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**UNDERSTANDING THE IMPACT OF ISLAMOPHOBIA ON OCCUPATIONAL
PARTICIPATION**

by

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UNDERSTANDING THE IMPACT OF ISLAMOPHOBIA ON OCCUPATIONAL PARTICIPATION

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ABSTRACT

Islamophobia, a form of discrimination targeting Muslims and individuals perceived to be Muslim, has been found to adversely affect health by disrupting various personal, social, and institutional systems within an individual and their environment (Samari, 2016). With reports of anti-muslim sentiments rising globally (Samari, 2016), Islamophobia deserves attention as a source of negative health outcomes and health disparities, yet little is known regarding the implications of Islamophobia for occupational therapy assessments and practice. This study aims to explore how Islamophobia impacts the participation of Muslim Americans in education, work, social activities, and other areas of occupation. A survey was conducted with 108 Muslim Americans, who shared their experiences and perceived effects of Islamophobia on their daily lives. Survey results indicated a significant correlation between experiences of Islamophobia and mental and emotional

well-being, social connections, and self-expression and identity. Data collected also provided information regarding Islamophobia in different occupational settings. The study's findings shed light on research gaps within occupational therapy, particularly regarding the role of occupational therapists in addressing the impact of Islamophobia and racial and religious discrimination. This study proposes next steps to enhance the profession's understanding and capacity to effectively address the consequences of Islamophobia through various facets of occupational therapy, including assessment, intervention, education, and advocacy.

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LIST OF ABBREVIATIONS

AOTA American Occupational Therapy Association

FOJ Framework of Occupational Justice

OTP Occupational Therapy Practitioner

PEO Person Environment Occupation Model

TU Temple University

WFOT World Federation of Occupational Therapists

GLOSSARY

Islamophobia – refers to the fear of and hostility toward Muslims and Islam that is driven by racism and that leads to exclusionary, discriminatory, and violent actions targeting Muslims and those perceived as Muslim (Green, 2021).

Occupational participation – refers to engagement in work, play, or activities of daily living that are not just a part of one's socio-cultural context, but is also purposeful, meaningful, and necessary for one's well-being (Vessby & Kjellberg, 2010)

Cultural Sensitivity – being aware that cultural differences and similarities between people exist without assigning them a value – positive or negative, better, or worse, right or wrong (NYCHRA, 2023).

Unconscious Bias – social stereotypes about certain groups of people that individuals form outside their own consciousness. Everyone holds unconscious beliefs about various social and identity groups, and these biases stem from a tendency to organize social and cultural worlds by categorizing different groups (UCSF, 2023).

CHAPTER ONE - Introduction

Background

The term "Islamophobia" was first used in academic texts in a report by the Runnymede Trust in 1997, defining it as "unfounded hostility towards Islam and a fear or dislike of all or most Muslims" (Runnymede Trust, 1997). In 2015, the Arab American Institute reported that unfavorable attitudes toward Muslim Americans reached a high of 67% (AAI, 2015) and while overall hate crimes in America decreased in 2014, anti-Muslim hate crimes increased by 14% compared to the previous year (FBI, 2014).

These alarming numbers highlight the persistent issue of Islamophobia and its detrimental impact on individuals and communities. However, despite the growing recognition of the effects of Islamophobia, research on its overall impact on occupational engagement, health, and wellness, especially within the occupational therapy profession, remains limited (Samari, 2018).

The World Health Organization (WHO) International Classification of Functioning, Disability and Health (ICF) defines participation as being involved in various aspects of life. According to WHO, participation not only plays a crucial role in health and well-being but also has a positive impact on overall quality of life (WHO, 2001). Law (2002) further emphasizes that occupational therapy holds a distinct and valuable role in promoting and enabling participation for individuals, regardless of their disability status. Law's (2002) insights from over two decades ago highlight the influence that customs, societal expectations, and cultural influences shape the occupations individuals choose to engage in. These external factors, including homes, families, communities, and

environmental supports, greatly influence the opportunities and choices available to individuals, impacting their level of participation in various life contexts.

Recognizing the value of participation, OTPs should be aware of the external factors that can influence an individuals' ability to fully engage in their desired occupations. Occupational therapists have an obligation to address these external factors that can become barriers to participation. Furthermore, OTPs should advocate for inclusive OT practices that address discrimination and promote equal access to meaningful participation for all individuals. By acknowledging and addressing these factors, occupational therapists can contribute to creating a safe and inclusive environment that's fosters participation and supports individuals in achieving their occupational goals and wellbeing.

Why this Problem Matters

Islamophobia deserves attention as a source of trauma, potentially resulting in adverse mental and physical health outcomes that significantly influence occupational performance. It can be experienced both at an individual and group level, making it a complex dilemma that calls for thoughtful consideration at the individual, community, and global population levels. According to Samari (2018), although Islamophobia undermines health equity, delineating its effects globally is challenging as it affects diverse groups geographically, racially, and socially. Existing health research pays insufficient attention to the impact of Islamophobia on the health and quality of life of Muslims and those perceived to be Muslim (Samari, 2018). Understanding the relationship between Islamophobia and health and wellness by investigating the effect of

Islamophobic microaggressions and discrimination on meaningful participation can contribute to the progression of the occupational therapy profession towards more inclusive care.

Due to the absence of methods of verification or measuring discrimination, self-reports of life events in which one perceives they are experiencing discrimination or othering are the primary and acceptable means of gathering information (Pascoe & Richman, 2009). Additionally, examining therapists' perceptions, beliefs, and attitudes regarding social justice, microaggressions, and their professional responsibilities can inform the development of interventions aimed at addressing the influence of Islamophobia as a discriminatory factor on occupational performance (Beagan & Etowa, 2009). Understanding how occupational therapy practitioners perceive and understand Islamophobia, microaggressions, and discrimination can inform strategies to promote inclusive care and address the negative impacts of Islamophobia on health and well-being.

Microaggressions refer to intentional or unintentional acts of communication that involve conveying hostile, derogatory, or negative racial slights and insults towards a specific individual or group (Sue et al., 2007). Recent years have seen an emergence of research on racial microaggressions, which are subtle forms of discrimination that send negative and denigrating messages to members of marginalized racial groups (Nadal, 2011; Sue, 2010). Discussions on the intersections of racial discrimination, occupation, and practice are also increasing in prevalence in occupational therapy literature, as noted

by Mahoney et al. (2019) and Suarez Balcazar et al. (2020). This literature suggests both immediate and cumulative impact of microaggressions upon occupational participation.

Role of Occupational Therapy with this Problem

Discrimination, defined by Healthy People 2030 as “socially structured action that is unfair or unjustified and harms individuals and groups” (ODPHP, 2020), can have negative impacts on physical and psychological health (Pascoe & Richman, 2009).

Discrimination, especially racial discrimination, has also been associated with symptoms of trauma (Mendez et al., 2022; Vines et al., 2017). Nondiscrimination, which aligns with the principles of the Occupational Therapy Code of Ethics (AOTA, 2015) and is a necessary prerequisite for inclusive occupational therapy practice (AOTA, 2014), exists when all people are treated equitably (AOTA, 2015). The American Occupational Therapy Association (AOTA) Code of Ethics and Occupational Therapy Practice Framework (OTPF-4) require practitioners to fully address a client's cultural needs and consider the context and resources required for equitable care (AOTA, 2021). However, occupational therapy practitioners may hold explicit or implicit biases that hinder communication with clients and recognition of occupational injustices and neglect of needed care (Hall et al., 2015).

Understanding the impact of Islamophobia on health and occupational participation is crucial for promoting inclusive care and addressing the adverse effects it causes. The limited research in this area highlights the need for further exploration and awareness of the relationship between Islamophobia, health outcomes, and meaningful participation. By examining therapists' perceptions, beliefs, and attitudes towards developing

interventions to address microaggressions and discrimination, as well as considering the perceived impact of Islamophobia on those directly affected, occupational therapists can play a vital role in fostering inclusive environments and improving the well-being of individuals impacted by Islamophobia.

Contributors to the problem

The current research gap surrounding the impact of Islamophobia on occupational participation presents a significant challenge in comprehending the full extent of this problem and the potential role of occupational therapy in addressing it. To bridge this gap, it is crucial to expand our understanding of the relationship between Islamophobia, health outcomes, and participation. By exploring the different factors at play when assessing the impact of Islamophobia, we can gain a comprehensive understanding of its effects on occupational participation and uncover possible avenues for occupational therapy intervention and support.

There are several external factors to consider when evaluating the impact of Islamophobia. One aspect is the way that Islamophobia is perpetuated through institutional policies and practices that marginalize or put Muslims at a disadvantage (Samari, 2018). Discriminatory immigration policies, racial profiling, and surveillance programs targeting Muslims and those perceived as Muslim have been associated with decreased mental health, feelings of anxiety, isolation, lack of safety, stigmatization and feeling disconnection from their communities (Abu-Ras & Abu-Bader, 2008; Samari, 2018).

In addition to institutional factors, barriers to education, employment, healthcare, and essential services due to Islamophobia further compound the issue. Limited access to education and employment opportunities can hinder social and economic advancement, contributing to experiences of discrimination, stress, and illness (Samari, 2018; Williams & Mohammed, 2013).

Furthermore, Islamophobia has the potential to cause social exclusion and stigmatization of Muslims, leading to feelings of alienation and strained interpersonal relationships. This strain on interpersonal relationships caused by Islamophobia can hinder individuals' ability to fully engage in their communities and establish a sense of belonging. Feelings of alienation and marginalization can further reduce occupational participation and engagement, impacting various aspects of health such as stress levels, resource access, social connections, and psychological and behavioral responses (Samari, 2018). These negative consequences can lead to adverse health outcomes for individuals affected by the stigmatization and social isolation associated with Islamophobia (Samari, 2018; Hatzenbuehler et al., 2013). It is important to consider the social impact and stigmatization of Muslims alongside other significant factors when examining health and wellness (Hatzenbuehler et al., 2013) to better understand the implications of social exclusion and take the necessary steps to address these issues for the well-being of affected individuals.

Proposed Solution to the Problem

This doctoral capstone project will measure and assess the impact of racial and religious discrimination on participation and engagement and explore the challenges

associated with the lack of objective verification methods or measures of discrimination. Much of the current research in this area relies on individuals' perceptions of discriminatory treatment based on self-reports of life events rather than directly observed discrimination (Pascoe & Richman, 2009). Exploring therapists' perceptions, beliefs, and attitudes regarding social justice, microaggressions, and our professional responsibilities can play a crucial role in shaping educational interventions aimed at addressing the impact of Islamophobia as a form of discrimination on occupational performance (Beagan & Etowa, 2009). Using the evidence gathered through this survey, a training program will be developed to promote increased understanding of the impact of Islamophobia on occupational participation, health, and wellness as well as strategies to combat the effects.

CHAPTER TWO – Project Evidence and Theoretical Base Supporting Central Commitment

Introduction

This chapter presents a visual model of the problem to guide understanding of contributors to the problem. Additionally, a theoretical framework to strengthen both the understanding of the problem as well as guide content of the training program to combat the problem is discussed. Finally, a synthesis of evidence supporting the contributors to the problem as well as previous efforts to address the problem is provided.

Model of the Problem

Racial and religious discrimination directed towards Muslims, and those racialized to be Muslim, continue to have a negative impact on health by disrupting individual, interpersonal, and structural systems within an individual and their environment, however, research pays insufficient attention to the impact of Islamophobia on the overall health and wellness of Muslim Americans (Samari et al., 2018). In addition to the limited research in this area, evidence supporting the effectiveness of Implicit Bias training for healthcare providers addressing trauma related to discrimination related to Islamophobia is also limited. Existing research also suggests that implicit bias training that does not teach specific, concrete strategies to healthcare providers could potentially have unintended harmful consequences (Hagiwara et al., 2020).

The AOTA Code of Ethics and Occupational Therapy Practice Framework requires practitioners to fully address a client's cultural needs and shape the need to address clients as individuals by addressing the context and required resources for equitable care (AOTA, 2020). When implicit and explicit bias amongst healthcare

providers persists, it becomes a barrier to Muslim Americans' participation in healthcare settings and prevents equitable care for them. An exploratory study examining the presence of implicit and explicit racial bias amongst healthcare professionals across the United States found that without addressing the issue of racial bias, healthcare providers and researchers are not fully committing to the health and wellness of their Muslim American clients (Abou-Arab & Mendonca, 2021).

The scarcity of research addressing the effects of Islamophobia and racial discrimination related to Islamophobia on occupational engagement among Muslim Americans requires immediate attention. The lack of adequate research in this area hinders the development of evidence-based continuing education tools and implicit bias training for healthcare providers including occupational therapists, leading to potential gaps in addressing these critical issues in practice. As a result, Muslim Americans who face discrimination and Islamophobic microaggressions may not receive equitable care, which can affect their occupational engagement and participation in various settings, such as schools, work, and social settings. This research gap can negatively impact the overall health and wellness of individuals impacted by Islamophobia, as occupational participation is closely tied to well-being.

