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An Islamic approach to psychology and mental health

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It is unclear whether the development of ''Western'' psychology and psychiatry, in the last century or so, has overall actually been good for our mental health. The article argues that a deficiency has been the lack of attention paid by these disciplines, to the spiritual component of the Self. There are, however, psychologies'' developed within religious traditions, which integrate the spiritual into a more holistic understanding of mental health. The psychology that has developed within the Islamic tradition is exampled.

For those of us in the field, it is easy to get caught up in a Whig view of mental health history, that since the beginning of ''modern'' psychology and psychiatry at the end of the nineteenth century, our understanding of mental illness and our way of treating it has become better and better.

Depending, of course, on how we define mental illness, there is, however, no clear evidence for this view. At best the effect of modern ''Western Psychology'' and Psychiatry has been a ''Curate's egg.'' Some people have been better for it, others probably worse. Anti depressants, for example, may only really benefit 10% of sufferers with depression (Moerman, 2002) but for those cases in which they do work, the relief is immense and maybe life saving. For the much greater number of people prescribed such medication, however, all that may be received are side effects, a sense of disempowerment, the stunting of processes of self healing, and a convenient means of suicide: contributing to an apparently worse prognosis for depression today in the UK than in 1870 (Healy, 2002). Users' experience of the help they have received from present-day mental health services seems variable, with clients often struggling to find their own ways of understanding and coping with their experiences of distress. And there is broad evidence that those with clearly defined serious mental health problems, who were without the benefit of modern ''Western'' psychiatry seem, generally to have enjoyed a better prognosis (Waxler, 1974).

The reasons for this lacklustre efficacy of mainstream psychology and psychiatry defy simplistic analysis. However, it seems to me one factor is the waxing ascending of biological and cognitive models of the self – in ''Western'' psychiatry and psychology; which can result in crudely simple diagnosis and incomplete if not damaging treatment. Furthermore, as the professional way of understanding the human condition, seeps into

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popular culture, this ascendancy marginalises more holistic, and personally meaningful religious and folkways of understanding distressing mental states. To return to depression as an example, we are now encouraged by the (Government's) National Institute for Clinical Excellence (NICE) to lump all states of low mood, substantially into one disease category (Depression), assume the cause is biological with cognitive enhancement, and treat all cases with recommended anti depressants and cognitive therapy. But, as a clinician, I recognise there are states of low mood relating to remorse or catharting grief which are part of a healthy growth process. To treat such with anti depressants or "by the book" CBT, gives no meaning to the experience and risks stunting personal growth.

The result we see in clinical practice (or could see if we had the eye to) is often two separate coexisting worlds of understanding mental distress. The overt professional formulation, and the clients' own private attempts to give meaning to experience. Sometimes these worlds jog along without being in conflict, sometimes they are so dissonant, clients leave treatment or become "non-compliant." This is not so in other parts of the world which have folk cultures less fractured. Skultans for example, (Skultans, 1997) has shown how, in Latvia, people struggling to make sense of "neurasthenia" resulting from multiple traumata – refer to the local heroic mythology. (Kleinman, 1981) in his seminal study of Neurasthenia and Depression in China showed that, even under the Communist regime, both clients and mainstream professional workers share the same understanding of mental illness – based on Daoistic models of health.

Unsurprisingly, empirical research has shown that when client and healer share the same ways of understanding mental disorder, – there are better therapeutic outcomes. (Callan & Littlewood, 1998; see also Thomas, Shah, & Thornton, 2009).

In our own society, for those with faith, there is access to a theology by which to give meaning to mental distress, and access to clergy that can counsel within a shared framework of belief. In effect, such counselling often constitutes a type of cognitive therapy, but of a depth that the professional cognitive therapist would be unequipped to touch.

More specific attempts to provide Christian compliant therapies had begun, at least by the 1950s, with the Clinical Theology movement, and I have come across more recent attempts to construct a clinical psychology from the writings of St. Thomas Aquinas.

