Widding (Ed.), *Identity: Personal and socio-cultural* (pp. 159-185). Almqvist & Wiskell.

Wiley, S., Lawrence, D., Figueroa, J., & Percontino, R. (2013). Rejection-(Dis)Identification and Ethnic Political Engagement Among First-Generation Latino Immigrants to the

United States. *Cultural Diversity and Ethnic Minority Psychology*, *19*(3), 310-319. https://doi.org/10.1037/a0031093

Wong, C. A., Eccles, J. S., & Sameroff, A. (2003). The Influence of Ethnic Discrimination and Ethnic Identification on African American Adolescents' School and Socioemotional Adjustment. *Journal of personality*, *71*(6), 1197-1232. https://doi.org/10.1111/1467-6494.7106012

World Bank (2015). Thinking Automatically. *World Development Report 2015: Mind, Society, and Behaviour*. (pp. 58-79). World Bank Publications.

Wylie, R. C. (1989). *Measures of Self-Concept*. University of Nebraska Press.

Yeh, C. J. (2003). Age, Acculturation, Cultural Adjustment, and Mental Health Symptoms of Chinese, Korean, and Japanese Immigrant Youths. *Cultural Diversity & Ethnic Minority Psychology*, *9*, 34-48. https://doi.org/10.1037/1099-9809.9.1.34