Figure 2.1 *Model of the Problem*

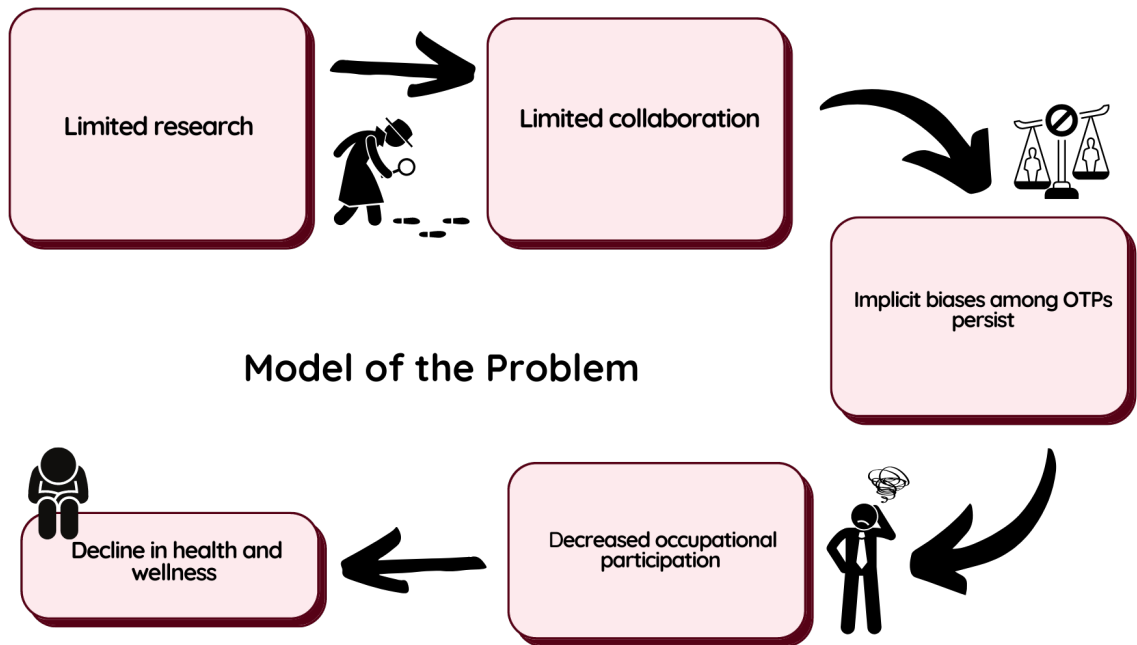


Figure 2.1 *Model of the Problem*

This figure illustrates how limited literature on the impact of racial and religious discrimination on occupational participation leads to the persistence of bias in occupational therapy settings and a decline in health and wellness and individuals impacted by Islamophobia.

Figure 2.2 Model of the Problem in School Settings

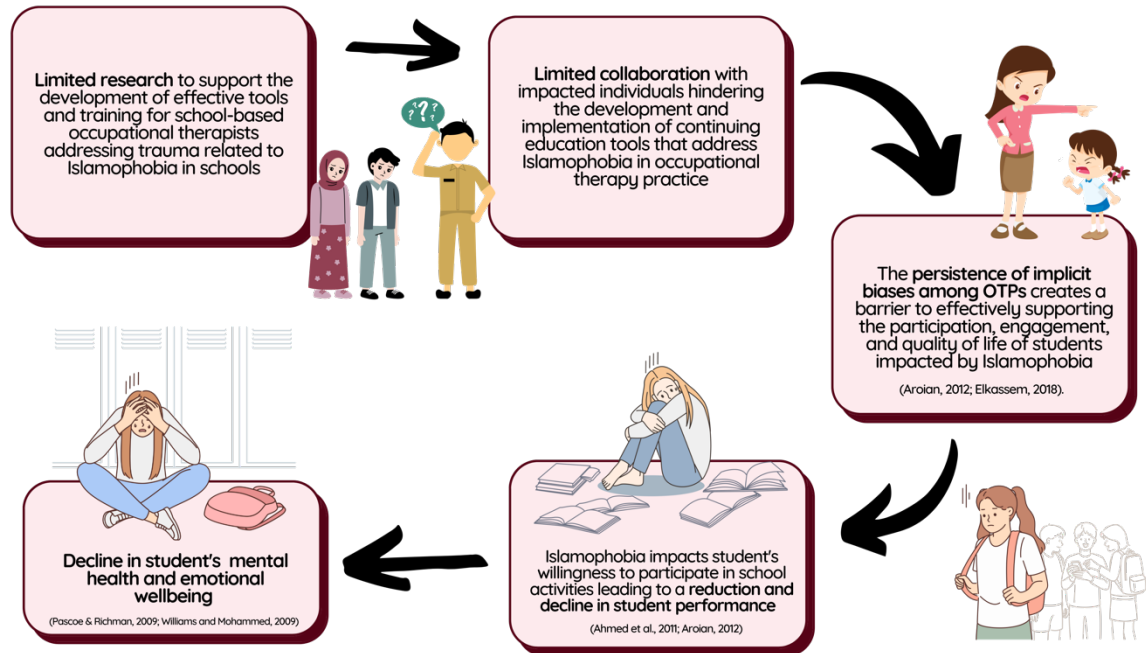


Figure 2.2 Model of the Problem in School Settings

Limited research and collaboration hinder occupational therapists from effectively addressing Islamophobia-related trauma in schools, leading to persistent biases and barriers to culturally sensitive and trauma informed OT practice. This can lead to limited engagement in school activities and a decline in student performance, ultimately leading to a significant mental health dilemma.

Theory to Understand the Problem

The impact of Islamophobic microaggressions towards Muslims, and those perceived as Muslim, on occupational engagement, health, and wellness can be best understood through the lens of occupational justice and cultural humility. Occupational justice is a unique framework that focuses explicitly on issues of justice related to occupation, emphasizing that participation in meaningful occupations is a fundamental individual right, and that barriers to participation are a form of injustice (Townsend & Wilcock, 2004). Applying an occupational justice framework allows occupational therapists to recognize barriers to participation and frame research problems, particularly the outcomes of occupational injustice resulting from Islamophobic microaggressions and discrimination, in terms of occupational justice.

The Framework of Occupational Justice (FOJ), primarily proposed by Townsend (2004) and further developed by Stadynk (2010), highlights the underlying principles of occupational justice. These principles include the belief that all individuals are occupational beings, that participation in meaningful occupations leads to positive health outcomes, and that occupational experiences and environments are influenced by economic, policy, cultural, and other determinants (Townsend & Wilcock, 2004; Benjamin-Thomas & Rudman, 2018). The FOJ also suggests that when occupational rights are respected, occupational justice is enabled, and individuals are afforded opportunities to participate in meaningful occupations (Durocher et al., 2014).

The values and assumptions of the framework for occupational justice align with the presented research problem. Specific values of an occupational justice framework include: all individuals are occupational beings (Wilcock, 1998), participation in

meaningful and enriching occupations leads to positive health outcomes (Townsend & Wilcock, 2004), and occupational experiences and environments are determined by economic, policy, cultural and other determinants (Townsend & Wilcock, 2004).

The FOJ further posits that structural and contextual factors can create conditions of occupational injustice, resulting in outcomes such as occupational apartheid, occupational marginalization, occupational deprivation, and occupational alienation (Townsend & Polatajko, 2013). Among these outcomes, occupational deprivation and occupational marginalization are particularly relevant to the research problem at hand. Occupational deprivation is defined as "a state of preclusion from engagement in occupations of necessity and/or meaning due to factors that stand outside the immediate control of the individual" (Whiteford, 2000). These external factors may include social, environmental, economic, geographic, historical, cultural, political, or interpersonal factors. Occupational marginalization, on the other hand, is defined as exclusion from participation in occupation based on 'invisible' norms and expectations about who should participate in what occupations (Townsend & Wilcock, 2004).

Utilizing an occupational justice framework, occupational therapy can provide insights into the research problem of the impact of Islamophobia in terms of outcomes related to occupational injustice. This approach allows for a holistic understanding of the individual's unique occupational needs, habits, and capacities, while also providing a lens to inform social change in addressing occupational deprivation and marginalization resulting from unexamined biases and behaviors (Durocher et al., 2014). Additionally, by applying an occupational justice framework, occupational therapists can better

understand the complexities of the problem and develop assessments, interventions, and policies that address the occupational needs of individuals while promoting social change.

Another relevant framework to the current model of the problem is the Person-Environment-Occupation (PEO) model. The PEO model emphasizes the interaction between the person, their environment, and their chosen occupations (Law et al, 1996). It recognizes that a person's occupational engagement is influenced by their unique characteristics, the physical and social environment, and the occupations they choose to engage in (Law et al, 1996). Using the PEO model, occupational therapists can assess how racial and religious discrimination, including Islamophobia, impact an individual's occupational choices, opportunities, and experiences. Occupational therapists can explore how discriminatory attitudes and behaviors within the environment limit participation in meaningful occupations and hinder the person's overall well-being.

Overall, understanding the FOJ and PEO models can emphasize the principles of individual rights, meaningful occupation, and social determinants of health, such as social participation, access to education, and quality healthcare (ODPHP, 2020). Addressing the research problem through an occupational justice framework and PEO model will not only allow occupational therapy practitioners to address the immediate impact of Islamophobia on individuals' participation in meaningful occupations but also advocate for systemic changes to promote occupational justice for those affected by Islamophobia.

Figure 2.3 *Overview of Theories*

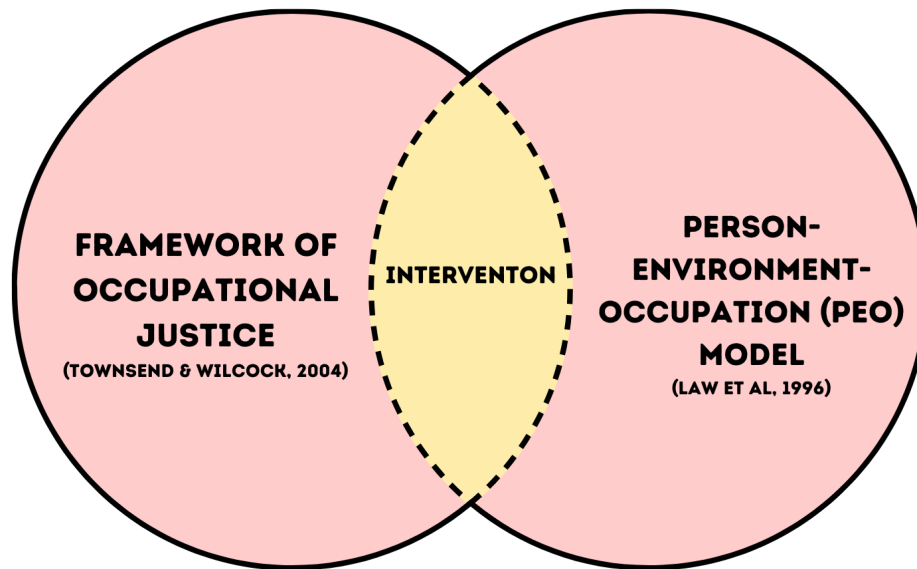


Figure 2.3 *Overview of Theories*

The two theories which underscore this work are the Framework of Occupational Justice and Person Environment Occupation. Results from the study may guide the space of overlap between these two models.

Guiding Questions Solidifying Understanding the Problem

1. Is there evidence regarding the impact of discrimination related to Islamophobia on the health and wellness of individuals?
2. Is there evidence that limited research regarding the impact of Islamophobia on occupational participation leads to a decline in health, wellness, participation, and engagement in impacted individuals?

3. Is there evidence that limited research regarding the impact of Islamophobia on occupational participation leads to a decline in health, wellness, participation, and engagement in impacted individuals?
4. Is there evidence that Islamophobia negatively impacts individuals' perception of self and their participation in their communities?
5. Is there evidence supporting the effectiveness of Implicit Bias training in equipping occupational therapists with strategies to address and prevent biases from interfering with the provision of optimal care?

Summary of Evidence Supporting the Problem Model

Is there evidence regarding the impact of discrimination related to Islamophobia on the health and wellness of individuals?

Although there is sufficient evidence on the adverse effects of discrimination on mental and physical health and child development, limited evidence exists specifically on Islamophobia (Aroian, 2012). The Council on American-Islamic Relations (CAIR), a civil rights and advocacy organization, defines Islamophobia as prejudice against or hatred of Islam and Muslims (CAIR, 2022). Studies have shown that Islamophobia has additive effects on mental health and functional daily tasks (Nadal et al., 2012). With anti-Muslim sentiments increasing in prevalence in the United States and globally, exploratory studies have emerged to synthesize evidence and inform intervention decisions for health professionals in all care settings. Emerging literature supports the

researcher's hypothesis that Islamophobia has additive effects on mental health and an individual's ability to engage in functional daily tasks (Nadal et al. 2012).

Is there evidence that limited research regarding the impact of Islamophobia on occupational participation leads to a decline in health, wellness, participation, and engagement in impacted individuals?

Current literature suggests that Islamophobia has a severe impact on the health and development of school-aged children, with numerous reports of discrimination encountered in schools (Aroian, 2012; Nadal et al., 2012; Elkassem et al., 2018). In 2022, CAIR reported that 34% of bias and hate crimes experienced by Muslim New Yorkers have occurred in educational institutions (CAIR, 2022). Previous studies have also found that Muslim girls are at higher risk for harassment, possibly due to more easily identifiable markers of their Muslim identity, such as the headscarf or hijab (Aroian, 2012; Nadal et al., 2012; Elkassem et al., 2018).

A descriptive qualitative study conducted by Aroian (2012) obtained in-depth accounts of Muslim American adolescents on their experiences with discrimination. Reports of Islamophobia were recorded in both school and non-school settings, with school settings being more prevalent in reports of discrimination and stigmatization related to Islamophobia directed at children and adolescents (Aroian, 2012). Findings identified school settings as "rife with discrimination toward Muslims," with Muslim American adolescents reporting encountering discrimination from teachers, school administrators, and classmates in school settings (El-Haj, 2007; Khanlou et al., 2008; Aroian, 2012). Additionally, reports of discrimination from strangers and other

individuals in non-school settings cannot be discounted, as acute and sustained exposure to discrimination has adverse effects on mental and physical health and child development (El-Haj, 2007; Khanlou et al., 2008). Study results also indicated that student interactions and performance in school settings, as well as their presenting cultural identity were affected (El-Haj, 2007; Khanlou et al., 2008).

Is there evidence that Islamophobia negatively impacts individuals' perception of self and their participation in their communities?