There are, however, other faiths that have generated cultures in which the secular and religious sciences have never split to the degree that have in Western Christianity. In these cultures there are long traditions of psychology that integrate with, and have been informed by a theological and spiritual understanding of the nature of the Self, and they use a conceptual system to which clients can relate, – even at a folk level (Malik, 2002). I shall illustrate with references to the psychology (Ilm ul Nafs and Tibb ul Nafs; Nafsiyat in the Persian-derived languages) that has developed within the Islamic world. There are also other well-established "psychologies" developed from Ayuvedic, Daoistic, and Buddhist traditions.

Models of the self, and their application to mental illness were already developed in the Islamic world by the eleventh-century Alkindi (9C AD) is to my knowledge the first recorded writer on this subject. Ilm ul Nafs (psychology) was being taught at Nishapur University by the fourteenth century; and Tibb ul Nafs (clinical psychology and psychiatry) by the fifteenth century. There is therefore unsurprisingly an evolved and involved richness of diversity within the tradition, and some fundamental controversies. I am therefore going to present, a simple description of common principles, from my own understanding.

Fundamentally, Islamic Psychology is holistic. It rests on a perception of the self as comprising several components and functions; Videlcit, the inner self (Qalb or "inner

heart''), the intellect (Aql) and the lower drives (Nafs Amara), and the body. These components are viewed as properly functioning in a hierarchical dynamic relationship. Simply put the inner self is seen as the core of the self in which is tasted the finer feelings (such as the response to beauty), and inherent natural wisdom and guidance (Fitra), and which, in its inner sanctum, can receive inspiration (Ruh), which expands, develops, and transforms the self.

An aspect of the inner self's function as the container of inspiration is its ability to translate inspirational spiritual truths into understandable images, normally through dreams of a certain type, or more rarely through visions. This realm of "true, imagery (Mithral) bears a relationship with Jungs work on Archetypes.

In my general view, the concept of the inner heart in Islamic Psychology touches on both Groddek''s and Jung's understanding of the depth unconscious, and similarly directs a fundamental aim of therapy, which is to open access to this part of the self when it has become closed or otherwise disassociated from consciousness. Particularly, as it is the state of the Inner Heart (Qalb) which is held to transfer into the next life, it could be described in English by the word Soul, though often other Arabic terms (Nafs, and Ruh, for example) are perhaps more commonly translated as such.

In what is regarded as the healthy self, the Inner heart directs the intellect, and both direct the basic drives (Nafs Amara; – a term which strictly speaking describes the state of being under the control of the basic drives). The state of the body is held to have a strong relationship with these drives. Diagnosis is directed to pinpointing the level within the self from which the presenting illness originates. The principle treatment ideally, is then aimed at this centre – and can be physical, "psychological" with a broad range, or "spiritual" as appropriate, with supplementary treatments for the disturbances that are likely to affect the other levels of the self.

There are methods of diagnosis that go with this model so that it is possible to recognise whether an "Anxiety State"; for instance, is primarily caused by inappropriate diet (too much caffeine maybe), or suppressed drives or dysfunctional cognition, or the sense of anomie arising from the inner centre being constricted, or a compound of these.

In a general way, illness is seen to arise when the dynamics of the self flow in the wrong direction – (for example, by intellect overriding intuitive wisdom), or through Dissociation within the self – at any level but particularly from the inner centre.

The way the self functions and the disorders that arise within its functioning, can be viewed as along a spectrum or continuum. With at one end, the body and biological treatments, and at the other, the inner centre and spiritual remedies. What in the west is considered the remit of psychology falling in the middle, but there are not, in the Islamic tradition, the same absolute Cartesian splits, between body and mind, mind and spirit, which tend to be Western paradigm.

Traditionally, the Hakim (Herbal Physician) deals with the biological end of the spectrum and the Guide, or Shaykh, at the spiritual end. Both from different perspectives, but from within the same basic model, dealing with the psychological. As far as I am aware a separate profession of psychology (that is a profession with a centre of expertise in between that of the Hakim and the Shaykh) did not develop within the classical Muslim world. There is, however, no reason why such a profession should not exist providing its professionals are aware of the limitations of their personal areas of expertise.

