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The interaction of traditional religious therapy and Western psychotherapy in Islam: A comparative-anthropological study

DOCTORAL DISSERTATION

Humanities,
Ethnology (H 006)

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The dissertation was prepared between 2017 and 2021 at Vilnius University.

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LIETUVOS MUZIKOS IR TEATRO AKADEMIJA

Dovilė Valaitė

Tradicinės religinės terapijos ir vakarietiškos psichoterapijos sąveika islame: lyginamoji-antropologinė studija

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INTRODUCTION

Research description

Religion is one of the most important psychosocial factors in people's lives, especially in Muslim-majority countries. Thus, in light of rapid intercultural interaction and migration, how Islam influences the perception, prevention, diagnosis, and treatment of mental disorders must be investigated. Different cultures shape a distinctive way of life and cause people in that culture to differ in their psychology from people of other cultures (Heine, 2008). Culture also influences the understanding and formulation of psychopathology (Bhugra & Bhui, 2007). One of the pioneers of cultural psychology, Richard Shweder (1991), argues that psyche and culture are constructed and inseparable. Thus, acquired cultural schemes and models play an important role in the perception of psychopathology, and the relationship between culture and psychopathology is multifaceted (Bhugra & Bhui, 2007, p. 95). Cultural beliefs can (often unconsciously) determine people's perceptions of causality, illness behaviour, and treatment (Azhar & Varma, 2000). For many centuries before psychotherapy became popular in the West (in the twentieth century), methods similar to psychotherapy were widely used to treat mental disorders. Indeed, the basis for psychological treatment likely came from ancient ethical theory (Harris, 2013), and the world's first psychiatric clinic was established in Iraq in 705 CE, where mental disorders were treated with methods similar to psychotherapy and medication (Sabry & Vohra, 2013). From an Islamic perspective, spiritual disorders can affect mental disorders; from a Western medicine perspective, the true causes of many mental disorders are unknown (Al-Issa, 2000).

Therefore, the present research aims to investigate the cultural interaction between traditional religious healing practices and Western psychotherapy. This interaction is revealed through the attitudes of groups of people who were selected for the site-specific study on local and Western mental health treatment traditions. Psychotherapy (Greek: ψυχοθεραπεία, *psychotherapía*, 'treatment of the soul') is defined as the treatment of mental, emotional, and psychosomatic disorders and diseases with a set of psychological methods including verbal and nonverbal communication (Walrond-Skinner, 1986). However, in the present study, the term 'psychotherapy' is used not in a medical sense but rather to refer to soul healing in a broad sense (i.e., psychological, chemical, and physiological). Herein, psychotherapy refers not only to the treatment of mental disorders but

also to the correction of defective psychological conditions. Religious therapy is defined as the integration of religion into the process of therapy (Rajaei, 2010), and it is relevant to the process of Islamic psychotherapy[1] due to the cultural peculiarities of the region. Moreover, traditional religious healing involves sociocultural values common to a particular society, such as a traditional healer, the family, and the society at large. The key factors of psychological counselling are cultural context, religion and traditions (Chiboola, 2020; McLeod, 2013).

Together Muslim communities (Arabic: الأمة *al-umah*) that profess the Islamic religion are referred to as 'the Muslim world'. The present study analyses the Arab-Muslim region, also known as 'the Arab world' (Arabic: العالم العربي *al-ʿālam al-ʿaraby*) or 'the Arab nation' (Arabic: الأمة العربي *al-ʿumah al-ʿarabyah*), comprising 22 Arabic-speaking countries. These countries range from the Atlantic Ocean in the west to the Arabian Sea in the east and from the Mediterranean in the north to the Horn of Africa and the Indian Ocean in the southeast.[2] These Arab societies are diverse, including heterogenous psychosocial backgrounds based on factors like national identities, ethnicities, and socioeconomics. However, despite its differences, the Arabic region possesses commonalities, not only in religion and language but also in psychosocial systems and cultural heritage. Considering the differences between countries belonging to the Arab world, the present study analyses the Jordanian case. To transliterate Arabic terms to Latin script, the Library of Congress transliteration system[3], which is approved by the Library of Congress and the American Library Association, was used.

Research object: Cultural interaction between traditional religious Islamic healing practices and Western psychotherapy.

Research aim: To analyse the spread, adaptation, and inculturation of Western psychotherapy in Islam through an empirical-anthropological and textological-historical study.

[1] Islamic psychotherapy is a methodology based on the Qur'an and Sunnah. The guiding principle of this therapy is to draw closer to God. The Qur'an and Sunnah are sources of the knowledge that is used in Islamic psychotherapy, which provides solutions to mental disorder (Rajab, 2014).

[2] Complete List of Arabic Speaking Countries (2017). http://istizada.com/complete-list-of-arabic-speaking-countries-2014/

[3] Library of Congress Transliteration system. (n.d.). Retrieved from: https://www.loc.gov/catdir/cpso/romanization/arabic.pdf

Thesis of research: Although Giddens (2000) argues that psychotherapy is not needed in traditional cultures[4], interest in psychotherapy in these cultures is growing due to the influence of secularisation. In these cultures, the two treatments for mental disorders interact: traditional religious healing and Western psychotherapy. Thus, Western psychotherapy and traditional religious healing tools, despite their differing worldview structures, social norms, and ideological contexts, can be applied to complement each other in a culturally correct and sensitive way.

Tasks of the research:

1. To clarify the understanding of mental disorders in Islam.
2. To identify the influence of religion (its leaders, theologians, and communities) on mental health and treatment.
3. To trace the development of traditional healing practices and therapies in Islam.
4. To analyse the attitude of Muslims in Jordan towards psychotherapy.
5. To reveal the problems of inculturation of Western psychotherapy in the Arab region.
6. To highlight the main differences between treatment methods in traditional Islam and Western psychotherapy and their points of contact.

Study review

This study reveals an understanding of mental disorders and the development of psychotherapy in Islam; it also analyses traditional religious healing methods, the influence of religion on treatment, and the role of spiritual leaders in treatment. The inculturation of Western psychotherapy in Islam and problems within this process are also analysed. Furthermore, psychotherapeutic approaches and their effectiveness for Muslim patients are reviewed, as are Muslim attitudes towards psychotherapy. The two treatment methods, traditional religious Islamic and Western psychotherapy, are compared, and their main differences and points of contact are identified (considering the relationship between therapists and patients from a cultural

[4] Traditional culture: systematic behaviour and knowledge transmitted over several generations, especially customs and beliefs originating before the advent of modern science and technology. This can exist at the level of a nation or community and can transcendent borders (Science Direct, n.d.).

perspective). Furthermore, the importance of religious ideas and visual and moral norms in counselling are addressed.

Review of the literature

The topic of study was analysed from the perspective of contemporary cultural psychology, which Shweder (1991) defines as the way in which cultural traditions and social practices regulate, express, and transform the human psyche, leading to decreased mental unity for humanity and exploration of ethnic differences, self, and emotions. Thus, in analysing the importance of cultural factors in the field of mental health, this dissertation is based on the most significant works of cultural psychology: Shinobu Kitayama and Dov Cohen's *Handbook of Cultural Psychology* (2010), Steven J. Heine's *Cultural Psychology* (2008), Richard Shweder's *Thinking Through Cultures: Expeditions in Cultural Psychology* (1991), David Matsumoto's *The Handbook of Culture and Psychology* (2001), and Dimesh Bhugra and Kamaldeep Bhui's *Cultural Psychiatry* (2007).

The primary research instrument is the theory of social constructivism, which, in psychiatry, discusses mental disorders as socially constructed, with the view that social environment and cultural formation shape mental disorders. Therefore, Michel Foucault's work, *Madness and Insanity: A History of Madness in the Classical Age* (2009), was particularly helpful for understanding how social norms and behaviour shape the concept of madness in Islam. The works of other scholars who developed the antipsychiatry approach were also useful: Ronald David Laing's work *The Divided Self: An Existential Study in Sanity and Madness* (1965) and Thomas Stephen Szasz's book *Myth of Mental Illness* (1961).

The focus of this dissertation is two treatment traditions: traditional religious healing and Western psychotherapy. These are analysed in detail in *Al-Junūn: Mental Illness in the Islamic World* (2000), the work of the General Secretary of the International Association of Arab Psychology, Ihsan Al-Issa. Al-Issa defines not only the relationship between religion and psychopathology and the development of psychotherapy in Muslim-majority countries but also the current role of psychotherapy in Muslim society. Traditional healing in Islam has also been reviewed by many other scholars: Edward Granville Browne (1921), Donald Campbell (1926), Michael W. Dols (1992), Muhammad Salim Khan (1986), Fuller E. Torrey (1986), Zain M. Azhar and S. L. Varma (2000), and Boaz Shoshan (2003). Furthermore, old texts regarding mental health in classical Arabic were studied by Rania Awaad and colleagues (2015).

Particularly relevant for the dissertation among the discussions of contemporary mental health specialists was the cultural adaptation of psychotherapy for Muslim patients and the role of religion in counselling. Extensive work experience has been gained and the most significant studies have been conducted by psychologist Malik B. Badri, whose books *The Dilemma of Muslim Psychologists* (1997), *Contemplation: An Islamic Psychospiritual Study* (2016), and *Cultural and Islamic Adaptation of Psychology: A Book of Collected Papers* (2016) were significant for this dissertation. Other works that were useful include *Islamic Faith-based Counselling* (2007) by Muslim psychologist Hanan Dover, who works with both Muslim and Western patients, as well as the works of Aysha Utz (*Psychology from the Islamic Perspective*, 2011), Scott P. Richards and Allen E. Bergin (*A Spiritual Strategy for Counselling and Psychotherapy*, 1997), Marwan A. Dwairy (*Counselling and Psychotherapy with Arabs and Muslims: A Culturally Sensitive Approach*, 2006), Hussein G. Rassool (*Islamic Counselling: An Introduction to Theory and Practice*, 2016), Sameera Ahmed and Mona M. Amer (2012), and Carrie York Al-Karam (2018). Additionally, works on religious, cultural, and social interactions of mental disorders in Islam were helpful, namely those written by Saxby Pridmore and Mohamed Iqbal Pasha (2004); Debra Stein (2000); Tariq A. Al Habeeb (2003); Amber Haque (1994, 2004); Majed A. Ashy (1999); W. M. Sabry and A. Vohra (2013); Osman M. Ali, Glen Milstein, and Peter M. Marzuk (2005); K. Shah and E. McGuiness (2011); Alien Al-Krenawi and John R. Graham (2000, 2005); and Zari Hedayat-Diba (2000).

Ethan Watters conducted a significant study on American cultural affliction on mental disorders and somatisation in the global mind[5] and investigated whether Western psychology is necessary in traditional Islamic culture. His work, *Crazy Like Us* (2010), analyses mental disorders and the occurrence of their features in different cultures (e.g., anorexia in Hong Kong, post-traumatic stress disorder in Sri Lanka, schizophrenia in Zanzibar, and depression in Japan).

Mike Poltorak (University of Kent) conducted medical anthropology research on traditional medicine and modern medicine (mental health and Tongan traditional healing interaction) in the South Pacific Island group of Tonga (2007, 2013, 2017), where a traditional healer and a psychiatrist treated spiritual afflictions and mental disorders in challenging and inspirational

[5] The global mind is defined as the ability to perceive and decode behaviours in multiple cultural contexts.

ways. Poltorak's research illuminated how traditional healing and psychiatry collaborate in other cultural settings.

Similar research that examined the role of psychiatrists in society and compared their work with traditional healers and priests in other cultures was undertaken by Fuller E. Torrey in *Witchdoctors and Psychiatrists: The Common Roots of Psychotherapy and Its Future* (1986).

Another significant work for this dissertation was written by Roy Moodley and William West; *Integrating Traditional Healing Practices into Counselling and Psychotherapy* (2005) discusses the rich healing traditions of various cultures from around the world, most of which are practiced alongside modern mental health care. Using examples of the collaboration between traditional healing and psychotherapy in various cultures and regions (e.g., southern Africa, the Caribbean, Latin America, South Asia, and Sub-Saharan Africa) and in various religious traditions (e.g., Christianity, Islam, Judaism, and Buddhism) with different practices (e.g., shamanic practices, aboriginal healing, spiritual healing, and others), Moodley and West's work discusses traditional healing in a modern world. In this dissertation, cultural issues in counselling and psychotherapy are extended beyond sterile notions of multiculturalism and cultural competency.

Part of the data used in this study were acquired from primary sources such as the Qur'an, Tafsir[6], Hadith[7], and Imam al-Ghazali, *The Revival of the Religious Sciences* (Arabic: إحياء علوم الدين *iḥyā' 'ulūm al-dīn*).

Regarding the research aims, many useful theoretical and empirical data were found in scientific articles published in journals, including *Psychology Today; The Journal of Muslim Mental Health; The Arab Journal of Psychiatry; The International Journal of Middle East Studies; Psychology of Religion and Spirituality; Cultural Diversity and Ethnic Minority Psychology; Medical Anthropology Quarterly; The American Journal of Islamic Social Sciences; The Journal of Religion and Health; Transcultural Psychiatry; Research in Psychology and Behavioral Sciences; World Psychiatry; Social Science and Medicine; The Journal of Health and Social*

[6] Tafsir (Arabic: تفسير *tafsīr*) refers to the explanation or exegesis of explanation of the Qur'an, the sacred scripture of Islam, or of Qur'anic commentary (Mir, 1995).

[7] Hadith (Arabic: حديث *Ḥadīth*) is the record of the traditions or sayings of the Prophet Muhammad, which are revered and received as a major source of religious law and moral guidance, second only to the authority of the Qur'an. It could be defined as the biography of Muhammad perpetuated by the long memory of his community for their exemplification and obedience. The development of Hadith was a vital part of the first three centuries of Islamic history, and its study provides a broad index for the mind and ethos of Islam (Encyclopaedia Britannica, n.d.).

Behaviour; The Journal of Nervous and Mental Disease; The Journal of Psychology; and many others.

Relevance of the problem and novelty of the study

The number of Muslims is a rapidly increasing, as is the scale of their migration around the world. This has led to processes of Muslim integration, separation, and acculturation in Europe. Practitioners are increasingly required to provide appropriate mental health services that meet the needs of Muslim community members. It must be determined how psychotherapeutic services should be adapted for the followers of this religious tradition, their principles, and their prevailing social behaviours. Furthermore, due to Western medical standards, psychological services in Arab countries are limited in demand and provision, and mental health is highly stigmatised. Despite the growing psychological tensions, crises, depressions, personal conflicts, and instances of social aggression, Muslims avoid secular psychotherapy services.

A significant number of studies have investigated the perceptions of mental disorders in Muslim-majority countries. However, few studies have specifically focused on Jordan. Studies on related topics, such as traditional healing, traditional healers, treatment of mental disorders, and Western psychotherapy have also been conducted in Muslim-majority countries. The present study covers a broad range of mental health topics in Arab countries, including perceptions of mental disorders (traditional understandings and understandings of contemporary society) and various treatment methods (traditional and modern) that have been utilised. This study aims to understand how well the West know 'others' and 'otherness', and how open and accepting 'otherness' is to Western culture. The study also aims to determine how and to what extent modernisation affects traditional culture and folk beliefs, as well as how traditional culture and perceptions change under the influence of modernisation and secularisation. Finally, the study aims to identify how the concepts of normality and abnormality are revealed in the consciousness of others.

In Lithuania, no scientific studies have analysed traditional religious healing or cultural adaptation of Western psychotherapy in Muslim-majority countries. The present study is significant in the Lithuanian context since the country was facing a migration crisis[8] in 2021, with a rapid increase in the

[8] The migration crisis started in Lithuania in the summer of 2021, when illegal immigrants began arriving in large numbers at the border with Belarus. At the

number of Muslim migrants. Due to this crisis, mental health professionals must face cultural differences. According to Professor Arūnas Germanavičius, head of the Republican Vilnius Psychiatric Hospital, welcoming the first migrants was a challenge as many did not speak English and had different mentalities. Therefore, talking with these migrants about psychological problems was nearly impossible (Morozovas, 2022).

Thus, the need for studies like the present is growing due to increasing migration processes and civilizational-ideological conflicts. Despite the relevance of this issue, however, such studies are lacking in the international academic arena. It is not primarily a medical matter but rather deals with interactions of cultures and religions, cultural psychology, and sociocultural anthropology. Thus, for proper analysis and resolution of the topic, a need exists for religious and oriental knowledge, Arabic language mastery, knowledge of Islamic history, and an ability to evaluate the inculturation of modern Western psychotherapy critically.

Today, the West has an increasing interest in Islamic culture, religion, and concepts of health. Thus, this research is also relevant in an applied sense. The international psychotherapy field has been increasingly concerned with Islam, and how effective Western psychotherapy is within this context must be determined. Therefore, the present study may be useful for specialists in various fields, including cultural researchers, scholars of religions, mental health specialists, orientalists, cultural mediators, and employees of migration and social services.

Ethnographic context

The current study is based on ethnographic research conducted between September and December 2019 in the northern part of Jordan, specifically in Irbid, which is located about 70 kilometres north of Amman and approximately 20 kilometres south of the Syrian border. The Irbid governorate has the second largest population in Jordan, after Amman, with

beginning of June 2021, the number of illegal migrants on the Belarusian border reached several dozen people, and in early July, the number of migrants reached up to 150 people per day. On 2 July 2021, a total of 822 illegal immigrants were recorded. On the same date, a state of emergency was declared throughout the country due to the influx of migrants. More than 4,000 nationals from Iraq, Syria, Congo, Cameroon, Iran, Afghanistan, Yemen, Egypt, Somalia, Morocco, and other countries have arrived in Lithuania during the summer months (Official Statistics Portal [OSP], 2021).

an estimated 1,911,600 inhabitants. Irbid is the third largest city, after Amman and Az Zarqa, with a population of 558,134 (World Statistical Data [WSD], 2019). In the Arab region, Irbid is a middle-sized city. Modern Irbid is one of Jordan's industrial areas as well as an agricultural centre for Jordan's most fertile region (Encyclopaedia Britannica, n.d.). Furthermore, the city's high concentration of higher education institutions has shaped its unique identity. Additionally, the city is a hub for the majority of the region's refugees (United Nations Relief and Works Agency [UNRWA], n.d.).

The Kingdom of Jordan is one of the most westernised Arab countries. According to the World Bank (2018), Jordan is classified as a country of 'high human development' with an 'upper middle income' economy. Jordan has a population of nearly 10 million people (Department of Population and Social Statistics [DPSS], 2018). The country also has the highest (98.2%) literacy rate among Arab countries (Statista, 2018). The overwhelming majority of people in Jordan are Arabs (98%), including Jordanians (69%), Palestinians (6.7%), and Syrians (13.3%). Sunni Muslims, represent about 95% of the country's population, while Christians represent about 4.2% (Encyclopaedia Britannica, n.d.).

Initially, contacting respondents and conducting interviews on such a sensitive topic was expected to be difficult. However, people were quite willing to discuss various issues related to mental health. They were hospitable and frequently invited me to family celebrations, engagement parties, weddings, picnics, lunch or dinner with their families, a coffee, or simply a walk together. Surprisingly, conversations about mental health occurred in almost every public place, including at the bus station, on board buses, and in many other places. People approached me in shops and restaurants and willingly talked; after learning the purpose of the study, most of them happily agreed to complete the questionnaire. Furthermore, they were willing to share local cultural knowledge and family stories, answer additional questions, meet for further interviews, and recommend friends for interviews. This willingness helped me collect several formal and informal interviews, and the rich ethnographic experience helped me gain a better grasp of local culture and traditions. The first-hand ethnographic information subsequently provided a cultural framework that aided the interpretation of the collected data. Additionally, communication with quite a large number of interlocutors continues now and has helped obtain extra data and answer questions that arose during data analysis and interpretation.

Potential respondents were recruited in different public areas, such as bus stations, streets, and university campuses; thus, the snowball sampling method was used (Bryman, 2004; Taylor & Bogdan, 1984). This approach

allowed adaptation to the peculiarities of the study participants and considered the possible cultural and religious sensitivities of the individuals. There were no special selection rules; I interviewed people who met the selection criteria, and these people then provided contact information for other potential participants (Bryman, 2004).

Theoretical approaches and methodology

A complex interdisciplinary methodology and several theoretical approaches were used to analyse the interaction between traditional religious healing and Western psychotherapy. The study was based on **cultural psychology**, with the assumption that culture influences mental disorders (Heine, 2008). The study was also based on the concept of cultural relativism used in contemporary cultural psychology and ethnopsychiatry, in which a person's beliefs, values, and practices are understood based on that person's culture rather than the criteria of another. Culture is treated as a separate world of social experience and religious values that are based on the culture's concepts; the diversity and uniqueness of the cultures existing in the world cannot be encased in a unified and universal scheme of human development (Heine, 2008; Kitayama & Cohen, 2010; Matsumoto, 2001; Shweder, 1991). **Medical anthropology**, together with cultural psychology, was applied as one of the core approaches of the present research, as it examines how health, well-being, and illness are socially and culturally constituted in transcultural contexts, as well as the ways in which culture influences the conception of illness, practices of healing for the individual and community, and non-Western medicines and healing traditions. Psychiatric anthropologist and professor of medical anthropology and cross-cultural psychiatry Arthur Kleinman (1985) has contributed to the anthropological and medical understanding of culture-bound syndromes. He claims that mental distress is much more likely to be expressed as somatisation than as psychological distress. American medical anthropologist Byron J. Good explored the cultural meaning of mental illness and its treatment in the non-Western medical field; his explorations is widely discussed in the present study. A comparative development of mental health systems is also included herein (Loewe, 2003). The concept of folk medicine, which demarcates between magical practices, medicine, and religion and explores the role and significance of popular healers and their self-medicating practices, was developed by medical anthropologist Samuel Lézé (2014). This concept, which includes identification of ethnic disorders and culture-bound syndromes that belong to specific cultures and have not been previously

described by medicine, is used in the present study to reveal the significant role of folk healers in Arab countries. According to this concept, medical systems are a product of each ethnic group's cultural history and thus help to discuss the influence of culture on what a society considers to be normal, pathological, or abnormal.

To analyse the conception of mental disorders, the approach of **social constructivism,** influenced by the poststructuralist ideas of Michel Foucault (2009) that state that madness is a social and historical construct, was applied. Furthermore, the theory of antipsychiatry formulated by Thomas Szasz (1961) and Ronald David Laing (1965) states that mental disorders are struggles for personal freedom.

This dissertation is partially dedicated to acquiring insight into how healing has functioned in Arab countries from a historical perspective informed by sociology. The **sociology of religion** attempts to understand the relation between religion and globalisation determined by the present research. One of the social thinkers, Ernest Gellner (1992), discusses relations between Islam and the West, and one of his core ideas is a 'return to the genuine and firm faith of religious tradition'. Sociologists Peter Berger (1969, 1977, 1999) and Anthony Giddens (2000) also discuss modernisation and secularisation and their impact on traditional culture and religion. All the above-mentioned theories are closely intertwined in terms of their construction of concepts regarding religious practice and psychological and cultural peculiarities.

The main tools of the present research are **critical hermeneutical analysis of scholarly literature** and **anthropological-empirical research** based on medical anthropology. This approach reveals the social processes and cultural representations of health, illness, and treatment methods. Surveys and interviews were performed using qualitative methods, and participant observation was also conducted.

A pilot study of the present research was completed in Egypt during multiple visits between 2018 and 2019.

Qualitative methods

Morrow (2007) states that qualitative research methods are well suited for counselling psychology research and culturally relevant theory building. Thus, qualitative methods were employed in the present study to present a detailed and in-depth view of a particular phenomenon. In line with Patton's (1999) conceptualisation of triangulation, which defines the use of multiple qualitative methods to develop a comprehensive understanding of phenomena,

the study combined free-listing tasks, semi-structured interviews, and participant observation. A comparative research method was also applied to compare two specific concepts of treatment: modern Western and traditional religious. Additionally, triangulation of theories enabled the data to be approached with multiple perspectives and hypotheses in mind, which was well suited for the current study; various theoretical points of view were compared to assess their utility and power (Denzin, 1978, p. 297).

Free-listing task

To clarify the understanding of mental disorders in the Arab world, the study employed a standard method in cognitive anthropology, the free-listing task. This method allows researchers to familiarize themselves with the terms shared and used by respondents themselves (de Munck, 2009; Quinlan, 2019; Weller & Romney, 1988). That is, the researcher obtains information about the conceptual domain from what anthropologists call an *emic* perspective, in which terms are used within a particular cultural group, as opposed to an *etic* perspective, in which terms are formulated in the technical social scientific language. This method has been applied in different fields of study, including mental health (Fiks et al., 2011; Vardar et al., 2012; Weaver & Hardley, 2011). The free-listing task is also a specific qualitative method that can be easily quantified and used for further analyses. Thus, several software tools have been developed to analyse free-list data, such as the classic but still widely used ANTHROPAC (Borgatti, 1996) and a more recent free add-in for Microsoft Excel, FLAME (Pennec et al., 2012).

Interview method

To elucidate the role of traditional religious healing and Western psychotherapy in the Arab-Muslim region, the study employed the interview method. In conjunction with the free-listing task, formal and informal interviews were conducted to enable ‘ethnographic cross-checking’, which enhances the accuracy and depth of ethnographic understanding (Liamputtong, 2019). According to Liamputtong (2019), ethnography and free-listing are complementary sources of information. Thus, one of the methods for finding emic domains is using free-listing cross-checked with ethnographic interviews. Experts on qualitative methodology suggest that sufficient data are more important than large samples of participants in qualitative studies (Morrow, 2007). Thus, to discover the role of traditional religious healing and psychotherapy in the Arab world, semi-structured

interviews were conducted with three different groups: mental health specialists, representatives of religion and traditional healers, and Jordanian inhabitants. Then, the triangulation method (Della Porta & Keatin, 2008; Patton, 1999), in which information about the same subject or object is collected from different sources, was applied for broader understanding of the topic. To deepen insights into the topic, participants from various psychological fields were recruited, including psychologists, Islamic psychologists, psychotherapists, and psychiatrists (both specialists who graduated abroad and those who studied in their homeland), as well as religious leaders (Arabic: شيخ *shaykh*)[9], imams[10] (Arabic: إمام *imām*), specialists in Islamic law (Arabic: شريعة إسلامية *sharī'ah Islāmīyah*) and religion, and local inhabitants (Sunni Muslims). Representatives of other religious minorities in Jordan were excluded due to the defined scope of research.

The local inhabitants were interviewed in an environment that was comfortable for them without causing tension – for example, a cafe, university library, innovation centre (ZINC), the respondent's home, or picnic areas. A convenient time and place for the formal interviews were agreed upon in advance. Typically, interviews lasted 1–2 hours, but each case was different; I had some interviews that lasted about 5 hours. Furthermore, interviews with some respondents occurred over several meetings. All respondents participated in live, semi-structured interviews to avoid limiting the type of information that was received, and all interlocutors were asked 10 questions. The questions were presented orally in English or Arabic; the respondents were free to choose the language. Open-ended questions were used, as is typical and recommended in qualitative research (Lincoln & Guba, 1985; Suzuki et al., 2007). The course of the interview was controlled, but new directions were allowed within the topic, and questions that arose while listening to the interlocutor's responses were asked (Bryman, 2004). The guiding interview questions are included in the appendices (Appendix A: 'Questions for Jordanian inhabitants', Appendix B: 'Questions for mental health specialists', Appendix C: 'Questions for *sheykhs*', and Appendix D: 'Questions for imams').

[9] *Sheykh* is a term that describes a faith healer or religious leader in Jordan who practices prayers or other rituals for spiritual and physical healing. In different Arabic countries, native or faith healers are called by different names.

[10] An imam is a leader in a general sense, one who leads Muslim worshippers in prayer and provides religious guidance. In a global sense, imam is used to refer to the head of the Muslim community (Encyclopaedia Britannica, n.d.).

Transcriptions were non-verbatim; thus, unnecessary utterances like ‘well’, ‘hm’, ‘you know’, among others, were eliminated, and only the foundational meaning of the interviewees’ words was preserved. Quotations presented through non-verbatim transcriptions, according to Blake Poland (1995), are clearer and easier to read and present interview subjects as articulate. The interviews were transcribed and translated, and the data were analysed. Interviews in Arabic were translated by me. Since the specifics of the research field placed me under an obligation to know Arabic, I purposely worked on improving my Arabic.

The collected qualitative data were analysed by thematic analysis, as suggested by Virginia Braun and Victoria Clarke (2006). Thematic analysis is one of the most common forms of analysis within qualitative research, and it has been widely used in psychology and social, behavioural, and applied sciences. Chosen for its flexibility, this method can be applied in several different ways, including various databases and research questions (Braun & Clarke, 2019). Thematic analysis not only identifies, analyses and reports themes within the data but also interprets various aspects of the research topic (Boyatzis, 1998). In accordance Braun and Clarke’s (2019) methodology, the data were first transcribed and explored. Second, the data were coded in a deductive (or concept-driven) way; coding and theme development were directed according to existing concepts or ideas to identify important features of the data that were relevant to the research questions. Third, the codes were examined, and the themes were identified. I used a latent approach, which means that I was interested not only in a respondent’s stated opinion but also what their statements revealed about assumptions and social context (Braun & Clarke, 2006). Fourth, the candidate themes were checked against the dataset to determine whether the themes answered the research questions. Finally, the defined themes were detailed, analysed, and interpreted according to the existing literature and studies.

The results are presented in the second, third, and fourth parts of this dissertation. Topics are divided into three categories: traditional treatment, modern psychotherapy, and the interaction of these two methods of treatment. Among the highlighted topics, those that reflected the tasks of the present work were selected for wider analysis and interpretation, while the themes that did not reflect the dissertation tasks were excluded.

Participant observation

Participant observation relies on participating in and observing the social life of people whom the researcher is studying. This method has been

used in a variety of disciplines as a tool for collecting data about people and cultures in qualitative research. Bernard (1994) argues for the importance of participant observation in cultural studies as providing the ability to collect different types of data, to become familiar to the community, and to be involved in activities to which the researcher would generally not be invited. Additionally, participant observation is important for developing questions that are culturally relevant, and it generates a better understanding of the culture. Other anthropologists, for example, de Munck and Sobo (1998), recommend participant observation for its several advantages, such as affording access to 'backstage culture' and the opportunities to view or participate in unscheduled events.

Thus, participant observation was used in addition to surveys, questionnaires, and interviews as strategy to achieve stronger validity when generating and testing hypotheses. During field work, participant observation was conducted in informal, personal spaces, as well as collective settings. I developed close relationships with several people, visiting them in their homes and workplaces, attending family events and religious events, and otherwise socialising. I observed as individuals performing their everyday routines of family and social life, work, and worship. This participation gave me a better understanding of the cultural context and enabled me to check for nonverbal expression of feelings, to grasp how participants communicate with each other, and to observe situations informants described in interviews. As Marshall and Rossman (1995) argue, participant observation allows researchers to check definitions of terms that participants used in interviews and observe events that informants may be unable or unwilling to share as doing so would be impolite, insensitive, or impolitic.