Findings from an exploratory study conducted by Elkassem et al. (2018) are consistent with previous studies examining the impact of Islamophobia on school-aged Muslim children and adolescents. Elkassem et al. (2018) identified Islamophobia as a key factor impacting how children felt about themselves, their community, and their safety. Subjection to Islamophobic discrimination can also lead to Muslim adolescents feeling further marginalized (Elkassem et al., 2018), resulting in feelings of isolation in school settings, poor academic performance, low self-esteem, internalized and externalized behavioral challenges, and possible impact on post-school plans, such as college choices and vocational interests (Ahmed et al., 2011; Aroian, 2012). In 2015, the Migration Policy Institute reported that school-aged children who have experienced discrimination may display stress responses similar to those prevalent in post-traumatic stress disorder (Brown, 2016). Similarly, children who experience discrimination from their teachers, classmates, and other members of their school communities are more likely to have

negative attitudes towards school, decreased motivation to engage in school activities, and a higher risk of dropping out of high school (Brown, 2016).

Is there evidence supporting the effectiveness of Implicit Bias training in equipping occupational therapists with strategies to address and prevent biases from interfering with the provision of optimal care?

It is evident that Islamophobic discrimination is detrimental to school-aged Muslim children and adolescents require immediate efforts to broaden available formal knowledge and understanding for future intervention. Occupational therapists have a professional and ethical responsibility to actively address all forms of discrimination, including Islamophobia, in various settings, including schools and non-school settings. School-based interventions addressing islamophobia are crucial. Existing literature highlights the importance of interventions from members of the school staff, such as teachers, social workers, and school nurses, in addressing Islamophobia (Aroian, 2012; Elkassem, 2018). However, there is a research gap in examining the impact of Islamophobia and discrimination on Muslim American adolescents' occupational performance and the implications for occupational therapy practitioners.

In 2021, The American Occupational Therapy Association (AOTA) took a significant step by releasing "AOTA's Guide to Addressing the Impact of Racial Discrimination, Stigma, and Implicit Bias on Provision of Services," a comprehensive document outlining the expectations for occupational therapy practitioners in tackling discrimination across all practice settings (AOTA, 2021). This guide, building on existing

evidence highlighting the critical nature of this issue concerning negative health outcomes, emphasizes the ethical and professional responsibility of occupational therapy practitioners in addressing the repercussions of Islamophobic discrimination on Muslim Americans and others who face discrimination due to being racially associated with Islam. The proposed study represents a pioneering effort, aligning with the professional organization's call for response as well as bridging existing gaps in evidence. It is anticipated that the work will offer valuable insights into the influence of Islamophobia on occupational participation. Research examining the relationship between perceived Islamophobia and individual health and well-being remains particularly scarce within occupation therapy research.

Synthesis of Previously Implemented Efforts

Pascoe and Richman (2009) conducted a significant meta-analysis using 134 samples to investigate the correlation between perceived discrimination and health outcomes. Their study sheds light on the impact of discrimination on an individual's well-being. The analysis included samples from articles that linked negative health outcomes to perceived discrimination, with a focus on self-reported experiences of discrimination rather than objectively observed measures. The findings supported the hypothesis that perceived discrimination is associated with both mental and physical health issues. However, it is essential to note that 91% of the articles included in the analysis relied on self-report surveys to measure perceived discrimination (Pascoe & Richman, 2009).

Mental health outcomes in the analyzed samples encompassed a range of symptoms, including depression, anxiety, posttraumatic stress, psychosis, and paranoia

(Pascoe & Richman, 2009). Additionally, the meta-analysis revealed that experiences of discrimination were linked to psychological distress, leading to decreased well-being and impacted self-esteem. On the physical health front, the samples indicated a connection between perceived discrimination and issues such as hypertension, self-reported poor health, obesity, high blood pressure, and substance use, which may serve as potential risk factors for disease (Pascoe & Richman, 2009; Williams & Mohammed, 2009).

The meta-analysis conducted in this study did not explore the experiences of Islamophobia. However, its results highlight the harmful consequences of discrimination on health and well-being. The use of self-reported measures of discrimination further underscores the significance of understanding individuals' perceptions of their discriminatory encounters. These findings reinforce the need for a research study that employs self-reported measures specifically focused on comprehending the perception and influence of Islamophobia experiences on occupational engagement.

Given the significance of this research and its relevance to the impact of discrimination, including Islamophobia, there is an opportunity to build on this existing knowledge to specifically address the unique challenges faced by individuals affected by Islamophobic discrimination. Further research in this area can contribute to a more comprehensive understanding of the health implications of Islamophobia and guide the development of interventions and support systems to address the specific needs of this population.

In a recent study conducted by Kathawalla and Syed (2021), two comprehensive meta-analyses were performed to investigate the connections between discrimination, life

stressors, and mental health in the Muslim community. Analyzing 295 correlations from 130 unique samples, the study examined these factors both independently and in combination. The researchers identified various variables that contribute to the variation in effect sizes for discrimination, including discrimination level, mental-health outcome, number of discrimination measure items, and refugee status. The results of the analyses clearly demonstrate a significant association between discrimination and negative mental-health outcomes (Kathawalla & Syed, 2021). These findings shed light on the crucial need for further research in this area to gain a deeper understanding of how discrimination and life stressors impact the mental health of individuals, especially in Muslim communities.

Existing literature highlights a noticeable gap in occupational therapy (OT) literature. One gap exists concerning the impact of experiences upon occupational engagement. A second gap exists regarding interventions or programs designed to effectively address and mitigate the anticipated negative impact of Islamophobia on occupational engagement, health, and wellness. In response, the central commitment of this capstone project is to develop a comprehensive training program with a well-structured curriculum to equip OT practitioners in tackling this pressing issue. This commitment to deliver and evaluate effectiveness of curriculum can be preceded by an exploratory study to better understand the impact of experiences of Islamophobia upon occupational engagement.

CHAPTER 3 – Description of Central Commitment

Introduction

This chapter presents a comprehensive and multifaceted proposed solution to address the research problem. The study aims to achieve the following objectives: (1) explore existing literature and evidence supporting the correlation between perceived racial and religious discrimination and negative mental and physical health outcomes, (2) document the lived experiences of Muslim Americans affected by Islamophobia to enhance understanding of occupational therapists' knowledge, beliefs, and actions regarding the impact of Islamophobia on occupational participation, (3) assess the influence of Islamophobia on occupational participation across various areas such as education, work, social engagement, health management, leisure, and other domains of occupation, and (4) understand the role of occupational therapy practitioners in collaborating with individuals and communities impacted by experiences of Islamophobia. To accomplish these objectives, the proposed solution involves conducting targeted research on the impact of Islamophobia on participation to fill the evidence gap and provide valuable insights guiding the development of specific occupational therapy education tools. The intervention was developed in three phases. Phase 1 will be discussed in Chapter 3 and phases two and three will be further discussed in Chapter 4.

Phase 1: Literature Review and Data Collection

During this phase, a comprehensive review of existing evidence and literature was completed to explore topics related to racial and religious discrimination, Islamophobia,

unconscious bias, and cultural sensitivity in occupational therapy practice. Additionally, a survey was conducted among Muslim Americans to gather information and insight into the lived experiences of Islamophobia and its impact of everyday life. The study's inclusion criteria consisted of participants who self-identified as Muslim, were currently residing in the United States, and were over the age of 18. Exclusion criteria included individuals who did not meet these inclusion criteria. The survey yielded 190 responses, 172 of which met the inclusion criteria. During data analysis, incomplete responses, where participants had not responded to one or more questions in the, were excluded from the analysis, resulting in a final sample size of 108 respondents who met the inclusion criteria and were included in the data analysis (N=108).

Gathering relevant data, including existing research studies and survey responses from impacted Muslim Americans about their experiences with Islamophobia, was used to inform the development of a training program aimed at supporting occupational therapy practitioners in providing culturally sensitive care to individuals affected by Islamophobia.

Phase 2: Training Program Development and Presentation

Phase 2 involved developing a comprehensive training program, “OT for All: Strategies for Providing Inclusive and Culturally Sensitive Care to Individuals Impacted by Islamophobia” that builds on the findings from the literature review and data collection in Phase 1. Educational materials, curricula, and training program outlines have been developed and will undergo further refinement to ensure they meet the needs and expectations of OTPs. These materials will be presented to relevant stakeholders, including OT practitioners, to gather valuable feedback and ensure alignment with their specific requirements. This process of development and feedback

will contribute to a comprehensive and effective training program that caters to the needs of the OT profession.

Phase 3: Program Implementation and Evaluation

Phase 3 focuses on implementing the training program and delivering it to OT practitioners. Throughout this phase, original data will continue to be collected to assess the program's impact. Practitioner feedback, including experiences and suggestions for improvement, will be recorded, and analyzed. Program outcomes will be evaluated by analyzing collected data and assessing changes in knowledge, attitudes, and skills among OT practitioners. Based on evaluation findings and practitioner feedback, the program was refined and improved. Additionally, the evaluation findings, including success stories and best practices, will be disseminated to relevant stakeholders, contributing to the broader field of occupational therapy. This process promotes awareness about addressing discrimination and bias, ultimately enhancing the quality of care for individuals impacted by Islamophobia.

Literature Review

A literature review was conducted using a systematic search strategy to identify relevant literature. Academic databases, including AJOT, PubMed, PsycINFO, and CINAHL, were utilized. Keywords, including "Islamophobia," "participation," "occupational therapy," "cultural sensitivity", and "unconscious bias" were employed to refine the search and retrieve relevant articles. Considerations for literature review included study design, publication date, language, and direct relevance to the research question. Appendix X includes an evidence summary table with information on each study.

Data collection

An objective of this study was to examine the perceived impact of islamophobia on Muslim Americans. To achieve this, survey questions were adapted and expanded from a national survey conducted by the Othering & Belonging Institute at the University of California, Berkeley, which assessed the impacts of Islamophobia on Muslim Americans. Permission was obtained from the report authors (Elsheikh and Sisemore, Othering & Belonging Institute, 2021) to utilize and modify their survey questions for this investigation. This study also aimed to closely analyze data within the context of occupational therapy and explore the relationships between various backgrounds, demographics, and experiences with different occupations and contexts.

The primary objective of this study was to conduct a comprehensive survey among Muslim Americans to gain valuable insights into the effects of Islamophobia on their daily lives and their capacity to engage in diverse occupations within different contexts. As the study progressed, the data collected from the survey served as a foundation for the development of continuing education tools. Nevertheless, throughout the phases of development, recruitment, survey administration, data collection, and data analysis, significant and helpful insights were acquired. These findings inform the subsequent development and refinement of future surveys and hold potential for shaping future occupational therapy research.

Participants for this study were recruited through social media platforms, such as Twitter, Facebook, and Instagram, as well as email invitations. To maximize participation, participants were encouraged to share the survey with their networks. The recruitment process predominantly employed convenience sampling, as the initial outreach involved contacting the researchers' readily available contacts whom largely met the inclusion criteria and were willing to participate.

Moreover, snowball sampling was utilized and encouraged, allowing participants who self-identify as Muslims to participate in the survey and refer others whom also met the inclusion criteria. Through this combined approach, the study aimed to achieve a diverse participant pool and improve the representativeness of the study sample.

Demographics

Table 1 presents the demographics of the survey participants. Out of the 108 participants, 89.81% identified as female, and 10.19% identified as male. In terms of age groups, the majority of respondents fell into the 25-29 age group with 37.96% of the sample, followed by 30-34 (28.70%) and 18-24 (14.81%) age groups. Regarding education, the largest proportion of respondents had a Master's degree (65.74%), followed closely by Bachelor's degree holders (63.89%). Other education levels included Doctoral degree (14.81%), Associate's degree (5.56%), High School Diploma (4.63%), and Professional degree (4.63%).

In terms of race/ethnicity, the majority of respondents identified as Arab/Middle Eastern/North African (39.44%) or South Asian/Desi (21.30%). Other racial/ethnic categories represented in the survey included White/Caucasian/European-American (11.11%), East Asian/Southeast Asian (2.78%), Spanish/Hispanic/Latinx (3.70%), Native American/Alaskan Native (0.93%), and Native Hawaiian/Pacific Islander (0.93%).

Table 1

Demographics of survey respondents

		n	%
Gender	Male	11	10.19
	Female	97	89.81
Age Group	18-24	16	14.81

	25-29	41	37.96
	30-34	31	28.70
	35-39	14	12.96
	40-44	3	2.78
	45-49	1	0.93
	55-64	2	1.85
Education	High School diploma or GED	5	4.63
	Associate degree	6	5.56
	Bachelor's Degree	69	63.89
	Master's Degree	71	65.74
	Professional Degree	5	4.63
	Doctoral Degree	16	14.81
Race/Ethnicity	South Asian / Desi	23	21.30%
	Arab / Middle Eastern / North African	71	39.44%
	Black / African American / Afro-Caribbean	1	0.93
	White / Caucasian /European-American	12	11.11
	East Asian / Southeast Asian	3	2.78
	Spanish / Hispanic / Latinx	4	3.70
	Native American / Alaskan Native	1	0.93
	Native Hawaiian / Pacific Islander	1	0.93

Data analysis

To draw meaningful insights from the data, 5 different cross-analysis were conducted to identify key trends and correlations, enhancing our understanding of the implications for occupational therapy. To facilitate an accurate cross-analysis, the following variables were considered:

1. "Within the last twelve months, how often (if at all) did you personally experience Islamophobia in your everyday life?"
 - a. Response options: Very often, Often, Sometimes, Rarely, Never
 - b. Coding: Very often, Often, Sometimes, and Rarely were coded as 'Yes', and 'Never' as 'No'
2. "Have you personally experienced Islamophobia directed at you?"
 - a. Response options: Yes, No

The cross-analysis considered the following additional variables:

1. If participants directly experienced Islamophobia, they were asked to specify where they encountered it.
2. Participants were asked to describe the impact of Islamophobia on their emotional and mental well-being and indicate its frequency.
3. Participants were asked to mark all applicable effects of Islamophobia on their emotional and mental well-being.
4. The extent to which Islamophobia affected participants' ability to build social connections with non-Muslims was assessed.
5. The survey also inquired whether participants had ever hidden or tried to hide their religious identity.