In that point of the spectrum veering towards the biological, mental illness is seen as the result of imbalance; remedies, whether physical or psychological, are aimed at correcting this imbalance and restoring homeostatic stability. The emphasis is on recognising and correcting the Secondary Cause (i.e. the immediate cause of an illness – such as a traumatic

stress or a vitamin deficiency). In effect, the goal of therapy is that described by Jung as "Integration." A neat example of this is provided by Hamid Al-Ghazali (IO58 AD–1111AD); who advised balancing the "anxiety nafs" with their opposite – essentially Wolpe's Reciprocal Inhibition principle of treatment. Unlike Wolpe, however, who defined the opposite to anxiety as relaxation; Al-Ghazziall, I think, more correctly, defined it as "Courage" and advised patients to take up riding as a way of developing this counter balancing strength.

The further one moves along the spectrum to the spiritual end, the more flux, change, growth, and internal instability become the indices of health, and static balance becomes a problem. Of particular importance in the Islamic underlying of psychological dynamics, is the change from the self being controlled by the Nafs Amara to the state of remorse (Nafs Lawwama) which is seen as part of the journey back to the state in which the Inner heart becomes the locus of consciousness. Not having a diagnostic system that can even acknowledge the difference between a depression caused by a biochemical balance, and a state of Nafs Lawwama, can be disastrous for a client.

There are remedies to facilitate these processes of growth within the self with the aim, up to a point, comparable with Jung's concept of "Individuation." There is. more concern with primary causation, in effect, the meaning of purpose of the illness. The importance of paying attention to primary/ultimate causation was well described by Al-Ghazali. (Al-Ghazali, trans. Field, 2007). He said; "if a man ceases to take any interest in worldly matters, conceives a distaste for . . . . . . .pleasures, and appears sunk in depression, the doctor will say this is a case of melancholy and requires a prescription. It does not occur to (him) that the Almighty has a concern for the welfare of that man and has therefore commanded his servants and the elements to produce such a condition in him that he may turn away from the world to his maker."

It can also be said, that the further one moves along the spectrum to dealing with change and growth, the more important becomes the cultivation or uncovering of virtue (Vide Bakhtiar, 1994), (described by Futtuwah, normally translated as "Chivalry," and which, again bears a relationship to Jung's theory on the emergence of the Archetypes). In particular, the virtues of compassion, humility, and heroic courage. Courage being necessary for ruthless self honesty, and to allow the self to deconstruct as a precursor to new growth. Compassion, to avoid the risk of a more ordered Nafs Amara simply resulting in the person being more effectively destructive, producing a Genghis Khan personality. And humility, to avoid the expansion of the self causing a destructive inflation of the Ego.

A flaw, which Jung said, afflicted Niezche and led to his paranoia and eventual incarceration in an Asylum with a moustache as big as a broom!

The actual methods of therapy, provided they have been stripped of culturally inappropriate components, can be used from wherever they have developed. In fact, the holistic model requires the practitioner to be expert in a wide range of methods. There are some techniques that have developed within Islamic paradigms but which fall quite outside the paradigms of Western psychological science. For example, the uses of the very specific types of music to either balance forces in the Nafs Amara, or to weaken disassociation from the Qalb. Such therapy was in use in Ottoman Turkish Asylums until snuffed out by the suffocating ash of Ataturkism after the First World War. Or the use of therapeutic Architectural principles in the design of mental hospitals; some still in use in the Middle east and still functioning from their original medieval endowment.

There are other techniques, such as dietary advice and the use of herbal psychotropic medicines which can be marginal to Western psychiatric practice, but which are not

uncommonly used by the general British population. There are other techniques, such as types of dream analysis or principles of cognitive behavioural therapy or the use of narrative which have developed in both Islamic and Western psychology.

What is important is not so much the particular techniques, but the model of the self that directs their use. In particular, the recognition that, as well as the biological and cognitive functions of the human being, there is also an inner spiritual core – and that mental distress or dyscopia may not always be a disease but can be part of a journey back to the Inner Heart.

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