The selected methods aided in an in-depth analysis of the topic. Furthermore, the selected study groups helped to reveal the following: the attitudes of modern Muslims toward mental health and psychotherapy; who seeks help more often, men or women; the social background of patients attending psychotherapy; problems of the inculturation of Western psychotherapy in Islam; reasons behind the choice of treatment methods; the main differences between treatment methods in traditional Islam and Western psychotherapy; and the points of contact of the two treatment methods.

Ethical review

The empirical field research using the qualitative research method (free-listing task, interviews) was carried out according to the document

'Guidelines for the assessment of compliance with research ethics'[11] on academic ethics and procedures approved by the Ombudsman of the Republic of Lithuania.

In line with the ethical standards of the research, the participants were first briefed on the purpose of the research and were given the researcher's self-introduction. The benefit of the study was presented as follows: the study will be useful in trying to learn about cultural interaction in the field of psychology. The participants could decide not to answer certain questions concerning their privacy after learning about the aims of the study. Furthermore, the study did not include forced participation, so the participants were informed of their ability to opt out of further participation at any stage of the survey or interview. Additionally, the participants could decide whether certain emotional information should be recorded. To avoid ethical issues, the purpose of the study, how anonymity would be ensured, how the data would be stored, and what would happen to the data in the future were presented to the participants before the interviews. Moreover, permission was gained before using audio recording tools to ensure that such recording did not conflict with the cultural beliefs of the participants or affect their well-being.

Prior to the research, the participants were informed of their rights regarding the study material (recordings, data, publications) and its dissemination. As the research was conducted in another country, researchers already working on a similar topic were contacted to discuss the ethical guidelines for research in the country of study and to ascertain the potential sensitivity of the participants to the topic.

One of the main ethical issues in the field of research is preserving the participants' privacy. The identities and records of the participants should be confidential, especially when publishing the results of a study, and the personalities of the participants should not be directly or indirectly identifiable. However, some of the participants in the study, such as psychotherapists and psychologists, consented to their identities being made public. Additionally, pseudonyms were used to protect the identity of other participants in the study.

According to the Guidelines for the Assessment of Compliance with Research Ethics, participant observation, does not require participant consent because the behaviour is observed in a public space (e.g., at home, at

[11] Guidelines for the assessment of compliance with research ethics. Retrieved from: https://etikostarnyba.lt/wp-content/uploads/2021/05/V-60-Dėl-Atitikties-mokslinių-tyrimų-etikai-vertinimo-gairių-tvirtinimo-su-pakeitimais.pdf

university, etc.) and does not involve the collection of personal data, nor does it involve the use of audio-visual recordings, which are identifiable.

Structure of the dissertation

The dissertation comprises an introduction, four parts, and a conclusion. **The first part** of the dissertation is dedicated to analysing the perceptions of mental disorders in Islam and contemporary Muslim society. In the first chapter, the construct of insanity is analysed based on different theories in order to distinguish madness as a social construct from mental disorder as a disease. In the second chapter, the concept and origins of mental disorders in traditional Islam are determined using critical analysis of the literature. The third chapter presents empirical data that help to reveal the concept of mental disorders in contemporary Islam, particularly in Jordan.

The second part of the dissertation reviews traditional healing in Islam in the past and present. The first chapter analyses mental health and its treatment in the Islamic Golden Age, and the second chapter presents traditional healing methods in Islam. Qualitative data revealing the role of traditional healing in contemporary Muslim society are presented in the third chapter, as is a discussion of the religious leader as psychotherapist.

The third part of the dissertation presents Western psychotherapy in Arab countries, which is a relatively new concept in the Arab world. Thus, considering the importance of culture, the first chapter discusses the need for psychotherapy in the Arab world. The second chapter examines the importance of cultural factors in counselling, as well as the inculturation of psychotherapy. Qualitative data on psychotherapy in Jordan, as well as the importance of religion in counselling, are shared in the third chapter.

The fourth part of the dissertation is dedicated to discussing the possible combination of the two treatment methods, presented in the second and third parts of the dissertation, traditional healing and Western psychotherapy. Qualitative research data are presented regarding reasons behind the choice of treatment method when Jordanians seek psychological help.

Each part is summarised in concluding remarks regarding the issues discussed in that section. The dissertation concludes with of summary of the research results.

1. PERCEPTION OF MENTAL DISORDERS IN ISLAM

> 'The way in which mental illness is seen in the Orient is very different from in the West.'
>
> (Benslama, 2006)

Mental disorders, or altered psychological states, are prevalent in all populations, regardless of race or ethnic origin. Although general psychology argues that people are the same everywhere, certain behaviours, such as eating, sleeping, and others, are generally common to all cultures, but each culture has different behavioural habits in terms of language, religion, rituals, and values, among others. Cultural anthropologists have long been critical of biomedical specificity, emphasising that health and disease can only be studied in cultural, economic, and ecological contexts, while cultural psychology and cultural psychiatry also emphasise the importance of culture and religion in understanding how mental health is conceptualised (Berry et al., 2002; Cole, 1996; Kitayama & Cohen, 2007; Matsumoto & Juang, 2012; Tseng, 2001). Kakar (1992) argues that myths, legends, and images can be read as a collective historical consciousness. Thus, they are a rich source of psychological information that forges the collective identity. In the context of different cultures, psychology must consider each culture from its own frame of reference, including its own ecological, historical, philosophical, and religious context (Kim et al., 2006, p. 5).

The understanding of normal, as well as abnormal, psychological functioning varies across cultures (Heine, 2008). Cultural factors, such as notions of suffering, normalcy, and deviation, shape the conception of diseases and their treatment methods (Bhugra & Bhui, 2007). Baer and colleagues (2012) state that a holistic approach is constitutive of the field of cultural psychology. Mental health specialists worldwide rely on the Diagnostic and Statistical Manual of Mental Disorders (DSM-V) and International Statistical Classification of Diseases and Related Health Problems (ICD-10). However, according to Heine (2008), universal mental disorders may have some cultural dimensions. Often unconsciously, cultural beliefs determine perceptions of causality, illness behaviour, and treatment (Azhar & Varma, 2000). Thus, cultural relativism questions the influence of genotypes and phenotypic factors on personality and forms of pathology, especially in psychosomatic symptoms; cultural influence in societies as demarcating the boundaries of normality and abnormality; the universality of

psychology across cultures; and the description of diseases that have not been defined in medicine and are described as cultural syndromes (Ialenti, 2011).

This part of the dissertation discusses mental health and mental disorders in the Arab world. The first chapter examines the perception of mental disorders in Islam using a literature analysis, and qualitative research was performed to examine the mental health conceptions of contemporary Muslim society.

1.1. Mental disorders or otherness: Madness as a social construct

Junūn (Arabic: جنون) is a term that describes madness, mental illnesses, or otherness among Muslims and reflects traditional attitudes of Muslim societies toward madness. In contrast, the term 'mental disorder' is related to Western medicine. Additionally, the word *majnūn* (Arabic: مجنون) describes not only a person who has a mental disorder but also anyone who deviates from cultural norms or manifests unacceptable behaviour (Al-Issa, 2000). Shoshan (2003) argues that the Arabic term *majnūn* refers to a culturally determined label of madness that is not a contemporary conceptualisation of mental disorders. The causes of madness are regarded as exterior to the person and often considered the result of persecution and sorcery. The term 'crazy' is used to described a person possessed by supernatural beings that control his or her behaviours, thoughts, and desires. The Arabic terms *junūn* and *jinn*[12] are derived from *janna* (to become insane/crazy). According to W. V. Harris (2013), mental disorders were thought to be caused by demons, in ancient Greece and in Roman society, and the role of demons had social, political, and theological aspects. Insanity and mental disorders are mentioned in Greek and Roman texts, especially in the tragedies of Athens and in philosophical works (Harris, 2013, p. 4). In medieval Muslim society, many forms of madness existed side by side with Galenic medical theories. A wide range of madness was viewed not as disorders but rather an untreatable condition — for example, being a romantic

[12] *Jinn* in Arabic mythology are supernatural spirits below the level of angels and devils. *Jinn* are beings of flame or air who are capable of assuming human or animal form and are said to dwell in all conceivable inanimate objects – stones, trees, ruins, and others – underneath the earth, in the air, and in fire. They possess the bodily needs of human beings and can even be killed, but they are free from all physical restraints. *Jinn* delight in punishing humans for any harm done them, intentionally or unintentionally, and are said to be responsible for many diseases and all kinds of accidents; however, those human beings who know the proper magical procedure can exploit the *jinn* to their advantage (Encyclopaedia Britannica, n.d.).

fool, holy fool, or intelligent fool. These forms of madness became part of popular Islamic culture and are still present in modern society. Furthermore, a marginal concept of madness in Muslim society reduces the distinction between norm and deviation and is more tolerant of distorted behaviour (Al-Issa, 2000, p. 50). Insanity in earlier epochs was considered to be determined by God's will, and the insane ones were worthy of community care (Giddens, 2000); this attitude still exists in present Arab culture.

Madness was defined as a social construct by French philosopher M. Foucault (2009) and separated from the term 'mental disorder'. The definition of madness in the eighteenth century included poverty, physical diseases, and rejected or unacceptable individuals. In the modern age, madness also often refers to stigmatised or socially marginalised individuals. However, the perception that mental disorders, along with crime, could strike any population in certain circumstances was widespread. Mental disorders, which used to be a special, though not clearly distinguished, characteristic of poverty and therefore widespread among the least privileged groups, began to be treated as one of the dangers posed by modern life (Giddens, 2000).

M. Foucault (2009) describes mental disorders in a social context and emphasises that they are constantly influenced by external economic and cultural interests. A. Giddens (2000) also supports the theory that most forms of insanity are caused by social conditions, arguing that behavioural control is the primary means of imaginary treatment. In the seventeenth century, the insane were separated from society. Later, in the nineteenth century, insanity was viewed as a disorder, and the definition of insanity excluded prisoners and beggars (Foucault, 1965). In the nineteenth, twentieth, and twenty-first centuries, insanity was seen as a medical problem, while in the seventeenth and eighteenth centuries, insanity was seen as a social problem (Harris, 2013, p. 459). According to A. Giddens (2000), many of the first psychiatrists attributed the etiological causes of mental illness to social factors.

In developing the framework of social constructivism, some scholars deconstructed psychiatry by stating that mental disorders are of social origin and are thus socially constructed (Foucault, 1965, 2009; Laing, 1965). Scottish psychiatrist R. D. Laing (1965) developed the antipsychiatry[13] approach, which argues that mental disorders may be a justifiable and even just way of escaping from unbearable social pressure, uncertainty of being, and lack of recognition. Laing believes that severe mental disorder has social causality and that patients with psychosis can be seen in two ways, as

[13] The term antipsychiatry was first used by psychoanalyst David Cooper in 1967 (Double, 2006, p. 19).

manifestations of illness or as expressions of existence. He also states that paranoid delusions are not symptoms of disease but rather a reaction to a persecuting and inevitable social law. Further developing the antipsychiatry approach, M. Foucault (1965), R. D. Laing (1965), and T. Szasz (1961) argue that personal reality and freedom do not depend on any definition of normality attempted by primary official psychiatry. M. Foucault (1965) and E. Goffman (1961) also criticised psychiatric society, the use of universal institutions, labelling, and stigmatisation.

Other psychoanalysts agree with the theory of social constructivism regarding mental disorders. Hungarian-American academic, psychiatrist, and psychoanalyst T. S. Szasz (1961) attempted to prove that mental disorders are a myth. Similarly, Goffman (1961) argues that mental disorders are the inability or unwillingness to adapt to certain basic 'rules of situation courtesy' that presuppose daily communication. Giddens (2000) supports this idea, stating that mental disorders as insanity have been enthusiastically defined as the language of social incapacity. In other words, insanity is the inability or unwillingness to live up to the demands of the outside world. These ideas correspond with one of the definitions of mental disorders in Muslim-majority countries, in which otherness or behaviours not in line with cultural traditions or social norms are attributed to insanity. Thus, one of the aims of this dissertation is to clarify the concept of mental disorders in Islam.

1.2. Concept of mental disorders in traditional Islam

Islamic psychology[14] studies the psyche[15] from a religious perspective that allows the cultural habits of individuals and the psychic peculiarities of Muslim society to be understood (Ashy, 1999, pp. 241–257). Indeed, in the Arab world, religion plays a significant role in everyday life. Thus, the understanding of what is health or disease is closely tied to religion (Khan, 1986). Normality and abnormality in Islam, as well as mental disorders, are

[14] Islamic psychology is an indigenous approach to the study and understanding of human psychology that is informed by the teaching and knowledge from the Qur'an and the Prophetic tradition (Haque, 1998; Utz, 2011).

[15] Psyche (gr. Psyche), the Greek goddess, is the embodiment of the human soul. In ancient Greek myths, she is described as the personification of the soul, the breath of life. Ancient artists depicted her in gems, reliefs, frescoes in Pompeii (in the form of a bird), in the Hellenistic period, and in Rome as a volatile virgin with the wings of a bird or a butterfly. In psychology, the psyche is the centre of thoughts, feelings, motivation, and the body's conscious and unconscious reactions to the social and physical environment (Stedman's Medical Dictionary, 2002).

described and defined by the Holy Qur'an and Sunnah[16]. As a result, mental and physical health are interconnected, and both are seen as necessary for performing religious obligations. In Islam, a person is understood as a totality of four interacting parts: mind (Arabic: عقل *'aql*), body (Arabic: جسم *jism*), inner self (Arabic: نفس *nafs*), and soul (Arabic: روح *rūḥ*) (Al-Ghazali, 1980). An interconnectedness and balance between these four parts is believed to be essential for spiritual identity and, thus, for maintaining connectivity to God; deviation from this balance results in abnormality. According to Al-Ghazali (1980), the heart, soul, and intellect are controlled by the inner self, which is further subdivided into satisfied 'I' (Arabic: النفس المطمئنة *al-nafs al-muṭma'innah*), critical 'I' (Arabic: النفس اللوامة *al-nafs al-lawwāmah*), and primary 'I' (Arabic: النفس الامَّارة *al-nafs al-'amārah*). Unrest in the inner self is believed to be a potential cause of mental disorders. Furthermore, critical 'I' and the main 'I' tend to succumb to the devil's temptations, which creates distorted thoughts and behaviour.

Islam, like all other religious traditions, has culturally specific conceptions of mental disorders that include spiritual and supernatural origins (Al-Subaie & Alhamad, 2000; Hedayat-Diba, 2000; Husain, 2006). Pre-Islamic Arabic medicine widely believed in supernatural powers, such as spirits (Arabic: الجن *al-jinn*), envy (Arabic: حسد *ḥasad)*, the evil eye (Arabic: عين *'ayn* or نزر *nazr)*, and magic (Arabic: سحر *siḥr*) (Dols, 1992; Haque, 2004; Stein, 2000). These beliefs formed folk models of health and disease and were passed to subsequent generations. Traditionally, the aetiology of mental disorders was attributed to signs of evil and was referred to as 'possession' (Arabic: واسواس *wāswās*). Possession-induced mental disorders were believed to manifest themselves through alienation, personality fragmentation, loss of faith, and identity crisis (Mubbashar, 1992). They were also believed to contribute to separate sources of disorders that could cause psychosis (Al Habeeb, 2003). Furthermore, Muslims believe that spiritual crises, which are caused by non-compliance with religious norms and social behaviour, can lead to mental disorders. Specifically, from the religious perspective and according to the Institute for Muslim Mental Health (IMMH, n.d.), mental disorders in the Muslim community are associated with being 'non-religious' or 'not religious enough'. God states, 'And whoever turns away from My

[16] Sunnah (Arabic: سنة, *sunnah*; form, way, course, rule, or habitual practice) is the body of traditional social and legal custom and practice of the Muslim community. Along with the Qur'an (the holy book of Islam) and Hadith (recorded sayings of the Prophet Muhammad), it is a major source of Islamic law (Encyclopaedia Britannica, n.d.).

remembrance – indeed, he will have a difficult life, and We will gather him on the Day of Resurrection blind' (Qur'an 20:124). Many Muslims believe that mental health issues are tests from God, and therefore these issues are not properly addressed. This belief that God's will is a fatalistic determinant of events is still common in contemporary Muslim society and perhaps that is one of the causes of taboos regarding mental health. Symptoms of illnesses, like any other event, can be attributed to God's will, which leads some people with symptoms to avoid appraising them at all, as a fatalistic belief implies that whatever appears through God's will will also disappear by God's will (El Islam, 2000).

Thus, the cultural understanding of mental disorders in Islam includes supernatural powers, faith, and God's will. Therefore, how much these believes are affected by modernisation in contemporary Muslim society must be determined. Furthermore, the conception of mental disorders in modern Muslim society must be identified. These topics were explored in the Jordanian study by conducting qualitative research, and the results are presented in the next chapter.

1.3. Conception of mental disorders in contemporary Jordan

In Arab countries, Western psychology has been increasingly adopted to help people in several areas. However, mental disorders and psychological counselling are stigmatised in Arab countries. Researchers observed that many Muslims hesitate to seek help from mental health professionals (Hedayat-Diba, 2000) to avoid being in conflict with their religious beliefs (Sabry & Vohra, 2013). Often, individuals facing mental disorders seek help from traditional healers or religious leaders (Al-Issa, 2000; Dols, 2004). For instance, Jordan is one of the most westernised Arab countries, with highly urbanised health care infrastructure (World Health Organization [WHO], 2013). However, according to WHO (2018), Jordan still needs to strengthen its mental health system. The country's social climate is influenced by ongoing political conflicts in the neighbouring countries and resettlement of refugee populations, leading to an increase of rates of mental disorders (Karnouk et al., 2019). Therefore, given these modern-day problems, how is mental health understood by Jordanian Muslims themselves? That is, how do Islamic beliefs and Western notions of mental health co-occur in Jordanian minds? And how do traditional religious conceptions of mental disorders interact with Western psychological conceptions in contemporary Muslim society?

To explore folk conceptions of mental disorders and their causes among Muslims in contemporary Jordan, a qualitative cognitive anthropological method – free-listing – has been employed to elicit the most cognitively salient conceptual elements of mental disorders among Jordanians. More specifically, Jordanian interlocuters were approached with three inter-related tasks: (a) what are the most typical instances of mental disorders; (b) what are the most typical causes of mental disorders; and (c) what are the most typical features that determine a person has a mental disorder. The collected qualitative data have been quantitatively analysed and interpreted in the context of ethnographic data (observations and interviews) collected in Jordan.

1.3.1. Participants

Weller and Romney (1988) note that 20 to 30 individuals are sufficient for the free-listing task, because lists reach a sufficient saturation of common items, and additional participants typically do not add any new items (Pennec et al., 2012). To make sure that the list was sufficiently saturated with salient items, 40 Jordanians were recruited. Most of them were educated Sunni Muslims. Table 1 summarizes participants' demographics. The age range was between 19 and 32 years old. The average age was 24, and the group was 42.5% females and 57.5% males. Of the respondents, 36 had a university education, 3 respondents had a secondary education, and 1 respondent had a higher education. Furthermore, 22 respondents were from urban areas, 6 were from small towns, and 12 were from rural areas.

Table 1. *Demographics (N = 40)*

Gender	Total	Male	Female
	N = 40	23 (57.5 %)	17 (42.5 %)
Age	19-32, average 24	25	23
Education[17]			
Secondary[18]	3 (7.5 %)	3 (13.05 %)	0

[17] The education in Jordan 'begins with pre-primary, followed by 10-year compulsory basic education, then secondary education and higher education. The Ministry of Education is responsible for school education in Jordan, and the Ministry of Higher Education and Scientific Research is responsible for higher education in Jordan' (Jordan Education Info, n.d.).

[18] Secondary education in Jordan is optional. 'Students who have finished 10-year compulsory basic education are eligible for secondary education in Jordan. Secondary

Higher[19]	1 (2.5 %)	1 (4.35 %)	0
University[20]	36 (90 %)	19 (82.6 %)	17 (100 %)
Living area			
Urban	22 (55 %)	17 (73.9 %)	5 (29.41 %)
Rural	12 (30 %)	2 (8.69 %)	10 (58.82 %)
Small town	6 (15 %)	4 (17.41 %)	2 (11.77 %)

1.3.2. Procedure

Free-listing tasks were presented on paper. The questionnaire was phrased in a simple, understandable way (see Appendix E, 'Free-listing questionnaire'). Interview sheets contained five parts. The first part included instructions and the aim of the study, as well as verbal explanation of the study's purpose. In the second part, participants were asked to provide demographic data including their gender, age, education level, and living area. The third part of the survey consisted of three open-ended questions that allowed participants to address their own definitions of mental disorders (Arabic: الاضطرابات النفسية *al-iḍṭirābāt al-nafsīyah*), causes of mental disorders, and determination of mental disorders. All three tasks included the following sentence: 'The aim of this study is to understand mental disorders in Islamic culture'. Then, particular prompts were provided:

Free-listing task 1: Please provide a list of mental disorders, as many as you know.

Free-listing task 2: Please provide a list of possible causes of mental disorders you know.

Free-listing task 3: Please provide a list of things that help you to determine that a person has mental disorders, e. g., symptoms, behaviour, etc.

After each question, there was a space to write extra comments. Note, since most of the participants were educated Jordanians, questionnaires were presented in English and Arabic for participants to choose the language. Thus,

education in Jordan consists of 2 educational streams: Comprehensive secondary education or Applied secondary education' (Jordan Education Info, n.d.).

[19] Higher Education in Jordan. 'Students who have the general secondary education certificate are qualified for admission to higher education in Jordan. Higher education in Jordan is offered by public as well private higher education institutions, which are community colleges and universities' (Jordan Education Info, n.d.).

[20] 'Universities in Jordan are both public and private, and offer a wide range of courses of study at the bachelor, master and doctorate level of studies' (Jordan Education Info, n.d.).

29 questionnaires (72.5%) were completed in English and 11 (27.5%) in Arabic.

1.3.3. Results

Participants listed simple verbs, nouns, or short descriptions referring to prototypical instances of mental disorders, their causes, and determining features. Responses were coded and standardized (Weller & Romney, 1988). For example, synonyms (e.g., bad eye, evil eye, etc.), morphological derivatives (e.g., sad, sadness, etc.), and phrases with similar meaning were coded as the same term. To analyse provided lists, FLAME was used, an add-in for Microsoft Excel (Pennec et al., 2012). The FLAME program analysed the final version of the lists, and there were 150 unique items in the first list (mental disorders), 218 unique items in the second list (causes), and 139 unique items in the third list (determination).

Results of the most frequently mentioned terms (in English), their frequencies, average ranks, and Smith's salience indexes are reported in Tables 2, 3, and 4. Typically, the cut-off point of the lists is selected depending on theoretical considerations (de Munck, 2009). For a more detailed exposition, the top 20 items were present. Items at the top of the list are the most cognitively salient terms in participants' minds. More specifically, the frequency in percentages indicates the proportion of participants who mentioned the item and the average rank of the term indicates where on the list the item tended to appear (e.g., the higher the average rank, the earlier it came up in participants' minds). Frequency and an average rank are important indicators of cognitive saliency, and Smith's salience index *S* is calculated by considering both values (Smith & Borgatti, 1997).

The data were analysed by gender, but no significant differences were observed; thus, the results are not presented in the study. Therefore, analysis was conducted between subgroups of languages English and Arabic, as many linguists and anthropologists argue that the language makes an influence on how individuals think (Bloom & Keil, 2001; Boroditsky, 2009; Carroll, 1956; Gleitman & Papafragou, 2005; Imai et al., 2016). The relationship between culture, language, and thought have long been important topic across a broad range of disciplines. Thus, the analysis among language subgroups showed that the language did not make a significant influence on the results.

1.3.3.1. Mental disorders

The list of the most salient mental disorders (Table 2) reflects a general knowledge about mental disorders. Apparently, Western terms of mental disorders are well known among young and educated Jordanians. The most common disorders that participants mentioned are depression (Smith's *S* = 0.67), anxiety (Smith's *S* = 0.246), and schizophrenia (Smith's *S* = 0.254). Frequently mentioned items among participants indicate common cultural knowledge, while differences in the list content are measures of intracultural variation (Quinlan, 2019). The answers also revealed that not all respondents related the notion of mental disorders to a Western type of terminology. Jordanian respondents listed not only typical terms of mental disorders but also psychological states such as stress (Smith's *S* = 0.184), sadness (Smith's *S* = 0.081), or loneliness (Smith's *S* = 0.009), as well as an abstract generic term 'mental disorders' (Smith's *S* = 0.108) and 'crazy' (Smith's *S* = 0.069). None of the participants mentioned eating disorders, such as anorexia nervosa or bulimia nervosa.

After providing the lists of typical mental disorders, many participants noted that mental disorders are stigmatised in Jordan. Here is a sample of comments:

> 'Unfortunately, in our culture, mental disorders are not understood.' [Male, 30]
>
> 'A lot of people have problems, but in our culture we do not speak. It is a shame to speak about problems coming out of the family. In the past it was not shameful to speak. Poets expressed their feelings in the poems. But traditions have changed.' [Male, 20]

Consequently, participants mentioned depression as a frequent disorder:

> 'There are many cases of depression in our country, especially among young people. A lot of stress causes depression.' [Female, 22]

Table 2. *Mental disorders*

Original name	Occurrence number	Frequency	Average rank	Smith index
Depression	31	77.50%	1.452	0.670
Anxiety	18	45.00%	2.944	0.246
Schizophrenia	17	42.50%	2.529	0.254
Stress	12	30.00%	2.583	0.184

Obsessive compulsive disorder	11	27.50%	3.909	0.106
Mental disorders	7	17.50%	2.571	0.108
Social phobia	6	15.00%	4.000	0.064
Bipolar disorder	5	12.50%	2.800	0.081
Crazy	4	10.00%	2.000	0.069
Sadness	4	10.00%	1.750	0.081
Abnormal behaviour	4	10.00%	1.750	0.081
Brain damage	3	7.50%	2.000	0.054
Amnesia	2	5.00%	1.000	0.050
Autism	2	5.00%	2.500	0.028
Mind disorder	2	5.00%	2.000	0.040
Loneliness	2	5.00%	5.500	0.009
Developmental disorder	2	5.00%	3.500	0.015
Physical causes	1	2.50%	1.000	0.025
Jinn	1	2.50%	2.000	0.017
Magic	1	2.50%	3.000	0.008

1.3.3.2. Causes of mental disorders

Responses (Table 3) revealed a wide range of causes of mental disorders. Participants were most likely to attribute mental disorders to social or environmental factors, such as family problems (Smith's S = 0.437), economic situations (Smith's S = 0.203), problems at work (Smith's S = 0.142), problems in studies (Smith's S = 0.119), stress (Smith's S = 0.122), or emotional trauma (Smith's S = 0.227); medical causes, such as heredity (Smith's S = 0.143); religious origins, such as lack of religion (Smith's S = 0.224), spiritual issues (Smith's S = 0.059), or a different religion (Smith's S = 0.068); and cultural explanations, such as *jinn* (Smith's S = 0.085) or magic (Smith's S = 0.065).

The most salient causes of mental disorders according to the respondents were related to social and environmental factors, as in the following comments:

> 'In my opinion, the reasons of mental disorders could be family and community pressure, or may be originate from childhood. Also, if a person wants to be perfect in everywhere.' [Male, 24]

> 'If people do not solve their problems, or do not seek for a help, the problems become bigger. People become depressive.' [Female, 26]

However, given the fact that religious beliefs underlie perceptions of mental disorders, participants pointed out spiritual origins of mental disorders:

> ‘In our culture are rules that protect people from mental disorders, but sometimes we do not follow these rules. Many reasons may determine mental disorders; and the main reason is people’s desires without following God’s instructions.’ [Female, 24]
>
> ‘Mental disorders may be caused by a wrong representation of religion by a religious leader.’ [Male, 24]
>
> ‘Different causes can determine mental disorders: family, education, behaviour of youth, lack of religion.’ [Male, 30]

Table 3. *Causes of mental disorders*

Original name	Occurrence number	Frequency	Average rank	Smith index
Family problems	28	70.00%	3.286	0.437
Emotional trauma	13	32.50%	2.769	0.227
Lack of religion	17	42.50%	3.529	0.224
Economic situation	14	35.00%	3.714	0.203
Social pressure	12	30.00%	2.917	0.199
Heredity	9	22.50%	3.222	0.143
Problems at work	9	22.50%	3.111	0.142
Stress	7	17.50%	2.857	0.122
Problems in studies	7	17.50%	2.714	0.119
Lifestyle	8	20.00%	3.875	0.117
Brain damage	6	15.00%	2.833	0.104
Jinn	6	15.00%	4.000	0.085
Psychological problems	4	10.00%	2.000	0.080
Childhood trauma	5	12.50%	2.800	0.078
Political situation	3	7.50%	1.000	0.075
Different religion	3	7.50%	1.667	0.068
Magic	6	15.00%	4.333	0.065
Spiritual	4	10.00%	3.500	0.059
Weak personality	3	7.50%	3.000	0.053
Loneliness	3	7.50%	4.000	0.044

1.3.3.3. How to know that someone has mental disorders?

Results in Table 4 represent that most of the respondents stated that abnormal behaviour (Smith's S = 0.683) is the best indicator to determine mental disorders. Normal or abnormal behaviour depends on the social norms, which was also mentioned in the comments:

> 'Usually, a society draws a border in understanding what is normal and what is abnormal.' [Male, 22]

Other salient features defining mental disorders that were often mentioned were: being asocial (Smith's S = 0.155), sadness (Smith's S = 0.148), lack of religion (Smith's S = 0.131), and anxiety (Smith's S = 0.088). A faith was not significant in this section; nor were cultural traditions (Smith's S = 0.073) such as *jinn*, evil eye, or magic. However, some comments point to the importance of culturally espoused beliefs about the supernatural power in mental disorders. That is, they did not differentiate between the supernatural and the medical:

> 'It is difficult to distinguish symptoms between mental disorders and supernatural powers, such as demons.' [Female, 24]

> 'There are many causes for abnormal behaviour, for example, medical, or bad spirits.' [Male, 23]

Table 4. *Factors defining mental disorders*

Original name	Occurrence number	Frequency	Average rank	Smith index
Abnormal behaviour	30	75.00%	1.333	0.683
Asocial	11	27.50%	2.818	0.155
Sadness	9	22.50%	2.444	0.148
Lack of religion	7	17.50%	2.286	0.131
Anxiety	7	17.50%	3.429	0.088
Aggression	6	15.00%	3.500	0.080
Illogical communication	6	15.00%	3.000	0.076
Cultural traditions	5	12.50%	2.400	0.073
Talking to himself	4	10.00%	2.250	0.075
Fear	4	10.00%	3.500	0.044
Body language	4	10.00%	2.250	0.069
Hurt himself and others	3	7.50%	3.000	0.039
Stress	3	7.50%	3.667	0.028
Reactions	3	7.50%	2.000	0.054

Apathy	3	7.50%	4.333	0.036
Do not care about others	2	5.00%	1.500	0.045
Clothing	2	5.00%	1.500	0.046
Look	2	5.00%	2.000	0.025
Changing mood	2	5.00%	5.000	0.010
Personality change	2	5.00%	1.500	0.044

1.3.4. Associations between particular variables

Smith's salience indexes of different items cannot be used for further statistical comparisons because this is a composite salience value of all individual participants (Quinlan, 2019). Therefore, responded-by-item matrices with categorical data indicating whether a participant mentioned a given item or not, were employed (coded as 1 and 0, respectively). The FLAME program provides such an output. Following this procedure, three matrices were created with items that were mentioned at least four times. All three matrices were within-subject responses indicating whether they mentioned a given mental disorder, a given cause, and a given determining feature of the disorder. Conceptually, all three lists are related, so it can be argued that a participant's listed disorders, causes, and determinants stem from the same conceptual source. Thus, one should expect some within-subject associations that elicit this hidden conceptual network. For the purposes of this research, and given the categorical nature of the data, the crosstabs procedure was employed (using SPSS). More specifically, crosstabs analyses provide a phi coefficient (as a variant of Pearson correlation) – an appropriate measure of association between two categorical variables.