Through a comprehensive cross-analysis, the study aims to gain valuable insights into the experiences of Muslim Americans with Islamophobia and its potential impact mental health and emotional well-being, social participation, self-expression, and occupational participation. These

findings can inform the development of targeted interventions to support individuals affected by Islamophobia and promote inclusivity and equitable care in occupational therapy practice.

The survey inquired whether participants have personally encountered Islamophobia directed at them and if they have experienced Islamophobia in their everyday life, specifically within the last 12 months. In response to the question about experiencing Islamophobia in their everyday life, within the last 12 months, 87.96% (n=95) of participants answered 'Yes', while 12.04% (n=13) responded with 'No'. In response to the question about personally experiencing Islamophobia directed at them, in their lifetime, 89.81% (n=97) of participants indicated that they have encountered such experiences, while 10.19% (n=11) stated that they have not.

Analysis 1: Islamophobia in Occupational Settings

The first analysis completed examined the frequency of experiences of Islamophobia in different occupational settings. Table 2 provides a breakdown of survey respondents' experiences with Islamophobia based on the frequency and locations where they encountered it within their lifetime and within last twelve months. For the question "Within the last twelve months, how often (if at all) did you personally experience Islamophobia in your everyday life?", 87.96% (n=95) of respondents answered 'Yes'. Among them, the majority experienced it in 2 to 5 locations 45.37% (n=49), followed by 22.22% (n=24) in 6 to 9 locations, and 16.67% (n=18) in at least one location. Similarly, in the table that presents responses to the question "Have you personally experienced Islamophobia directed at you?", 89.81% (n=97) of respondents answered 'Yes', indicating that they have experienced Islamophobia directed specifically at them. Among them, 46.30% (n=50) encountered Islamophobia in 2 to 5 locations, followed by 22.22% (n=24) in 6 to 9 locations, and 17.59% (n=19) in at least one location.

Table 3 provides further insight into the frequency of Islamophobia experiences in various occupational settings among the survey respondents. The most frequently reported occupational setting where Islamophobia was experienced is the airport, with 46.30% (n=50) reporting encounters with Islamophobia in this setting. Following is college or university, where 40.74% (n=44) of respondents experienced Islamophobia. Other frequently mentioned occupational settings include the workplace (38.89%, n=42), online or on the internet (37.96%, n=41), and public transport (32.41%, n=35). Additional settings where Islamophobia was experienced, but with lower frequencies, include retail stores (32.41%, n=35), K-12 schools (31.48%, n=34), and restaurants (30.56%, n=33). Public parks and playgrounds were also mentioned, with 16.67% (n=18) experiencing Islamophobia in public parks and 5.56% (n=6) in public playgrounds. An even smaller number of respondents reported experiencing Islamophobia in vocational or technical schools (2.78%, n=3) and sports settings (1.85%, n=2). Additionally, 8.33% (n=9) of respondents reported experiencing Islamophobia in other occupational settings not listed in the table but had the option to type in responses. Typed in responses included “walking in the neighborhood”, “in my apartment building”, and “at the gym”.

The data provides valuable insights into the varied occupational settings where Islamophobia is experienced and emphasizes the need for further research on the impact of such experiences on individuals' participation in these settings.

Table 2 *Experiences of Islamophobia*

Within the last twelve months, how often (if at all) did you personally experience Islamophobia in your everyday life?	Number of Locations Islamophobia Experienced				
	1	10 or more	2 to 5	6 to 9	Total
No	11	0	2	0	13

	10.19	0.00	1.85	0.00	12.04
	84.62	0.00	15.38	0.00	
	37.93	0.00	3.92	0.00	
Yes	18	4	49	24	95
	16.67	3.70	45.37	22.22	87.96
	18.95	4.21	51.58	25.26	
	62.07	100.00	96.08	100.00	
Total	29	4	51	24	108
	26.85	3.70	47.22	22.22	100.00
	Number of Locations Islamophobia Experienced				
	1	10 or more	2 to 5	6 to 9	Total
No	10	0	1	0	11
	9.26	0.00	0.93	0.00	10.19
	90.91	0.00	9.09	0.00	
	34.48	0.00	1.96	0.00	
Yes	19	4	50	24	97
	17.59	3.70	46.30	22.22	89.81
	19.59	4.12	51.55	24.74	
	65.52	100.00	98.04	100.00	
Total	29	4	51	24	108
	26.85	3.70	47.22	22.22	100.00

Table 3 *Occupational Settings*

Occupational Setting	n	%
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Airport	50	46.30
College or University	44	40.74
Workplace	42	38.89
Online or on the Internet	41	37.96
Public Transport	35	32.41
Retail Store	35	32.41
K-12 Schools	34	31.48
Restaurant	33	30.56
Public Park	18	16.67
Public Playground	6	5.56
Vocational or Technical School	3	2.78
Sports Setting	2	1.85
Other	9	8.33

Analysis 2: Experiences of Islamophobia and Mental Health

The second analysis examines the relationship between experiencing Islamophobia and its impact on mental health and emotional well-being. Tables 4 and 5 present data on the frequency of respondents who reported experiencing Islamophobia and whether it affects their mental and emotional well-being.

The first part of this analysis looked at experiences of Islamophobia in the last 12 months. Among those who reported not experiencing Islamophobia (n=13), 11 respondents (84.62%) indicated that it does not affect their mental and emotional well-being, while 2 respondents (15.38%) reported that it does have an impact.

Among those who experienced Islamophobia (n=95), 93 respondents (97.89%) stated that it affects their mental and emotional well-being, while only 2 respondents (2.11%) reported no impact.

The Fisher's Exact Test was conducted to analyze the relationship between experiencing Islamophobia and its impact on mental and emotional well-being. The two-sided p-value for this analysis was found to be 0.0702, indicating a trend toward significance but not reaching statistical significance.

In the second part of the analysis, the relationship between personally experiencing Islamophobia in a lifetime and its impact on mental and emotional well-being was examined. Among those who reported not experiencing Islamophobia directed at them (n=11), 9 respondents (81.82%) stated that it does not affect their mental and emotional well-being, while 2 respondents (18.18%) reported that it does. Among those who experienced Islamophobia directed at them (n=97), 95 respondents (97.94%) indicated that it affects their mental and emotional well-being, while only 2 respondents (2.06%) reported no impact.

The Fisher's Exact Test for this part of the analysis yielded a two-sided p-value of 0.0508, which indicates a trend toward significance, suggesting a potential relationship between experiencing Islamophobia directed at them and its impact on mental and emotional well-being.

Analysis 2 suggests a potential association between experiencing Islamophobia and its impact on mental and emotional well-being. It also indicates that further research with a larger sample size would be needed to establish statistical significance and draw definitive conclusions about the relationship between Islamophobia and mental health.

Table 4 *Islamophobia and Mental health (last 12 months)*

Within the last twelve months, how often (if at all) did you personally experience Islamophobia in your everyday life?	Does Islamophobia Affect Your Mental and Emotional Well-Being		
	No	Yes	Total
No	2	11	13
	1.85	10.19	12.04
	15.38	84.62	
	50.00	10.58	
Yes	2	93	95
	1.85	86.11	87.96
	2.11	97.89	
	50.00	89.42	
Total	4	104	108
	3.70	96.30	100.00
Fisher's Exact Test			
Cell (1,1) Frequency (F)		2	
Left-sided Pr <= F		0.9948	
Right-sided Pr >= F		0.0702	
Table Probability (P)		0.0650	
Two-sided Pr <= P		0.0702	

Table 5 *Islamophobia and Mental health*

Have you personally experienced Islamophobia directed at you?	Does Islamophobia Affect Your Mental and Emotional Well-Being		
	No	Yes	Total

No	2	9	11
	1.85	8.33	10.19
	18.18	81.82	
	50.00	8.65	
Yes	2	95	97
	1.85	87.96	89.81
	2.06	97.94	
	50.00	91.35	
Total	4	104	108
	3.70	96.30	100.00
Fisher's Exact Test			
Cell (1,1) Frequency (F)	2		
Left-sided Pr <= F	0.9970		
Right-sided Pr >= F	0.0508		
Table Probability (P)	0.0478		
Two-sided Pr <= P	0.0508		

Analysis 3: Number of Ways Mental and Emotional Well-Being Affected

Analysis 3 focuses on the number of ways mental and emotional well-being is affected by experiencing Islamophobia and the specific mental health symptoms reported. Table 6 shows the data for participants who responded to experiencing Islamophobia in the last twelve months and the number of ways their mental health was affected. Among those who reported not

experiencing Islamophobia (n=13), 3 respondents indicated that their mental and emotional well-being was affected in one way, 9 respondents in two to four ways, and 1 respondent in five to nine ways. For those who experienced Islamophobia (n=97), 13 respondents (12.04%) reported their mental and emotional well-being being affected in at least one way, 56 respondents (51.85%) in two to four ways, and 26 respondents (24.07%) in five to nine ways.

The Fisher's Exact Test was conducted to analyze the relationship between experiencing Islamophobia and the number of ways mental and emotional well-being was affected. The two-sided p-value for this analysis was found to be 0.0235., which indicates a statistically significant relationship between experiencing Islamophobia and the number of ways well-being is affected.

Similarly, Table 7 presents the distribution of the numbers of ways mental health was affected. Among participants who experienced Islamophobia directed at them in their lifetime (n=97), 13 respondents (13.40%) reported their mental and emotional well-being being affected in one way, 58 respondents (59.79%) in two to four ways, and 26 respondents (26.80%) in five to nine ways.

The Fisher's Exact Test was conducted to analyze the relationship between personally experiencing Islamophobia and the number of ways mental and emotional well-being was affected. The two-sided p-value for this analysis was found to be 0.0305, indicating a statistically significant relationship between experiencing Islamophobia and the number of ways well-being is affected.

Table 8 includes the frequencies of specific mental health symptoms reported by the participants. The most frequently reported symptoms were anxiety (61.11%), fear (54.63%), insecurity (50.00%), anger (49.07%), and stress (49.07%). Other reported symptoms include isolation (31.48%), paranoia (26.85%), and depression (18.52%).

The findings from Analysis 3 suggest that personally experiencing Islamophobia is associated with a greater number of ways mental and emotional well-being is affected. Moreover, the data highlights the prevalence of various mental health symptoms among those who have experienced Islamophobia. This information can provide valuable insights for addressing the mental health impact of Islamophobia and informing future occupational therapy interventions and support for impacted individuals. However, further research may be needed to explore these relationships in more depth and understand the complexities of mental and emotional well-being in the context of experiencing Islamophobia and its effect on participation and engagement.

Table 6 *Islamophobia and Mental Health*

Within the last twelve months, how often (if at all) did you personally experience Islamophobia in your everyday life?	Number of Ways Well-Being Affected			
	1	2 to 4	5 to 9	Total
No	3	9	1	13
	2.78	8.33	0.93	12.04
	23.08	69.23	7.69	
	18.75	13.85	3.70	
Yes	13	56	26	95
	12.04	51.85	24.07	87.96
	13.68	58.95	27.37	
	81.25	86.15	96.30	
Total	16	65	27	108
	14.81	60.19	25.00	100.00

Fisher's Exact Test	
Table Probability (P)	0.0235
Pr <= P	0.2808

Table 7 Islamophobia and Mental Health

Have you personally experienced Islamophobia directed at you?	Number of Ways Well-Being Affected			
	1	2 to 4	5 to 9	Total
No	3	7	1	11
	2.78	6.48	0.93	10.19
	27.27	63.64	9.09	
	18.75	10.77	3.70	
Yes	13	58	26	97
	12.04	53.70	24.07	89.81
	13.40	59.79	26.80	
	81.25	89.23	96.30	
Total	16	65	27	108
	14.81	60.19	25.00	100.00

Fisher's Exact Test	
Table Probability (P)	0.0305
Pr <= P	0.2213

Table 8 Islamophobia and Mental Health

Mental Health Symptom	Frequency
Anxiety	61.11% (n=66)
Fear	54.63% (n=59)
Insecurity	50.00% (n=54)
Anger	49.07% (n=53)
Stress	49.07% (n=53)
Isolation	31.48% (n=34)
Paranoia	26.85% (n=29)
Depression	18.52% (n=20)

Analysis 4: Social Connections with Non-Muslims

Analysis 4 explores the relationship between experiencing Islamophobia and its impact on building social connections with non-Muslims. Table 9 presents the data for participants based on their responses to experiencing Islamophobia directed at them in the last 12 months and whether it prevents them from building social connections with non-Muslims.

Among participants who reported not experiencing Islamophobia (n=13), 5 respondents (38.46%) indicated that Islamophobia does not prevent them from building social connections with non-Muslims, and 8 respondents (61.54%) said it does. For participants who experienced Islamophobia (n=95), 12 respondents (12.63%) reported that Islamophobia does not prevent them from building social connections with non-Muslims, and 83 respondents (87.37%) said it does.

The Fisher's Exact Test was conducted to analyze the relationship between personally experiencing Islamophobia in the last 12 months and its impact on building social connections with non-Muslims. The two-sided p-value for this analysis was found to be 0.0311, indicating a statistically significant relationship between experiencing Islamophobia and the likelihood of it preventing individuals from building social connections with non-Muslims.

Analysis 5 also investigates the relationship between personally experiencing Islamophobia in a lifetime and its potential impact on building social connections with non-Muslims. Table 10 presents data showing that for those who experienced Islamophobia (n=97), 13 respondents (13.40%) reported that Islamophobia does not prevent them from building social connections with non-Muslims, while 84 respondents (86.60%) mentioned that it does.

The Fisher's Exact Test was also conducted to assess the relationship between personally experiencing Islamophobia in a lifetime and its potential impact on building social connections with non-Muslims. The two-sided p-value obtained from this analysis is 0.0696, which suggests a notable relationship, though not statistically significant at the conventional threshold of 0.05.

