Editor's Introduction

It is with great pleasure that I introduce our second open access issue (Volume VI, Issue 2) of the Journal of Muslim Mental Health. We continue to provide articles that are both timely and relevant to Muslim communities globally. In the first article, Ali et al assesses U.S. imam's counseling training background and willingness to refer to mental health and allied resources. They found that less than 50% of imams have completed any college courses in psychology, had formal counseling or clinical pastoral training, or had read about counseling independently. Imams are considered "first responders" in their communities; American Muslims often come to them first for their emotional needs, whether for depressed mood, family conflict, or perceived persecution. Unfortunately, as Ali et al demonstrate, imams are ill prepared to manage the basic mental health care needs of the communities they serve and they are not trained to identify and appropriately refer Muslims to mental health professionals. In the study, American imams were presented with a clinical vignette and asked how they would manage the case. The vignette was of a gentleman who expressed depressed mood and passive suicidal ideation. Although the imams generally recognized that the gentleman described in the vignette was unlikely to improve without help, on average the imams reported that they were not likely to seek a mental health professional for advice or refer the presenting case to a professional. Importantly, Ali et al demonstrated that imams who had experience with mental health professionals reported to be more likely to refer such emergent cases to a mental health professional. These imams also have a more favorable view toward counseling and psychotropic treatment. Interestingly, imams with counseling training reported to be less willing to collaborate with mental health professionals. This last provocative finding begs the question of why imams with counseling training are less open to collaboration. Is this a function of the nature and content of imams' counseling training? If so, how can counseling training be modified to encourage collaboration?

The second article of this issue by Nadal et al is particularly timely given the media coverage of New York Police Department (NYPD) monitoring several Muslim Student Associations (MSAs) in the northeast including MSAs at Yale, Syracuse University, several unnamed New York City universities, and Rutgers. As a member of Yale's community during the time when the story broke, I witnessed firsthand how the possibility of invasive surveillance on the part of the NYPD impacted Muslim students on campus and had a chilling effect on the

campus. Muslim students at Yale reported difficulty with concentrating, work and school performance, and interpersonal relationships. Without pathologizing vulnerable peoples' reaction to structural aggression and perceived injustice against them, Nadel et al show us the psychological effects of microaggressions which cause disillusionment, agitation, and frustration in religious and ethnic minority communities. While this pilot study has a small sample size, the interview data is very rich and the analysis provides a model that lays the foundation for further research. The themes that emerged from focus group interviews of American Muslims fit with the taxonomy of microaggression proposed by the investigators. These include stereotypes of Muslims as terrorists and as "the Other", treating Islam as though the religion itself is pathological, and the pervasive sense among Muslims of being "alien" in spite of being American.

In the final two articles, the researchers track the ways religion informs attitudes towards mental health as well as coping styles among different Muslim diaspora populations. Driscoll & Wierzbicki explore the role of acculturation and religiosity in beliefs about depression and in the ways Palestinian and Pakistani immigrants to the U.S. attribute causality for depression. The researchers categorized attribution to depression styles into those oriented to internal, individual causes and those oriented towards external, social causes. "Individual Reasons for Depression" included instances when subjects explained depression in terms of individuals' self-expectations and sense or lack of fulfillment, individual personality characteristics, and individual personal health. "Interpersonal Reasons for Depression" included external social causes such as relationship issues and interpersonal conflict issues. Interestingly, greater religiosity correlated to greater external attribution for the causes of depression. Conversely, those subjects with a greater level of acculturation were less likely to draw on this external attribution style when explaining depression. Sulaiman-Hill and Thompson administered the General Health Questionnaire-12 and Kessler-10 to 193 Afghan and Kurdish refugees of New Zealand and Australia, with special attention to gender differences, in order to assess levels of psychological distress and conducted face-to-face interviews. The major finding from the qualitative data was that subjects felt that having too much time to reflect, introspect, and relive traumatic experience, what they described as "thinking too much", contributed to emotional distress, especially among men. Additionally, social isolation, status dissonance, and disempowerment were identified as stressors relatively more common among female refugees in these communities. Exercise, socializing, and religious practice were coping strategies refugees found helpful when dealing with these stressors.

We thank all the authors and peer reviewers for their contribution and look forward to manuscripts that further expand this work.

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