First, for within-subject associations of mental disorders and causes (see Table A1 in Appendix 1), there was a significant positive association between 'depression' and a cause of 'family problems' ($\varphi = 0.431$), indicating that if participants listed 'depression' as a mental disorder, he or she tended to list 'family problems' as a cause as well. Further, the results showed a significant (though moderate) positive association between 'anxiety' and 'family problems' ($\varphi = 0.373$), as well as between 'anxiety' and 'economic situation' ($\varphi = 0.390$), and 'anxiety' and 'problems at work' ($\varphi = 0.355$). 'Stress' was associated with 'lack of religion' ($\varphi = 0.320$). Surprisingly, 'obsessive compulsive disorder', which is viewed and managed in Arab countries mostly on the basis of religion (Okasha et al., 2001), was associated with 'heredity' ($\varphi = 0.339$). 'Social phobia' had an association with 'brain damage' ($\varphi = 0.412$). An association between 'sadness' and a cause of 'magic'

(φ = 0.327) was also found. The results revealed that 'crazy' was significantly associated with 'society pressure' (φ = 0.509), as well as with '*jinn*' (φ = 0.327), which reflects traditional attitudes in Muslim societies toward mental disorders. Additionally, Table A1 in Appendices presents negative associations between mental disorders and possible causes of mental disorders. There was a significant negative association between 'depression' and the cause of '*jinn*' (φ = - 0.444), indicating that if participants listed 'depression' as a mental disorder, he or she tended to not list '*jinn*' as a cause. The results showed a negative association between 'schizophrenia' and 'social pressure' (φ = - 0.342), as well as with '*jinn*' (φ = - 0,361). Finally, those respondents who mentioned 'stress' as a disorder tended not to list 'problems at work' as a cause (φ = - 0.353), and 'bipolar disorder' had a negative association with the cause 'family problems' (φ = - 0.412).

Second, associations between mental disorders and determination of mental disorders are presented in Table A2 in Appendices. There was a positive association between 'depression' and a determination of mental disorder by 'abnormal behaviour' (φ = 0.380). At the same time, 'depression' had negative associations with 'lack of religion' (φ = - 0.382) and 'cultural traditions' (φ = - 0.339). Positive associations were revealed between 'anxiety' and 'abnormal behaviour' (φ = 0.406), and 'sadness' (φ = 0.355). 'Schizophrenia' was associated with 'fear' (φ = 0.388). 'Obsessive compulsive disorder' was associated with 'sadness' (φ = 0.339) and with 'fear' (φ = 0.355) as the determination of the disorder. 'Social phobia' was associated with 'fear' (φ = 0.327) as well. Respondents who listed 'abnormal behaviour' as a disorder tended to list 'cultural traditions' as a determination of mental disorders, as there was a positive association between 'abnormal behaviour' and 'cultural traditions' (φ = 0.378).

Associations between the second question – causes of mental disorders – and the third question – determination of mental disorders (see appendix Table A3) were not so significant. 'Emotional trauma' was associated with 'aggression' (φ = 0.383), 'problems at work' with 'abnormal behaviour' (φ = 0.311), and 'brain damage' with 'fear' (φ = 0.327). Only one negative association was revealed in this section, between 'family problems' and 'abnormal communication' (φ = - 0.416).

1.3.5. Discussion

The current study demonstrated that depression, anxiety, and schizophrenia are well known among Jordanians. However, according to a WHO (2011) report, depression, schizophrenia, and anxiety have also been

indicated as the most prevalent forms of mental disorders in Jordan. Previous studies note that these disorders are mostly associated with stigma in Jordan (Brohan et al., 2010; Crisp et al., 2005; Hasan & Musleh, 2017). Depression is identified as one of the most common mental disorders worldwide regardless of religion or culture and is affected by disasters, wars, poverty, growing populations, modernisation, urbanisation, etc. Comparing Western and non-Western societies, the incidence of depression varies considerably. In the West, depression is diagnosed much more often than in Eastern cultures. In the West, depression is most commonly expressed through sadness, while in Eastern cultures, depression commonly occurs through somatic symptoms (Kleinman & Good, 1985) and usually refers to 'masked depression' (Bhugra & Bhui, 2007).

1.3.5.1. Mental disorders and the social factors

The present research revealed a positive association between depression and family problems (as a cause)[21] ($\varphi = 0.431$). The majority of respondents (70%) named family problems as a main cause of mental disorders. Herein, a progress is revealed in that there it implies less denial about family difficulties instead of protecting its 'honor' at any cost. The social structure in Arab countries strongly supports the collective good over the individual. This is one of the features of interdependent relationship between individuals, family, and groups, which has an influence on mental health. Sociology studies of mental health reported the importance of social integration as a fundamental reason for well-being, with an example that people with close contact with family, neighbours, and friends have better mental health (Thoits & Hewitt, 2001). Supposedly, close relationships within Muslim families are one of the key factors for strong mental health, compared to Western societies where family ties have become increasingly weakened. However, it has been observed that family relationships in Jordan are weaker compared to other Arab countries. In particular, according to the Department

[21] Note, associational analyses such as these do not show a causal relation. However, on theoretical grounds there is a reason to think that when the notion of depression (as a disorder) associates with family problems (as a cause) within individuals, it is the latter to consider to be the cause of the former (depression). That is, by virtue of questions themselves, it can be inferred a plausible conceptual structure of causes and disorders. The same goes with other instances as well. Also, it should be noted, that such associations uncover conceptual networks that operate unconsciously – i.e., it could be argued that those who, say, mention depression have activated adjacent conceptual nodes of typical depression causes (e.g., family problems), that are later mentioned in the second list as well. Some sort of self-priming is in action.

of Statistics (DOS, 2016), the number of divorces in Jordan has increased to 21,969 registered in 2016 from 1000 in 2011, making it the most divorcing country in the Arab region. Similarly, respondents commented on the situation:

> 'In Jordan are many divorce cases. 30% of my classmates were from divorced families. My parents divorced when I was 7 years old.' [Respondent no. 24, male, 24]
>
> 'Our country has a high divorce rate.' [Mental health specialist no. 20, male, 54]

But why does depression have such a significant association with family problems? Are people not happy in their families? One answer given by a respondent clarifies this issue:

> 'Children are the only advantage in a marriage. A lot of women are depressed in their families.' [Respondent no. 7, female, 38]

Relatedly, one of the possible reasons expressed by respondents is postpartum depression. Women are facing postpartum depression worldwide, which is one of the most common complications of childbearing (Thurgood et al., 2009). Studies from Jordan have reported postpartum depression indicating a rate of 22% in northern Jordan (Mohammad et al., 2011). Three female participants noted that they have experienced postpartum depression:

> 'Postpartum depression is not understood in our culture. A child is a blessing from God, so why women sad or unhappy?' [Respondent no. 7, female, 38]

According to the study by Reema R. Safadi and colleagues (2016), there are cultural factors that play an important role and should be taken into consideration while caring for women in the postpartum period. One participant recounted similar issues in his family:

> 'My wife had depression after giving birth; this state lasted for two years. At first, I did not recognize what was happening. My wife's family brought her to *sheykh* several times, but no improvement has been observed. Only later I decided to contact a psychologist. The problem was recognized and solved by a specialist.' [Respondent no. 5, male, 42]

Another issue that could be placed under the category of 'family problems' (as the general cause) but not mentioned by participants is domestic violence. Violence against women is a social problem regardless of culture and exists worldwide. WHO (2017) statistics indicate that in the Middle East 37% of women suffer from domestic violence, but the percentage could be higher, given that the notion of 'pride for all and shame on all' is widely

espoused. According to a study by Diab M. Al-Badayneh (2012), violence against women in families is socially and culturally accepted in Jordan, widely regarded as a family matter, and not publicly discussed because of the potential damage to family reputation.

Most studies have focused on the role of women in Arab countries as oppressed. The studies of masculinity in the context of Muslim societies are rare (Fedele, 2013; Marranci, 2008). Thus, what is the role of men in the family? Jordanian society is patriarchal, and men have authority over their wives and children, as well as control of material and social resources. A Muslim father traditionally is the family's breadwinner, as the Qur'an dictates. Indeed, men stated that it is a big responsibility to take care of the family:

> 'Traditionally, a man is the only one who works in the family; usually, he has two jobs to maintain the family. At the same time, he feels wife's and her family's pressure regarding better family's well-being. Usually, a man feels tired, depressed, and anxious.' [Respondent no. 4, male, 40]

Furthermore, the present study revealed a positive relationship between anxiety and family problems ($\varphi = 0.373$), economic situation ($\varphi = 0.390$), and problems at work ($\varphi = 0.355$). According to data presented by WHO (2017), there are 306,823 (4.3% of population) cases of anxiety disorder in Jordan. Although anxiety is a universal human experience, its understanding varies from culture to culture (Al-Issa & Oudji, 1998). As it was mentioned before, the Kingdom is influenced by the ongoing political conflicts in nearby countries, which have led to an increase in poverty rates within the country (Karnouk et al., 2019). A United Nations (2017) report states that about 14.4% of the population in Jordan live below the internationally specified poverty line. Respondents confirm that:

> 'It is difficult to find a job.' [Respondent no. 25, female, 22]
>
> 'Salaries are very low in Jordan.' [Respondent no.14, male, 22]

The present economic situation creates another problem that young Jordanians are facing – starting a family:

> 'I would like to marry, but unfortunately my salary is very low, and I do not have enough money for marriage, or to take care of my own family.' [Respondent no. 10, male, 22]

All the above listed issues make people anxious and depressed. According to Al-Issa (2000), the rates of anxiety in some Muslim-majority countries are similar to the rates reported in the West. Respondents claimed that young people suffer from fear for their future after graduation, about finding jobs. As some commented:

> ‘I am a student, but I am afraid of my future life after graduation from university. The current economic situation in my country is complicated, salaries are very low, especially for the young specialists.’ [Respondent no. 33, female, 21]
>
> ‘I am very worried for my future. I see, the present situation and it makes me anxious.’ [Respondent no. 15, male, 20]

However, people were facing problems at work and anxiety that carried cultural dimensions, for instance:

> ‘We are between cultural traditions and modernity, and it makes me suffer. I work at a company where a Western style of behaviour is accepted. But it is complicated to work together with women. I mean about behaviour with opposite gender. According to our traditions, we cannot shake hands or hug women. If I behave in a modern way, I make my parents suffer from comments of the neighbours and social pressure. I am confused regarding behaviour with my sister; can I take her to events, or go out together with my friends [men], or take photos with her and my friends, or even post them on social media? All these issues make me stressed.’ [Respondent no. 13, male, 24]

It should be noted that adherence to social norms and values is central to a collectivistic culture, in which social closeness is very important and less sociable individuals are deemed to have a disorder. While, people often fear society’s condemnation and stigmatisation. Indeed, all respondents indicated that social and individual perceptions of mental disorders carried a negative social stigma and fear of condemnation. Respondents noted that society’s perception of mental disorders hinders individuals’ ability to utilise mental health services due to the fear of condemnation, which then affects not only the person with the mental disorder but also all the family. Thus, usually people hide the existence of mental disorders, explaining:

> ‘If you have a mental disorder, nobody will marry you, or your family members.’ [Respondent no. 30, female, 21]
>
> ‘You will never get married if you or someone from your family has mental disorders. The same difficulties are faced when getting a job.’ [Respondent no. 9, male, 23]

According to the majority of respondents (75%), an individual with a mental disorder is mainly characterized by abnormal behaviour. Abnormal behaviour has significant associations with mental disorders such as depression ($\varphi = 0.380$,) and anxiety ($\varphi = 0.406$) in the minds of participants. However, abnormal behaviour that was mentioned as a disorder associated with cultural traditions ($\varphi = 0.378$), which perhaps refers to possible causes of

mental disorders. Does this mean that if someone behaves out of accordance with cultural traditions or is from another culture, he or she is crazy or has mental disorders? In general, in Muslim societies, those who behave in a different way than required by social mores are considered to be crazy, and otherness can sometimes be understood as abnormal behaviour of the co-religionists or as abnormal behaviour of those from other religions (by virtue of adhering to different norms). However, more ethnographic and survey evidence is needed to delineate the conditions under which people attribute mental disorders to members of other cultural and religious groups.

But how to know what is abnormal behaviour? Again, culture emerges as a key aspect of mental health understanding. What is normal in one culture may be abnormal in other culture and vice versa. Berry and colleagues (2002) state that many of the unusual behaviours that occur in different cultures are culturally induced. Yap (1969) attempts to draw a line between abnormal behaviour and disorders, between socially abnormal and mentally abnormal behaviour, while Durkheim (1951) states that 'normal' and 'pathological' are based on behaviour. The understanding of other and otherness requires an understanding not only of cultural attitudes, values, and assumptions but also of the group experience and history. In another words, in a world affected by rapid modernisation is important to know the moral and social meanings of identity.

Present study found that eating disorders, namely anorexia nervosa and bulimia nervosa, are not common in Jordan. Eating disorders were not listed in the survey. After this observation, respondents were additionally asked regarding eating disorders. Surprisingly, eating disorders were unknown or even unheard of; respondents made an association with diet but not with the disorders themselves. According to previous studies, eating disorders are rare in non-Western communities, including among Arabs. This is due to a culture that does not define the standards of the female body, or those standards are not publicly discussed, and plumpness is seen as a value, a sign of beauty, health, and fertility (Al-Shammari et al., 2010; Mousa et al., 1994; Shuriquie, 1999). Al-Issa (2000) states eating disorders are popularly regarded as an issue only in developed societies, where Western concepts of female body shape and dieting behaviours are common. Muslim women who live in Western culture face more eating disorders. However, modernisation, globalisation, and cultural changes in many rapidly developing Arab countries have led to a widespread adoption of Western style, habits, and attitudes (Mousa et al., 2010), due these mentioned issues, eating disorders appear to be increasing in Arab countries (Pike et al., 2014). Recent studies' findings suggested, that women in developing countries such as Jordan will experience

weight and shape concerns similar to that in Western populations (Eapen et al., 2006; Mousa et al., 2010).

Muslim-majority countries have one of the lowest suicide rates worldwide (Rezaeian, 2009). Suicidal feelings and intentions to end life by self-inflicted death are uncommon in Muslim societies. The WHO (2016) statistics showed 1.89 suicides per 100,000 population in most Muslim-majority countries, and 2.9 suicides per 100,000 in Jordan (World Bank [WB], 2016). Islamic religion prohibits all forms of self-harm and condemns to eternal hell in the afterlife those who kill themselves. Thus, such low suicide rates could be influenced by several factors: religion forbids suicide and considers it a sin; religion which plays an important role in everyday life of Muslim society, thereby acting as suicide prevention. Durkheim (1951) found that people who have strong social ties were least likely to commit suicide, which may contribute to low suicide rates in the Muslim-majority countries, where social ties are particularly strong. However, the modernisation can weaken the ties of the individual to a society and faith. The annual report of the Department of Statistics (Jordan) showed an increased number of suicide cases in recent years in Jordan; 142 people committed suicide during 2018, compared to 100 suicide cases were registered in 2014, 113 in 2015, 120 in 2016, and 130 cases in 2017.

Respondents did not mention culturally prohibited items, such as alcohol and drugs, which are thought to be a cause of mental disorders. Alcohol is forbidden and is a taboo in Muslim-majority countries. Stronger associations between alcoholism and other psychiatric disturbances were observed in Arab countries than in Western countries. However, according to mental health specialists, alcohol was associated with social and family problems such as divorce (Al-Issa, 2000, p. 113).

1.3.5.2. Mental disorders and religion

Religion permeates all aspects of everyday life among Jordanians; this is visible in the present study as well. The importance of religion and a unity with God was vividly pointed out during fieldwork when I was insisted to attend prayers at the local Christian church, noting that ‘religion and spirituality is very important’, and asking: ‘Did you bring the Bible with you?’ [Male, 54]. Almost half of respondents (42.5%) stated that a lack of religion (as well as spiritual reasons, 10%) could be a cause of mental disorders. Findings also indicate that participants viewed mental disorders as usually associated with being ‘non-religious’ or ‘not religious enough’ in Islam. Fear of being in conflict with religious norms and condemnation by society is one

of the potential reasons for individuals dealing with mental disorders not to seek professional treatment.

Islam acknowledges spiritual power as an internal power that can be exercised to have a calm mind, positive thoughts, and healthy consciousness (Institute for Muslim Mental Health, n.d.), while Idler (1995) agrees that in general religious people report less distress than those who are not religious. This approach is also reflected in the survey data, which show an association between stress and a lack of religion ($\varphi = 0.320$). Based on the available literature, Qur'an recitation can be a useful non-pharmacological treatment to reduce stress and anxiety (Badri, 2009; Ghiasi & Karamat, 2018; Utz 2011). Respondents mentioned that religion is a primary source of comfort during times of distress. Ethnographic observations illustrated this point nicely. During a visit to one Jordanian family, a woman was sad and began crying; suddenly, her six-year-old daughter came up to her and said, 'Mom, do not be sad, read the Qur'an'. Likewise, the importance of spirituality was highlighted when during a picnic with the Jordanians, a young girl separated from the group in order to read Qur'an. Similar situations were observed several times during visits to other Jordanian families. Participation in daily life and attendance of lectures at the university let me observe that students are very religious, as it is allowed to go for prayer during the lecture time, and many students take the opportunity. Additionally, children are brought up based in religion. This was observed when I was invited by a Jordanian family to attend the event of Prophet Muhammad's birthday at a primary school, where the family's children participated in the event.

Cultural beliefs play a significant role in the traditional understanding of mental health. Findings of the present study include, that supernatural powers, such as *jinn* (15%), black magic (15%), or evil eye (5%) can cause mental disorders. As one participant noted:

> 'People facing mental disorders, firstly relate them with spiritual causes, evil eye or magic, and only after with the medical point.' [Respondent no. 5, male, 42]

Similar results have been found in previous studies in traditional Muslim societies (Abu-Rabia, 2005; Al-Adawi et al., 2002; Al-Issa, 2000). The topic is rich with local folklore and is employed as an explanatory framework by the participants. Most respondents mentioned that they know people who were possessed by *jinn,* for example:

‘I know a girl who was possessed by *jinn*. She behaved strangely during Qur’an recitation and listening *’ādhān*[22].’ [Respondent no. 1, female, 22]

‘I know several cases of *jinn* possession in my environment.’ [Respondent no. 26, female, 21]

‘I know many cases of *jinn* possession. One of them my father told me; the owner of a neighbouring store was communicating with *jinn.*’ [Respondent no. 24, male, 56]

Or they have encountered *jinn* possession in their families:

‘I remember, one of my cousins was walking at nights and screaming. Her parents brought her to a *sheykh*, who said she has a *jinni’s* name.’ [Respondent no. 5, male, 42]

‘My grandmother saw many cases of *jinn* possession. Her sons were possessed by *jinn.*’ [Respondent no. 10, male, 24]

‘My aunt was possessed by *jinn*. She behaved in a strange way, talked about strange things. She was talking to herself and screaming.’ [Respondent no. 9, male, 23]

Given the abundance of *jinn* possession testimonies, how do people differentiate between a *jinn* possession and obvious psychotic symptoms, for example, schizophrenia? In different cultures, schizophrenia has similar symptoms – hallucinations, voices talking in the third person – that are usually mixed with the spirits possession. For instance, a study made in three different cultures observes that ‘voice-hearing experiences of people with serious psychotic disorder are shaped by local culture’ (Luhrmann et al., 2015, p. 41). The present study found a negative association (φ = - 0.361) between schizophrenia and *jinn*. According to previous research, schizophrenia has a much greater stigma in comparison to other mental disorders in Muslim society (Hasan & Musleh, 2017). The present data showed a positive association between schizophrenia and fear (φ = 0.388). As discussed earlier, fear may be related to stigmatisation. However, in non-Western cultures, schizophrenia is often difficult to diagnose and is mixed with other mental disorders (Sartorius et al., 1978). Consequently, priority is often given to faith healers before or even after visiting a psychologist or psychiatrist (Al-Subaie, 1994; Hussein, 1991; Sakr, 2012).

[22] *’ādhān* (Arabic أذان) is the Islamic call to prayer, recited by a *muezzin* (a person who gives the call to prayer at a mosque) five times a day. *Muezzin* traditionally from the minaret (a type of tower typically built into or adjacent to mosques), summoning Muslims for obligatory prayer (Encyclopaedia Britannica, n.d.).

Most respondents believed that *sheykh* can reliably identify issues related to *jinn* possession and mental disorders:

> '*Sheykh* can distinguish issues regarding *jinn* possession and mental disorders from the reactions to the Holy Qur'an.' [Respondent no. 1, male, 21]

> 'Mental disorders and *jinn* possession are different issues. A *sheykh* knows when his assistance is needed; when the Qur'an recitation can help, and when a person needs medical assistance.' [Respondent no. 27, male, 22]

Although black magic is condemned by religion, sorcery is believed to be another means of inducing harmful mental effects on others by employing evil spirits for revenge or even out of spite (Al-Issa, 2000; Dols, 2004). Apparently, Jordanians also believe in magic, and here are some examples:

> 'Magic exists. Islamic religious texts talk about magic, and Christian texts, too. We believe in magic. Especially in the north part of Jordan there are people who work with black magic. Magic is mentioned in the Holy Qur'an and Sunnah.' [Respondent no. 15, male, 20]

> 'Magic is very popular in Morocco. In our university are students from Morocco, they are using magic.' [Respondent no. 16, male, 24]

Envy is another supernatural force which is believed to arise from representing the evil wishes of others and is attributed to the evil eye (Al-Issa, 2000). Envy arises out of desire for greater status, health, or prosperity. Meanwhile, Hadith affirm that envy is capable of causing harm or misfortune. Thus, it is traditionally believed that changes in a person's mental or physical health, failings, or bad moods are caused by the evil eye. Interviews provided a deeper understanding of evil eye:

> 'Suddenly my hair started to fall. I visited a *sheykh*; he said that the cause was the evil eye.' [Respondent no. 38, female, 21]

> 'I was feeling tired for a while and I was in a bad mood all the time. A *sheykh* affirmed I was affected by the evil eye. Someone was envious because of my beauty and success.' [Respondent no. 33, female, 23]

The current study also found that 'crazy' (as a disorder) and *jinn* possession (as a cause) had a positive association ($\varphi = 0.327$). This relationship may be explained by reference to an Arabic term *junūn*, which defines madness and is derived from *jinn* (evil spirits). As previously mentioned, the term 'crazy' (Arabic term: *majnūn*) is traditionally used to

describe a person who behaves in a different way or has mental disorders, as well as someone possessed by supernatural beings which control his or her behaviour, thoughts, and desires (Al-Issa, 2000). Generally, respondents confirmed this explanation; here are some comments regarding the term *majnūn* in contemporary Jordan:

> 'People with mental disorders are called *majnūn*.' [Respondent no. 1, female, 21]

> 'In general, people with mental disorders are called *majnūn*, but I would rather say people who have mental disorders.' [Respondent no. 25, female, 22]

> '*Majnūn* is more likely characterizing those who are aggressive, homeless, or vagabonds, those who can hurt. But people with mental disorders are medical cases and simply named as people who have mental disorders.' [Respondent no. 4, male, 40]

Thus, according to cultural traditions, the causes of madness are often considered to be a result of sorcery. Although the symptoms of mental disorders are believed to be caused by possession, at the same time, they are closely linked with social relationships and position in a society. Furthermore, the present study found that the term 'crazy' is tightly associated with social pressure, for example:

> 'We must behave according to our traditions; if we behave in a different way, we and our families are condemned by relatives, neighbours, and society.' [Respondent no. 17, female, 25]

But still, the existence of mental disorders in the contemporary Arab world is not always recognized and sometimes negated, for many reasons:

> 'A lot of people have mental disorders, but usually they do not understand what is happening with them, because there is no such understanding as mental disorders. Most people think that it must be so, and they suffer inside.' [Respondent no. 4, male, 40]

The same conception was observed from the feedback on several questionnaires, in which was noted: 'In our country we do not have mental disorders.'

1.4. Concluding remarks

In the present section of the dissertation, conceptions of mental disorders were examined in traditional Islam and from the Jordanian population perspective. The conception of mental disorders in Islam is defined in several aspects. First, the traditional understanding that mental disorders are caused by supernatural powers such as demons, spirits, evil eye, and magic.

Second, the religious aspect states that diseases are test from God, and closely related to being ‘non-religious’ or ‘not religious enough’. However, in the Middle Ages, great Islamic physicians assumed that mental disorders were influenced by a person’s inner state and environmental factors, which is accepted in modern medicine.

The current free-listing study, together with ethnographic data, provided some preliminary evidence about how contemporary Jordanians conceptualise mental disorders, causes of mental disorders, and determining features of mental disorders. The responses to open-ended questions and additional interviews provided an insight into how traditional conceptions of mental disorders manifest in personal experiences, as well as how personal experiences form participants’ beliefs and attitudes.

At the crossroads of traditions and modernity, when a rapid process of modernisation adds additional stressors, mental health continues to be highly stigmatised in the minds of contemporary Jordanians. Cultural models of mental disorders strongly influence the concept of mental health and, at the same time, influence the choice of treatment methods. While Western terms of mental disorders were well known among young and educated Jordanians, the study demonstrated that Jordanians generally employ cultural and religious notions alongside them. This co-existence, or amalgamation, of different conceptions confirmed the importance of Islamic psychology in the modern rendering of mental health.

2. TREATMENT OF MENTAL DISORDERS IN ISLAM

> ‘Culture and its beliefs give shade to folk medicine.’
> (Lézé, 2014)

Treatment methods used in each ethnic group are specific products formatted to the group mores. Traditions, beliefs, and practices differ across cultures and selectively activate mental structures. If the treatment methods do not engage with cultural traditions, they become peripheralized (Ialenti, 2011). Thus, folk medicine, which includes local methods of treatment, religion, and other practices, is important to the mental health field. The present section discusses conceptions of mental health and treatment of mental disorders in the Islamic Golden Age, between the eighth and thirteenth centuries. Arab medicine flourished during this period through contributions from the great Arab physicians. Later Arab medicine (up to the twentieth century) further developed the theories and medical knowledge of the Golden Age. The findings that are relevant to current psychology and treatment methods were selected for analysis herein. A brief overview of hospitals of that time, as well as famous Arab scholars and their ideas about mental health, is presented, as well as a short overview of different treatment methods. Attention is drawn to the traditional religious healing of the past and its current popularity among Muslims.

2.1. Mental health and treatment in the Islamic Golden Age

The roots of Islamic ethnopsychiatry and ethnopsychology go back to the seventh to twelfth centuries. Islamic psychiatry is often attributed to Arabic medicine (Browne, 1921; Campbell, 1926), and one important contribution of Islamic medicine was the care of persons with mental disorders in a hospital, called a *bimaristan*[23] (Al-Issa, 2000, p. 55). The first psychiatric clinic in the world was established in Bagdad, Iraq, in 705 CE by the famous Islamic physician Al Razi (865–925 CE), who considered mental disorders to be medical and treated them with methods similar to psychotherapy and medication (Murad & Gordon, 2002, pp. 28–30). Another hospital for the mentally ill was established in Cairo, Egypt, in 872–873 by Ahmad ibn Tulun (835–884 CE). Such hospitals were usually built in the city centre, and patients

[23] *Bimaristan* (Arabic بِيمارِستان *bīmāristān*) or simply *maristan* is a hospital in the historic Islamic world, a place for a sick.

were not isolated from the public. Instead, they were able to communicate with relatives, friends, and community members. Memoirs of travellers, including Ibn Jubayr (twelfth century), Leo Africantus (fifteenth to sixteenth centuries), and Eviliya Chaleby (seventeenth century), reported on treatment facilities for mental disorders in Arab countries. Hospitals for the mentally ill were also described in popular Arabic literature, including the collection of fairy tales *A Thousand and One Nights* (Al-Issa, 2000).

In the Golden Age of Islamic civilisation, Muslim scholars investigated the connection between psychology, psychiatry, psychotherapy, and mental health. Abu Bakr Muhammad Zakaria Al-Razi, known as the father of Islamic psychiatry, was the first physician to introduce the term *psychotherapy* (Arabic: العلاج النفساني *al-ʻilāj al-nafsānī*) and to utilise methods of psychotherapy. He presented his findings on mental health in the books *On Surgery* (المنصوري *al-Manṣūrī*) and *A General Book on Therapy* (الطب الروحاني *al-ṭibb al-rūḥānī*) (Murad & Gordon 2002, pp. 28–30). His works and ideas were recognised by medieval European practitioners and profoundly influenced medical education (Iskandar, 2006). In a medical encyclopaedia (كتاب الحاوي *kitāb al-ḥāwī*), Al-Razi described mental disorders, devoting an entire chapter to melancholy, and proposed a cognitive-behavioural therapy approach. Several additional famous Islamic scholars, such as Ali Ibn Abbas Al-Majusi (994 CE), Ali ibn Rabban Al-Tabari (838–870 CE), Ishaq ibn Imran (908 CE), and Ibn Sina (970–1037 CE), were interested in mental health and origins of disorders. The Persian physician and psychologist Al-Majusi provided 29 prescriptions for the treatment of mental disorders in *The Royal Book* (كتاب المالكي *kitāb al-mālikī*), and another Persian physician, Al-Tabari, distinguished 13 kinds of mental disorders in the book *Paradise of Wisdom* (فردوس الحكمة *firdaws al-ḥikmah*). The Muslim physician and pioneer of psychotherapy and psychosomatic medicine Al-Balkhi (850 CE) distinguished neuroses and psychosis and classified neuroses similarly to the modern classification: fear and anxiety, anger and aggression, sadness and depression, and obsessions (Awaad & Ali, 2015; Haque, 2004). While obsessive compulsive disorder tends to be considered as a new disorder, Al Balkhi portrayed obsessive compulsive disorder with the same symptoms as in the DSM-V (2014) in the ninth century (Awaad & Ali, 2015), though he called it ‘spiritual whisperings’ (Arabic: وسوسة *waswasah*) (Al-Issa, 2000).

Melancholy as a mental health condition was one of the top interests among Muslim physicians at the time; for example, Iraqi physician Ishaq Ibn Imran wrote a monograph on melancholy (Al-Issa, 2000, pp. 46–208). Physician Ibn Sina described various mental disorders, including melancholia, amnesia, insomnia, and others, in an encyclopaedia of medicine (Arabic:

القانون في الطب *al-qānūn fī al-ṭibb*) (Browne, 1921). Iraqi scholar Ahmad ibn Muhammad Miskawayh (932–1030 CE) developed a later concept of melancholy. For context, Greek physician Rufus contributed melancholy to madness (Harris, 2013, p. 12).