These findings suggest that experiencing Islamophobia is associated with a higher likelihood of it impacting social connections with non-Muslims. The statistically significant relationship highlights the potential barriers that Islamophobia may pose to building connections and fostering relationships between different communities. Understanding and addressing these social impacts are crucial for promoting inclusivity, tolerance, and cultural sensitivity both in occupational therapy practice settings and occupational settings. Additionally, the implications of Islamophobia extend to the therapeutic alliance, providing valuable insights for occupational therapists to comprehend the impact of social engagement with Muslim clients.

This highlights the vital need to expand diversity within our profession to effectively support and care for individuals of different backgrounds.

Table 9 *Social Connections with Non-Muslims*

Within the last twelve months, how often (if at all) did you personally experience Islamophobia in your everyday life?	(Does Islamophobia Prevent you From Building Social Connections with non-Muslims?)		
	No	Yes	Total
No	5	8	13
	4.63	7.41	12.04
	38.46	61.54	
	29.41	8.79	
Yes	12	83	95
	11.11	76.85	87.96
	12.63	87.37	
	70.59	91.21	
Total	17	91	108
	15.74	84.26	100.00
Fisher's Exact Test			
Cell (1,1) Frequency (F)	5		
Left-sided Pr <= F	0.9944		
Right-sided Pr >= F	0.0311		

Table Probability (P)	0.0255
Two-sided Pr <= P	0.0311

Table 10 *Social Connections with Non-Muslims*

Have you personally experienced Islamophobia directed at you?	(Does Islamophobia Prevent you From Building Social Connections with non-Muslims?)		
	No	Yes	Total
No	4	7	11
	3.70	6.48	10.19
	36.36	63.64	
	23.53	7.69	
Yes	13	84	97
	12.04	77.78	89.81
	13.40	86.60	
	76.47	92.31	
Total	17	91	108
	15.74	84.26	100.00
Fisher's Exact Test			
Cell (1,1) Frequency (F)	4		
Left-sided Pr <= F	0.9862		
Right-sided Pr >= F	0.0696		

Table Probability (P)	0.0558
Two-sided Pr <= P	0.0696

Analysis 5: Hiding Identity

Analysis 5 explores the relationship between personally experiencing Islamophobia and whether individuals have ever hid or tried to hide their religious identity. Table 11 presents the data based on the reported experiences of Islamophobia in the last twelve months and whether respondents tried to hide or have hidden their religious identity.

Among participants who reported not experiencing Islamophobia (n=13), 2 respondents (15.38%) indicated that they have hid or tried to hide their religious identity, while 11 respondents (84.62%) stated that they have not.

For those who experienced Islamophobia (n=95), 42 respondents (44.21%) reported that they have hid or tried to hide their religious identity, while 53 respondents (55.79%) reported that they have not.

The Fisher's Exact Test was conducted to assess the relationship between personally experiencing Islamophobia and hiding or trying to hide religious identity. The two-sided p-value obtained from this analysis is 0.0695, which suggests a trend towards a potential relationship, although it does not reach statistical significance at the conventional threshold of 0.05.

Table 12 presents data based on reports personally experiencing islamophobia in a lifetime and hiding or tryingt o hide religious idenity. Participants who reported not experiencing Islamophobia directed at them (n=11), 3 respondents (27.27%) indicated that they

have ever hid or tried to hide their religious identity, while 8 respondents (72.73%) stated that they have not.

For those who experienced Islamophobia directed at them (n=97), 41 respondents (42.27%) reported that they have ever hid or tried to hide their religious identity, while 56 respondents (57.73%) mentioned that they have not.

The Fisher's Exact Test was conducted to assess the relationship between personally experiencing Islamophobia and hiding or trying to hide religious identity. The two-sided p-value obtained from this analysis is 0.5195, indicating that there is no statistically significant association between experiencing Islamophobia and the tendency to hide or try to hide religious identity.

While the results do not indicate a significant relationship, it is important to recognize that these findings do not capture all the complexities of individuals' experiences. The decision to hide or try to hide one's religious identity can be influenced by various factors, and this analysis provides only a snapshot of the relationship. Additionally, results from this analysis indicate a need for occupational therapy intervention in this area due to the impact of Islamophobia and occupational identity. Occupational identity, that is based on the premise that participation in meaningful occupation, such as religious observance, is what builds one's identity and sense of self (Kielhofner, 2008).

Table 11 *Islamophobia and self-expression*

Within the last twelve months, how often (if at all) did you personally experience Islamophobia in your everyday life?	Ever Hid or Tried to Hide Religious Identity		
	Yes	No	Total

No	2	11	13
	1.85	10.19	12.04
	15.38	84.62	
	4.55	17.19	
Yes	42	53	95
	38.89	49.07	87.96
	44.21	55.79	
	95.45	82.81	
Total	44	64	108
	40.74	59.26	100.00
Fisher's Exact Test			
Cell (1,1) Frequency (F)	2		
Left-sided Pr <= F	0.0418		
Right-sided Pr >= F	0.9923		
Table Probability (P)	0.0342		
Two-sided Pr <= P	0.0695		

Table 12 *Islamophobia and self-expression*

Have you personally experienced Islamophobia directed at you?	Ever Hid or Tried to Hide Religious Identity		
	Yes	No	Total
No	3	8	11
	2.78	7.41	10.19
	27.27	72.73	

	6.82	12.50	
Yes	41	56	97
	37.96	51.85	89.81
	42.27	57.73	
	93.18	87.50	
Total	44	64	108
	40.74	59.26	100.00
Fisher's Exact Test			
Cell (1,1) Frequency (F)	3		
Left-sided Pr <= F	0.2669		
Right-sided Pr >= F	0.9030		
Table Probability (P)	0.1699		
Two-sided Pr <= P	0.5195		

Survey Limitations

This study had several limitations that should be considered when interpreting the findings. First, the participant size was relatively small (N=108), which may limit the generalizability of the results to a larger population. While the survey provided valuable insights into the experiences of Muslim Americans with Islamophobia, future research with a larger and more diverse sample could enhance the external validity of the findings.

Second, the gender distribution in the survey may not fully represent the diversity of the target population. This imbalance could potentially impact the validity of gender-related

conclusions. To ensure more comprehensive and accurate findings, future research should strive for a more balanced representation of gender identities.

Another limitation is that the survey's focus might not have been specifically tailored to assess occupational participation or engagement. While the survey provided valuable data related to Islamophobia's impact on various aspects of participants' lives, including mental and emotional well-being, social connections, and access to public spaces, more specific questions directly related to occupational participation could improve the relevance of the results to the occupational therapy context.

Despite these limitations, the survey offered significant insights into the experiences of Muslim Americans impacted by Islamophobia. It sheds light on the multifaceted effects of discrimination on mental health, social interactions, and community engagement. By identifying areas for improvement, this research paves the way for future studies that can delve deeper into the specific intersection of Islamophobia, occupational participation, and the role of occupational therapy in addressing discrimination and promoting inclusive environments.

CHAPTER FOUR - Outcome Measurement Plan for Artifact(s)

Introduction

Chapter 4 outlines the comprehensive development phases 2 and 3 of the proposed solution described in Chapter 3. This chapter will also provide a detailed overview of the development of the training program and the evaluation and outcomes measurement plan. While the program was not fully executed during the doctoral journey, its structured outline and comprehensive evaluation plan lay the groundwork for future research aimed at addressing the research gap and promoting equitable and culturally sensitive care for individuals impacted by Islamophobia.

Phase 2: Training Program Development and Presentation

Phase 2 of the proposed solution focused on the development of a comprehensive training program for occupational therapists to address the impact of Islamophobia on mental health and occupational participation. An outline was created, including different modules that will be integrated into the training. Additionally, a program logic model and evaluation plan were designed to provide insight into the program's objectives, strategies, and data collection and analysis methods.

Program Background

OT for All: Strategies for Providing Inclusive and Culturally Sensitive Care to Individuals Impacted by Islamophobia is an educational program that aims to increase occupational therapy practitioners' understanding of the impact of racial and religious discrimination on occupational participation and promote trauma aware and culturally sensitive

practice. To provide effective care to individuals impacted by Islamophobia, occupational therapy practitioners must first recognize and address their own unconscious biases. This requires an understanding of the factors that contribute to clinical reasoning, assessment, and occupational therapy practice ethics (Shafaroodi et al, 2014).

To achieve this goal, the OT for All program focuses on three main strategies, discussed in detail in a later section. The first involves creating educational materials that address the impact of racial and religious discrimination, including Islamophobia, on occupational participation. The second strategy provides education for occupational therapy practitioners regarding unconscious biases and how they may manifest in OT settings. The third strategy is to provide access to resources and informed strategies for addressing racial discrimination and unconscious bias in occupational therapy practice. The Person-Environment-Occupation-Performance (PEOP) model is used to identify intrinsic and extrinsic factors that may limit OTPs' understanding of the problem and contribute to unconscious biases. To measure the effectiveness of the program, specific indicators will be used, such as self-report surveys or observations of OTPs' interactions with clients. With the use of the identified strategies and indicators, OT for All program seeks to empower occupational therapy practitioners with the knowledge and tools necessary to provide inclusive and culturally sensitive care to individuals impacted by Islamophobia and other forms of racial and religious discrimination.

Program Objectives

1. Early Objectives

- a. Increase availability of education on racial and religious discrimination, including Islamophobia, and how it affects occupational participation across different contexts.
- b. Increase availability of education on unconscious bias and its impact on occupational therapy service provision.
- c. Increase availability of educational resources on cultural sensitivity in OT service provision

2. Intermediate Objectives:

- a. OTPs who participated in the program will be able to define and identify examples of Islamophobia and describe its impact on occupational participation in various contexts, as demonstrated by a post-program assessment.
- b. Increase in the number of OTPs who can recognize and articulate the impact of unconscious biases on clinical reasoning, assessment, and OT practice ethics, as demonstrated by a post-program assessment.
- c. OTPs who participated in the program will identify at least one strategy to promote cultural sensitivity in OT practice as demonstrated by a post-program assessment.

3. Long-Term Objectives (4-6 months):

- a. Within 6 months after completing the program, OTPs will demonstrate improved attitudes towards individuals impacted by racial and religious discrimination, including Islamophobia.

- b. Within 6 months after completing the program, OTPs will integrate strategies to promote cultural sensitivity into their client care, as demonstrated by a 25% increase in the use of culturally responsive interventions documented in client records.

Program Strategies

The OT For All program is divided into three modules that use specific strategies to achieve program objectives: creating educational materials on racial and religious discrimination, including Islamophobia, unconscious bias, and providing education on cultural sensitivity, and providing access to resources and strategies for addressing discrimination and bias in OT service provision. The program's early objectives include increasing the availability of education and resources on racial and religious discrimination, including Islamophobia, unconscious bias, and cultural sensitivity in OT service provision. Intermediate objectives include OTPs demonstrating their knowledge and skills by defining and identifying examples of Islamophobia, recognizing the impact of unconscious biases, and identifying strategies to promote cultural sensitivity in OT practice. Lastly, the program's Long-term objectives aim for OTPs to demonstrate improved attitudes towards individuals impacted by discrimination and bias and integrate strategies to promote cultural sensitivity into their client care. These changes will be measured through specific indicators including pre- and post-program surveys, interviews with OTPs on interactions with clients, post-program training, and a review of program records and documents.

1 Module 1: Understanding the Impact of Islamophobia

1.1 Islamophobia's social impact

- 1.1.1 Explore the societal manifestations of Islamophobia and its impact on individuals,
- 1.1.2 Discuss the implications of Islamophobia on social inclusion and participation.

1.2 Impact on mental health

- 1.2.1 Examine the psychological effects of Islamophobia on individuals, such as increased stress, anxiety, and trauma.
- 1.2.2 Review the potential barriers to seeking mental health support due to Islamophobia.

1.3 Impact on self-expression and identity

- 1.3.1 Explore how Islamophobia may affect an individual's ability to express their cultural or religious identity freely.
- 1.3.2 Discuss the concept of religious observance and physical markers (i.e. hijab, dishdasha, etc.) and its impact on occupational participation and identity formation.

1.4 Impact on participation in different occupational settings

- 1.4.1 Examine how Islamophobia can hinder individuals' engagement in various settings, including education, employment, and social activities.
- 1.4.2 Identify specific challenges faced by individuals impacted by Islamophobia in participating fully in their occupations.

2 Module 2: Implicit Bias and Its Impact on Client Care

2.1 Introduction to different types of biases

- 2.1.1 Define and differentiate between implicit and explicit biases, as well as conscious and unconscious biases.
- 2.1.2 Explore how implicit biases influence occupational therapy practice and therapeutic alliance

2.2 Self-assessment checklists

- 2.2.1 Introduce self-assessment checklists to help OTs measure their perception of unconscious bias.

2.2.2 Encourage reflective practice and self-awareness regarding biases that may affect client care.

2.3 Impact of implicit biases on health outcomes

2.3.1 Present research literature and findings on the impact of implicit biases on physical and psychological health outcomes.

2.3.2 Highlight the potential consequences of biases on treatment planning, client outcomes, and disparities in care.

2.4 Overcoming implicit bias

2.4.1 Identify strategies for overcoming implicit bias in occupational therapy practice.

2.4.2 Emphasize the importance of ongoing self-reflection, cultural humility, and challenging personal biases.

3 Module 3: Presentation of Resources and Strategies

3.1 AOTA's Guide to Addressing the Impact of Racial Discrimination, Stigma, and Implicit Bias

3.1.1 Provide an overview of the AOTA guide and its relevance to promoting cultural awareness and reducing bias in OT practice.

3.1.2 Discuss practical strategies for implementing the recommendations from the guide.

3.2 AOTA's Occupational Therapy Code of Ethics

3.2.1 Review the 2020 Occupational Therapy Code of Ethics, focusing on cultural competence and addressing bias.

3.2.2 Explore the ethical responsibilities of OTs in providing equitable care to individuals impacted by discrimination.

3.3 Strategies and tools for addressing Bias

3.3.1 Discuss specific strategies outlined by AOTA for addressing unconscious bias in OT practice.

3.3.2 Introduce and utilize the AOTA Cultural Competency Tool Kit as a resource for promoting cultural awareness and reducing bias.

3.4 Implicit Association Test (IAT) for self-reflection

3.4.1 Explain the Implicit Association Test as a tool for OTs to reflect on their implicit biases and assumptions.

3.4.2 Encourage individuals to engage in self-reflection and increase awareness of their biases.

Program theory

The OT For All program theory (Figure 4.1) involves several strategies including creating educational materials and providing resources to address unconscious biases promote cultural sensitivity. Additionally, the program will utilize the PEOP model to identify the intrinsic and extrinsic factors contributing to unconscious biases and a lack of understanding of racial and religious discrimination, including Islamophobia.

The program theory suggests that creating educational materials on Islamophobia and discrimination will increase the number of OTPs who understand the impact of discrimination on occupational participation. This will lead to an increase in trauma aware and culturally sensitive practice. It also suggests that providing OTPs with resources on unconscious biases, will increase awareness of these biases and their impact on occupational therapy service provision.

Furthermore, by using The PEOP model, the program can identify the intrinsic and extrinsic factors that limit OTPs' understanding of the problem and contribute to unconscious biases.

Addressing these factors through education and resources is expected to lead to changes in OTPs' behavior, attitudes, and knowledge, resulting in improved client care and outcomes.

Figure 4.1 *OT For All Program Theory*

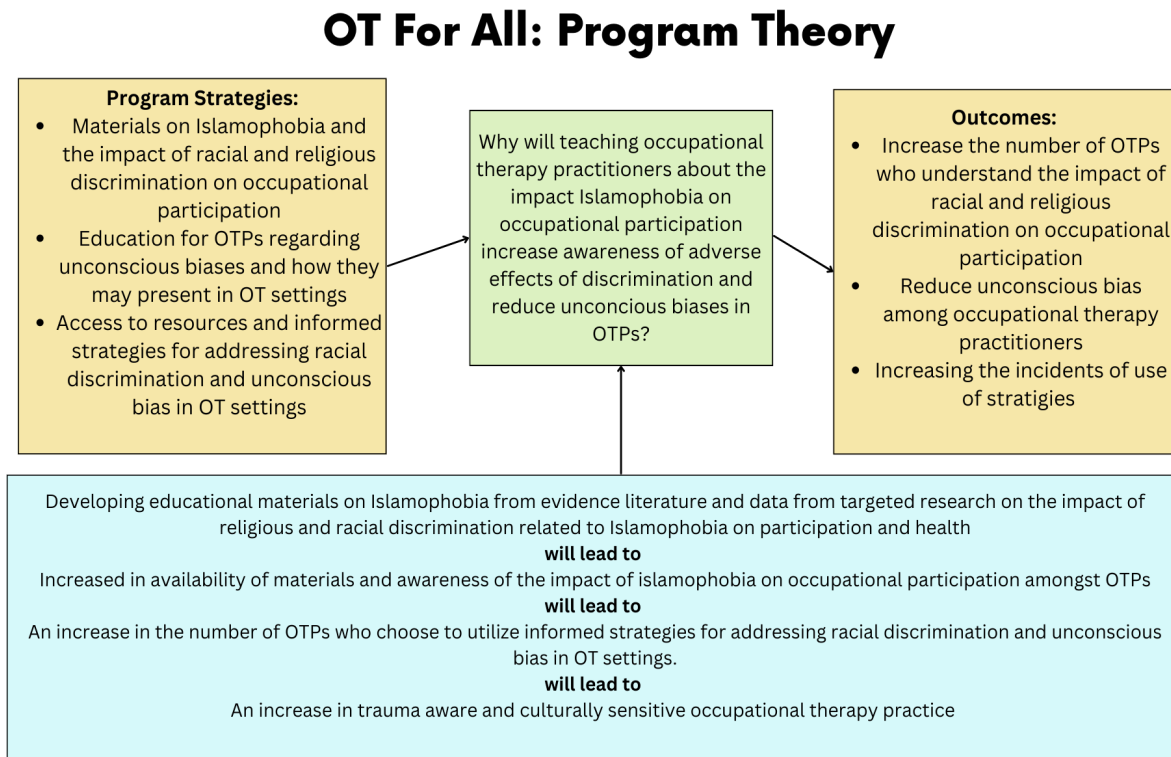


Figure 4.1 *OT For All Program Theory*

Figure offers narrative description of the tiers of the program aimed to educate occupational therapists about impact of and warranted response to client experiences with impact of Islamophobia.

Logic Model

The logic model (Figure 4.2) shows the relationship between the OT For All program strategies and its intended outcomes (Gianocola, 2021). As discussed in a later section, logic modeling will be used in the evaluation process to continually improve OT For All's vision and effectiveness (Gianocola, 2021).

Figure 4.2 OT For All Logic Model

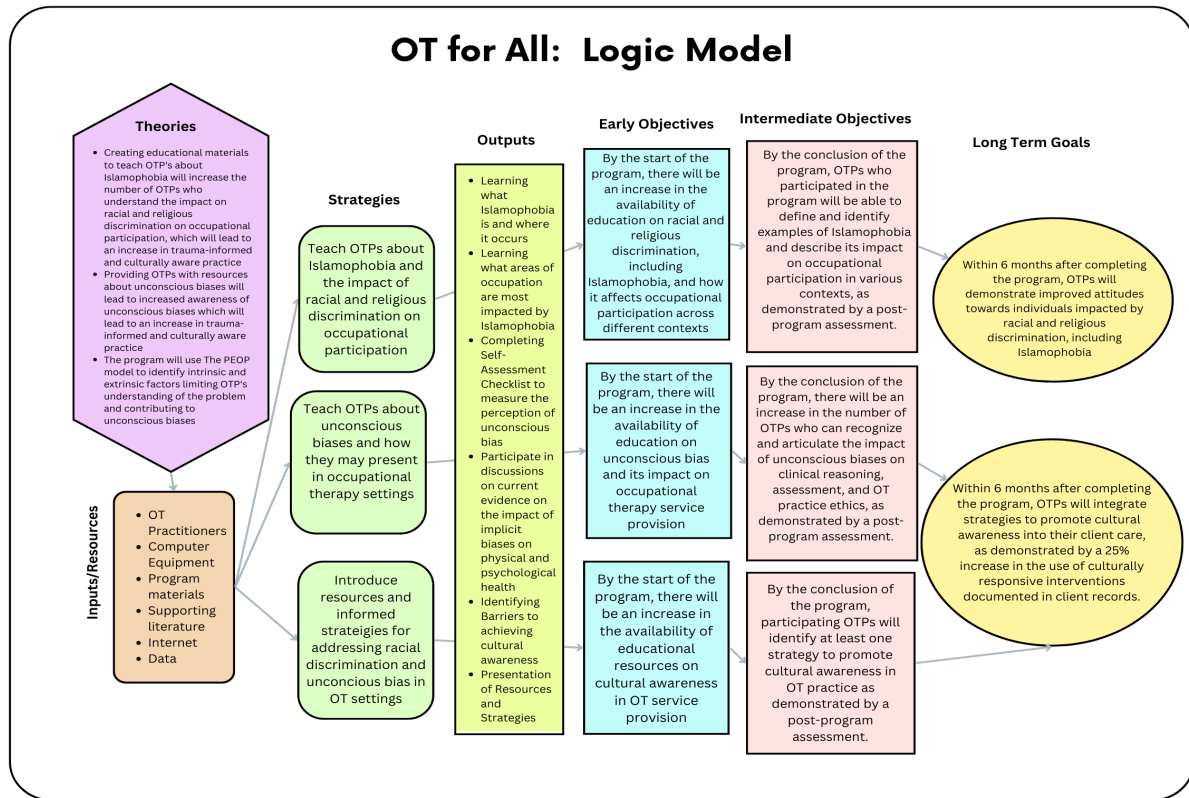


Figure 4.2 OT For All Logic Model

Figure 4.2 offers a narrative description of the OT For All program resources, strategies, outputs, and objectives.

Phase 3: Program Implementation and Evaluation

Evaluation Approach

OT For All will use an Embedded evaluation (EMB-E) approach that focuses on continuous improvement, and which program processes and practices are examined and refined to improve program outcomes (Gianocola, 2021). This approach is appropriate for the program because it involves integrating evaluation into the implementation process. Using an embedded evaluation approach, data will be collected before, during, and after program implementation to assess the effectiveness of the program in achieving its intended goals. Additionally, this approach allows for the incorporation of data collected from OTPs on their current understanding of the impact of racial and religious discrimination on participation, unconscious bias, and culturally sensitive occupational therapy practice. This data, along with feedback collected from participants during pre-program and post-program assessments, can be used to refine the program and improve its effectiveness. Furthermore, an embedded evaluation incorporates aspects of a participatory evaluation approach which values the partnership between stakeholders and evaluators (Gianocola, 2021) as well as aspects of an objectives-oriented evaluation approach, that focuses on how well the program meets its predetermined set of objectives (Gianocola, 2021).

Evaluation Design

OT For All will use a single-group design to evaluate the effectiveness of specific intervention of the program. Although this design is a relatively simple and straightforward method to implement, there are both strengths and weaknesses to its use. The single-group design is an appropriate design when it is not feasible or appropriate to have a comparison group. For the OT For All program, it would be difficult to identify a suitable comparison group due to the sensitive nature of the topic, which involves the impact of racial and religious discrimination, including Islamophobia, on occupational participation.

Another strength to using a single-group design for this program is the feasibility of this design for evaluating a program with limited resources. OT For All is expected to run for one day, with a follow up survey two months post-program, and 6 months post-program. Using a single-group design for evaluation is more feasible at this time because it is easier and less time-consuming to work with a single group, meaning it will require less resources, such as funding, personnel, and time.

Additionally, using the program's logic model, a single-group design can be used to help improve credibility to the program's findings (Giancola, 2021). Although the program won't have another set of OTPs to compare changes in perception of unconscious bias in occupational therapy, the logic model will use data from the program's early and intermediate objectives, that include obtaining and securing available resources and data on unconscious bias in occupational therapy service provision, presenting long-term outcomes that demonstrate an increase in OTP understanding of unconscious bias and its impact on services, and providing a theoretical connection between the program and long-term outcomes. (Giancola, 2021).

While this non-experimental design offers the above stated advantages, it also has limitations that need to be considered. A major limitation of this design is the lack of a comparison group. Without a comparison group, it is difficult to determine if changes observed in the group are actually due to the program or other factors (such as history or maturation). This places major limitations on the program's internal validity. Additionally, since there is no control group, the findings cannot be generalized to other populations, which threatens the external validity of the program.

Furthermore, IRB approval will be received from the Temple University Institutional Review Board so that the results of program evaluation may be disseminated. Once IRB

approval is received, a quasi-experimental one-group, pretest/posttest design can be used to evaluate the overall effectiveness of the OT For All program by comparing pre-program mean scores to post program mean scores. Pre- and post-program surveys will be conducted to assess changes in the participants' knowledge of racial and religious discrimination, including Islamophobia, and how it affects occupational participation across different contexts. Open-ended questions will also be included to gather qualitative data on participants' experiences and perspectives. For data analysis, descriptive statistics will be used to summarize the quantitative data collected from the pre- and post-program surveys, specifically the mean, standard deviation, and frequency distribution that can be used for comparison. A thematic analysis will be conducted to collect qualitative data and identify key thematic themes and sub-themes from open-ended questions. Additionally, a match paired t-test will be conducted to compare the pre- and post-survey scores and determine if there is a statistically significant increase in knowledge.

Using both a single-group design to evaluate the effectiveness of specific intervention as well as a quasi-experimental one-group, pretest/posttest design to evaluate the overall effectiveness of the OT For All program can provide a comprehensive understanding of the program's effectiveness and identify which components of the program are most effective in reaching its objectives.

CHAPTER FIVE – Artifact Funding Plan & Dissemination Plan

Artifact Funding Plan

Table 5.1 summarizes materials, resources and costs necessary to replicate the original data collection study and implement the program. Table 5.2 highlights potential funding sources that were selected based on grant description and requirements.

Table 5.1 Program Cost

Program Material	Cost	Total
Participant Recruitment	Recruitment materials development: \$300 Incentives for participants: \$1,000 Recruitment advertisements: \$500 Compensation for recruitment assistants: \$500	\$2300
Data Collection	Surveys and questionnaires printing: \$300 Software and tools for online surveys: \$200 Data collection assistants: \$800	\$1300
Training Program Replication	Program materials development: \$1,000 Workshop venue rental: \$500 Workshop facilitators' fees: \$1,500	\$3000
Data Analysis	Statistical software licenses: \$800 Data analysis experts' fees: \$1,500	\$2300

Evaluation and Outcomes Measurement	Evaluation materials development: \$500 Evaluation data collection assistants: \$300 Outcomes measurement tools: \$200	\$1000
Total		9,900

Table 5.2 *Potential Funding Sources*

Potential Funding Sources		
Organization Grants	Grant Description	Award amount
Dr. Gary Kielhofner Doctoral Research Scholarship in Occupational Therapy	The Dr. Gary Kielhofner Doctoral Research Scholarship in Occupational Therapy aims to advance the field by supporting research in areas such as social justice, theoretical foundations, innovative interventions, and utilizing existing data and measures. The scholarship promotes scientific progress and the application of research findings in occupational therapy practice.	\$5,000
STRIDE OT Research Fund	The American Occupational Therapy Foundation (AOTF) Standing for Research Inclusion, Diversity, and Equity (STRIDE) committee is offering research funds to occupational therapy (OT) graduates and clinicians to address the urgent need of broadening their representation in OT research. This research fund will support their participation in a mentored research experience at an institution other than their own.	up to US \$10,000

Dissemination Plan

Key Message	Audience	Delivery Method	Timing
Islamophobia's adverse effects on participation and health can be addressed through continuing education and cultural sensitivity training.	OT Practitioners Local and National OT Associations	Paper publications In-person and virtual presentations	Short courses Poster sessions
Occupational Therapists play a vital role in advocating for children impacted by racial and religious discrimination in schools	School administration OT practitioners local and national OT Associations	Providing resilience and self-determination classes Workshops on self-expression and identity	Integrated into School based occupational therapy practices

Target Audience

The target audience for the dissemination plan includes two main groups, OTPs and local and national OT Associations. The first target audience comprises occupational therapy practitioners who are practicing or studying in the field. These professionals are the primary focus of the intervention, as they will receive the continuing education and cultural sensitivity training. They play a crucial role in addressing the impact of Islamophobia on individuals' health and participation. By equipping them with knowledge and strategies, they can provide more inclusive and culturally sensitive care to those affected by Islamophobia.