Great Muslim physicians perceived the connection between body and soul, as well as the fact that spiritual crises are influenced by a person's inner state and environmental factors. The psychosomatic approach of modern medicine was already recognised at that time. For instance, Abu Sa'id Ibn Bakhtishu (940–1058 CE) stated that interaction between the mental and the physical determines a somatic condition, which causes a psychological effect (Dols, 1992).

Arab medicine based on Hellenism argued that changing the emotional and psychological state of patients is possible by prescribing medication or diet (Al-Issa, 2000, pp. 49–58). Thus, medication was the mainstay of treatment for mental disorders, but physicians also applied 'soul therapy' to stabilise the patient's condition (Al-Issa, 2000, pp. 142–143). For example, Al-Balkhi provided instructions on how to pass through the time of distress by talking, preaching, and advising, among others. During the Islamic Golden Age, Muslim scholars expanded on existing medical models from the Hellenistic tradition, such as those of Hippocrates and Galen.

During the Islamic Golden Age, religious healing and medical treatment were concurrent (Dols, 1992). Most scholars, including Ibn Sina, Al-Razi, Al-Balkhi, and Ibn Imran, rejected folk beliefs as causes of mental disorders and suggested different theories, such as the humoral theory and the role of balance. Furthermore, Muslim scholars developed institutions in which medical systems were practiced without the intervention of religion. Physician Ibn Rushd (1126–1198 CE) contributed to the separation of religion from science by arguing for a double truth – one based in faith (religion) and one in rational philosophy. He argued that a physician or scientist may have his or her own religious beliefs but must be guided by scientific theories and practices (Browne, 1921).

Great Muslim scholars have long been interested in the origins of mental disorders, have tried to describe and classify them, and have searched for appropriate treatment methods. Attempts were made to treat mental disorders medically instead of following religious or folk healing methods. However, many Muslims believe that psychotherapy is not suitable in their cultural context, despite the evidence that the science of psychology is rooted in the Islamic tradition and that Muslim physicians applied soul therapy similar to modern psychotherapy many years ago. The specific treatment

methods that these physicians used and whether they are still used are discussed in the next section.

2.2. Traditional treatment methods of mental disorders

> 'God has sent both the disease and the cure, and He has appointed a cure for every disease, so treat yourselves medically, but use nothing unlawful.'
>
> (Abu Dawud 29:20)

According to the Prophet Muhammad, Muslims can use various treatment methods that do not conflict with Islamic rules. However, a person with mental disorders is not obliged to follow Islamic rules, including the five obligations[24] (Arabic: ارکان *arkān*); Islamic law allows a person with mental disorders to behave differently from a healthy person.

For many centuries, Muslim physicians employed various approaches to treat disorders, such as aromatherapy, music therapy, and talk therapy. Specifically, music was used as a method for treating mental disorders, even though it is considered a successful twenty-first-century therapeutic technique (Ajmal, 1987, pp. 294–307). For example, patients were treated by relaxing music in Al-Mansuri Hospital in Cairo (established in 1284 CE). Additionally, Sufis used music to treat nervous and mental disorders. The positive effects of music in the treatment of mental disorders were scientifically proven by the greatest Islamic scholars and physicians, including Al Razi, Farabi (870–950 CE), Ishaq ibn Imran, and Ibn Sina (Al-Issa 2000, p. 59).

Aromatherapy is considered an approach to physical and mental relaxation that has a positive effect on mental disorders, such as anxiety or depression. Ibn Sina was the first to extract oils from the plants used for aromatherapy and described more than 800 species of plants and oils, including Damascus rose, saffron, lime, lavender, musk, sandalwood, jasmine, lily, and others (Akram Bhatty et al., 1986; Hussein, 1991). Another Arab physician, Al Samarqandi, used herbs and flowers in his healing practice in the thirteenth century. Phytotherapy (herbal treatment) was also widely used in Arabic medicine (Battaglia, 2003).

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[24] Pillars of faith (Arabic أركان الايمان *arkān al-imān*) – the five basic obligations of Islam, the observance of which is the minimum condition for attaining salvation: confession of faith (شهادة *shahādah*), five daily ritual prayers (صلاة *ṣalāh*), annual religious charge (زكاة *zakāh*), annual fasting (صوم *ṣawm*) for a month (Ramadan in the ninth month of the Muslim liturgical year), and the great pilgrimage (حج *ḥajj*), which must be performed at least once in a lifetime (Račius, 2016).

Although most Arab scholars practiced medicine separately from religion, their healing methods had a strong cultural background, of which religion was an integral part. Thus, meditation was considered one of the most effective and powerful forms of Islamic healing methods (Sabry & Vohra, 2013, pp. 205–214). Another form of prayer believed to reduce stress was *dhikr*, the repetition of holy words or phrases, such as the 99 divine names of God. Such meditation was believed to strengthen the patient's relationship with God and focused on words linked to patience, forgiveness, compassion, or gratitude, supporting retention of their meanings and their integration into behaviour (Oman & Borman, 2015). Prayer was thought to help with depression and anxiety and is proof of the existing link between religion and mental health. Furthermore, prayer was used to supplement other treatments in hospitals (Pormann & Savage-Smith, 2007).

In Islam, the Qur'an is believed to have healing power: 'And We sent down of the Qur'an that which is healing and mercy for the believers, but it does not increase the wrongdoers except in loss' (Qur'an 17:82). Thus, special prayers and reading the Islamic Holy Book are believed to help different situations. One of the rituals, *ruqyah*[25], is mostly used for healing *jinn* possession, evil eye, or magic (Al-Issa, 2000, pp. 212–214). Traditionally, the existence of evil spirits (*jinn*) is accepted.[26] Possession by *jinn* is also an accepted belief, in which *jinn* can possess a person's body and minds and cause harm or insanity. Magical practices were forbidden by religion because they did not relay on God, but certain magic was legal. For example, the use of the names of God and Qur'anic phrases were common in healing and exorcism (Dols, 2004, p. 95). However, exorcism in Islam was allowed only under performance of the name of God. The exorcists (Arabic: معظمون *mu'aẓẓimūn*) sought God's help in asking *jinn* to leave the possessed body. In contrast, black magicians claim that they cooperate with demons by making offerings; these actions are against religion (Dols, 2004). This *ruqyah* treatment can be used against Christian and Jewish *jinn*. Furthermore, the Qur'an can be read by the religious leader or by the patient. However, not all rituals associated with reading the Qur'an agree with Islamic doctrines; for

[25] *Ruqyah* (Arabic: رقية) is the healing method based on the Qur'an and Hadith through the recitation of the Qur'an, to seek refuge. Remembrance and supplication are used as a means of treating sickness and other problems by reading verses of the Qur'an, the names and attributes of God, or by using the prayers (Ahmed et al. 2016). This is the most common treatment method (Al Habeeb, 2003).

[26] Beliefs in spirits played an important part in pre-Islamic Arabia as well as in the present-day in Arab region (Henninger, 2004).

example, *azeemah*[27] and *maho*[28] are considered unconventional. The healing cults that confront fundamental Islamic tradition still exist. One of these is the cult of the saints, in which people visit graves or shrines for the blessing of the saint or to ask for aid in cases of *jinn* possession (Al-Issa, 2000, p. 65).

Zār is another ritual practiced in the Arab region to exorcise spirits from a possessed individual (Guiley, 2009, p. 277). As previously mentioned, a common belief among Muslims is that spirits can be a cause of physical and mental discomfort. The ritual occurs through a dialogue between the patient and healer, and gifts or sacrifices are given to *zār*[29] to alleviate the patient's suffering (Al Subaie, 1989).

This analysis provides a synopsis of the general understanding and foundations of mental health and Islamic psychology in the Islamic Golden Age. Most of the traditional healing methods are related to religion, and the lay population relied mostly on folk healers and religious practices for treatment. However, a number of current medical treatments that are widely used and considered modern were developed within religious tradition. This chapter examined how mental health and disorders were understood in the Islamic Golden Age, as well as the development of treatment facilities and treatment methods for mental disorders. At that time, scholars built their theories based on Galenic and Hippocratic theories of medicine. Thus, the scientific understanding of mental disorders was based on biological factors and socio-environmental stressors, which conflicted with the folk discourse of mental disorders as derived from supernatural powers. Regardless, this folk discourse continues to be rooted in the perceptions of Muslims worldwide.

2.3. Traditional healing in contemporary Islam

> 'There is no disease that Allah has created, except that He also has created its treatment.'
>
> (Sahih al Bukhari 71:582)

[27] *Azeemah* (Arabic: عظيمه *'aẓīmah*): prayers from the Qur'an are written on a piece of paper, which the patient soaks in water. Then, the patients drink the water or used it to wash the affected areas of the body (Al-Issa, 2000, p. 212).

[28] *Maho* (Arabic ماهو *māhw*): treatment by touching the patient's head or shoulders or massaging the affected areas of the body. According to Islamic tradition, men are forbidden to touch a women (Al-Issa, 2000, p. 212).

[29] *Zār*, a demon or spirit assumed to possess individuals, mostly women (Guiley, 2009).

Every culture has its own methods for tending to the sick and emotionally disturbed. Mental health and psychological treatments are highly stigmatised in the Muslim community; seeking mental health services is considered shameful, as mental illness is perceived to be due to a lack of faith, weakness of character, and bad family upbringing (Alou & Rathur, 2009). Traditional healing in the Arab world has a rich heritage based on the sociocultural and religious foundations of the Muslim community, and these practices are increasingly adopted in most Arab countries (Al Subaie & Alhamad, 2000, p. 207). However, in many Arab countries, such as Tunisia, Iraq, and Kuwait, the practice of traditional healing is illegal due to a desire for modernisation, as traditional healing is closely associated with underdevelopment (Al-Issa, 2000, p. 104).

One of the present research aims is to reveal the role of traditional religious healing in contemporary Muslim community. Thus, qualitative research was conducted using semi-structured interviews. Furthermore, triangulation (Della Porta & Keating, 2008; Patton, 1999) was applied to obtain a wider understanding of the topic, and information about the same subject was collected from different sources. Five groups of interlocutors were chosen (see Table 5): *sheykhs* (n = 3), imams (n = 2), specialists in Islamic law (n = 3), mental health specialists (n = 20), and local inhabitants – Jordanians (n = 40). Table 6 summarises the participants' (Jordanian inhabitants, Sunni Muslims) demographics. The age range among the Jordanian inhabitants was between 20 and 65 years old. Their average age was 30, and the group comprised 40% females and 60% males. Of the respondents, 36 had a university education, 2 had a secondary education, and 2 had a higher education. Furthermore, 22 respondents were from urban areas, 4 were from small towns, and 14 were from rural areas.

The collected qualitative data were analysed using thematic analysis as suggested by Braun and Clarke (2006). The topic of traditional healing was analysed according to data collected from different perspectives. The principal topics – the importance of traditional healing, *sheykh* over psychologist, traditional healers, 'true *sheykh'* and 'fake *sheykh',* the effectiveness of traditional healing, *sheykhs'* patients, modern *sheykhs*, and the role of imams in Muslim society – were identified after analysis. These are discussed and in the present chapter and interpreted in light of the previously described studies.

Table 5. *Demographics*

Respondents	Number (*n*)
Sheykhs	3
Imams	2
Specialists of Islamic law and religion	3
Local inhabitants (Jordanians, Sunni Muslims)	40
Mental health specialists:	20
Psychologists	13
Islamic psychologists	1
Psychotherapists	3
Psychiatrists	3

Table 6. *Demographics (Jordanian inhabitants, N = 40)*

Gender	Total	Male	Female
	N = 40	24 (60 %)	16 (40 %)
Age	20–65, average 30	33	26
Education			
Secondary	2 (5 %)	1 (4.17 %)	1 (6.25 %)
Higher	2 (5 %)	2 (8.33 %)	0
University	36 (90 %)	21 (87.5 %)	15 (93.75 %)
Living area			
Urban	22 (55 %)	17 (70.83 %)	5 (31.25 %)
Rural	14 (35 %)	5 (20.83 %)	9 (56.25 %)
Small town	4 (10 %)	2 (8.33 %)	2 (12.5 %)

2.3.1. The popularity of traditional healing among Muslims

‘To visit a psychologist is shameful, but to visit a *sheykh* is normal.’
– Stated by all 40 respondents (Jordanian inhabitants)

Traditional healing plays an important role in the mental health field, and the benefits of this type of healing are recognised by many scholars (Jilek, 1993; Prince, 1980). Such healing is prevalent in most Arab countries, where faith or traditional healers play the role of psychiatrists in healing mental disorders (Younis et al., 2019). In various Arab countries, folk healers are

called by different names, such as *taleb, marabout, clairvoyant, sheykh, dervish,* or other terms for holy person, depending on the geographical location (Al-Issa, 2000). The healers' function both as religious teachers and healers, and their practices are primarily related to religion. Traditional healing can involve various rituals, such as Qur'an recitation, or the healer may give patients an amulet or soak a paper with religious writings in water, after which the patient is given the water to drink. These healing methods tend to solve most personal problems caused by spirits, envy, or magic. Patients may seek help from traditional healers for different reasons, such as emotional, physical, or social problems. Healers usually provide explanations of illnesses to patients that are compatible with common folklore and therefore understandable by clients. The traditional portrayal of a healer is as follows: 'Usually native healers are middle-aged men, who tend to be religious leaders or otherwise outstanding figures in society. Most of them are semi-illiterate and have no traditional or modern medical knowledge. They usually do not charge patients for their services, but they expect voluntary donations' (Al Subaie & Alhamad, 2000, p. 209).

The mental health specialists who were interviewed stated that Jordanians facing mental health issues choose to visit religious leaders first:

> 'Usually, people visit a *sheykh* first and after the psychologist.' [Mental health specialist 5]
>
> 'Usually, people used to visit religious leaders first.' [Mental health specialists 12, 17, 18, and 19]
>
> 'People avoid to visit a psychologist. Traditional healing can help in most cases. People visit a psychologist only facing serious problems. Usually, people choosing traditional healing: herbs or *sheykh's* services.' [Mental health specialist 7]

Previous research (Pew Research Centre [PRC], 2012) has found that traditional healing is most prevalent among Muslims in Iraq (46%), Egypt (44%), Jordan (42%), and Tunisia (41%). In these regions, many people perceive visiting faith healers as less stigmatising than visiting a mental health specialist or taking medications, and this perception explains the increasing number of patients who choose treatment from faith healers before visiting mental health specialists. Previous studies in various Arab countries found that between 50% and 70% of psychiatric outpatients used the services of a traditional healer, and 21– 50% did so before seeking help from mental health services (Al Subaie, 1994; Hussein, 1991). According to research in Saudi Arabia, more than 50% of patients first consult traditional healers for mental health issues (Hussein, 1991). The most recent research on Muslim patients in Iraq conducted by Younis and colleagues (2019), found that 73.1% of patients

visited faith healers before psychiatric clinics, and 23% of patients receiving medical treatment visited the faith healer simultaneously. Patients who reported visiting faith healers less than 10 times comprised 84.6% of the sample, while 15.4% went 10 or more times. Recitation of the Qur'an was the main treatment method for 49.8% of the patients, and most of the patients (77%) paid money to the faith healer for the treatment (Younis et al., 2019). As mentioned above, traditional healing services are widespread in Jordan. Al-Krenawi and colleagues (2000) conducted a study to examine differences in help-seeking between men and women in Jordan and found no significant differences; both women and men tended to attribute their disorders to supernatural forces and sought help from a traditional healer before seeking professional help (Al-Krenawi et al., 2000). Thus, how traditional healing works in contemporary society, what healing methods are used, and what reasons encourage Jordanians to choose traditional healing instead of modern medicine should be investigated.

During field work conducted in Jordan, I met three faith healers, called *sheykhs*. These *sheykhs* did not match the traditional description of faith healers; all three were well-educated intellectuals, one was a doctor and professor at the university, and the other two were specialists in Sharia and religion. In Jordan, 'there are women *sheykhs*' [Sharia specialist 2], likely because women prefer a women healer due to gender segregation in Muslim society. However, traditional healer women are not common, and the majority of information provided about traditional healers regards men. According to Dr Fawwaz Ayoub Momani, '94% of faith healers are "charlatans" or so-called "fake *sheykhs*". Only 6% of *sheykhs* are "true *sheykhs*"'.[30] The same issue was confirmed by *sheykh* and Sharia specialists in Jordan:

> 'Here are "true" *sheykhs* who work according to the Qur'an and for free. Some *sheykhs* have certificates; they apply *ruqyah* as a treatment method. Another kind of *sheykhs*, as we call them, are "fake" *sheykhs*. These *sheykhs* use black magic; work in the cemeteries with the deceased; these practices are prohibited by the religion.' [*Sheykh* 3]
>
> 'Some *sheykhs* are not qualified specialists, their practice is just a business.' [Sharia specialist 1]
>
> 'Here exist "true" *sheykhs* and "fake" *sheykhs*.' [Sharia specialist 2]

[30] Dr Fawwaz Ayoub Momani. Public lecture 'Psychology and culture' at Vilnius University, 30 April 2019.

According to Al Subaie (1994), more women than men tend to seek aid from traditional healers, as females tend to suffer more from evil eye and magic because women are traditionally viewed as weak, misinformed, and uneducated. Furthermore, they present with an array of interpersonal conflicts and somatic symptoms (Al-Habeeb, 2003). Al-Krenawi and colleagues (2000) showed that women tend to attribute mental health issues to supernatural powers, while men tend to believe that God is responsible for their disorders. In contrast, the present research found that patients of various demographics sought the help of faith healers; gender, age, social class, and education did not seem to play a role in patients' choices regarding traditional healing and modern medicine. Comments from *sheykhs* highlighted this phenomenon:

> 'My patients represent different age groups, students and the elder people, literate and illiterate, also professors from university.' [*Sheykh* 2]

> 'Most of my patients are representers of different age and social status. Islam is tended to answer humans' questions, whether it is physical, psychological, or spiritual.' [*Sheykh* 1]

Although traditional healing is popular, and the majority of Muslims faced with altered psychological states seek aid from traditional healers, scholars agree that the majority of those seeking help from traditional healers tend to be psychiatric patients (Al Subaie & Alhamad, 2000, p. 209). A famous traditional healer from Saudi Arabia admitted, after more than 20 years of practice, that all his patients had mental disorders that should be handled by mental health specialists (El Islam, 2000, p. 134). El Islam (2000) states, 'The relationship between psychiatric professionals and traditional religious healers is neither supportive nor complementary in most Arab Gulf communities' (p. 134). In contrast, Al-Habeeb (2003) claims that some faith healers (77.3%) recommend their clients consult with mental health professionals. The present research revealed an interaction between traditional healers and mental health specialists in Jordan. Three mental health specialists indicated that they received referrals from a *sheykh*:

> 'Here is one *sheykh* who is sending patients to us.' [Mental health specialist 19]

> 'One *sheykh* sends patients to us.' [Mental health specialist 18]

Moreover, Jordanians shared their family stories that suggested the opposite interaction – not only that *sheykhs* send patients to mental health specialists, but also that mental health specialists recommend their patients visit faith healers:

‘My relative behaved in a strange way. The family took her to a psychiatrist, but he said these are not mental problems, these are spiritual issues, and indirectly gave an advice to visit a *sheykh*. Indeed, the *sheykh* helped.’ [Respondent no. 16, male, 24]

‘My aunt behaved in a strange way, and was taken to a psychiatrist. Her personality changed, she shouted in a strange voice, she was not normal and could not communicate normally. The psychiatrist said, these are not psychological issues, these are spiritual issues, and he was not able to help. In Jordan, doctors believe in spirit possession. A psychiatrist did not recommend to visit a religious leader directly, but he made it to understand.’ [Respondent no. 34, male, 24]

One *sheykh* described his opinion on how to know whether a person needs psychological aid from mental health specialists or a faith healer:

‘First, a person should visit a psychologist or psychiatrist, and if a mental health specialist does not confirm any disorder and a person feels bad anyway, only then Qur’an is recited.’ [*Sheykh* 3]

The study revealed that Jordanian Christians also believe in the healing power of the Qur’an, according to one of the interviewed *sheykhs*:

‘In my country, Christians believe in the Qur’an healing power. My neighbours are two Christian families; they came to ask me to pray for them, to recite the Qur’an on them. Another case, the old and sick Christian man asked me to pray for him.’ [*Sheykh* 3]

A similar story was shared by one of the interlocutors:

‘One of my mother’s friend’s daughters got sick. A cause of the illness was unknown. A doctor asked if she is a Muslim, because she is needed to visit a *sheykh* for the Qur’an recitation. She was a Christian and visited a priest to get an advice. A priest told she was needed the Qur’an recitation. A *sheykh* read the Qur’an on her (*ruqyah*). The treatment was successful. As a *sheykh* told, the girl was envied for her beauty.’ [Respondent no. 38, female, 21]

Fatwa[31] No. 88454 (helping non-Muslims with *ruqyah*) states that making *ruqyah* for non-Muslims is allowed (Mufti of Federal Territory,

[31] Fatwa (Arabic: fatwá فتوى) is a nonbinding legal opinion on a point of Islamic law (*sharia*) given by a qualified jurist in response to a question posed by a private individual, judge, or government (Berger, 2014). A fatwa may deal with rituals, ethical questions, religious doctrines, and sometimes even philosophical issues, while court cases dealt with legal matters in the narrow sense (Masud & Kechichian, 2009). Additionally, fatwas have played an important role throughout Islamic history, taking on new forms in the modern era.

2016). However, whether Qur'an recitation can cure non-Muslims is less clear. Abu Qatadah al-Ansari, also known as Harith ibn Rab'i, who was one of the companions of the Prophet Muhammad, explained the healing power of the Qur'an: 'If a believer listens to the Qur'an, he benefits from it while a disbeliever does not benefit' (Tafsir Ibn Kathir 17:82). Although Abu Qatadah al-Ansari stated that Qur'an recitation for disbelievers does not work, some interlocutors claimed that Qur'an recitation is effective for Christians. Another example illustrating Jordanians' belief in the effectiveness of Qur'an reciting for the non-Muslim was shared; one Islamic belief is that *jinn* can settle in the house when is left empty (without people) for more than a month. I stated that while I was in Jordan, my home was empty (two months). The person explained that *jinn* had already settled in my house and that I would have to expel them by reading the Qur'an. The man then sent me the necessary records of the Qur'an Surahs that I should use to expel the *jinn* from my home after my return.

Opinions and theories regarding the healing power of traditional healing methods are contradictory, and many family stories were related by Jordanian interlocutors about successful and unsuccessful cures of faith healing and *sheykhs'* services. Whether traditional healing could really provide recovery was uncertain.

According to Jilek (1993), most traditional treatment methods have an effect no worse than psychotherapy and cannot be dismissed as ineffective. Based on the observations of scholars, the methods for correcting psychological states that form in a certain culture correspond to the local cultural values and are effective for the local patients. However, many of these non-Western traditional treatments are recognised by Western medicine as complementary to other psychotherapeutic practices (Jilek, 1993). Prince (1980) agrees that traditional healing is effective simply because it is believed to be effective and is consistent with patients' cultural values and beliefs. These practices allow for the connection of endogenous resources – that is, family and community – factors that are singled out as important in the discourse of mental health. Thus, traditional healing will survive as long as it is acceptable to patients.

2.3.2. Modern *sheykhs*: *Sheykhs* on social media

Rapid modernisation has influenced in all walks of life, and religion is no exception. *Sheykhs* and other religious leaders are active on social media, such as Facebook, Instagram, Twitter, and YouTube, or they have websites. The younger generation actively follows these religious accounts:

‘Online broadcasts are really strong support in various situations.’ [Respondent no. 33, female, 21]

‘Yes, I am following some *sheykhs’* accounts.’ [Respondent no. 29, male, 21]

Furthermore, one of the respondents suggested I follow the account of Dr Jasem (*sheykh* Dr Jassem Al-Mutawa, د. جاسم المطوع), a popular figure among Jordanians, on Instagram and Facebook. His popularity is high; on Instagram Dr Jasem has 4.8 million followers and, on Facebook, 5.4 million followers. On a nearly daily basis, the accounts of *sheykhs* are updated with religious messages that help shape individuals’ understanding of religion. Periodically, online broadcasts are hosted that deal with various religious topics, answer questions and offer advice in rearing children, navigating marital and family relationships, and dealing with evil eye and sadness, among others. However, some religious leaders, including Abdul Aziz Al Sheykh, Grand Mufti in Saudi Arabia, are critical of social media platforms, stating that they are methods for disseminating lies and are incompatible with Islamic practices (Ibrahrine, 2016). Nevertheless, religious leaders are creating accounts on social media to reach audiences with religious information, and they argue that social media has the potential to influence people’s religiosity and practices of piety. The Arab world has witnessed rapid adoption of social media platforms, such as Facebook, Instagram, Twitter, and YouTube. According to a survey conducted by the Arab Social Media Report (ASMR, 2012) in eight Arab countries regarding social media’s impact on culture and society, over 70% of respondents in Jordan, Kuwait, Egypt, Bahrain, and Saudi Arabia stated that social media enforced their religious identity.

2.3.3. Do imams play a role of psychotherapist in Muslim society?

‘In small cities or even in villages, there are no mental health specialists, but instead, there are ten, twenty, or thirty *sheykhs*, who perform the work of psychotherapist. Our society is very religious and believes in the healing power of religious leaders.’

[Respondent no. 40, male, 60]

Regarding the psychosocial model, Muslim societies have long included a form of counselling similar to Western psychotherapy, in which patients search for aid from a person qualified to deal with psychological issues (Ali et al., 2004, pp. 635–642). As the present study showed, Muslims mostly seek psychological aid from religious leaders. Spiritual status is an important interior power that generates positive thoughts, a calm mind, and a

healthy psychological state. If faith is the foundation of health (Al Gesir, 1961), then a religious leader or imam can correspond to the role of counsellor or psychotherapist. Of course, the main role of the imam is to advise on the correct application of the principles of the Qur'an and the Prophetic tradition. However, the imam is also considered an important advisor on social matters, mental health, and marital and family relationships (Ali et al., 2005, pp. 202–205). Consultation with a religious leader or imam can thus be useful (Hall & Livingston, 2006, pp. 139–150), as this leader is the best presenter of Islamic tradition and permissible (Arabic: حلال *ḥalāl*) and illegitimate (Arabic: حرام *ḥarām*) concepts.

Many Muslims seek advice from imams, which begets the question of whether the imam corresponds to the role of psychotherapist in Muslim society. People dealing with mental health issues may visit the mosque to consult with the imam. However, the majority of imams are not trained in mental health: 'Friends, family, and religious leaders may be good listeners but are probably not trained to offer professional guidance and support' (Al Rashid Mosque, n.d.). They do typically understand that a person dealing with mental health issues needs professional help. Some people believe that imams are counsellors. For example, Al Rashid Mosque offers to 'book an appointment with a counselling imam where you will get the opportunity to discuss your problems privately and seek the best Islamic advice and assistance' (Al Rashid Mosque, n.d.). The Jordanian study showed that consultation with imams is a common practice:

> 'We are an Islamic centre and people come here for advice.' [Imam 2]

According to previous studies, congregants consulted imams most often for religious or spiritual guidance and relationship or marital concerns (Ali et al., 2005), as well as counselling (Abu-Ras et al., 2008). These results agreed with those of the present study:

> 'Most people come to consult regarding religious issues, or to learn religion. Women usually ask such questions, as can they work, about family issues, relationships between family members and society. People usually come when they have family problems, in case of divorce, economic problems, lack of money, etc. They ask how to choose a good husband. Also, people come when they feel sad or anxious.' [Imam 2]
>
> 'Usually, people ask for advice regarding life, job, family, or religion. In reference to the previous mentioned problems, people come when they are feeling sad.' [Imam 1]

Age and social class do not play a significant role among people who seek help from imams:

> 'People of different age coming for consultation. I mostly consult women.' [Imam 1]
>
> 'Different age and social class.' [Imam 2]

Comments also revealed a religious point of view toward mental health:

> 'Of course, people can visit mental health specialists, but first of all, a person should believe in God.' [Imam 1]
>
> 'The first help is the Qur'an, in all cases. The best way to reduce sadness or anxiety, that is the Qur'an recitation. Qur'an recitation always helps. Of course, there are cases when a person needs help from mental health specialists. When a person is physically ill, he or she needs medical help, but when a person has spiritual problems, the best aid is the Qur'an. The last option is a psychologist, first should be religious healing and only then visit to mental health specialist. All problems can be solved by the Qur'an and Sunnah.' [Imam 2]

Thus, the religious point of view is that mental health is closely related to religion, and lack of faith, or not being religious enough, can cause mental disorders. Therefore, faith is the main condition for strong mental health. However, this understanding can cause social stigma; if a person has mental disorders, it means that he or she is not religious enough. Given that religiosity plays an important role in the Arab world, a person with a mental disorder may be condemned by society. The fear of condemnation forces these individuals to hide mental health problems, as the respondents stated:

> 'Mental disorders do not exist in our country.' [Respondent no. 21, male, 43]
>
> 'It is shameful to speak about mental disorders.' [Respondent no. 15, male, 20]

Indeed, such an understanding can deepen altered psychological states due to lack of intervention from mental health specialists and suitable treatment. As scholars (Pormann & Savage-Smith, 2007) agree, faith can be useful, but not as a separate treatment. Nevertheless, religious leaders play an important role in creating and maintaining a strong and healthy psychological climate in communities, and can assume the role of psychotherapist.

2.4. Concluding remarks

Based on the conceptions of mental disorders described in the first section, this section reviewed various methods of treating mental disorders that were applied in the Islamic Golden Age and are used in the present, including the understanding and classification of mental disorders by the greatest Muslim scholars. A short review of treatment methods covered those treatments that are still widely used. Furthermore, the study revealed that traditional healing based on folk beliefs is still widely applied in the Arab region. Thus, religion is inseparable from the mental health discourse. One of the main factors in choices regarding the mode of healing is the cause of the mental disorder. Disorders caused by supernatural forces are treated by traditional folk methods, which sometimes can be cruel, such as chaining to prevent harm or beating to expel the *jinn* from a human's body. In these cases, the *sheykh* is a healer that provides treatment related to cultural traditions and beliefs. The religious aspect determines the healing based on religion and Holy Qur'an. In this case, the healer is a spiritual or a religious leader who plays the role of religious counsellor and provides advice related to religion. As previously observed, 'Patients and their relatives often go from a method of traditional healing to another in search of a cure; from religious amulets to Qur'anic recitation, and from rituals undoing sorcery to exorcism, and finally cautery' (El Islam, 2000, p. 126).

The third part of the dissertation, related to modernity, describes medical treatment by modern approaches, namely medication and psychotherapy. Through modernisation and Westernisation in the Arab world, 'Muslims become educated and can differentiate proper religious substance from pseudo-religious techniques; they tend to look for more scientific forms of treatment' (Azhar & Varma, 2000, p. 176). Thus, the next part of the dissertation discusses Western psychotherapy in Arab countries.