The second target audience consists of local and national occupational therapy associations. These associations serve as a platform for professional development, knowledge exchange, and networking among OT practitioners. Engaging with OT associations allows for broader

dissemination of the research findings and the developed training program. OT associations can also play a vital role in promoting and endorsing the training, encouraging their members to participate in the intervention.

Dissemination Plan 1

Key Message

"Islamophobia's adverse effects on participation and health can be addressed through continuing education and cultural sensitivity training."

Delivery Method

- **Paper Publications:** Research articles and papers will be submitted to be considered for publication in relevant occupational therapy journals to disseminate the findings on the impact of Islamophobia and the importance of cultural sensitivity training.
- **In-person and Virtual Presentations:** Seminars, workshops, and webinars will be organized to present the research results and introduce the cultural sensitivity training program to OT practitioners. These events will provide an opportunity for interaction and discussion.
- **Short Courses:** Short courses specifically designed for OTPs will be developed based on the research findings. These courses will focus on practical strategies and techniques for addressing Islamophobia in occupational therapy practice.
- **Poster Sessions:** Poster presentations at local and national occupational therapy conferences will visually highlight the research outcomes and training program, attracting the attention of attendees.

Dissemination Plan 2

Key Message

"Occupational Therapists play a vital role in advocating for children impacted by racial and religious discrimination in schools."

Delivery Method

- **Providing Resilience Classes:** Resilience classes will be developed and offered to school administrations and OT practitioners, emphasizing the importance of building resilience in children impacted by discrimination and the role of occupational therapists in developing and carrying out these classes. OTPs will have the opportunity to equip students with knowledge and tools to foster a supportive environment for affected children, which is well within the scope of OT practice.
- **Self-Determination Classes:** Self-determination classes will be conducted, focusing on empowering individuals impacted by discrimination to take control of their lives and choices, including their occupational engagement. This will be particularly relevant for OT practitioners working in schools and community settings.
- **Workshops on Self-expression and Identity:** Workshops will be organized to help individuals affected by discrimination develop a positive sense of self-worth and identity, fostering confidence and self-advocacy.
- **Integration into School-Based Occupational Therapy Practices:** The training program, including the resilience classes, self-determination classes, and workshops, can be integrated into school-based occupational therapy practices to ensure a holistic approach to supporting children affected by discrimination.

Overall, the dissemination plan is designed to raise awareness about the impact of Islamophobia, empower OTPs with knowledge and skills, and create supportive environment for individuals impacted by discrimination. By targeting both OTPs and various stakeholders, the plan aims to create a positive impact on the well-being and participation of those affected by Islamophobia and highlight the important role OTPs play in creating positive change in this area.

CHAPTER SIX – Conclusion

Chapter 1 describes the contributors to the research problem, including institutional policies, barriers to education and employment, and social exclusion. The proposed solution involves measuring the impact of discrimination on participation and engagement, developing a training program to address the effects of Islamophobia, and promoting understanding and strategies to combat its impact on occupational performance and well-being.

Chapter 2 of this capstone presents a visual model of the problem and discusses the theoretical frameworks that support this capstone project. The model illustrates how limited research on the impact of racial and religious discrimination, specifically Islamophobia, leads to biases in occupational therapy settings and negatively affects the health and well-being of individuals impacted by Islamophobia. The theoretical framework used to understand the problem includes the Framework of Occupational Justice (FOJ) and the Person-Environment-Occupation (PEO) model. The FOJ highlights the principles of occupational justice, emphasizing the importance of meaningful participation and the impact of structural and contextual factors on occupational injustice. The PEO model emphasizes the interaction between the person, environment, and occupations, guiding the assessment of how discrimination affects occupational choices and experiences. The chapter also provides a synthesis of evidence supporting the problem, including the impact of discrimination on mental and physical health, its effects on school-aged children, and the association between discrimination and negative mental health outcomes. The lack of specific research on Islamophobia emphasizes the need for further exploration and research efforts to address its impact on occupational engagement and well-being.

Objectives of the proposed solution includes exploring existing literature on racial and religious discrimination, documenting lived experiences of Muslim Americans affected by Islamophobia, assessing its influence on occupational participation in various domains, and understanding the role of occupational therapy practitioners in supporting impacted individuals. The proposed solution involves three phases: Literature Review and Data Collection, Training Program Development and Presentation, and Program Implementation and Evaluation. The survey gathered valuable insights into the experiences of Islamophobia and its impact on mental health, social connections, and self-expression. The data analysis revealed significant relationships between experiencing Islamophobia and its effects on mental health, social connections with non-Muslims, and self-expression. Information from phase 1 provided a foundation for the development of a training program for occupational therapy practitioners to provide culturally sensitive care and support for individuals impacted by Islamophobia.

The "OT for All: Strategies for Providing Inclusive and Culturally Sensitive Care to Individuals Impacted by Islamophobia" program aims to increase occupational therapy practitioners' awareness of racial and religious discrimination's impact on occupational participation, promote trauma aware and culturally sensitive practice, and address unconscious biases. The program utilizes three modules focusing on Islamophobia, unconscious bias, and access to resources, alongside a logic model and embedded evaluation approach to continuously improve its outcomes. By providing education, resources, and using the PEOP model, the program seeks to empower occupational therapy practitioners to offer inclusive care to individuals impacted by discrimination and bias, fostering improved attitudes and cultural competence for long-term client care enhancement.

Lastly, the artifact funding plan outlines the materials, resources, and costs needed for replicating the original data collection study and implementing the "OT for All" program. The program cost includes participant recruitment, data collection, training program replication, data analysis, and evaluation and outcomes measurement, totaling \$9,900. Potential funding sources are identified, such as the Dr. Gary Kielhofner Doctoral Research Scholarship and STRIDE OT Research Fund, to support the program's implementation. The Dissemination Plan emphasizes the key messages regarding Islamophobia's impact on participation and the vital role of occupational therapists in advocating for those impacted by discrimination. Various delivery methods, including paper publications, presentations, short courses, and workshops, will target OT practitioners and local/national OT associations to create awareness and promote culturally sensitive care. Additionally, resilience and self-determination classes will be offered to schools to empower affected children, emphasizing the crucial role of OT practitioners in supporting their well-being and participation.

Overall, research on the impact of Islamophobia on occupational participation, health, and well-being, particularly within the occupational therapy profession is limited. However, despite the limited evidence, the current literature does suggest that Islamophobia can have negative consequences on health, daily functioning, and activities (Nadal et al., 2012). The original data collected for this study served as a foundation for refining the survey and developing training programs. Sharing the findings on the perceived impact of Islamophobia can make a valuable contribution to the evidence and literature in the field of occupational therapy. Occupational therapists should actively address the impact of Islamophobia to provide better support for individuals affected by it, through trauma-aware, sensitivity-focused, and inclusive interventions.

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applying an occupational justice framework. *Occupational Therapy Now*, 12(1), 15-17

APPENDIX A

PARTICIPANT CONSENT FORM

Title: Understanding the Impact of Islamophobia on Occupational Participation
Protocol No.: 30312
Investigator: Principal investigator: Amy Lynch, PhD, OTR/L
Co-investigator: Gillian Rai, DOT, MEd, OTR/L
Co-investigator: Jasmine Eldomyati, MS, OTR/L
Daytime Phone Number: 347-302-0123
Email: jasmine.eldomyati@temple.edu

CONSENT FOR SURVEY AND FOCUS GROUP PARTICIPATION

You are being asked for your consent to take part in a research study. This consent document describes the key information that we believe most people need to decide whether to take part in this research.

Why am I being invited to participate in this research?

Your participation in the current study will be used to document the lived experiences of Muslim Americans impacted by Islamophobia and its impact on occupational participation.

What happens to me if I agree to take part in this research?

If you decide to take part in this research study, you will be asked to complete a focus group interview and survey. We expect the survey to take 10 to 15 minutes to complete. The focus group will last between 60 to 90 minutes. The focus group will be audio-recorded, with all identifiable markers removed. No identifiable information will be saved. Please note that you may choose to participate in the survey or focus group only if unable to participate in both.

What are the risks of this study?

There are no physical risks but since the survey asks you to recall your experience with discrimination, you might experience discomfort. You do not have to answer any questions that make you too uncomfortable. You can find resources for managing stress that may surface after answering questions about your experience at the end of this form.

There is also a mild risk of breach of confidentiality. Your participation in this research will be held strictly confidential, however, confidentiality cannot be guaranteed. Confidentiality will have to be broken if an individual expresses a current plan to harm themselves or others, or if they report they have committed child abuse or neglect.

APPENDIX A – cont.

What happens to the information collected for this research?

Your private information may be shared with individuals and organizations that conduct or watch over this research, including, if applicable:

- The Institutional Review Board (IRB) that reviewed this research
- Temple University
- Temple University Health System and its affiliates

We may publish the results of this research. However, we will keep your name and other identifying information confidential. We may de-identify this data and share it with other researchers for research that is currently unknown.

Who can answer my questions about this research?

If you have questions, concerns, or complaints, or think this research has hurt you or made you sick, talk to the research team at the phone number or email listed above on the first page.

This research is being overseen by an Institutional Review Board (“IRB”). An IRB is a group of people who perform independent review of research studies. You may talk to them at (215) 707-3390 or irb@temple.edu if:

- You have questions, concerns, or complaints that are not being answered by the research team.
- You have questions about your rights as a research subject.

CONSENT FOR SURVEY

You will be asked to consent at the beginning of your online survey. If you choose to participate you can select “yes” to continue the survey. If “no”, you will be directed to exit the survey.

CONSENT FOR FOCUS GROUP PARTICIPATION

Your voluntary participation in the focus group indicates that you are volunteering as a research participant for this study and that you have read and understood the information provided above. You will also be given resources for managing stress that may surface after answering questions about your

APPENDIX B

RECRUITMENT EMAIL

Hello,

My name is Jasmine Eldomyati, I am an occupational therapist and doctoral student of the PP-OTD program at Temple University. As part of this program, I am conducting a research study on the impact of Islamophobia on participation in day-to-day life. The goal of this study is to improve our understanding of the effects of racial and religious discrimination, including Islamophobia, on how individuals engage in different roles, occupations, and activities.

If you are interested in participating in this research study, please read the participant consent form and review the requirements below. *Please note: your responses will be anonymous and cannot be traced back to you.*

To qualify for this study, you will need to

- a) identify as Muslim
- b) be over the age of 18
- c) currently live in the United States
- d) be willing to participate in a 5 to 10 minute online survey about your experience with Islamophobia

If you meet these requirements and are interested in participating, please follow this link to [complete the survey](#).

Or copy and paste the URL below into your internet browser:

https://chpswtemple.co1.qualtrics.com/jfe/form/SV_2b0a38BGvox9ZYO

Participants will have the option to participate in an optional focus group in addition to the survey. They will be presented with the option at the conclusion of the survey.

If you have any questions or concerns about this research study, feel free to contact Jasmine Eldomyati at jasmine.eldomyati@temple.edu or, 516-817 6721.

If you know anyone that would be willing to participate in this study, I kindly ask you to spread the word by sharing our link or flyer.

Thank you for your time,

Jasmine Eldomyati, MS, OTR/L
jasmine.eldomyati@temple.edu

Amy Lynch, PhD, OTR/L, FAOTA
Principal Investigator

APPENDIX C
RECRUITMENT FLYER



Temple
University

RESEARCH PARTICIPANTS NEEDED

We are currently looking for volunteers to participate in a survey for a study on the impact of Islamophobia on occupational participation

WHO?

To qualify for this study, you will need to

- identify as Muslim
- be over the age of 18
- currently live in the United States

WHAT?

Take part in a 5-10 minute survey on your experiences with Islamophobia

WHY?

Your participation in the current study will be used to document the lived experiences of Muslim Americans impacted by Islamophobia and understand its impact on occupational participation

More Information?

Contact Jasmine Eldomyati at jasmine.eldomyati@temple.edu

If interested in participating in this study please complete the participant forms found [here](#) or scan the QR code on this flyer



APPENDIX D

EVALUATION MATRIX

	Logic model Component	Evaluation Questions	Indicators	Targets	Data Source	Data Collection	Data Analysis
Program Strategies/ Implementation	Teach OTPs about Islamophobia and the impact of racial and religious discrimination on occupational participation	What evidence will be presented on the impact of racial and religious discrimination on occupational participation? Did the evidence provide enough information to increase understanding of the problem?	Content and evidence on the impact of racial and religious discrimination, including Islamophobia. Method of delivering educational materials to OTPs	By the start of the program, materials on understanding racial and religious discrimination are developed and implemented with fidelity.	OTPs who participated in the program. Program materials.	Pre and post program surveys, focus groups, individual case studies of OTPs who have applied program content in their practice	Descriptive statistics, Inferential statistics.
	Teach OTPs about unconscious biases and how they may present in occupational therapy settings	What will be the content and format of education regarding unconscious biases (i.e., peer review literature, evidence)?	Content and format of education regarding unconscious biases. Method of delivering education regarding	By the program start, education regarding unconscious bias will be implemented with Fidelity.	OTPs who participated in the program. Program materials.	Pre and post program surveys, focus groups, individual case studies of OTPs who have applied program content in their practice	Descriptive statistics, Inferential statistics.

			unconscious bias to OTPs				
	Introduce resources and informed strategies for addressing racial discrimination and unconscious bias in OT settings	How will OTPs access strategies and program materials for future application? What types of strategies and resources were made available through the OT For All program?	Content and format of education regarding strategies and resources for addressing racial discrimination and unconscious bias in OT settings. Method of teaching strategies and distributing program materials for future application to OTPs	By the program start, methods of accessing resources and strategies will be implemented with fidelity.	OTPs who participated in the program. Program materials.	Pre and post program surveys, focus groups, individual case studies of OTPs who have applied program content in their practice	Descriptive statistics, Inferential statistics.
Early Objectives	By the start of the program, there will be an increase in the availability of	To what extent was education regarding racial and religious	Availability of educational materials regarding	By the start of the program, materials on understanding racial and religious	OTPs who participated in program. Program	Pre and post program survey.	Descriptive statistics to determine the percentage of

	education on racial and religious discrimination, including Islamophobia, and how it affects occupational participation across different contexts	discrimination, including Islamophobia, and how it affects occupational participation across different contexts made available to OTPs?	Rayshawn religious discrimination, including Islamophobia to OTPs	discrimination, including islamophobia, will be made available to OTPs	records and documentat ion.	Program records and documentation.	increase in availability of education on the topics of racial and religious discrimination before and after the program
	By the start of the program, there will be an increase in the availability of education on unconscious bias and its impact on occupational therapy service provision	To what extent was education regarding unconscious bias and its impact on occupational therapy service provision made available to OTPs?	Availability of educational materials regarding unconscious bias and its impact on occupational therapy service provision	By the start of the program, materials regarding unconscious bias and its impact on occupational therapy service provision, will be made available to OTPs	OTPs who have participated in the program and access to program's educational materials. Program staff. Program records and documentat ion.	Pre and post program survey. Program records and documentation.	Descriptive statistics to determine the percentage of increase in availability of education on unconscious bias before and after the program
	By the start of the program, there will be an increase in the availability of	To what extent did OTPs have access to materials on	Availability of educational resources on cultural	By the start of the program, educational resources on	Existing literature and educational	Pre and post program survey to assess changes	Match paired t-test to compare differences in participants

	educational resources on cultural awareness in OT service provision	cultural awareness in OT service provision?	awareness in OT service provision	cultural awareness in OT service provision, will be made available to OTPs.	resources on cultural awareness in OT service provision.	in knowledge and attitudes.	responses on pre and post program assessment.
Intermediate Objectives	By the conclusion of the program, OTPs who participated in the program will be able to define and identify three examples of Islamophobia and describe its impact on occupational participation in various contexts, as demonstrated by a post-program assessment.	To what extent did the number of occupational therapy practitioners who received education regarding Islamophobia and its impact on occupational participation in various contexts increase? How did OTPs receive education regarding Islamophobia?	Availability of materials and evidence on the impact of racial and religious discrimination, including islamophobia Method of delivering educational materials to OTPs	By the conclusion of the program, OTPs will identify specific examples of Islamophobia and its impact on occupational participation.	OTPs who participated in the program. Program records.	Pre and post program survey to assess OTPs' ability to define and identify examples of Islamophobia and its impact on occupational participation in various contexts.	Match paired t-test to compare differences in participants responses on pre and post program assessment.
	By the conclusion of the program, there will be an increase in the number of OTPs who can recognize and articulate the impact	To what extent did the number of occupational therapy practitioners who can recognize and	Number of OTPs who can recognize and articulate the impact of unconscious	By the conclusion of the program, OTPs will be able to define and articulate specific examples of	OTPs who participated in the program. Program records.	Pre and post program survey (about increase in OTP knowledge and ability to	Match paired t-test to compare differences in participants responses on pre and post

	of unconscious biases on clinical reasoning, assessment, and OT practice ethics, as demonstrated by a post-program assessment.	articulate the impact of unconscious biases on clinical reasoning, assessment, and OT practice ethics increase? How did OTPs receive education regarding unconscious biases?	biases on clinical reasoning, assessment, and OT practice ethic	unconscious bias in OT practice.		recognize and articulate the impact of unconscious biases in their practice)	program assessment.
	By the conclusion of the program, participating OTPs will identify at least one strategy to promote cultural awareness in OT practice as demonstrated by a post-program assessment.	To what extent were OTPs able to identify strategies to promote cultural awareness and OT practice?	Availability of provided strategies as part of the OT For All program	By the conclusion of the program, strategies to promote cultural awareness and OT practice will be made available to OTPs	OTPs who participated in the program. Program records.	Pre and post program survey (about specific strategies that the OTPs have identified to promote cultural awareness in OT practice)	Descriptive statistics to determine the frequency of OTPs identifying strategies to promote cultural awareness in OT practice
Long-Term Goals	Within 6 months after completing the program, OTPs will demonstrate improved attitudes towards individuals impacted	To what extent has OTPs attitudes towards individuals impacted by racial and	Availability of surveys or other forms of evaluation that measure changes in	Within 6 months after program completion, there will be an improvement in attitudes towards	OTPs who participated in the program.	Pre and post program survey.	Match paired t-test to compare differences in participants responses on pre and post

	<p>by racial and religious discrimination, including Islamophobia</p>	<p>religious discrimination, including Islamophobia improve?</p>	<p>attitudes and beliefs to measure improvement in OTP attitudes towards individuals impacted by racial and religious discrimination, including Islamophobia</p>	<p>individuals impacted by racial and religious discrimination, including Islamophobia.</p>			<p>program assessment.</p>
	<p>Within 6 months after completing the program, OTPs will integrate strategies to promote cultural awareness into their client care, as demonstrated by a 25% increase in the use of culturally responsive interventions documented in client records.</p>	<p>To what extent have OTPs integrated strategies to promote cultural awareness into their client care?</p>	<p>Number of OTPs using interventions that promote cultural awareness in client care.</p>	<p>Within 6 months, OTPs will integrate strategies to promote cultural awareness into their client care.</p>	<p>OTPs who participated in the program.</p>	<p>Review of sample client records before and after the program.</p>	<p>Match paired t-test to compare differences in participants responses on pre and post program assessment.</p>

FACT SHEET



Temple
University

Understanding the Impact of Islamophobia on Occupational Participation

Jasmine Eldomyati, MS, OTR/L
2023 OTD Candidate

Key words: Islamophobia, Occupational Participation, Cultural Sensitivity, Unconscious Bias

Problem: *Limited research exists to support the role of occupational therapy in addressing the adverse effects of racial and religious discrimination, including islamophobia, on individuals' health and participation*

Limited research on the impact of racial and religious discrimination, including Islamophobia, hinders the understanding of its effects on occupational engagement, participation, and health. There is also insufficient evidence regarding the effectiveness of cultural sensitivity education and unconscious bias training for occupational therapists addressing trauma related to racial and religious discrimination. The limited collaboration with individuals and communities directly impacted by these issues further obstructs the development and implementation of continuing education tools and implicit bias training in occupational therapy practice. This lack of research and collaboration results in the persistence of explicit and implicit biases among occupational therapists, creating a barrier to providing optimal care for individuals affected by Islamophobia. Consequently, the impact of Islamophobia on individuals leads to decreased occupational engagement due to lower mental health, diminished sense of belonging, and lowered self-esteem caused by discrimination, resulting in a decline in health and wellness among those impacted by Islamophobia.

Proposed Solution:

Conducting targeted research on the impact of Islamophobia on participation to fill the evidence gap and guide the development of occupational therapy education tools



Phase 1: Literature Review and Data Collection:

- Comprehensive review of racial and religious discrimination, Islamophobia, unconscious bias, and cultural awareness in OT practice.
- Collection of relevant data from impacted individuals to inform training program development.

Phase 2: Training Program Development and Presentation:

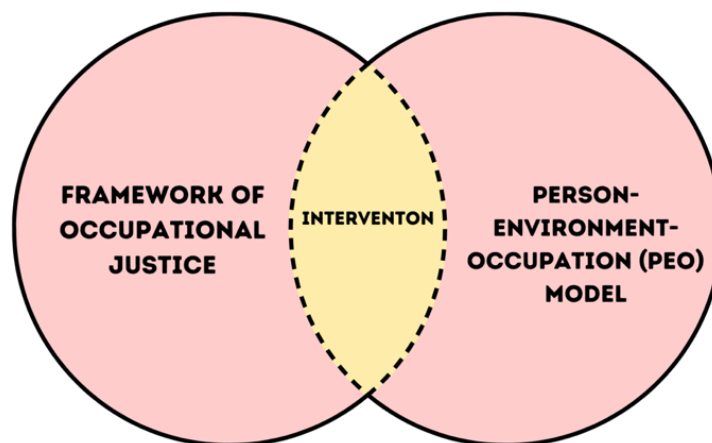
- Creation of a comprehensive training program based on research findings.
- Presentation to OT practitioners for feedback and alignment with their needs.

Phase 3: Program Implementation and Evaluation:

- Implementation of the training program for OT practitioners
- Continuous data collection and analysis for evaluation.
- Refinement based on evaluation findings and practitioner feedback.

Overview of Theories

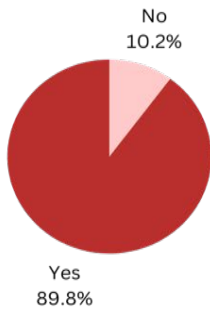
The intervention in this study was informed by two frameworks: the Framework of Occupational Justice (FOJ) and the Person-Environment-Occupation (PEO) Model. The FOJ focuses on justice related to occupation and emphasizes meaningful participation as a fundamental right (Townsend & Wilcock, 2004). The PEO Model highlights the interaction between the person, environment, and chosen occupations, considering individual characteristics, environment, and occupational choices on engagement (Law et al, 1996). By utilizing a combination of both frameworks, the intervention aimed to understand and begin addressing the deprivation and marginalization caused by Islamophobia, while also assessing how discriminatory attitudes, policies, and contexts have limited participation and hindered well-being.



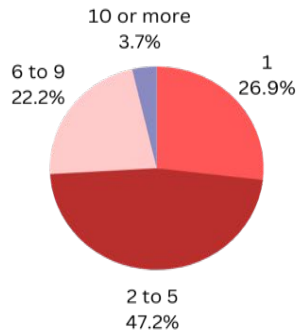
Data Collection:

Data was collected from Muslim American on the perceived impact of Islamophobia, then incorporated into the program development for *OT For All: Strategies For Providing Inclusive And Culturally Sensitive Care To Individuals Impacted By Islamophobia*.

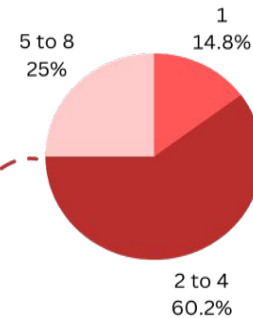
Have you personally experienced Islamophobia directed at you?



Number of occupational settings Islamophobia was reported



Number of mental health symptoms reported due to Islamophobia



Module 1: Understanding Islamophobia

- 1.1 Islamophobia's social impact
- 1.2 Impact on mental health:
- 1.3 Impact on self-expression and identity
- 1.4 Impact on participation in different settings



Module 2: Implicit Bias in Client Care

- 2.1 Introduction to different types of biases
- 2.2 Self-assessment checklists
- 2.3 Impact of implicit biases on health outcomes
- 2.4 Overcoming implicit bias



Module 3: Resources and Strategies

- 3.1 Practical strategies for implementing recommendations
- 3.2 Ethical responsibilities of OTPs in providing equitable care
- 3.3 Strategies and Tools for addressing bias



CURRICULUM VITAE

Jasmine Eldomyati

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jasmineeldomyati@gmail.com

400 5th Street, Brooklyn, NY 11209

Education

- | | | |
|------------|---|-------------|
| OTD | Temple University, Occupational Therapy
Dissertation: “Understanding the Impact of Islamophobia on Occupational Participation” | August 2023 |
| MS | New York Institute of Technology, Occupational Therapy
Thesis: “Examining the Role of Occupational Therapy in Primary Care Settings” | May 2017 |
| BS | New York Institute of Technology, Health Sciences | May 2015 |

Professional Experience

- | | |
|---|----------------------|
| New York City Department of Education
Present
<i>Senior Occupational Therapist</i> | March 2020 – |
| Learning Resource Center
January 2020
<i>Occupational Therapist</i> | August 2018 – |
| Sensory Freeway Therapy Services
2018
<i>Occupational Therapist</i> | August 2017 – August |

Professional Presentations

- Presentation**, “*The Role of Occupational Therapy in an Inclusive Classroom*”, Learning Resource Center 16th Educational Conference, *March 2019*
- Presentation**, “*Applying Sensory Strategies in the Classroom*”, Learning Resource Center 16th Educational Conference, *March 2019*

Presentation, “Utilizing OT Strategies to Enhance Inclusive Learning”, Learning Resource Center 17th Educational Conference, March 2020

Staff Training, “Overview of Occupational Therapy Assessments” – Learning Resource Center, January 2020

Staff Training, “What are Fine Motor skills? Guide to Fine Motor Intervention” – Learning Resource Center, January 2020

Staff Training, “Using Sensory Bins to Reach Fine Motor Goals” – Learning Resource Center, December 2019

Staff Training, “Introduction to Handwriting Without Tears” – Learning Resource Center, November 2019

Professional and Community Service

Level I & II Fieldwork Supervisor May 2020 – Present

Al Noor School and Community Center June 2021 – Present
Volunteer

Egyptian Society for Developing Skills of Children with Special Needs Dec 2018 - 2019
Volunteer Occupational Therapist

Arab American Association of New York January 2012 – January 2018
Volunteer

Professional Memberships

American Occupational Therapy Association (AOTA)
Coalition of Occupational Therapy Advocates for Diversity (COTAD)
New York State Occupational Therapy Association (NYSOTA)