3. WESTERN PSYCHOTHERAPY IN ISLAM

Psychology, commonly known among Muslims as *ilm al-nafs* (Arabic: علم النفس), came to the Middle East in the early twentieth century. Egypt was the gateway for Western psychology to Arab countries (Sueif & Ahmad, 2001, p. 216) and the first Arabian country to model scientific psychological approaches in practice, teaching, and research. Departments of psychology were first established at Cairo University and Ain Shams University, and the first psychological association in Arab countries was established in Egypt in 1929. National societies of psychology were then established in many other Arab countries, including Iraq, Lebanon, Morocco, Algeria, United Arab Emirates, and Kuwait. The growth of the discipline in other Arab countries began in the 1960s due to political and sociocultural factors, such as rapid modernisation in Arabian Gulf countries, as well as increasing interests in psychology in Jordan, Syria, and Lebanon. The majority of studies and publications, which cover a wide range of topics on social and educational developmental, clinical pathology, personality, religiosity, cognitive-behavioural therapy, and others, have been performed in Jordan, Egypt, Iraq, Lebanon, the United Arab Emirates, Kuwait, and Saudi Arabia (Ibrahim, 2013, pp. 1–4).

In Jordan, a department of psychiatry was first established in 1966 within the main military psychiatric hospital in Amman. In 1975, a psychiatric department was established in King Hussein Medical Centre. The Jordan Psychiatric Association had registered 60 psychiatrists in 2004, as well as other medical staff, such as psychologists, social workers, and occupational therapists, which constituted teams in mental health hospitals and departments (Takriti, 2004). The Jordanian Psychological Association, which is committed to the promotion and advancement of psychology as a science and profession and as a means of promoting health, education, and human welfare, was founded in 1995 and has about 350 members (Jordanian Psychological Association [JPS], n.d.). Psychologists are currently employed in all Jordanian educational institutions:

‘In every school and university in Jordan work a counsellor.’

[Mental health specialists 13 and 20]

‘Nowadays, there are growing interests in psychological health in Muslim communities from the perspective of Western countries, which means incorporation of Islamic views of human nature while using different psychological strategies and evidence-based treatments for Muslim patients’ (Sabry & Vohra, 2013). However, mental disorders and psychological

counselling are still stigmatised in Arab countries, and the social stigma is particularly strong in relation to psychological health and treatment (Ahmedani, 2011; Aloud & Rathur, 2009; Rothman, 2017). Consequently, people often resort to faith healers before or even after visiting a psychologist or psychiatrist. Great ignorance about psychological health exists in all sectors of society, from rich to poor, illiterate to educated. The social stigma also affects the status of psychology and psychiatry among the other medical specialties, which has restricted progress in the delivery of psychiatric and psychological services. Thus, culture plays a significant role in the discourse of mental health, which gives rise to many questions such as how psychotherapy, which is based on Western mores and traditions, works in other cultural traditions, and how do cultural traditions influence counselling. This study aimed to determine the extent to which the Western model of psychotherapy is appropriate in Islamic culture; how the International Classification of Mental Disorders is applied in different cultural contexts; and how folk beliefs are integrated into science-based diagnoses of disorders. Particularly, attention was drawn to the role of religion in the current discourse of mental disorders.

After thematic analysis, nine topics were identified: psychotherapy and culture, cultural influence on diagnosis, mental health in Jordan, causes of mental disorders, the most common mental disorders in Jordan, mental health specialists' patients, medication in the treatment of mental disorder, psychotherapy approaches in Jordan, religion in counselling, and the role of the counsellor. These are discussed in this part of the dissertation.

3.1. The need for psychotherapy in traditional cultures

> 'Psychotherapy is treated as an export product to the rest of the world.'
>
> (Badri, 2009)

American sociologist and cultural critic Philip Rieff (1966) attributes the rise of psychotherapy to secularisation and what he refers to as a lack of morality caused by the weakening of traditional religion. According to Rieff, 'psychotherapeutic control' helps maintain a certain level of 'adequate social functioning' in an environment in which religion no longer guarantees firm principles. 'In the past, unhappy people sought comfort in the church, now they turn to the nearest psychotherapist, who becomes a secular substitute for a clergyman' (Giddens, 2000, p. 229). While Gidden's statement reflects the present situation in Western societies, the situation is different in the Arab

world, where religion shapes large-scale social institutions, such as government and social movements; plays a large role in families, class, gender, and race; and is the cornerstone of everyday life. Praying and visiting the mosque are inseparable activities of daily life, and the imam is a life guide in all situations. Thus, if psychotherapy is associated with the weakening of religion and the psychotherapist is a substitution for a clergyman, then psychotherapy may not be needed in Muslim culture.

Psychotherapy is highly associated with the Western tradition and, moreover, with American tradition: 'We are engaged in the grand project of Americanizing the world's understanding of the human mind' (Watters, 2010, p. 12). European psychologists and psychotherapists argue that American psychotherapy occupies a hegemonic position all over the world. However, European and American cultures have similarities, while Muslim culture is completely different from Western culture. Bernal and Sharrón-Del Río (2001) note that psychotherapy has cultural values that are rarely in line with non-Western cultures, while Said (2003) emphasises the cultural hegemony and 'certain cultural forms which dominate over others' (pp. 6–7). Here, the impact of American theories is seen on the global mind:

> 'Over the past thirty years, we Americans have been industriously exporting our ideas about mental illness. Our definitions and treatments have become the international standards. Although this has often been done with the best of intentions, we've failed to foresee the full impact of these efforts. It turns out that how a people in a culture think about mental illnesses – how they categorize and prioritize the symptoms, attempt to heal them, and set expectations for their course and outcome – influences the diseases themselves. In teaching the rest of the world to think like us, we have been, for better and worse, homogenizing the way the world goes mad.'
>
> (Watters, 2010, p. 13)

Watters aptly describes the hegemony of American ideas in the global field of mental health. Thus, how American theories of mental disorders and treatment are incorporated in Muslim culture must be investigated. Although Muslim culture has a strong traditional foundation and is relatively nonsecular, attention should be paid to global modernisation, and Arab countries are no exception. As Watters notes,

> 'With the increasing speed of globalization, something has changed. The remarkable diversity once seen among different

> cultures' conceptions of madness is rapidly disappearing. A few mental illnesses identified and popularized in the United States – depression, post-traumatic stress disorder, and anorexia among them – now appear to be spreading across cultural boundaries and around the world with the speed of contagious diseases.'
>
> (Watters, 2010, p. 15)

Watters's claims were reflected in the present study, which highlighted the prevailing mental disorders both in Jordan and throughout the Arab world. As was concluded in the first part of the dissertation, which analysed perceptions of mental health amongst Jordanians, Western terms for mental disorders are well known among young and educated Jordanians. Although religious traditions still play a significant role in the Arab world, many Arab countries face problems influenced by modernisation, and the mental health specialists agreed that 'most problems are connected to modern life. In the past it was not so complicated' [Mental health specialist 6]. As Giddens (2000) observes, modernity destroys the protective framework created by a small community and tradition, as it replaces this community and tradition with much larger, impersonal organisations. The individual feels abandoned and lonely in a world where person lacks the psychological support and sense of security guaranteed by a more traditional environment. Psychotherapy as an expression of generalized reflexivity fully reveals the disorders and doubts caused by modernity (p. 50). Meanwhile, American theories 'promise people in other cultures that mental health (and a modern style of self-awareness) can be found by throwing off traditional social roles and engaging in individualistic quests of introspection' (Watters, 2010, p. 17).

Although Berger (1969) and Watters (2010) discuss the influence of secularisation on cultures, the question arises as to the extent of secularisation's influence in Arab countries. James and Mandaville (2010) state that religion and globalisation have been intertwined with each other since the early empires attempted to extend their reach across what they perceived to be world-space, and this inter-relation has continued to the present time with changing and new contradictions. Despite the rapid process of modernisation, religion remains a cornerstone of Muslim society; as this empirical research showed, religion is a strong foundation in the consciousness of young Jordanians. Furthermore, Gellner (1992) argues, that much of the world is as religious as ever. This importance of faith in society is revealed through the rebirth of religious beliefs and convictions, emerging religious movements, and forms of spiritual aspirations (Giddens, 2000). As

globalisation intensifies, many cultures have begun to incorporate various religious beliefs into society (Davie, 2003).

However, despite the arguments that, in the context of a strong background of traditional culture, Western psychology is unnecessary, the present empirical research showed the impact of modernisation on sociocultural factors in Jordan, for instance, in changing work and study environments, weakening family relations, and shifting attitudes toward mental health, with a preference to visit mental health specialists instead of traditional healers. Indeed, mental disorders were equated with physical ailments that are treated by physicians, and thus required treatment from specialists. Consequently, considering the research data, interest and need for mental health services will increase in the Arab world. Thus, the present situation of Western psychology in Arab countries and how Western mental health institutions are incorporated into Arab culture will be discussed.

3.2. Psychotherapy and culture

Psychotherapy is a product of Western culture, and 'many of the basic techniques of psychotherapy are at odds with core beliefs of the Arabic culture' (Dwairy & Van Sickle, 1996, p. 231). Ibrahim and colleagues (1993) reviewed psychology and psychiatry in Arab countries, such as Saudi Arabia, Egypt, Libya, and Kuwait, and found that psychological patterns emerging in the Arabic region were similar to those usually noted in the West. However, disorders appear in different cultures in endlessly complex and unique forms and thus cannot be separated from culture (Watters, 2010, p. 13), as culture shapes different symptoms and perceptions of the same disorders. In other words, some symptoms are more common in some cultures than in others. In different cultures, people also choose different treatment methods and receive those treatments differently, and culture influences the meanings that people attach to disease. The DSM-V is used for diagnosis worldwide, regardless of culture, even though Kraepelin (1904), the father of the modern diagnostic system, proposed the inclusion of cultural features to understand mental disorders. Asian Indian psychiatrist Chakraborty (1991) also stresses the importance of cultural diversity. Likewise, Kirmayer (1998) emphasises that cultural analysis is particularly important in diagnosing mental disorders. Many non-Western specialists have encountered the problems with diagnosing disorders, given that the signs of disorders defined in international standards have additional dimensions in local culture that are not included in the international classification. The present research revealed two contrasting opinions among mental health specialists regarding use of the DSM-V for

diagnosis. First, several specialists argued that disorders are the same everywhere:

> ‘DSM-V is used; disorders are the same everywhere.’ [Mental health specialists 12 and 19]
>
> ‘All criteria and all points of DSM-V are suitable in all cultures.’ [Mental health specialist 17]

Another point of view referred to cultural traditions as necessary for consideration:

> ‘Cultural aspects in counselling are very important, as people sometimes do not recognize psychological problems.’ [Mental health specialists 1 and 18]
>
> ‘The applying of DSM-V is problematic, while culture makes a significant influence on mental disorders.’ [Mental health specialist 16]
>
> ‘Cultural context is very important in counselling.’ [Mental health specialist 20]
>
> ‘Some points of DSM-V do not meet cultural issues.’ [Mental health specialist 12]

The mental health specialists also indicated that disorders have a cultural context:

> ‘Some disorders exist in specific cultures, because of the elements of these cultures. In general, some disorders are not applicable in our culture, because it is American based. Sometimes people express their feelings different in different cultures. Basic disorders like depression are different in the cultures because the cultures have different elements, like family relations. Sometimes we say it is an adjustment from God.’ [Mental health specialist 10]

Other mental disorders were not inherent to or understandable in some culture. For example:

> ‘Eating disorders are culturally determined. In my opinion, these disorders are American. Bulimia nervosa and anorexia nervosa mostly reflect American culture. Here are no standards for the female body.’ [Mental health specialist 10]
>
> ‘Suicide is not common in Muslim communities. Religion forbids killing yourself. Humans’ bodies belong to the God.’ [Mental health specialist 2]

‘Some psychotherapists treat homosexuals to change their orientation.’[32] [Mental health specialist 10]

Thus, considering the significant role culture plays in understanding and diagnosing mental disorders, another question arises: how can the DSM-V be applied in consideration of cultural peculiarities?

The fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV), published in 1994, emphasises the role of culture in the symptoms of mental disorders. In this edition, disorders are marked by variations in symptoms due to cultural differences, and the term ‘culture-bound syndromes’ is introduced (American Psychiatric Association [APA], 1994). One example of this culture-bound syndrome in Arab culture is *Zār*. Furthermore, several steps were taken to increase the applicability of the International Classification of Mental Disorders, such as providing information on cultural differences. For this purpose, 25 culturally induced syndromes were described, and cultural formulations were presented in the context of cultures. Cultural narrative was also included, such as clinical history, cultural formulation, cultural identity, cultural explanation of the disease, cultural factors influencing the psychosocial environment, cultural elements in the patient-physician relationship, and cultural evaluation. The DSM-IV also introduces the glossary of culture-bound syndromes, while the DSM-V defines the outline for the cultural formulation of a case.

Culturally bound symptoms were discussed with the mental health specialists to determine how traditions and modern medicine interact, as all interviewed mental health specialists were representatives of Islamic culture. The specialists made the following comments:

‘*Jinn* can possess people’s bodies and these cases are not the same as mental disorders.’ [Mental health specialist 7]

‘The confusion exists regarding schizophrenia and *jinn*. The symptoms for both cases are the same.’ [Mental health specialist 10]

From this perspective, to manage psychiatric symptoms attributed to *jinn*, evil eye, or magic, Western mental health care should consult a religious leader or imam, who can explain the religious issues. Recently, various initiatives and protocols have been developed in the field of cognitive-

[32] Here, I want to add an explanation regarding homosexuality in Muslim culture. First, it is forbidden by the religion and, as mentioned by interlocutors, is understood as a disorder to be treated. In the DSM-V, homosexuality is not defined as a disorder. However, even in the West, the American Psychiatric Association did not remove the diagnosis ‘homosexuality’ from the third edition of the Standard Classification of Mental Disorders until 1973, under pressure from the gay association (Drescher, 2015).

behavioural therapy with modifications that are adjusted specifically to Islamic values (Lim et al., 2018). Al-Habeeb (2003) states that the majority of contemporary psychiatrists believe in supernatural spirits and tend to ignore the therapeutic value of culture in spiritual or other mental disorders. A pilot study in Saudi Arabia by Al Habeeb (2003) revealed that the symptoms of supernatural powers, such as *jinn*, evil eye, and magic, can be somatic and psychological. The most frequently reported somatic symptoms were headache, chest pain, abdominal pain, leg pain, eye ache, earache, pain in all joints, and backache. Psychological symptoms were also mentioned, including anxiety, fear, obsessive thinking, and depression. However, due to the lesser stigmatisation of physical symptoms, mental health problems are often expressed as physical symptoms (Al-Krenawi, 2005; El-Islam, 2000). Al-Krenawi and colleagues (2000) note that, 'patients' help-seeking tends to be motivated by overt physical symptoms and the expectation, common among Arab patients, of receiving medicine' (p. 508). The mental health specialists noted that conceptualising mental disorders as a medical diagnosis is more acceptable in Muslim culture than conceptualising them as a psychological issue. Therefore, help-seeking from a medical doctor is more acceptable to patients than seeking help from a psychologist. The mental health specialists also agreed that patients do not follow doctors' recommendations to visit psychologists to solve physical illnesses or pains:

> 'People visit medical doctors first, and if a doctor recommends psychological treatment, they do not visit a psychologist. Again, people return to a *sheykh* for a treatment.' [Mental health specialist 13]

While culture affects conceptions of mental health and disorders, empirical research conducted in Jordan will provide a broader understanding of the need for counselling and its adaptation to cultural specificities. In the first part of the dissertation, the general field of mental health was revealed through the perspective of the respondents (Jordanian inhabitants). In the next subsection, the situation will be assessed from the viewpoint of mental health professionals, who assess the reasons patients most often seek consultation, diagnosis, and treatment options. In contrast, religious specialists place more emphasis on cultural and religious factors.

3.2.1. Mental health situation in Jordan

Globally, more than 450 million people suffer from mental disorders (WHO, 2017). Specifically, Jordan has been identified (WHO, 2008) as a country in need of intense support for strengthening the mental health system,

and it was selected to join the Mental Health Gap programme (mgGAP)[33]. The WHO (2017) indicated that 305 individuals per 100,000 inhabitants are diagnosed with mental disorders in Jordan. However, this rate of diagnosis might be higher, consider the stress around economics, politics, unemployment, immigration, and ongoing conflicts in neighbouring countries that impacts the Kingdom of Jordan. According to the mental health specialists, who were asked to identify the most common issues Jordanians face that force them to visit mental health specialists, patients commonly face social problems, including family problems, family violence, problems at work or in studies, communication with the opposite gender, and social phobia (more common for women). They also cited economic reasons, including growing poverty rates. Furthermore, refugees face many problems that encourage visits to a mental health specialist. For example, interlocutors shared the following:

> 'Mostly problems in the society, such as violence, which is widespread, as well as economic reasons. In Jordan unemployment is high ranked. According to a statistical data the rank of unemployment is 18.5% in the country. Indeed, the real situation is worse. About 27% of Jordanians are unemployed. Thus, the present situation causes, such problems as starting a family, especially for men.[34] To find a job after graduation is difficult. These previously mentioned problems can cause anxiety and depression.' [Mental health specialist 7]
>
> 'I am counselling students, and problems of my patients are related to university, communication with the opposite gender, stress,

[33] The purpose of the programme is integration of mental health into primary health care. The programme aims to scale up services for mental, neurological, and substance use disorders while offering treatment options for depression, schizophrenia, and other major mental conditions in primary health care facilities, thereby meeting the needs of most of the population even where resources are scarce. The implementation of the mhGAP began with training and rigorous supervision for health care practitioners in Amman, Irbid, and Az Zarqa. At the secondary level of care, three outpatient community mental health centres have been established in the same areas to ensure availability, accessibility, and quality service provision where people work and live. Additionally, acute inpatient model units within general hospitals in the Ministry of Health and at university facilities have been established in addition instead to psychiatric hospitals (WHO, EMRO, 2008).

[34] As interlocutors explained, according to wedding traditions in Jordan, the groom or his family is responsible for paying all wedding expenses. Additionally, the groom must have home (rent or buy) where the new family will live and to offer the bride a valuable gift.

anxiety about the future, communication with parents, and loneliness.' [mental health specialist 8]

The most common diagnoses, according to interlocutors (mental health specialists), are depression, anxiety, obsessive compulsive disorder, schizophrenia, and bipolar disorder. Alternatively, the religious leaders emphasised sociocultural factors as providing a strong mental health background:

> 'In our country here are not as much depression as in the Western countries, because we have strong relationships among family members and in the community. We are communicating to each other; we are going out together. Here is no suicide in our country, or eating disorders, as for example the Prophet Muhammad said, "It is sufficient for a human being to eat a few mouthfuls to keep his spine straight. But if he must (fill it), then one third for food, one third for drink, and one third for air" (Ibn Majah 29: 3349).' [Sharia specialist 2]

Although the study drew attention to mental disorders from a cultural perspective without considering genetic causes, the genetic causes of mental disorders are influenced by the specific cultural traditions in Arab countries. For example, the free-listing task presented one of the causes of mental disorders as heredity (Smith's $S = 0.143$) or genetic disorders, which are thought to be caused by high rates of marriage among relatives in the Arab world (Al-Gazali et al., 2006). This tradition remains prevalent in most Arab countries; consanguinity rates in the Arab world range from 25–60%, and among Jordanians, the rate of marriage between first cousins is close to 30% (Al-Gazali et al., 2006). However, genetic disorders were not mentioned as a factor by mental health professionals.

The mental health specialists reported that people from all walks of life, social classes, and ages seek professional psychological aid. However, they noted differences in attitudes between younger and older generations, rural versus urban dwellers, and individuals with different education levels:

> 'My patients are different age, but mostly young people and different social class.' [Mental health specialist 1]

> 'I am a psychologist at university; thus, my patients are 18–22 years old.' [Mental health specialist 4]

> 'I work with adults, and the age of my patients varies from 20–70 years old. Here, at the hospital, we have children's psychiatrists as well.' [Mental health specialist 18]

As the analysis revealed, patients of traditional healers do not differ in their level of education, but the patients of mental health specialists are

mostly educated and therefore tend to be more open to mental health treatment:

> ‘My patients are different age, but usually from 20–30 years old, mostly educated.’ [Mental health specialist 5]
>
> ‘Educated people more often seeking for professional psychological aid. But here in the north part of the country, which is rural, I have different patients. Still, the situation in Amman is different. There are private clinics, but anyway psychological counselling is not developed enough.’ [Mental health specialist 18]

Another relevant issue is the use of medications to treat mental disorders. In a study conducted in Jordan by Al-Krenawi and colleagues (2000), all patients were prescribed medication, to the exclusion of therapy, as treatment. In the present research, the opinions of mental health specialists differed regarding the preference for medication or counselling. Psychotherapists (respondents 15 and 17) who worked at the hospital in clinical counselling stated their patients preferred counselling over medication, as the patients believed that medication can be harmful. The idea that medication is harmful was also widespread among traditional healers. Meanwhile, the psychologists claimed that medication was more acceptable than counselling because of the fear of being seen by someone while going to a therapist. Thus, they believed taking medication was preferable (mental health specialists 2, 3, and 9):

> ‘Medication is more popular than counselling. The main causes are stigma, and shame.’ [Mental health specialist 2]
>
> ‘People prefer medication instead of counselling. If a person takes medication nobody knows, while a person visits a psychologist somebody can see. Money is another issue for the preference of medication. The country’s economic situation is complicated, and people do not have enough money for counselling; while the medication is cheaper.’ [Mental health specialist 9]
>
> ‘People prefer medication, because visiting a psychologist is shameful.’ [Mental health specialist 11]

Although I did not have the opportunity to communicate directly with patients during the study, as permission from the Ministry of Health would be required to do so, three individuals among the participants had visited mental health professionals and were willing to share their experiences. One of the respondents (no. 10, male, 40) stated that he was diagnosed with depression and anxiety, and the psychiatrist he visited immediately prescribed medication, at the exclusion of counselling. The respondent also stated that

Muslims are more likely to be treated with medication than visits with a psychologist.

In the first part of the dissertation, mental health was examined from the perspective of the Jordanian population. In this section, the reflection was based upon interviews with mental health professionals. A comparison of the two analyses shows that the reasons listed by the Jordanian population for turning to specialists and the most common mental disorders coincide with those listed by mental health professionals. According to the data, Jordanians are sufficiently familiar with the field of mental health.

Moreover, the present subsection has revealed the main reasons why patients turn to mental health professionals from the perspective of those professionals, as well as the most common mental disorders. Although the disorders of Jordanians and their causes coincide with those of Western patients, the same causes and mental disorders have cultural nuances that the inculturation of Western psychological counselling in Arab countries will be discussed in the next section.

3.3. Inculturation of Western psychotherapy in Islam

Adaptation of psychotherapy for Muslims is an important discussion among therapists from non-Western cultures. Previous anthropological research has stated that cultural values influence the acceptability of treatment (Fiks et al., 2011), and several core sociocultural factors deserve attention to adapt psychotherapy to cultural traditions. First, behaviour that is considered pathological in one culture may not be considered so in another. In the Islamic tradition, patients' problems are identified as social and interpersonal rather than as an internal psychological conflict, as is emphasised in the classical Western approach. Western psychology focuses on ego and individualism, but the collective identity prevails over the self in Muslim society. Openness, intimacy, and sharing personal or social problems are often unacceptable to Muslim representatives, as problems may not be individual but family wide. In collectivistic societies, the individual is taught not to tell strangers personal things (Dwairy & van Sickle, 1996). This reveals a contraposition in counselling, as Muslims live in collectivistic societies, while psychotherapists have mostly studied in the West and are trained to apply Western approaches, leading to problems of conceptual equivalence (Badri, 2009; Utz, 2011). The Western term 'express emotions' has a completely different meaning in Muslim societies; Westerners explain behaviour through their experiences, while Easterners interpret behaviour through relationships with others (Marcus et al., 1996). Western psychotherapy focuses on individuals who are

able to express their thoughts and feelings clearly; while thoughts are not verbalized in Muslim societies. Verbal communication usually is extended from a higher status person, such as a father, to a lower status person, and control of emotions and feelings is viewed as a sign of maturity (Al-Issa, 2000, pp. 288–289). Interest in local psychology has led several therapists and counsellors to reject Western methods that do not reflect local culture (Berry, 1997; Kim et al., 2006), which has its methods for gaining understanding, is compatible with the local ethos and can thus provide reliable solutions to human problems. In most cases, cultural beliefs and practices prevalent in society are included in psychotherapy because they contribute to a better understanding of the problem.

Religion is another important factor that significantly impacts the mental health discourse, especially in the Arab region. Psychology is based on the Western model of medicine, while Islamic psychology is adapted specifically for Muslims (Al-Issa, 2000, p. 345). Religion is a basic concept of counselling, and without adaptation, some approaches of Western psychotherapy can be harmful to Muslim patients (Badri, 2009; Rothman, 2018; Utz, 2011), as the therapist may guide patients in a direction other than defined by the religious tradition. Western psychology and sociocultural components shape the Western personality, while Islamic religion and culture shape the Muslim personality. Therefore, what works for one is not necessarily suitable to the other.

3.3.1. Psychotherapy techniques in Islam

The American Psychological Association (APA) organises psychotherapy into five broad categories: psychoanalysis and psychodynamic therapies[35], behaviour therapy[36], cognitive therapy[37], humanistic therapy[38],

[35] Psychoanalysis and psychodynamic therapies 'focus on changing problematic behaviours, feelings, and thoughts by discovering their unconscious meanings and motivations. Psychoanalytically oriented therapies are characterized by a close working partnership between therapist and patient. Patients learn about themselves by exploring their interactions in the therapeutic relationship' (APA, n.d.).
[36] Behaviour therapy 'focuses on the learning role in developing both normal and abnormal behaviours' (APA, n.d.).
[37] Cognitive therapy 'emphasizes what people think rather than what they do' (APA, n.d.).
[38] Humanistic therapy 'emphasizes people's capacity to make rational choices and develop to their maximum potential. Concern and respect for others are also important themes' (APA, n.d.).

and integrative or holistic therapy[39]. These all have been used by Muslim psychiatrists and psychologists (Al Mutlaq & Chaleby, 1995) to counsel Muslim patients. Although there are several publications about psychoanalysis and psychodynamic psychotherapy in the Arab world (Benslama, 2009; El Shakry, 2017; Maasad, 2009; Parker & Siddiqui, 2018), M. Z. Azhar and S. L. Varma (2000) argue that Freud's psychoanalysis does not fit into either the religious or scientific categories (p. 176). Psychoanalysis integrated with religion has been applied to treat Muslims, but this is not widespread or acceptable among Muslims (Al-Abdul-Jabbar & Al-Issa, 2000, pp. 277–293) compared to Western countries. Some mental health specialists practice supportive psychotherapy rather than psychoanalysis (Azhar & Varma, 2000, p. 176). However, as psychodynamic psychotherapy is based on psychoanalytic theories and the individualistic concept, it also is not widely used among Muslims (Rassool, 2016, pp. 108–109).

Critical literature analysis showed that cognitive-behavioural therapy is dominant in Arab countries and is well appreciated by therapists there. According to Chambless and Ollendick (2001), this therapy is effective in treating disorders such as anxiety, stress, depression, eating disorders, panic, and fear. Abudabbeh and Hays (2006) culturally adapted cognitive-behavioural therapy for Muslim patients by replacing certain Western concepts with Islamic teaching concepts, and studies have revealed the effectiveness of this Islamic-based therapy for Muslims (Shafranske, 2002). Other studies of Muslim patients showed that modified cognitive therapy for the treatment of anxiety and depression achieves faster and better results than Western models, which do not meet the needs of Muslim patients (Azhar & Varma, 2000, pp. 163–185). Similar results were found by a study in Saudi Arabia on Muslim patients dealing with schizophrenia (Wahass & Kent, 1997, pp. 664–668). Several assumptions have been made regarding why cognitive-behavioural therapy is so prevalent in Muslim-majority countries. First, this type of therapy has recently become popular in the West; thus, one assumption is that what is popular in the West is popular in the East. Second, this therapy is simpler, shorter, and cheaper than other forms of psychotherapy, and it is more superficial. Because it does not analyse as deeply, and perhaps does not

[39] Integrative or holistic therapy 'is grounded in psychosynthesis, focuses on the relationship between mind, body, and spirit, attempting to understand the ways issues in one aspect of a person can lead to concerns in other areas. Many therapists don't tie themselves to anyone's approach. Instead, they blend elements from different approaches and tailor their treatment according to each client's needs' (APA, n.d.).

approach what religion forbids, it may more easily account for religion. For example, this type of therapy does not delve into sexuality, which is taboo in Arab countries.

Group psychotherapy in Muslim culture was first attempted in Egypt in 1970 (Carter & El Hindi, 1999, pp. 183–188). Although Banawi and Stockton (1993) state that group therapy is not acceptable to Muslims due to the confrontation of religious values (pp. 115–160), Jordanian mental health specialists Takriti and Ahmad (2000), argue that this form of therapy, with a religious integration, is useful (p. 247). However, some patients may feel uncomfortable during group sessions when sharing details of their personal life and experiences, especially in the presence of opposite-gender members. Group therapy is therefore possible with same-gender groups and in accordance with Islamic traditions (Carter & El Hindi, 1999, pp. 183–188). Al Mutlaq and Chaleby (1995) observe that the most common problems in group psychotherapy in Muslim culture are personal and intergroup conflict, sensitivity to insights, hierarchy in the Arab world, group stability, understanding group attitudes, privacy issues, and society's view.

Family therapy is recommended for clients from collectivistic cultures (Dwairy, 1998; McGoldrick et al., 2005), as this psychosocial approach is oriented towards the family, group, or community and individuals are identified as members of a family or group in Muslim societies. Often, many decisions are made not by an individual but by a family or group. However, family therapy and group therapy grew in popularity only when patients became more educated and understood that disorders could be caused by or have effects on other family members (Azhar & Varma, 2000, p. 177). Patients from collectivist cultures are more interested in family therapy, and people from individualistic societies are more prone to pursue individually expressed psychodynamic psychotherapy (Caraballo et al., 2006).

Not all Muslims recognize psychotherapy as a treatment. Therefore, to counsel Muslim patients, various psychotherapy approaches have been adapted to incorporate religious values. Patients' willingness to solve a particular problem depends on the knowledge that the process will improve their relationship with God (Hodge & Nadir, 2008, pp. 31–41). From a religious perspective, therapy is more likely to affect the soul than to change thinking, emotions, and behaviour, and therefore, the process of therapy focuses more on spiritual development (Utz, 2011). Psychotherapy is primarily related to the patient's motivation and willingness to change. If the patient does not have such desire, no progress occurs during therapy. The patient is responsible for his or her own habits and choices, as well as the willingness to change. This approach is also noted in the Qur'an: 'God will

not change the condition of people until they change what is within themselves' (Qur'an 8:53). This passage emphasises that humans can change their negative traits and develop a healthy personality and habits. Individuals have the ability to overcome their weaknesses but can be affected and blocked by environmental factors. This philosophy guides effective Muslim psychotherapy (Utz, 2011).

In the Arab region, attempts have been made to apply various approaches of psychotherapy. However, given the sociocultural distinctions of the region, such as community and patriarchal society, not all approaches have been appropriate for Muslim patients. The most effective and acceptable approach is modified cognitive-behavioural therapy.

3.3.2. Psychotherapy in Jordan

As the above analysis revealed, cognitive-behavioural therapy, humanistic therapy, and existential psychotherapy are usually applied in Arab countries. The present qualitative research investigated the Jordanian case specifically. In Jordan, 'psychotherapy is being practiced by some psychiatrists who were trained in specialized centres in the United Kingdom and United States of America, generally in the field of cognitive-behavioural therapy; psychodynamic therapies are not practiced in Jordan' (Takriti, 2004, p. 10). The currently adopted psychotherapeutic practices in Jordan were discussed by the mental health specialists, who shared their experiences. All interlocutors agreed that cognitive-behavioural therapy was the most popular approach. Despite the fact that the Arab world resists psychoanalysis, as many Muslims think that psychoanalysis propagates atheism (Benslama, 2009) and contradicts religious mores, several specialists stated that they used psychoanalysis in their practice:

> 'In Jordan, we are practicing cognitive therapy, but I am applying all approaches, psychoanalysis as well. Freud's theories are applied as well.' [Mental health specialist 1]
>
> 'The cognitive approach is the most popular in Jordan. While Freud's ideas could be used as well, those who fit according to traditions.' [Mental health specialist 5]
>
> 'Freud's ideas can be used, but not all of them.' [Mental health specialist 4]
>
> 'Psychosexual development and religious points conflict, but some of Freud's ideas, such as free associations are very useful.' [Mental health specialist 6]

Religious counselling was indicated as the most prevalent method in Jordan by an Islamic psychologist (interlocutor no. 12). Existential therapy, which is based on a model of human nature and focuses on concepts that are universally applicable to human existence, including death, freedom, responsibility, and the meaning of life, was also mentioned:

> 'Existential therapy is suitable for religious people. Of course, it depends on the client.' [Mental health specialist 6]

The present study confirmed that the most popular therapy in Jordan, as in all the entire Arab world, is cognitive-behavioural therapy. Contrary to the statement of one the most prominent Jordanian specialists, Adnan Takriti (2004), who argues that psychoanalysis is not used in the region due to its many contradictions with Muslim culture and religion, some Jordanian specialists applied psychoanalysis is in some form, depending on the patient. The application of psychoanalysis in Arab culture, which faces rapid social change, has been discussed by several Muslim specialists (Benslama, 2009; El Shakry, 2017; Maasad, 2009; Parker & Siddiqui, 2018) in other Muslim-majority countries. Specialists have studied the complex relationships between Islam (as religion) and psychoanalysis to explore connections that link these two traditions, as well as the tensions that exist between them.

Still, psychotherapy in Jordan is not as popular as in the West. Psychotherapy is practiced mostly in hospitals, where the psychotherapists work with psychiatrists:

> 'Here is no psychotherapy in Jordan. Here are counselling and psychiatry, and only in the hospitals patients have a long-term therapy.' [Mental health specialist 20]

> 'Psychotherapy is not popular. Psychotherapists work together with psychiatrists. People do not attend psychotherapy like in Western countries.' [Mental health specialist 1]

> 'In my city, there are no clinics for psychotherapy. There are psychiatrists and counsellors. In Amman there are some clinics for psychotherapy, but in general, it is not common. Here psychotherapists work in the hospitals side by side with psychiatrists.' [Mental health specialist 6]

Some cultural differences also exist in the therapist–patient relationship. A therapist in Muslim-majority countries is expected to take an advisory role (Al-Abdul-Jabbar & Al-Issa, 2000, p. 282) and produce quick improvement: 'Arab clients tend to be in favour of "quick fixes" and want me to cure them from the first session' (Sakr, 2012). Meanwhile, in Western psychotherapy, the therapist does not play the role of an advisor. According

to psychiatrist and psychoanalyst R. Milašiūnas[40], a psychotherapist attempts to stay as neutral as possible – sometimes even passive – and stimulates the person to find answers and solutions. The key to this approach is that only the individual knows best what he or she needs in life. In contrast, Jordanian mental health specialists indicated that people usually come to a mental health specialist only a few times and expect to receive an advice:

> 'Usually, patients visit me just once or twice for an advice.' [Mental health specialist 9]
>
> 'People come for consultation and want to get an advice. They do not attend a therapy constantly.' [Mental health specialist 5]
>
> 'Patients constantly attend psychotherapy only with a doctor's prescription.' [Mental health specialist 18]
>
> 'I am a psychotherapist in a hospital. I have patients who attend therapy one, two, even three years. But that is not popular in Jordan.' [Mental health specialist 17]

The above data from the present study revealed the situation of psychotherapy in Jordan. The term 'psychotherapy' is mostly not understood or widely used among Jordanians, as there are two definitions of mental health aid in the country: counselling and psychiatry. The term 'psychotherapy' is understood only among mental health specialists. In light of Arab culture and in the minds of Jordanians, psychotherapy is understood differently than in the West. Muslims do not attend therapy to discover or understand themselves; psychotherapy is viewed more as a medical treatment for solving serious mental issues, and psychotherapists work together with psychiatrists in hospitals. Private psychotherapy clinics, such as those popular in the West, are located only in the capital. According to the analysis, of 60 mental health specialists that are available to register on the internet[41], 56 were located in Amman, 2 were located in Irbid and 2 in Az Zarqa. Consequently, private consultations are not available in other cities, and the main assumption is that there is no need for it – a state that is conditioned by cultural traditions.

Considering these results, the next section will discuss the influence of culture to answer the following question: How do cultural factors influence counselling and change the face of Western psychotherapy, and how does Western psychotherapy work in a cultural context? Csordas (2005) also raises questions: If ritual healing is a form of psychotherapy, is psychotherapy also

[40] Interview with psychiatrist and psychoanalyst Raimundas Milašiūnas, Vilnius, 16 March 2017.

[41] Registration for consultation to mental helth specialists via internet. Retrieved from: https://tebcan.com/en/Jordan/Doctors/psychotherapy/jordan?PageNumber=1

inherently a ritual? If certain forms of prayers can be considered psychotherapy, can psychotherapy legitimately include prayer as one of its therapeutic techniques?

3.4. Religion in counselling

Western psychology is often believed to be unaccommodating of religion (Al-Karam, 2018), and religion and spirituality were excluded from psychological therapies for a long time. The relationship between religion, psychiatry, and clinical psychology was controversial, as the various psychotherapies are perceived as secular sciences. Early figures including S. Freud, the founder of psychoanalysis, and American psychologist A. Ellis equated religion with neuroses and irrationality. For example, Freud associated religious beliefs and practices with the repression of instincts, intrapsychic conflicts, and obsessional neurosis. In contrast, American psychologists G. Alport and O. H. Mower suggested that religion had a positive influence on mental health (Al-Issa, 2000, p. 3). In contrast, Bhugra (1996) highlights religion as a strong defence against several types of neuroses, stating, 'The relationship between religion and mental health can be a mutually beneficial one as religion provides guidelines which may help individuals to devise a course for their lives' (p. 2). Similarly, Larson and colleagues (1992) found a positive relationship between religious commitment and mental health. Al-Ghazali and Yusuf (2010) state that the only way to achieve happiness is to be in close relationship with God.

Religious psychotherapy[42] began in the early nineties and was found to contribute to faster recoveries and to be more acceptable to religious patients (Azhar & Varma, 1994; Badri, 2009). To measure the relationship between belief in God and treatment outcomes for psychiatric patients, Rosmarin and colleagues (2013) conducted research that showed that a stronger belief in God corresponded to greater improvements in psychological well-being. Their results suggested that belief in God is psychologically protective and affirmed that religiously integrated psychotherapy could be more effective than other approaches. M. E. Koltko (1990) also considered the impact of religious beliefs in psychotherapy. Pargament and colleagues (2007, 2013) and Richards and Bergin (1997, 2005) provide suggestions for including religious and spiritual factors in counselling. In his counselling

[42] Integration of spirituality and religion into psychotherapy practice.

practice, psychologist Malik B. Badri[43] applied religion-oriented psychotherapy for over 40 years. He states that this kind of therapy is effective for Muslim patients. Indeed, Islamically integrated psychotherapy is a modern approach that integrates Islamic teachings, principles, and philosophies into the Western therapeutic approach (Al-Karam, 2018) using the Qur'an and Sunnah as guidance.

Psychotherapist Abdallah Rothman (2018) distinguishes Muslim psychology from Islamic psychology and Muslim psychologists from Muslims who practice Islamic psychology. Rothman (2018) states, 'Muslim psychology focuses on how Muslims think and behave. It is primarily a culturally adapted approach to Western therapy that incorporates language, customs, and culturally relevant sentiments into the therapeutic process' (p. 26). Thus, Islamic psychology is an indigenous approach to the study and understanding of the human psychology that is informed by the teaching and knowledge from the Qur'an and the Prophetic tradition (Haque, 1998; Utz, 2011).

Therefore, Muslim specialists apply cultural or religious viewpoints in their work with Muslim patients, changing the understanding of psychotherapy as Western and secular. Religious psychotherapy is based on a 'value search' and 'value change' rather than 'conflict search' and 'conflict resolution' (Azhar & Varma, 2000, p. 179), and Islamic psychology often focuses on the heart and soul rather than the mind as the centre of the person (Rothman, 2018, p. 26). Religious psychotherapy has become popular because most of the patients in the Arab counties are religious, and almost 70% of these patients undergo this therapy approach (Azhar & Varma, 1994).

The present empirical research found that Jordanian mental health specialists supported the importance of religion in counselling. Some therapists specialised in religious therapy:

[43] Psychologist Malik B. Badri integrates Islamic tradition into his clinical practice. He worked as a psychologist in many clinics in the Middle East and Africa, and in 1971 founded the Clinic of Psychology at Riyadh University in Saudi Arabia. During those years, the psychologist treated patients suffering from depression, anxiety, phobias, obsessive compulsive disorder, trauma, and addictions. Badri has played an important role in Muslim universities, establishing many faculties of psychology, including the Faculty of Applied Psychology at Khartoum University, the Faculties of Education and Islamic Studies at the International University of Africa, and the Department of Psychology in Imam Mohammad bin Saudi University in Riyad, Saudi Arabia. The doctor has received many awards, and his articles are published in international journals (Badri, 2009).

‘As an Islamic psychologist, I am focusing on religious counselling. I am applying religion in my work. We believe in destiny, in God’s will.’ [Mental health specialist 15]

Other mental health specialists agreed with the importance of religion:

‘Religion and spirituality are important.’ [Mental health specialist 19]

‘Religion can be useful, because in our country religion is a part of everyday life.’ [Mental health specialist 16]

‘Religion is very important in counselling. If patient is a Muslim, then I apply religion in counselling.’ [Mental health specialist 8]

‘Religion is important in counselling and is used by psychologists. It is a part of our culture. We are not very secular.’ [Mental health specialist 20]

‘I am applying religion in counselling.’ [Mental health specialist 2]

‘Religion is important in counselling. We are applying religion in counselling. I give advices to my patients, such as to pray, to read the Qur’an.’ [Mental health specialist 3]

At the same time, other specialists believed that the importance of religious counselling depended on patients’ religiousness:

‘Religion is important in counselling, but it depends on a person’s religiousness.’ [Mental health specialist 1]

‘It depends on a patient’s religiousness to incorporate religion in counselling or not.’ [Mental health specialists 5 and 19]

Religion is incorporated in many aspects of life, and religious rituals can help achieve spiritual peace (Rüschoff, 1992). The mental health specialists stated:

‘Faith can heal, that is like a placebo effect.’ [Mental health specialist 1]

‘The Qur’an makes a soul calm.’ [Mental health specialist 15]

‘The Qur’an makes people comfortable. Thus, when people have problems, they usually read the Qur’an.’ [Mental health specialist 2]

‘We believe that the Qur’an recitation can solve problems.’ [Mental health specialist 20]

‘The Qur’an has answers to all questions and can solve every problem.’ [Mental health specialist 12]

Additionally, Jordanians noted the importance of religion during periods of distress:

> ‘When I am feeling sad or depressed, I talk to my mother. And her advice is always the same: “Pray”. The best way to help yourself is a spiritual way.’ [Respondent no. 15, male, 20]
>
> ‘An individual can solve his problems by himself. Religion is a way to heal.’ [Respondent no. 28, male, 21]

Thus, religion is another example of the importance of cultural values. Malik (2018) argues that ‘religion and psychotherapy are both well placed to learn from one another as they deal with the human condition’ (p. 171). Religious therapy plays a large role in Muslim counselling, as Muslim patients are very sensitive to religious issues. Therefore, therapists working with Islamic practitioners should have a good understanding of religion. Whether Western psychotherapy can be effective without the incorporation of religion will be discussed in the next section.

3.4.1. The effectiveness of psychotherapy without the integration of religion

> ‘If you want to understand people, you should understand their language and culture. If you want to understand a culture, you have to live in that culture.’
>
> [Mental health specialist 10]

Scholars (Badri, 2009; Chaleby, 1992; Dover, 2011; Haque, 1998; Utz, 2011) state that psychotherapy must be culturally adapted. As M. B. Badri explains, one of the main reasons for the Islamisation of psychotherapy is that disorders are not treatable without the intervention of religion or local culture. According to the previously mentioned specialists, Muslim patients complain of phobias of death, illness, or *jinn*. Therefore, to treat fears related to cultural peculiarities, therapists must have knowledge of Islamic traditions, for instance, life, death, afterlife, *jinn*, and other cultural concepts. The cultural challenges in the field of mental health are well illustrated by a situation described by professor Arūnas Germanavičius, head of the Republican Vilnius Psychiatric Hospital. According to professor A. Germanavičius, people from migrant camps who come to the Republican Vilnius Psychiatric Hospital often describe their feelings as having ‘been possessed by a bad *jinni*’. The Professor added, ‘We were only able to thoroughly investigate, diagnose, and prescribe appropriate treatment for half of these patients’ (Morozovas, 2022).

Therapy cannot help a patient without a change in beliefs related to spiritual problems (Badri, 2009). M. Z. Azhar and S. L. Varma (1994) hypothesise that emotional disorders are not the result of conflicts, especially of a sexual nature, but are defects in the person’s value system and ideas. Ideas

and values influence actions and emotions, and different moral values form different emotional conditions. Negative emotions can be caused by many factors, but based on the Qur'anic approach to psychology, ideas and values are the principal etiological factor (Azhar & Varma, 2000, p. 178). The growing number of psychological issues in many Arab countries are a consequence of urbanisation and a changing lifestyle, especially among the younger generation, who finds themselves caught between traditions and a modern lifestyle and between parental and social pressure. This causes stress and intrapersonal conflicts.

M. B. Badri (2009) believes that helping patients who face problems in a relationship or marriage is not possible without knowledge of family law, sexual regulation, heredity, divorce, child custody, and other traditions, including drug and alcohol use, deviant sexual behaviour, or homosexuality. Western psychotherapy requires neutrality and impartiality in assessments. Religious attitudes in therapy are not considered, unless requested by the patient. However, if Islamic issues are not discussed, no improvement in the patient's condition can typically be expected (Badri, 1997, 2009).

The present anthropological research revealed contrary opinions about the cultural importance of religion in counselling:

> 'I can consult patients of any religion. Reciting the Qur'an recitation is calming, but mental disorders are treated in a medical way.' [Mental health specialists 5 and 18]

> 'I can consult people from any religion or culture. Illnesses and symptoms are the same everywhere. Just the societal attitudes towards mental disorders and treatment are different. As an example, in Jordan mental health is still stigmatised and taboo.' [Mental health specialist 19]

Furthermore, the following statement suggests that traditions do not have an influence in counselling:

> 'I have supervised a Christian priest. The question is not about religion or culture, that is about the competence of counsellor.' [Mental health specialist 6]

Although specialists say they can counsel patients of any culture, certain cultural attitudes and moral norms may be opposed to the therapist's beliefs, as was revealed in one mental health professional's (no. 10) experience working as a psychotherapist in America. The therapist recommended that a homosexual patient visit a colleague, as the patient's sexual orientation contradicted the therapist's moral norms and religious beliefs.

Contrary to the arguments of M. B. Badri and other Muslim psychologists regarding the impact of culture on counselling, the current research revealed that Muslim specialists can provide counselling based on general psychology. However, the arguments presented by M. B. Badri, H. Dover, A. Utz, and other specialists, suggest that non-Islamised psychotherapy is essentially ineffective with Muslim patients due to the specific cultural traditions, lifestyle, and customs of the region. Although Muslim therapists claim to be capable of counselling patients regardless of culture or religion, and non-Muslim therapists of consulting Muslims, whether therapists from other cultures can help Muslim patients must still be determined.

3.4.2. The effect of the counsellor

Culturally sensitive psychotherapy clearly requires an understanding and adaptation of religious principles. Thus, a couple questions arise regarding the therapist: Can non-Muslim therapists successfully treat Muslim patients, and do Muslim patients accept non-Muslim therapists?

Scholars agree that Muslims can accept non-Muslim therapists, but Muslim therapists can develop closer relationships with their patients (Badri 1997, 2009; Dover, 2011; Wikler, 1989). Psychologist Hanan Dover (2011) believes patients and their religiosity must be understood when applying different psychotherapy approaches. Amri and Bemak (2012) suggest that Muslims often avoid seeking mental health services if the therapist does not provide therapy with a religious or spiritual context. Often, Muslims select a Muslim specialist because he or she knows the patient's lifestyle, religion, and spiritual experiences, which may not be understood by non-Muslim professionals. Psychologist H. Dover (2011) uses the metaphors of the Qur'an in her work with Muslim patients because doing so facilitates communication. However, if patients expect theological advice from a Muslim specialist, she suggests they seek advice from a *sheykh*, imam, or other religious leader, as psychologists and psychotherapists do not provide religious information.

Western psychotherapy may be adapted to different cultures; however, depending on whether the specialist is Western or a representative of the same culture, a variety of problems can arise in the counselling process. Patients who are of the same religion as their counsellor can idealize the therapist (Caraballo et al., 2006; Comas-Díaz & Jacobsen, 1991). Conversely, patients who confess the same religion as their therapist may be ashamed to admit certain situations that are prohibited by religious norms, such as alcohol consumption, non-marital relationships, etc. During my field work in Jordan,

I expected communication with local inhabitants on sensitive mental health topics would be difficult. However, people communicated with me openly, sharing their family stories and problems. In some cases, I felt like a 'psychologist', and advice or problem solving was expected from me. I wondered why these people were so open with me but afraid to talk to a psychologist. Some reasons for this easy communication were given by the mental health specialists:

> 'You are a stranger here, you do not know anyone here, you do not know those people's friends, family, or neighbours. Usually, people are afraid to talk to a psychologist because of that specialist might know his or her family, friends, or neighbours, and be non-confidential. In Jordan is a tribal society, and everybody knows each other, unlike an individualistic Western society.' [Mental health specialist 20]

Thus, I was a person who could be trusted. Other mental health specialists agreed:

> 'I will share my experience. I was working in another city, and many patients were comfortable in communication with me. People would not trust me if they saw me in a bakery or shop or walking in the street. People more trust those who are not from their surroundings, who do not know their friends, colleagues, and family members.' [Mental health specialist 6]

The above subsection discussed the role of the psychotherapist from different perspectives. Despite contrasting opinions from specialists and scholars, the choice of psychotherapist remains with the patient and is made depending on religiosity, social environment, fears, and many other factors.

3.5. Concluding remarks

This part of the dissertation was dedicated to an overview of Western psychotherapy in Arab countries. Based on various arguments from scholars, attempts were made to clarify whether the Western model of counselling, which is exclusively associated with secularisation, is generally needed in traditional cultures. Given the rapid process of globalisation and certain aspects of general psychology, the results of previous studies and the present research conducted in Jordan highlighted the importance of Western counselling. The role of culture in the international field of psychology through the applicability of the DSM-V in the Islamic cultural context was also analysed, using comments from mental health professionals and DSM-V analysis. This analysis resulted in two conclusions. First, mental disorders are

the same everywhere. Second, culture plays a clear role in the onset and diagnosis of mental disorders. Each time the Diagnostic and Statistical Manual of Mental Disorders is updated,[44] additional cultural factors and culturally related disorders and their manifestations are included. To further investigate the applicability of psychotherapy in Arab culture, the mental health situation in Jordan was examined through a qualitative study.

To analyse Western psychotherapy in Arab countries, inculturation and its problems were investigated. The applicability and relevance of each psychotherapeutic approach in Muslim culture was reviewed in light of cultural traditions and the interview data. The study confirmed that cognitive-behavioural therapy is the most prevalent in Jordan. Furthermore, despite the abundance of co-versions and criticisms of the application of psychoanalysis in Muslim culture, this approach of therapy is also used, but relatively little. Religion emerged as a key factor in the success of the therapeutic process. The main topic discussed by Muslim mental health professionals was the importance of religion in counselling, and the benefits of religious therapy for Muslim patients were highlighted. The present section also addressed the question of the psychotherapist – that is, an attempt was made to clarify the importance of therapist's knowledge of cultural traditions and the extent to which the therapist's moral values influence counselling.

Thus, the second and third parts of the dissertation analysed traditional religious healing and its approaches, as well as the inculturation of Western psychotherapy in Islam. The fourth part is dedicated to clarifying whether and how these two treatment methods, which are based on different cultural backgrounds, interact with each other.

[44] The Diagnostic and Statistical Manual of Mental Disorders is revised every 15 years. The first edition was published in 1952 by the American Psychiatric Association (APA). The most recent edition was the fifth edition, published in 2013.

4. THE INTERACTION OF TRADITIONAL RELIGIOUS HEALING AND PSYCHOTHERAPY

> 'Science without religion can be destructive, and religion without science can become superstition.'
>
> (Feibleman, 1963, as cited in Bhugra, 1996, p. 15)

In the Arab world, traditional healing and Western psychotherapy co-exist, and thus this thesis investigated how traditional healing and psychotherapy work together or are used to complement each other. In most Arab countries, mental health specialists and traditional healers do not interact; however, in Jordan, the specialists and healers do maintain an informal and unorganised relationship (Okasha et al., 2012). A recent study by Petro van der Merve (2019) regarding the collaboration between traditional healing and psychological counselling used qualitative interviews in South Africa and found opportunities for the two types of services to collaborate in order to facilitate transformation in people's lives. Quantitative outcomes that measure the effectiveness of traditional healers in treating mental disorders and psychological distress suggest that traditional healing can be effective for disorders like depression and anxiety. However, little evidence has been found supporting traditional healing's influence on severe mental disorders, for example, bipolar and psychotic disorders (Nortje at al., 2016). Thus, Feibleman (1963) believes that medical, religious, and social disciplines should cooperate in treatment.

Many discussions, studies, and controversial opinions exist regarding mental health treatment methods and their effectiveness, but whether traditional healing can work with Western psychotherapy remains unclear. Of the 20 interlocutors (mental health specialists) in Jordan, 19 agreed that these two treatment methods can work together:

> 'Traditional healing and medicine can work together.' [Mental health specialist 15]
>
> 'Traditional religious healing and psychology can work together, but qualified specialists are needed.' [Mental health specialist 11]
>
> 'Yes, traditional healing and counselling work together. In my opinion, it could improve counselling, and these two approaches should be integrated work together.' [Mental health specialist 2]
>
> 'Traditional healing and counselling can work together. Traditional treatment can improve counselling. Traditional religious

healing and psychological counselling should work together.' [Mental health specialist 3]

'Science and religion complement each other.' [Mental health specialist 16]

However, doubts about the collaboration of the two different approaches also exist:

'Psychological counselling and traditional healing are different approaches. And collaboration depends on a person.' [Mental health specialist 10]

'At the moment, traditional healing and psychology cannot work together.' [Mental health specialist 20]

Interactions between traditional healing and Western psychotherapy are revealed in several points. First, several mental health specialists mentioned that a *sheykh* sent his patients to the mental health specialists, and some mental health specialists recommended their patients visit the *sheykh*. Mental health specialists also used *sheykhs'* services (as stated by several mental health specialists, as well as a *sheykh* who mentioned he had psychologists as clients). Psychotherapist Rothman, Executive Director of the International Association of Islamic Psychology, works at the intersection of Islamic spirituality and mental health practice with clients of different faiths. Rothman (2018) states that he refers his patients to their own religious leaders, as he believes doing so 'allows for an alliance that is an ideal model for the developing field of Islamic psychology' (p. 31). Furthermore, these referrals provide an opportunity for therapists to spread ideas of mental health and best counselling practices among imams or other religious leaders (Rothman, 2018). Second, some patients used both services – faith healers and mental health specialists – at the same time. Finally, folk beliefs and the symptoms of disorders caused by supernatural powers are included in the DSM-V, which unequivocally shows that traditions and science are culturally intertwined. Furthermore, the WHO Traditional Medicine Strategy 2014–2023 discusses the global integration of traditional medicine[45] and complementary medicine[46] in health systems. This strategy partially confirms

[45] Traditional medicine has a long history. It is the sum total of the knowledge, skill, and practices based on the theories, beliefs, and experiences indigenous to different cultures, whether explicable or not, used in the maintenance of health as well as in the prevention, diagnosis, improvement, or treatment of physical and mental illness (WHO, 2013, p. 15).

[46] The terms 'complementary medicine' or 'alternative medicine' refer to a broad set of health care practices that are not part of that country's tradition or conventional

that the two methods of treatment interact with and complement each other. Bhugra (1996), observes that, in the past, priests and physicians were the same individuals, playing the same role in different cultures worldwide. Until the fifteenth century, medicine and the priesthood worked together, but secularisation caused the two professions to separate (Bhugra, 1996, pp. 1–2).

4.1. Traditional healing versus Western psychology

Because the two treatment approaches work collaterally in the Arab world, and, as the research data show, traditional healing is more popular as the primary option for psychological aid in Jordan, what determines the choice of treatment method must be identified. This was investigated utilising the opinions of the interlocutors (e.g., mental health specialists, Jordanians, and religious leaders). Thematic analysis of the qualitative data revealed four topics as determinants of choice in searching for mental health aid: traditional beliefs about the origin of mental disorders, stigma about mental health, the cost of mental health services, and the low number of mental health specialists. The topic of changing attitudes towards mental health in Jordan is discussed in the fourth part of this dissertation as well.

4.1.1. Traditional beliefs

Sociocultural aspects of Muslim societies, such as cultural traditions, values, and beliefs, affect Muslims' attitudes towards seeking professional psychological aid. Rayan and Jaradati (2016) agree that cultural factors play an important role in attitudes towards seeking professional psychological aid. Studies in Pakistan (Saeed et al., 2000), Saudi Arabia (Alosaimi et al., 2014), and Iraq (Younis et al., 2019) found that Muslims worldwide, believe in the existence of supernatural forces, such as *jinn*, magic, and the evil eye, based on religious teaching. Furthermore, data from previous research (Pew Research Center, 2012) showed that beliefs in supernatural powers are common and widespread throughout most Muslim-majority countries, such as Tunisia, Morocco, Iraq, Jordan, and Egypt (Table 7).

medicine and are not fully integrated into the dominant health-care system. They are used interchangeably with traditional medicine in some countries (WHO, 2013, p. 15).

Table 7. *Beliefs in supernatural powers (Pew Research Center, 2012)*

	Evil eye	Sorcery	*Jinn*
Tunisia	90%	89 %	79 %
Morocco	80%	78%	86 %
Iraq	72 %	50 %	55 %
Jordan	65 %	26 %	58 %
Egypt	62%	73 %	69 %

Another study regarding belief in supernatural powers was conducted with Muslim patients in the Netherlands (Lim et al., 2018), and the results showed that 78.7% of the patients believed in *jinn*, 63.8% in magic, and 80.9% in the evil eye. The present research agrees with the results of the previous studies; Jordanians strongly believe in supernatural powers:

> 'We believe in black magic.' [Sharia specialist 1]
>
> 'We are between traditions and religion. Traditionally, people believe in evil eye, amulets' power, and fortune telling. All these are against religion, but still people believe in them, especially in villages.' [Respondent no. 13, male, 24]

One of the interlocutors shared his family story:

> 'My younger brother had mental disorders. The diagnosis was bipolar disorder and schizophrenia. When my family faced this first, my parents thought about spiritual issues, as traditionally mental issues are attributed to evil eye or black magic. So, my brother was taken to a *sheykh*, while I insisted that this is a mental issue and psychiatrist's consultation is needed. In total, three *sheykhs'* services were used. When one *sheykh* did not help, then another one was visited. After every visit my brother used to say he was feeling better and my mother was telling the same. Finally, my brother was taken to a psychiatrist.' [Respondent no. 5, male, 42]

All interlocutors (Jordanian inhabitants) agreed on the existence of supernatural powers. Some people even attributed their lazy character or misfortunes to *jinn*, as they did not want to accept responsibility for their actions or minds:

> 'In most cases bad behaviour or failures are attributed to *jinn*. For example, that is *jinn's* fault, not mine.' [*Sheykh* 3]
>
> 'Sometimes people blame *jinn* for their bad behaviour and mistakes. For example, a husband cheats on his wife and pleads *jinn* for his behaviour.' [*Sheykh* 2]

‘People tend to attribute their problems to *jinn*. Like as *jinn’s* fault in their misfortunes, or bad behaviour. This happens when people do not want to take responsibility for their actions.’ [Respondent no. 25, Female, 22]

Among Muslims’ common cultural concept of distress is the notion that supernatural powers may be a cause of mental disorders, as was explained by a *sheykh*:

‘Sometimes people are tended to attribute psychological problems to *jinn.*’ [*Sheykh* 2]

As the present study showed, folk beliefs are deeply rooted in the minds of contemporary Jordanians and influence mental health conceptions. Similarly, a study conducted by Lim and colleagues (2018) found that mental health issues were attributed by patients to supernatural powers, including *jinn* (44.7%), magic (21.3%), and the evil eye (12.8%). In folk psychiatry, spiritual disorders and mental disorders caused by supernatural powers are treated by faith healers. Thus, the study data partly explain why traditional healing is widespread among Muslims and is chosen as the first option when searching for a psychological aid for mental health issues.

4.1.2. Religious perception of mental disorders

‘Religion plays an important role in the mental health field. If people believe in God, they do not have mental disorders.’ [Imams 1 and 2]

As religion plays a major role in daily life in the Arab world, the religious perception of mental health is strong. From this perspective, mental disorders are understood in several ways. First, they may be perceived as a test from God:

‘Culturally is believed that illness is sent by God, that is a test from God.’ [Respondent no. 40, male, 60]

As God said in the Qur’an, ‘And We will surely test you with something of fear and hunger and a loss of wealth and lives and fruits ….’ (Qur’an 2:155). God’s will (Arabic: قدر *qader*) is a strong tenet of Islam, which argues that deciding when someone lives and dies is God’s prerogative. While a belief in destiny, in some cases, can lead to fatalism (Shah et al., 2011), scholars (Hasnain et al., 2005) state that this belief can also provoke a positive acceptance of God’s will and optimism with respect to healing. Second, as the current study showed, many Muslims believe that mental disorders can be caused by a lack of faith:

> ‘From the religious point of view, if something happened, that means you are not religious enough.’ [Respondent no. 30, female, 21]

Finally, disorders may also be seen as an opportunity for strengthening the individual’s relationship with God (Institute of Muslim Mental Health, n.d.). These religious perceptions of mental disorders may help explain why many Muslims do not seek psychological aid at all:

> ‘Physical illness is treated by doctors, and when it is mental illness, it is not treated, the person should live with the illness, as in this case only God can give a recovery.’ [Respondent no. 40, male, 60]

4.1.3. Stigma

Stigma has been identified as a main reason for avoiding mental health treatment in conjunction with traditional beliefs about mental disorders, religion, socioeconomic status, and education. A qualitative study in Egypt by Coker (2005) reported that mental disorders are strongly stigmatised and related to social rejection. Even when Muslims have positive attitudes towards treatment of mental disorders, the social stigma remains strong. In Jordan specifically, mental health services are not broadly accepted. All interlocutors (mental health specialists) agreed that psychological counselling in Jordan is problematic and complicated because it is considered ‘shameful’ among Jordanians. Researchers have reported these same attitudes in other Arab countries (Ahmed & Amer, 2012; Aloud & Rathur, 2009; Erickson & Al-Timimi, 2001; Youssef & Deane 2006). I was informed that mental health clinics do not display signs; instead, the doctor explains how to find the clinic to the patients. The stigma was also revealed in several ways in the data, for instance, in the shame of visiting a psychologist:

> ‘Most people are unhappy in their lives, but do not speak about their problems. Usually, they think that nobody can understand them. It is shameful to talk about problems. To visit a psychologist or psychiatrist is also shameful.’ [Mental health specialist 2]

> ‘In Jordan is a problem in the society’s mentality. To visit a mental health specialist is shame. It is a social stigma.’ [Sharia specialist 1]

For this reason, people typically hide the fact that they are visiting mental health specialists. Instead, they will say they are visiting the dentist, doctor, or another provider:

> ‘People hide the fact they are visiting a psychologist.’ [Respondent no. 34, male, 24]

The mental health specialists shared stories that reflect social stigma in Muslim society:

> 'Usually, patients do not tell their names to psychologists. They want to be anonymous.' [Mental health specialist 9]

> 'I had many different cases in my practice. One of my patients secretly attended psychotherapy; even her husband did not know this fact. When my patient's husband was at work, the woman was coming for consultations and always wore a niqab[47] (although she does not normally wear it) that nobody could recognize her.' [Mental health specialist 18]

> 'I had a patient (she was 21 years old student) with depression. After a few counselling sessions, I recommended her to visit a psychiatrist for medication, but she refused. She did not want her mother or her family to know that she was taking medication or even visiting a psychiatrist. She is young and educated, but social stigma and family view have a strong influence on the treatment of mental disorders.' [Mental health specialist 17]

While shame may be caused by several aspects, including the religious perception of mental disorders, another reason for the conditional choice of treatment is being labelled *majnūn*:

> 'If someone visits a mental health specialist – that is like official recognition that he or she is *majnūn*.' [Respondent no. 40, male, 60]

> 'Only crazy people visit a psychologist – that is the opinion of our society.' [Mental health specialist 9]

The social stigma also affects the status of psychiatry among the other medical specialties (Takriti, 2004); according to Dr Fawwaz Ayoub Momani[48], mental health specialists are stigmatised. 'Even medicine students rarely choose psychiatry' [Respondent no. 40, male, 60]. Another influence on the present condition of the mental health field, and one of the possible causes of problems that facing the mental health field, is the lack of mental health specialists, which will be discussed in the next subsection.

[47] Niqab (Arabic: نِقاب *niqāb*) is a garment of clothing that covers the face, while leaving the eyes uncovered, that is worn by some Muslim women.

[48] Dr Fawwaz Ayoub Momani. Public lecture 'Psychology and culture' at Vilnius University, 30 April 2019.

4.1.4. Contemporary situation in the mental health field in the Arab world

Traditional healing is also preferable in Arab countries due to several problems faced by the mental health field in those countries. First, psychiatric facilities and mental health specialists are lacking. Although some progress in mental health services was observed in the Arab world over the last two decades in this respect, these services are still less developed than they are in the West (though certainly this situation varies depending on the country or subregion). Research conducted by Ahmed Okasha and colleagues (2012) found that the highest number of psychiatrists in the Arab world is located in the Gulf countries – Qatar, Bahrain, and Kuwait – while in Iraq, Libya, Morocco, Syria, and Yemen there are only 0.5 psychiatrist per 100,000 inhabitants. In Jordan, there are only 2 psychiatrists, 0.27 psychologists, and 0.04 nurses for every 100,000 inhabitants, and the number of mental health institutions in the country is small as well – only three mental health hospitals for adults, one for children, and 64 outpatient facilities (Karnouk et al., 2019). Although all institutions of education, such as schools and universities, have psychologists, the mental health specialists agreed that the lack of specialists was one of the problems facing the mental health field in the region:

> 'In Jordan no enough qualified mental health specialists.' [Mental health specialist 11]

> 'In Jordan are about 120 psychiatrists for a population of 10 million.' [Mental health specialist 18]

Scholars Rayan and Jaradat (2016) state that trained professionals who can provide psychological help in a culturally appropriate way are needed to enhance attitudes towards seeking professional psychological help, along with culturally sensitive treatment programs (Karnouk et al., 2019).

Poor socioeconomic status and the high cost of psychological counselling in Jordan are another reason why people avoid seeking professional psychological aid. The current study revealed that most people are facing economic problems and self-identify as having a low income. Similarly, a study by Rayan and Jaradat (2016) found that about 45.1% of students are not satisfied with their socioeconomic status. The mental health specialists commented on this financial situation surrounding counselling:

> 'The present situation in the country regarding mental health is complicated. People do not have enough money to take care of their mental health.' [Mental health specialist 9]

‘People do not seek professional psychological help because of their financial situation, as they cannot meet their primary needs.’ [Mental health specialist 12]

‘Therapists pay attention to the social status of their patients. Even consultation prices depend on how much has a person. Those who have less, pay less; those who have more, pay more. In general, psychological services are expensive. Prices vary between 10 to 120 JOD[49].’ [Mental health specialist 1]

The Jordanian inhabitants stated that they could not afford to attend counselling:

‘My friend once visited a psychologist, but the consultation costs 50 JOD – it is very expensive. He was forced to go back to *sheykh* for a treatment due his financial situation. *Sheykh’s* services cost much cheaper.’ [Respondent no. 10, male, 22]

‘People do not have enough money to get professional psychological treatment.’ [Respondent no. 35, male, 22]

‘Psychotherapy is very expensive, and that is the reason why most people choose the Qur’an reading.’ [Respondent no. 30, female, 21]

‘Many young people would like to visit a psychologist, but the main problem is that the services of mental health specialists are very expensive.’ [respondent no. 38, female, 21]

‘Psychotherapy can attend only rich people.’ [Respondent no. 31, female, 21]

‘Mostly financial reason cause that people do not seek professional psychological treatment.’ [respondent no. 34, male, 24]

The present study revealed a complicated situation in counselling similar to what psychologist Kashmala Qasim (2016) identified: family view and financial problems as the main reasons for choosing a treatment method. Indeed, the preference for traditional healing was based on financial reasons, as *sheykh’s* services are cheaper than psychologists or even free. In research by Aloud and Rathur (2009), 21% of participants said they would obtain psychological help from a family member and 19% from a religious leader in the community. Thus, people mostly rely on social support from family members and relatives or friends rather than seeking professional psychological aid.

[49] JOD, the Jordanian dinar, which is the national currency of the Kingdom of Jordan. The dinar became Jordan’s official currency in 1950. 1 Jordanian dinar equals 1.20 Euro (according to the global exchange rate on 3 August 2021)

4.2. Changing attitudes towards mental health among the young generation in Jordan

Although cultural traditions still play a key role in the Arab world and social stigma remains strong, the current research revealed changing attitudes towards mental health among the younger Jordanians. In this generation, which is mostly educated, individuals are becoming more open to the mental health, and mental issues are more understood. A similar situation has been observed in other Arab countries. According to Saudi psychiatrist and cognitive-behavioural therapy consultant Haifa Al-Gahtani, the situation in Saudi Arabia regarding mental health has changed in the past 20 years, and 'the new generation is already very open about seeking treatment, and part of their openness is due to increased awareness' (Bashraheel, 2000).

Indeed, participation in university life allowed me to observe that students in Jordan are interested in psychology. For example, some students took the initiative to organise public lectures on psychology, to which they invited mental health specialists, and these lectures attracted many students. Another example showed that not only the young people have positive attitudes about professional psychological aid. During one of my trips, when I came to the bus station to buy water, the elderly seller asked me what I was doing there. When I told him the purpose of my visit to Jordan, the man gladly came to an interview. To my surprise, he possessed a lot of knowledge about psychology and emphasised the importance of psychological aid given by specialists. Thus, attitudes towards psychotherapy are changing, as influenced by secularisation, education, the relationship between the elder and younger generation, and the relationship between rural and urban residents. Although the participants of the current study mostly comprised young Jordanians, the differences in attitudes between generations towards psychological counselling were disclosed through the parent-child relationship:

> 'My brother has been visiting a psychologist, but our father found out the fact and asked, "are you crazy, or what…?" He forced my brother to visit a *sheykh*. My brother wants to visit a psychologist, but he cannot contradict his father.' [Respondent 32, female, 20]

> 'I have visited a psychologist several times, but when my father found out, he said I was crazy and prohibited me to attend counselling. So, I went back to the *sheykh*. I would like to attend counselling, but unfortunately my family is hostile.' [Respondent no. 13, male, 24]

‘People hesitate to visit mental health specialists, but the situation changes slowly. For our parents, it was shameful to visit a psychologist. But people become more open. Students and young people understand their problems and choosing professional mental health services. One of my friends had a difficult period. She decided to visit a psychologist no matter what others was thinking. “The most important is my health” – this is what she said.’ [Respondent no. 38, female, 21]

The different attitudes towards mental health amongst generations was further revealed in the participants’ comments:

‘One of the cases happened during a counselling. The patient’s mother came and took her daughter from the counselling session and forced her to visit a religious leader for healing. The mother of that young lady did not believe in psychological treatment. So, sometimes it is complicated to treat patients regarding the family interruptions, like in the present case.’ [Mental health specialist 17]

‘The elder generation, especially those who follow the traditions, do not recognize psychological treatment.’ [Respondent no. 15, male, 20]

‘Elderly women are tended to visit a *sheykh*, while youngsters do not prefer to visit religious leaders.’ [Respondent no. 30, female, 21]

‘The current young generation is tended to choose professional psychological treatment. At present time people have more knowledge and information regarding psychological treatment.’ [Mental health specialist 2]

‘I see, people became more open in understanding mental health.’ [Mental health specialist 17]

While traditional healing maintained its position as the primary psychological aid, from the perspective of young and educated Jordanians, psychological counselling is an effective treatment method:

‘Me and my friends are interested in psychology in all cultures. We are creating movies about psychology. In this way we are trying to show for our society that mental disorders are like other illnesses and must be treated. If person has a headache, he or she goes to a doctor, if person facing psychological issues, he or she also should visit a doctor, in this case a mental health specialist.’ [Respondent no. 30, female, 21]

‘On the social media in Jordan, as an example, Facebook, there are psychological support groups for women, where women and

girls can talk about their problems. Women can have an anonymous psychological counselling. Me and my friend, we are a part of these groups.' [Respondent no. 30, female, 21]

'In our country, here are psychological support groups on the social media like in Europe and America. I belong to one of those groups.' [Respondent no. 31, female, 21]

'I am obsessed by the idea to visit a psychologist. I deal with stress at work; I have a lot of questions regarding communication with the opposite gender.' [Respondent no. 13, male, 24]

While attitudes towards psychological counselling are clearly changing among young Jordanians, progress is hampered by the attitudes of the elder generation, by which young people are traditionally required to abide. A comment from a respondent perfectly reflected this situation:

'We cannot express ourselves; we cannot say "no" to our parents; we cannot think differently; we have to obey our parents; we have to be copies of our parents; we cannot express our opinion... Otherwise we are considered different. If you are different, then you are assigned the label of *majnūn*.' [Respondent no. 40, male, 60]

'We have to follow the traditions. I cannot hurt my parents. If I behave in a way that is not accepted in our society, my parents will face society pressure; they will be gossiped by neighbours regarding my misbehaviour. The shame is a part of our tradition that run counter to the norms of the modernising world.' [Respondent no. 13, male, 24]

Thus, the family and its hierarchical structure emerged as another sociocultural aspect of the state of the mental health field. According to B. Jalali (1982), the patriarchal family model of the Arab world is based on the authority of the father as the head of the family. Senior family members are respected for their life experience and wisdom and occupy a high hierarchical position not only in the family but also in the community. However, despite its potential negative influence on seeking psychological help, family is also usually the first institution to support its members in all situations, including those facing mental health issues:

'Family plays an important role in creating a psychological climate. Usually, family members are the first ones the person talks with.' [Mental health specialist 11]

Thus, mental health attitudes in the Arab world are related to the significant role of the family in responding to mental health concerns. Participants indicated that family, as a whole, rather than the individual, is responsible for helping the family member deal with mental disorders.

Although weakening ties within the family have been revealed in several regards, such as increasing divorce rates and changing conceptions of the traditional Arab family[50], the family institution still has a great deal of influence both internally and externally, affecting both its members and the community. During participant observation, for example, I observed the importance of family communication. Every weekend, I was invited to join a Jordanian family at family gatherings or picnics. Every weekend, children with their families gather at their parents' house or go out for picnics – communicating, preparing meals together, or praying. As I was informed, close and distant relatives commonly gather for a meeting at the eldest family member's home in Jordan. Another situation that highlighted the importance of family relationships was the invitation of a professor at the university (after an interview) to have lunch with her student son who studied at the same university. The mother and son had lunch together at the university's café every day.

4.3. Concluding remarks

The second and third parts of this dissertation discussed traditional healing and Western psychotherapy in Islam, while the final part of the dissertation identified whether the two treatment methods can work together. Based on data from previous studies and the empirical study in Jordan, the relationship between traditional treatment and Western psychotherapy was clarified; the qualitative data confirmed that the treatments can work together. Attempts were made to reveal the points of contact and differences between the two treatment methods by identifying the reasons for choosing a specific treatment. This revealed that sociocultural and economic reasons influence the choice of treatment method, and these reasons were discussed in detail based on respondents' comments. Differences in attitudes towards mental health treatment were also evident between generations, and the changing attitude of the younger generation towards psychological counselling was observed. However, the influence of the family and society on the choice of treatment was evident.

Modernisation influences traditional culture; the beliefs and perspectives of the young generation are influenced by Western culture. The

[50] A traditional Arab family consists of several generations living under one roof. This tradition is still alive in Egypt, Saudi Arabia, and other countries, when the bride moves into her husband's house after marriage. In Jordan, meanwhile, the newly formed family lives in their own home apart from their parents. In some Arab countries, the entire extended family lives together as a tribe or clan.

participants suggested that, in a variety of ways, mental disorders are becoming better understood and less taboo in some subgroups of the population. They also suggested that people are becoming more open regarding psychological counselling. Considering the changing attitudes, the situation of mental health and counselling will likely continue changing in the Arab world. These inevitable societal changes and the growing demand for psychological services are opening up a wider range of treatment options.

CONCLUSIONS

The interaction between traditional religious healing and Western psychotherapy in Islam was studied and presented in three sections: analysis of the concept of mental disorders from a historical perspective and in contemporary Muslim society, traditional religious healing from a historical perspective and contemporary Arab world, and Western psychotherapy in Islam. A comparative study allowed the comparison of the two treatment approaches based on fundamentally different cultural traditions. The problem of inculturation of Western psychotherapy was also highlighted and discussed in detail in the assessment of the influence of sociocultural factors on counselling. This comparison of the two treatment methods for mental disorders led to the following conclusions:

1. The origins of mental disorders in Islam are based on many theories, most of which are culturally conditioned. While modern-day Jordanian consciousness reveals knowledge of the terms for Western mental disorders, the concept of mental disorders is closely intertwined with tradition. Thus, cultural traditions, formed exclusively in the Arab world play an important role in the perception of psychopathology. Additionally, Foucault's theory of social constructivism was affirmed in the study, in which insanity in contemporary Muslim society emerges as a social construct and disregard for social norms, while otherness is defined by the term *majnūn*. This term includes disorders as a disease and adds a label of madness. Thus, for the most part, the concepts of cultural and medical mental disorders emerge in the Muslim consciousness as a single unit.

2. Many proponents of secularisation theory argue that religion must inevitably disappear and, as Berger (1969) states, that secularisation and rationalisation separated believers from God. However, in the context of the modernising Arab world, religion undoubtedly remains a cornerstone not only in everyday life but also in shaping the concept of mental health in Islam. Traditional religious healing is based on religious tradition; at the same time, religion is integrated into psychotherapy as a factor that positively impacts treating. However, the religion-shaped concept of mental disorders and the community's approach to mental disorders determine the predominance of traditional religious healing in the Arab world. Meanwhile, imams and *sheykhs* play important roles in shaping the psychological climate of communities and, in fact, play the role of psychotherapists in communities. Thus, religion and religious leaders are an integral part of Islamic psychology in both traditional and medical treatment of mental disorders.

3. Traditional religious healing, representative of folk medicine and based on cultural beliefs, not only operates in parallel with medical treatment, but also is the first choice for treating mental disorders. Thus, many mental disorders do not reach specialists because they are treated by traditional healers. The hegemony of traditional religious healing is driven by beliefs about the provision of the psyche, the stigma attached to mental disorders as understood by the community, and the underdeveloped mental health system in the Arab world. The main problem with treatment is highlighted in the case of Jordan; in the contemporary Arab world, the treatment has transformed into a business, and *sheykhs* have become entrepreneurs applying obscure methods of treatment that often contradict religious norms. However, traditional religious healing, provided by qualified professionals, is considered beneficial because it aligns with patients' cultural values and beliefs, and in some cases, is used in conjunction with psychotherapy. Moreover, traditional religious treatment involving recitation of the Qur'an may be effective for representatives of other religions as well. As the present study found, in the case of Jordan, traditional Islamic religious healing is also used by Arab Christians. Modernisation, meanwhile, clearly influences traditional culture, particularly under the influence of modern technology. The case of Jordan revealed that *sheykhs* are utilising social media platforms to attract the attention of the younger generation, which is already partly influenced by Western traditions.

4. Mental health, like its treatment, is severely stigmatised in the Arab world. However, the changing attitude of the young Jordanian generation towards counselling was observed. Psychotherapy is considered a treatment method not only for mental disorders but also as a means to prevent stress, anxiety, and other psychological conditions caused by modernisation. This modernisation places the younger generation at the crossroads of cultures, between the traditions followed by their parents and the rapid invasion of Western culture. Furthermore, traditional culture is affected by modernisation, which weakens some sociocultural aspects, thereby impacting approaches to psychopathology and psychological counselling. In the context of secularisation, the weakening of traditional families and, in some cases of religion, affected the psychosocial development of the region. As a result, a favourable environment for the development of psychotherapy has been formed. Moreover, the need for psychological counselling in Jordan is growing. Although Giddens (2000) states that psychotherapy is not needed in traditional cultures, Western psychotherapy is needed due to extra stressors added by modernity. Nevertheless, problems in the field of mental health due to sociocultural factors are emerging. Stigma affects the entire field of mental

health, including the profession, which results in additional problems (i.e., the lack of mental health professionals and high prices for services).

5. International standards are applied in the field of mental health in the Arab world, but Western psychotherapy cannot fully unfold in the context of different cultures. Furthermore, the full development of Islamic psychotherapy lacks a theoretical basis that fits the Arab sociocultural framework. Meanwhile, the problem of inculturation is reflected in several respects; not all approaches of therapy correspond to Islamic traditions, and not all types of therapy can be successfully enculturated. Additionally, Islamic psychology has emerged in the cultural context as a separate branch of counselling, where Muslim psychologists focus on religious counselling in their work practice. As psychotherapy assumes the casing of religion, it performs resacralisation and is subordinate to sacral therapy.

6. A comparison of Western and Islamic psychotherapy revealed not only their differences but also points of contact. The differences manifested themselves through sociocultural factors, such as Islamic communality versus Western individuality, where independence is transformed into interdependence, where the power distance manifests itself through the family hierarchy. Culturally determined differences and similarities in the therapist–patient relationship and in the therapy process also emerged. The interaction between traditional religious healing and Western psychotherapy leads to the conclusion that combined Western and Islamic approaches complement each other and can work together.

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APPENDICES

Appendix A

‘Questions for Jordanian inhabitants’

1. What are individuals with mental disorders called?
2. How mental disorders and/or psychological distress are understood in your family/culture?
    - 2.1. What do you understand ‘mental disorder’ to mean?
    - 2.2. How do you know someone has a mental disorder?
    - 2.3. What does mental illness look like? What are the symptoms of mental disorders?
    - 2.4. What are the causes of mental disorders?
3. When someone has a mental disorder, what happens to that person?
    - 3.1. What happens within the family?
4. What is society’s attitude towards people with mental disorders?
5. When someone is mentally ill or psychologically distressed, who is responsible for helping a person find relief?
6. How are psychological distress or mental disorders treated in your culture?
7. Where people most often seek psychological aid? (i.e., religious leader, family, friends, mental health specialist)
8. What kind of treatment methods for mental disorders do you know?
9. Do people in your culture believe in *jinn* possession?
10. How to distinguish the symptoms between mental disorders and, for example, *jinn* possession?

Appendix B

‘Questions for mental health specialists’

1. What are the most common reasons why people seek help from psychologists/psychotherapists?
   1.1. What are the most common mental disorders among your patients?
   1.2. What are the most common mental disorders in Jordan?
2. What age and social class are your patients?
3. Where people most often seek psychological help?
   3.1. What are the most common treatment methods people choosing before visit a psychologist/psychotherapist?
   3.2. Do people prefer the services of traditional healers?
   3.3. Do people visit imams for advices?
   3.4. Which method of treating mental disorders is more popular in Arab countries: counselling or medication?
4. Are there patients who are constantly attend psychotherapy?
5. Which psychotherapeutic methods are most commonly used with Muslim patients?
6. How the International Classification of Mental Disorders is used to identify disorders in a cultural context?
7. How to distinguish symptoms between mental disorders and, for example, *jinn* possession?
8. What sociocultural factors do you think influence counselling?
   8.1. Is religion important in counselling?
   8.2. Do you apply religious aspects in counselling?
9. What is your opinion, can traditional healing and psychological counselling work together?
10. Can traditional treatment be effective?

Appendix C

‘Questions for *sheykh’*

1. What are the most common reasons why people visit you?
2. What age and social class are your patients?
3. Who seek help more often, men or women?
4. How do you know that a person needs help from a *sheykh* or mental health specialist?
5. What healing methods you use in your practice?
6. How do you know that a person is possessed by *jinn*?
7. What are the symptoms of *jinn* possession?
8. What are the causes of *jinn* possession?
9. How do you distinguish symptoms between mental disorders and, for example, *jinn* possession?
10. How much do *sheykh* services cost?

Appendix D

‘Questions for imams (religious leaders)’

1. Do people come to you for advice?
2. What are the most common reasons why people seek help? (i.e., family problems, problems at work, advice about religion, or other)
3. What age and social class of people most often visit you?
4. Who seeks help more often, men or women?
5. Do people come to you when they feel sad or anxious?
6. Have you had cases where you see that a person needs psychological aid? What do you do in this case?
7. What is your opinion, can traditional healing be effective for individuals with mental disorders? Or the help of mental health professionals is needed?
8. What are the most common causes of mental disorders?
9. What is your opinion, can lack of religion be a cause of mental disorders?
10. How do you distinguish symptoms between mental disorders and, for example, *jinn* possession?

Appendix E

'Free listing questionnaire'

Dear Respondent,

I am a PhD student at Vilnius University, Institute of Asian and Transcultural Studies. The aim of this study is to understand mental disorders and origin of mental disorders in Islamic culture. It should take five minutes to answer the questions.
Your responses will remain confidential and anonymity is guaranteed. The survey data will not identify any individual person.

Thank you for your time and taking part in the research.

Please answer the following questions:

1. Gender (circle one):
   - Female
   - Male

2. Age _____

3. Education (circle one)
   - Secondary
   - Higher
   - High
   - University

4. What kind of area do you live? (circle one)
   - Rural
   - Small town
   - Suburban
   - Urban

Other _____

5. The aim of this study is to understand mental disorders in Islamic culture. Please provide a list of mental disorders as many as you know. There are no correct or incorrect answers, we are just interested in your opinion.

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If you have any comments please write.

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Thank you for your participation!

6. The aim of this study is to learn the origins and causes of mental disorders. Please provide a list of possible causes of mental disorders you know. There are no correct or incorrect answers, we are just interested in your opinion.

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If you have any comments please write.

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Thank you for your participation!

7. The aim of this study is to learn how people in Islamic culture determine mental disorders. Please provide a list of things that helps you to determine that a person has mental disorders, e. g. symptoms, behaviour etc. There are no correct or incorrect answers, we are just interested in your opinion.

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If you have any comments please write.

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Thank you for your participation!

Appendix 1

Table A1. *Associations between mental disorders and causes (φ)*

1st question \ 2nd question	Family problems	Lack of religion	Economic situation	Emotional trauma	Society pressure	Heredity	Problems at work	Lifestyle	Problems in studies	Stress	Jinn	Brain damage	Magic
Depression	**0.431****	0.100	0.196	-0.010	-0.170	0.004	0.290	0.120	0.248	0.248	**-0.444****	0.059	0.059
Anxiety	**0.373***	-0.066	**0.390***	-0.091	-0.044	0.235	**0.355***	0.050	-0.020	-0.152	-0.239	0.183	0.183
Schizophrenia	0.232	-0.023	0.227	-0.057	**-0.342***	0.142	0.263	0.202	-0.263	0.136	**-0.361***	0.205	0.064
Stress	0.310	**0.320***	0.245	0.012	-0.071	-0.091	**-0.353***	0.082	0.273	0.129	-0.122	0.031	0.031
Obsessive compulsive disorder	0.037	-0.190	0.183	-0.069	-0.159	**0.339***	0.204	0.252	0.158	-0.136	-0.259	0.212	0.055
Mental disorders	-0.300	0.021	-0.073	0.010	-0.091	0.140	-0.290	0.180	0.067	-0.091	0.109	-0.059	0.109
Social phobia	-0.031	0.064	0.086	0.157	-0.122	0.277	-0.059	0.140	-0.193	-0.009	0.216	**0.412****	0.020
Bipolar disorder	**-0.412****	-0.019	-0.154	0.061	-0.082	0.158	-0.204	0.000	-0.174	0.025	0.265	-0.159	0.265

Crazy	-0.145	-0.287	0.068	0.302	**0.509****	0.020	0.020	-0.167	-0.154	0.066	**0.327***	-0.140	-0.140
Sadness	0.218	0.219	0.238	-0.053	-0.036	0.020	-0.180	-.0167	0.285	-0.154	0.093	0.093	**0.327***
Abnormal behaviour	-0.145	0.051	0.068	-0.053	0.145	-0.180	-0.180	-0.167	-0.154	-0.154	0.093	-0.140	0.093

* Medium strength of association between the two variables.

** Large strength of association between the two variables.

Table A2. *Associations between mental disorders and determination of mental disorders (φ)*

3rd question / 1st question	Abnormal behaviour	Asocial	Sadness	Lack of religion	Aggression	Anxiety	Abnormal communication	Cultural traditions	Talking to oneself	Fear	Body language
Depression	**0.380***	-0.039	0.147	**-0.382***	0.091	0.248	-0.225	**-0.339***	-0.220	0.180	-0.220
Anxiety	**0.406****	-0.044	**0.355***	-0.284	-0.020	0.112	-0.284	-0.038	-0.134	0.201	-0.302
Schizophrenia	0.029	-0.011	0.263	-0.130	0.003	0.270	-0.263	-0.172	-0.118	**0.388***	0.051
Stress	0.000	0.286	-0.091	-0.014	0.273	0.273	-0.014	-0.247	-0.036	-0.218	-0.036
Obsessive compulsive disorder	0.226	-0.159	**0.339***	-0.284	0.011	0.306	-0.136	-0.233	-0.019	**0.355***	-0.205
Mental disorders	0.035	-0.222	-0.147	0.225	-0.091	-0.248	0.225	0.158	0.220	0.020	0.220
Social phobia	-0.081	-0.275	0.109	-0.193	0.175	0.175	-0.009	-0.159	0.093	**0.327***	0.093
Bipolar disorder	0.218	-0.247	0.158	-0.174	-0.174	0.025	0.025	0.086	-0.126	-0.126	0.126
Crazy	0.000	0.145	-0.180	0.285	-0.154	-0.154	0.066	0.126	-0.111	-0.111	-0.111
Sadness	-0.192	-0.218	-0.180	0.066	-0.154	-0.154	-0.154	0.126	-0.111	-0.111	-0.111
Abnormal behaviour	-0.192	-0.036	-0.180	0.285	0.066	0.066	0.285	**0.378***	-0.111	-0.111	0.167

* Medium strength of association between the two variables.

** Large strength of association between the two variables.

Table A3. *Associations between causes of mental disorders and determination of mental disorders (φ)*

3rd question / 2nd question	Abnormal behaviour	Asocial	Sadness	Lack of religion	Aggression	Anxiety	Abnormal communication	Cultural traditions	Talking to oneself	Fear	Body language
Family problems	0.000	0.071	0.091	0.014	-0.129	-0.129	**-0.416****	-0.082	-0.145	0.036	-0.145
Lack of religion	0.029	-0.011	0.021	-0.130	-0.130	0.136	0.003	-0.172	0.051	-0.118	0.051
Economic situation	0.236	-0.089	0.171	-0.107	-0.242	0.027	-0.107	0.154	-0.272	0.238	-0.102
Emotional trauma	0.031	0.012	-0.246	-0.039	**0.383***	0.102	0.102	-0.101	-0.053	0.125	-0.053
Social pressure	0.000	0.167	-0.091	0.129	0.273	-0.014	0.129	0.247	-0.036	-0.036	-0.036
Heredity	0.035	-0.091	0.283	-0.091	0.067	0.067	-0.091	-0.204	-0.180	0.220	-0.180
Problems at work	**0.311***	-0.091	0.140	-0.091	-0.091	-0.091	-0.091	-0.023	0.020	0.220	-0.180
Lifestyle	0.144	-0.191	0.030	-0.066	-0.066	0.099	0.263	-0.189	0.042	0.250	-0.167
Problems in studies	0.266	-0.158	-0.091	-0.039	-0.039	-0.212	-0.039	-0.174	0.066	-0.154	-0.154

Stress	-0.038	-0.014	0.067	-0.212	-0.212	-0.212	-0.212	0.025	-0.154	-0.154	0.285
Jinn	-0.081	-0.122	0.109	-0.009	-0.193	-0.193	-0.009	0.053	0.093	-0.140	-0.140
Brain damage	0.081	-0.122	0.277	-0.193	-0.009	0.175	-0.009	-0.159	-0.140	**0.327***	-0.140
Magic	0.081	-0.275	0.277	-0.009	-0.193	-0.009	-0.193	0.053	0.093	0.093	-0.140

* Medium strength of association between the two variables.

** Large strength of association between the two variables.

SANTRAUKA

Įvadas

Disertacijos objektas yra kultūrinė sąveika tarp tradicinės religinės islamo gydymo praktikos ir vakarietiškos psichoterapijos. Religija yra vienas svarbiausių psichosocialinių veiksnių žmonių gyvenime, ypač musulmonų bendruomenėse. Taigi, atsižvelgiant į sparčią tarpkultūrinę sąveiką ir migraciją, yra svarbu suprasti, kokią įtaką kultūra daro psichikos sutrikimų suvokimui, prevencijai, diagnostikai ir gydymui. Daugeliu atžvilgių skirtingos kultūros formuoja savitą gyvenimo būdą, o žmonės yra skirtingi savo psichologija (Heine, 2008). Kultūra, taip pat, daro įtaką psichopatologijos supratimui bei formulavimui (Bhugra ir Bhui, 2007). Vienas iš kultūros psichologijos pradininkų Richardas Shwederis (1991) teigia, kad psichika ir kultūra yra sukonstruotos ir neatskiriamos. Susiformavusios kultūrinės schemos ir modeliai vaidina svarbų vaidmenį psichopatologijos suvokime, o ryšys tarp kultūros ir psichopatologijos yra daugialypis (Bhugra ir Bhui, 2007, p. 95). Dažnai kultūriniai įsitikinimai lemia sutrikimų priežastingumo suvokimą, elgesį ligos metu ir gydymo metodo pasirinkimą (Azhar ir Varma, 2000). Gydymo metodai, panašūs į šiuolaikinę psichoterapiją, buvo plačiai taikomi psichikos sutrikimams gydyti daugelį šimtmečių, kol XX a. išpopuliarėjo Vakaruose. Manoma, kad psichologinio konsultavimo metodų šaknys glūdi senovės etikos teorijoje (Harris, 2013). Istoriniai šaltiniai teigia, kad pirmojoje pasaulyje psichiatrijos klinikoje Irake (įkurtoje 705 metais), psichikos sutrikimai buvo gydomi metodais, panašiais į psichoterapiją ir medikamentinį gydymą (Sabry ir Vohra, 2013). Žvelgiant iš religinės perspektyvos, manoma, kad dvasiniai sutrikimai gali turėti įtakos psichikos sutrikimams; o Vakarų medicina pripažįsta, kad tikrosios daugelio psichikos sutrikimų priežastys yra nežinomos.

Taigi, **tyrimo tikslas** yra išanalizuoti Vakarų psichoterapijos paplitimą, adaptaciją ir inkultūraciją arabų šalyse, atliekant empirinį-antropologinį ir tekstologinį-istorinį tyrimą.

Tikslui pasiekti keliami šie **uždaviniai**:

1. Išsiaiškinti psichikos sutrikimų supratimą islame.
2. Identifikuoti religijos (religinių lyderių, teologų ir bendruomenių) įtaką psichikos sveikatai bei gydymui.

3. Apžvelgti tradicinės religinės gydymo praktikos ir terapijos raidą islame.

4. Išanalizuoti musulmonų požiūrį į psichoterapiją Jordanijoje.

5. Atskleisti vakarietiškos psichoterapijos inkultūracijos islamo kultūroje problemas.

6. Išryškinti pagrindinius skirtumus tarp gydymo metodų islamo kultūroje ir vakarietiškoje psichoterapijoje bei jų sąlyčio taškus.

Tyrimo tezė: Nors Antonis Giddensas (2000) teigia, kad tradicinėse kultūrose psichoterapija yra nereikalinga, tačiau sekuliarėjančio pasaulio kontekste, matomas augantis susidomėjimas psichoterapija. Tradicinėse kultūrose sąveikauja du psichikos sutrikimų gydymo būdai – tradicinis religinis ir vakarietiška psichoterapija. Taigi, psichoterapija ir tradiciniai religiniai gydymo metodai, nepaisant skirtingų pasaulėžiūrinių struktūrų, socialinių normų ir ideologinių kontekstų, kultūriškai korektiškai ir jautriai taikomi kartu gali papildyti vienas kitą.

Tyrimo aktualumas ir naujumas

Pasaulyje sparčiai augant musulmonų skaičiui, didėjant migracijos mastams, vykstant sudėtingiems musulmonų integracijos/akultūracijos procesams Europoje, susiduriama su tarpkultūrine psichikos sveikatos priežiūros paslaugų teikimo problematika: kas geriausiai atitiktų musulmonų poreikius ir kaip priderinti psichoterapijos paslaugas prie religinių šios tradicijos sekėjų nuostatų, pasaulėžiūrinių principų ir vyraujančių socialinio elgesio normų. Psichologinės paslaugos arabų šalyse atsižvelgiant į medicininius Vakarų standartus vis dar yra ribotai paklausios ir teikiamos, o psichologinės sveikatos problemos dažniausiai yra stigmatizuojamos.

Nors akademinėje literatūroje yra nemažai darbų nagrinėjančių psichikos sutrikimų sampratą islame, tačiau tyrimų atliktų Jordanijoje nėra daug. Nemažai literatūros sutinkama apie tradicinį religinį gydymą, liaudies gydytojus, psichikos sutrikimų gydymą ir psichoterapiją islamo kultūroje. Atliktas tyrimas apima platų spektrą psichikos sveikatos temų arabų šalyse, įskaitant ir psichikos sutrikimų sampratas (tradicinį ir šiuolaikinės visuomenės supratimą) bei įvairius gydymo metodus (tradicinius ir šiuolaikinius). Šiuo tyrimu bandoma išsiaiškinti, kaip gerai pažįstame “kitus” ir “kitoniškumą”; kiek “kitoniškumas” yra atviras Vakarų kultūrai ir kaip priima bei įsileidžia Vakarų kultūrą; kaip ir kiek modernizacija veikia tradicinę kultūrą bei liaudies tikėjimus; kaip keičiasi tradicinė kultūra bei visuomenės mąstymas veikiami

modernizacijos ir sekuliarizacijos; kaip normalumo ir nenormalumo sąvokos atsiskleidžia skirtingų kultūrų visuomenių sąmonėje.

Lietuvoje nėra mokslinių tyrimų, analizuojančių tradicinį religinį gydymą ir vakarietiškos psichoterapijos kultūrinę adaptaciją arabų šalyse. Tačiau pastaraisiais metais, šaliai susidūrus su migracijos krize bei sparčiai didėjančiu musulmonų migrantų skaičiumi, tyrimas tapo reikšmingas Lietuvos kontekste. Psichikos sveikatos specialistai susiduria su kultūriniais skirtumais. Pasak Respublikinės Vilniaus psichiatrijos ligoninės vadovo profesoriaus Arūno Germanavičiaus, „pirmųjų migrantų priėmimas buvo iššūkis – daugelis jų nekalba angliškai ir yra kitokio mentaliteto, todėl kalbėtis apie psichologines problemas buvo beveik neįmanoma“ (Morozovas, 2022).

Atsižvelgiant į sparčiai augančius migracijos procesus ir civilizacinius-ideologinius konfliktus, tokių tyrimų poreikis auga. Be to, nepaisant temos aktualumo, tyrimų trūksta ir tarptautiniame akademiniame lauke. Dažniausiai, tai nėra medicinos klausimas, o veikiau, kalbama apie kultūrų ir religijų sąveiką, kultūros psichologiją ir sociokultūrinę antropologiją. Tai reiškia, kad norint tinkamai analizuoti ir spręsti šią problemą, reikia religijos ir kultūros žinių, arabų kalbos mokėjimo, islamo istorijos išmanymo ir gebėjimo kritiškai vertinti šiuolaikinės vakarietiškos psichoterapijos inkultūraciją.

Vakarų šalyse auga susidomėjimas islamo kultūra, religija ir sveikatos samprata, todėl tokio pobūdžio tyrimai yra aktualūs ir taikomąja prasme. Pastaraisiais metais, tarptautiniame psichoterapijos lauke, vis daugiau dėmesio skiriama islamo kultūrai, todėl kyla klausimas, kiek veiksminga vakarietiška psichoterapija islamo religijos kontekste. Šis tyrimas gali būti naudingas įvairių sričių specialistams, pavyzdžiui, kultūrologams, religijų tyrinėtojams, psichikos sveikatos specialistams, orientalistams, kultūriniams mediatoriams, migracijos ir socialinių tarnybų darbuotojams.

Literatūros ir anksčiau atliktų tyrimų apžvalga

Tema analizuojama per kultūros psichologijos perspektyvą, kurią R. Shwederis (1991) apibrėžia per tai, kaip kultūros tradicijos ir socialinės praktikos reguliuoja, išreiškia bei transformuoja žmogaus psichiką. Taigi, analizuojant kultūrinių veiksnių svarbą psichikos sveikatos lauke, disertacijoje remiamasi reikšmingiausiais kultūros psichologų darbais: Shinobu Kitayamos ir Dovo Coheno *Handbook of Cultural Psychology* (2010), Steveno J. Heines *Cultural Psychology* (2008), Richardo Shwederio *Thinking Through Cultures: Expeditions in Cultural Psychology* (1991),

Davido Matsumoto *The Handbook of Culture and Psychology* (2001), Dimesho Bhugros ir Kamaldeepo Bhui *Cultural Psychiatry* (2007).

Darbe remiamasi socialinio konstruktyvizmo teorija, kuri psichikos sutrikimus traktuoja kaip socialiai sukonstruotus ir teigia, kad psichikos sutrikimų sampratas formuoja socialinė aplinka. Todėl Michelio Foucaulto veikalas *Madness and Insanity: A History of Madness in the Classical Age* (2009), buvo ypač naudingas bandant suprasti, kaip socialinės normos ir elgesys formuoja beprotybės sampratą islamo kultūroje. Neabejotinai naudingi buvo ir kitų mokslininkų, plėtojusių antipsichiatrinį požiūrį, darbai: Ronaldo Davido Laingo veikalas *The Divided Self: An Existential Study in Sanity and Madness* (1965) ir Thomo Stepheno Szaszo knyga *Myth of Mental Illness* (1961).

Disertacijoje daugiausia dėmesio yra skiriama dviems gydymo tradicijoms – tradiciniam religiniam gydymui ir Vakarų psichoterapijai, kurios išsamiai analizuojamos Tarptautinės arabų psichologijos asociacijos generalinio sekretoriaus Ihsano Al-Issos darbe *Al-Junūn: Mental Illness in the Islamic World* (2000). Šiame veikale apibrėžiamas ne tik religijos ir psichopatologijos santykis bei psichoterapijos raida arabų šalyse, bet ir dabartinis psichoterapijos vaidmuo musulmonų visuomenėje. Tuo tarpu, liaudies gydymo metodus arabų šalyse apžvelgia daugelis mokslininkų: Michaelis W. Dolsas (1992), Muhammadas Salimas Khanas (1986), Fulleris E. Torreyus (1986), Zainas M. Azharas ir S. L. Varma (2000), Boazas Shoshanas (2003). Senuosius klasikinės arabų kalbos tekstus apie psichikos sveikatą tyrinėjo ir apibendrino Rania Awaad su kolegomis (2015).

Disertacijoje yra apžvelgiamos psichoterapijos adaptavimo galimybės musulmonams pacientams ir religijos vaidmuo konsultavime. Šiuos klausimus analizuoja žymus islamo psichologas, Malikas B. Badris, kurio darbai *The Dilemma of Muslim Psychologists* (1997), *Contemplation: An Islamic Psychospiritual Study* (2016) ir *Cultural and Islamic Adaptation of Psychology: A Book of Collected Papers* (2016) buvo reikšmingi šiai disertacijai.

Religijos integracija į psichoterapiją yra apžvelgiama psichologės Hananos Dover, dirbančios tiek su musulmonais, tiek ir su vakariečiais pacientais, darbe *Islamic Faith-Based Counselling* (2007), Scotto P. Richardso ir Alleno Bergino knygoje *A Spiritual Strategy for Counseling and Psychotherapy* (1997). Psichoterapijos adaptaciją, dirbant su musulmonais pacientais, gvildena psichologijos profesoriaus Marwano A. Dwairy darbas *Counseling and Psychotherapy with Arabs and Muslims: A Culturally Sensitive Approach* (2006), o taip pat Aysha Utz, *Psychology from the Islamic Perspective* (2011), Husseinas G. Rassoolas, *Islamic Counselling: An*

Introduction to Theory and Practice (2016), Sameera Ahmed and Mona M. Amer (2012) ir Carrie Yorkas Al-Karamas (2018). Disertacijai, taip pat, buvo naudingi darbai analizuojantys religijos, kultūros ir socialinių veiksnių sąveiką psichikos sveikatos lauke, tyrinėti Saxby Pridmores ir Mohamedo Iqbalo Pashos (2004), Debros Stein (2000), Tariqo A. Al Habeebo (2003), Amber Haque (1994, 2004), Majedo A. Ashy (1999), Walaa M. Sabry ir Adarsho Vohros (2013), Osmano M. Ali, Gleno Milsteino ir Peterio M. Marzuko (2005), Khalido Shaho ir Erino McGuinesso (2011), Alieno Al-Krenawio ir Johno R. Grahamo (2000, 2005), Zario Hedayat-Dibos (2000).

Mokslininkai visame pasaulyje aktyviai tyrinėja psichikos sveikatą ir jos gydymo būdus. Ethanas Wattersas savo darbe *Crazy Like Us* (2010) analizuoja Amerikos kultūros įtaką psichikos sutrikimų ir somatinių simptomų sampratai. O taip pat aprašo psichikos sutrikimus ir jų požymių pasireiškimą skirtingose kultūrose, pavyzdžiui, anoreksijos Honkonge, potrauminio streso sindromo Šri Lankoje, šizofrenijos Zanzibare ir depresijos Japonijoje.

Medicinos antropologijos tyrimus apie liaudies ir šiuolaikinės medicinos sąveiką psichikos sveikatos lauke atliko antropologas, Mikas Poltorakas, pietiniame Ramiojo vandenyno Tongos salyne (2007, 2013, 2017). Šis tyrimas atskleidė, kaip bendradarbiauja liaudies gydymo tradicija ir psichiatrija per tai, kaip liaudies gydytojas, ir psichiatras gydo dvasinius negalavimus bei psichikos sutrikimus.

Panašūs tyrimai, kuriuose aptariamas psichiatrų, liaudies gydytojų bei šventikų vaidmuo visuomenėje, buvo atlikti Fullerio E. Torrey, ir publikuoti knygoje *Witchdoctors and Psychiatrists: The Common Roots of Psychotherapy and its Future* (1986).

Disertacijoje taip pat remiamasi pirminiais šaltiniais, tokiais kaip Koranas, Tafsiras, ir Imamo al-Ghazalio knyga *The Revival of the Religious Sciences* (Arab.: إحياء علوم الدين *iḥyā' 'ulūm al-dīn*).

Tyrimo tikslui ir uždaviniams įgyvendinti daug naudingų teorinių ir empirinių duomenų buvo rasta moksliniuose straipsniuose, publikuotuose tokiuose žurnaluose kaip: *Psychology Today; The Journal of Muslim Mental Health; The Arab Journal of Psychiatry; The International Journal of Middle East Studies; Psychology of Religion and Spirituality; Cultural Diversity and Ethnic Minority Psychology; Medical Anthropology Quarterly; The American Journal of Islamic Social Sciences; The Journal of Religion and Health; Transcultural Psychiatry; Research in Psychology and Behavioral Sciences; World Psychiatry; Social Science and Medicine; The Journal of Health and Social Behaviour; The Journal of Nervous and Mental Disease; The Journal of Psychology;* ir daugelyje kitų.

Teorinės prieigos ir metodologija

Analizuojant tradicinio religinio gydymo ir vakarietiškos psichoterapijos sąveiką, buvo naudota įvairi tarpdisciplininė metodologija ir kelios teorinės prieigos. Tyrime remiamasi **kultūros psichologijos** teorija teigiančia, kad kultūra daro įtaką psichikos sutrikimams (Heine, 2008); taip pat kultūros psichologijoje ir etnopsichiatrijoje naudojama kultūrinio reliatyvizmo koncepcija, teigiančia, kad asmens įsitikinimai, vertybės ir praktika turėtų būti suprantami atsižvelgiant į jo paties kultūrą, o ne vertinami pagal kitos kultūros kriterijus. Kultūra yra traktuojama kaip atskiras socialinės patirties ir religinių vertybių pasaulis, kuris remiasi tik savo koncepcijomis, nes pasaulyje egzistuojančių kultūrų įvairovė bei unikalumas negali būti įtraukti į vieningą, ir universalią žmogaus raidos schemą (Heine, 2008; Kitayama ir Cohen, 2010; Matsumoto, 2001; Shweder, 1991). **Medicinos antropologija**, kartu su kultūrine psichologija, šiame tyrime yra viena iš pagrindinių teorinių prieigų, nagrinėjanti, kaip sveikata, gerovė bei liga yra socialiai ir kultūriškai suformuotos, bei kokią įtaką kultūra daro ligos sampratai ir gydymo tradicijoms. Taigi, remiamasi medicinos antropologijos ir tarpkultūrinės psichiatrijos profesoriaus Arthuro Kleinmano (1985) tyrimais, aiškinančiais kultūrinių sindromų sampratą bei kaip psichikos sutrikimai reiškiasi per psichosomatinius simptomus. Taip pat yra remiamasi medicinos antropologo Byrono J. Goodo darbais, tyrinėjančiais kultūrinę psichikos sutrikimų reikšmę bei jų gydymą ne vakarietiškoje tradicijoje.

Šiame tyrime analizuojami liaudies medicinos bei liaudies gydytojų klausimai, todėl darbe yra naudojama liaudies medicinos sąvoka, kurią plėtoja medicinos antropologas Samuelis Lézé (2014). Sąvoka apibrėžia magines praktikas, liaudies mediciną, religiją bei siekia ištirti liaudies gydytojų ir jų gydymo praktikų vaidmenį, bei reikšmę. Ši koncepcija apima kultūros sąlygotus sindromus, kurie nėra apibrėžti medicinos. Be to, analizuoja medicinos sistemas, kaip specifinį kiekvienos etninės grupės darinį, sąlygotą kultūros ir kelia klausimą kas yra normalu, o kas yra nenormalu skirtinguose kultūriniuose kontekstuose.

Dalis disertacijos yra skirta apžvelgti gydymo praktikas arabų šalyse, remiantis **religijos sociologijos** teorija, kuri nagrinėja religijos ir globalizacijos santykį. Socialinis antropologas Ernestas Gellneris (1992) analizuoja Vakarų ir islamo kultūros santykį, o viena iš pagrindinių idėjų yra „grįžimas prie tikėjimo“. Sociologai Peteris Bergeris (1969, 1977, 1999) ir Anthonis Giddensas (2000) taip pat aptaria modernizacijos ir sekuliarizacijos įtaką tradicinei kultūrai ir religijai.

Pagrindinės šio tyrimo priemonės, tai **kritinė-hermeneutinė mokslinės literatūros analizė** ir **antropologinis-empirinis tyrimas**. Tyrimo metodai buvo pasirinkti remiantis Morrowo (2007) idėjomis, teigiančiomis, kad kokybiniai tyrimo metodai puikiai tinka psichologijos tyrimams ir kultūriškai svarbių teorijų kūrimui. Šiame tyrime, kokybiniai metodai yra taikomi, siekiant pateikti išsamų ir giluminį konkretaus reiškinio vaizdą (Morrow, 2007). Naudota Pattono (1999) trianguliacijos koncepcija, apimanti kelių kokybinių tyrimų metodų naudojimą, siekiant visapusiškai suprasti reiškinius. Taigi, tyrime naudoti laisvojo sąrašo metodas, pusiau struktūruoti interviu ir dalyvaujamasis stebėjimas. Taip pat, buvo taikytas lyginamasis tyrimo metodas, lyginant dvi specifines gydymo koncepcijas bei skirtingas metodikas – šiuolaikinę vakarietišką ir tradicinę religinę. Buvo naudota teorijų trianguliacija, kuomet įvairūs teoriniai požiūriai pateikiami vienas šalia kito, taip siekiant įvertinti jų naudingumą ir galią (Denzin, 1978, p. 297). Tai leido išanalizuoti duomenis atsižvelgiant į kelias perspektyvas ir hipotezes.

Disertacijos struktūra

Disertaciją sudaro įvadas ir keturi skyriai. Įvade pristatomas disertacijos objektas, tikslas, uždaviniai, tyrimo aktualumas bei naujumas, anksčiau atliktų tyrimų apžvalga, teorinės prieigos ir metodologija, naudotos literatūros apžvalga. Pirmoji disertacijos dalis skirta išanalizuoti psichikos sutrikimų sampratą islamo kultūroje. Remiantis skirtingomis teorijomis, analizuojamas beprotybės konstravimas, siekiant atskirti beprotybę kaip socialinį konstruktą nuo psichikos sutrikimų kaip ligos. Empirinių duomenų, surinktų Jordanijoje, pagalba atskleidžiama psichikos sutrikimų samprata arabų šalyse. Antroje disertacijos dalyje, remiantis literatūros analize, apžvelgiamas tradicinis religinis gydymas arabų šalyse praeityje ir dabar, pristatomi gydymo metodai taikyti islamo aukso amžiuje. Kokybiniais tyrimų metodais surinkti empiriniai duomenys, leido išsiaiškinti tradicinio religinio gydymo bei religinių lyderių vaidmenį šiuolaikinėje musulmonų visuomenėje. Trečioje disertacijos dalyje pristatoma Vakarų psichoterapija arabų šalyse, aptariamas psichoterapijos poreikio klausimas bei kultūrinių veiksnių svarba konsultuojant musulmonus. Pusiau struktūruotų interviu pagalba išsiaiškinta psichoterapijos situacija Jordanijoje bei religijos svarba konsultavime. Ketvirtoji disertacijos dalis yra skirta aptarti galimą sąveiką tarp dviejų gydymo metodų – tradicinio religinio ir psichoterapijos. Pristatomi empiriniai duomenys atskleidžia priežastis, lemiančias gydymo metodo pasirinkimą ieškant psichologinės pagalbos. Kiekviena dalis apibendrinama baigiamosiomis pastabomis, kuriose pateikiama toje dalyje aptartų klausimų

santrauka. Disertacija baigiama išvadomis, kuriose apibendrinami tyrimo rezultatai.

Psichikos sutrikimų samprata islame

Pirmoje disertacijos dalyje analizuojama psichikos sutrikimų samprata arabų šalyse, remiantis literatūros analize bei Jordanijoje atliktais tyrimais. Psichikos sutrikimų samprata islamo kultūroje apibrėžiama keliais aspektais: tradiciniu liaudies supratimu, aiškinančiu, kad psichikos sutrikimus sukelia antgamtinės jėgos, tokios kaip demonai, piktosios dvasios, nužiūrėjimai ar magija; religiniu aspektu, teigiančiu, kad ligos yra Dievo siųsti išbandymai ir kartu glaudžiai susijusios su „nereligingumo“ ar „nepakankamo religingumo“ sampratomis; medicininiu aspektu, teigiančiu, kad psichikos sutrikimus sukelia žmogaus vidinės būsenos ir aplinkos veiksniai.

Laisvojo sąrašo metodo pagalba surinkti duomenys leido suprasti, kaip Jordanijos gyventojai suvokia psichikos sutrikimus, jų priežastis ir sutrikimus nulemiančius veiksnius. Atsakymai į atvirus klausimus ir papildomi interviu padėjo geriau suprasti, kaip tradicinės psichikos sutrikimų sampratos pasireiškia asmeninėje Jordanijos gyventojų patirtyje, o taip pat, kaip asmeninė patirtis formuoja respondentų įsitikinimus ir nuostatas.

Tyrime išryškėjo, kad tradicijų ir modernėjančio pasaulio sankirtoje, psichikos sveikata vis dar stigmatizuojama Jordanijoje. Nors vakarietiškos psichikos sutrikimų sąvokos yra gerai žinomos jauniems ir išsilavinusiems jordaniečiams, tačiau tyrimas parodė, kad Jordanijos gyventojai gretina jas su kultūrinėmis ir religinėmis sampratomis. Toks skirtingų sampratų gretinimas pabrėžia islamo psichologijos svarbą.

Psichikos sutrikimų gydymas islame

Išsiaiškinus psichikos sutrikimų sampratas arabų šalyse, antroje disertacijos dalyje yra apžvelgiami psichikos sutrikimų gydymo metodai, kurie buvo taikyti islamo aukso amžiuje ir yra taikomi iki šių dienų. Taip pat aptarta, kaip psichikos sutrikimai buvo suprantami ir klasifikuojami didžiųjų islamo mokslininkų. Tyrimas atskleidė, kad tradicinis religinis gydymas, paremtas liaudies tikėjimais, arabų šalyse yra plačiai taikomas ir šiandien. Religija yra glaudžiai susijusi su psichikos sveikatos supratimu. Vienas iš pagrindinių veiksnių, lemiančių gydymo metodo pasirinkimą, yra psichikos sutrikimų kilmės priežastis. Taigi, antgamtinių jėgų sukelti sutrikimai yra gydomi tradiciniais liaudies metodais, kurie kartais gali būti žiaurūs, pavyzdžiui, surakinimas grandinėmis, kad pacientas nepridarytų žalos, arba

mušimas, taip siekiant išvaryti piktąsias dvasias iš žmogaus kūno. Tokiais atvejais, liaudies gydytojas, taiko gydymą paremtą kultūrinėmis tradicijomis ir vietiniais tikėjimais. Tuo tarpu, religinis aspektas apibrėžia gydymą, kur pagrindinį vaidmenį atlieka religinis lyderis, t.y. konsultuoja pacientus ir duoda patarimus paremtus religinėmis tiesomis. Mokslininkai pastebėjo, kad „ieškodami pagalbos, pacientai ir jų artimieji, dažnai išbando skirtingus liaudies gydymo metodus, pradedant amuletais, Korano recitavimu, ritualais panaikinančiais burtus ir baigiant egzorcizmu“ (El Islam, 2000, p. 126).

Vakarų psichoterapija islame

Ši disertacijos dalis apžvelgia Vakarų psichoterapiją arabų šalyse. Remiantis anksčiau atliktais tyrimais, bandyta išsiaiškinti, ar vakarietiškas konsultavimo modelis, siejamas su sekuliarizacija, yra reikalingas tradicinėse kultūrose. Atsižvelgiant į spartų globalizacijos procesą ir tam tikrus bendrosios psichologijos aspektus, o taip pat remiantis Jordanijoje atlikto tyrimo rezultatais, išryškėjo vakarietiško konsultavimo svarba. Kultūros vaidmuo tarptautiniame psichikos sveikatos lauke buvo analizuojamas remiantis „Psichikos sutrikimų diagnostikos ir statistikos vadovu“ (DSM-V) bei psichikos sveikatos specialistų komentarais, bandant išsiaiškinti, kaip tarptautinė klasifikacija yra taikoma islamo kultūros kontekste. Išryškėjo du aspektai, pirmas – psichikos sutrikimai yra visur vienodi neatsižvelgiant į kultūrinius faktorius, ir antras – kultūra neabejotinai daro įtaką psichikos sutrikimų diagnozavimui ir gydymui. Tuo tarpu, „Psichikos sutrikimų diagnostikos ir statistikos vadovas“ yra periodiškai atnaujinamas ir papildomas įtraukiant kultūrinius veiksnius, apibūdinančius psichikos sutrikimų sampratas, kultūros sąlygotus sutrikimus bei jų simptomus skirtinguose kultūriniuose kontekstuose. Remiantis empirinio tyrimo rezultatais, buvo apžvelgta psichikos sveikatos situacija Jordanijoje, siekiant suprasti psichoterapijos pritaikomumą arabų šalyse.

Pagrindinis klausimas, kylantis analizuojant Vakarų psichoterapiją arabų šalyse, tai inkultūracija ir jos problematika. Kiekvienos psichoterapijos krypties pritaikomumas buvo aptartas remiantis kultūros tradicijomis bei interviu duomenimis. Tyrimas patvirtino, kad Jordanijoje labiausiai paplitusi kognityvinė-elgesio terapija. Tuo tarpu, daug kritikos ir diskusijų dėl pritaikomumo kultūriniu atžvilgiu sulaukianti psichoanalizė, yra taikoma ir musulmonams pacientams, tačiau nėra plačiai paplitusi. Religija išryškėja kaip svarbus veiksnys konsultavime ir yra aktyviai diskutuojama tarp musulmonų psichikos sveikatos specialistų, ypač pabrėžiant jo naudą. Atskirai

buvo analizuojamas psichoterapeuto vaidmuo, bandant išsiaiškinti, kiek svarbus yra kultūrinių tradicijų išmanymas jo darbo praktikoje.

Ar gali tradicinis religinis gydymas ir psichoterapija dirbti kartu?

Ketvirtoje disertacijos dalyje, remiantis ankstesnių tyrimų duomenimis bei empiriniu tyrimu atliktu Jordanijoje, buvo analizuoti tradicinio religinio gydymo ir vakarietiškos psichoterapijos santykio aspektai. Buvo bandoma išsiaiškinti dviejų skirtingų gydymo metodų sąlyčio taškai ir skirtumai bei priežastys nulemiančios gydymo metodo pasirinkimą. Paaiškėjo, kad gydymo metodo pasirinkimui įtakos turi sociokultūrinės ir ekonominės priežastys, kurios buvo išsamiai aptartos remiantis respondentų komentarais. Tyrimas atskleidė požiūrio skirtumus į psichikos sutrikimų gydymą tarp kartų. Modernizacija daro įtaką tradicinei kultūrai, o pasak tyrimo dalyvių, psichikos sutrikimai kai kuriose gyventojų grupėse tampa geriau suprantami ir mažiau stigmatizuojami. Kaip paaiškėjo, žmonės tampa atviresni psichologinio konsultavimo atžvilgiu. Dėl to, galima daryti prielaidą, kad ateityje psichikos sveikatos ir psichologinio konsultavimo padėtis arabų šalyse keisis. O neišvengiami pokyčiai visuomenėje ir didėjanti psichologinių paslaugų paklausa atveria platesnes gydymo galimybes.

IŠVADOS

Tradicinio religinio gydymo ir psichoterapijos sąveika islamo kultūroje buvo nagrinėjama ir pristatoma keturiuose skyriuose: psichikos sutrikimų sampratos analizė istorinėje perspektyvoje ir šiuolaikinėje islamo visuomenėje, tradicinis religinis gydymas istorinėje perspektyvoje ir šiuolaikinėje islamo kultūroje bei Vakarų psichoterapija arabų šalyse. Lyginamasis tyrimas, pristatytas ketvirtame skyriuje, leido palyginti du gydymo metodus, pagrįstus skirtingomis kultūros tradicijomis. Psichoterapijos inkultūracijos problema buvo išsamiai aptarta vertinant sociokultūrinių veiksnių įtaką konsultavimui. Taigi, palyginus du psichikos sutrikimų gydymo metodus, buvo padarytos šios išvados:

1. Psichikos sutrikimų kilmė islamo kultūroje yra grindžiama keliomis teorijomis, tačiau visos jos yra kultūriškai sąlygotos. Nors Jordanijos gyventojai puikiai išmano vakarietiškus psichikos sutrikimų terminus, tačiau jų samprata yra glaudžiai susijusi su tradicijomis. Kultūrinės tradicijos, susiformavusios išskirtinai arabų regione, atlieka svarbų vaidmenį psichopatologijos suvokime. Beprotybė šiuolaikinėje musulmonų

visuomenėje iškyla kaip socialinis konstruktas (M. Foucaulto socialinio konstruktyvizmo teorija), o socialinių normų nepaisymas ir kitoniškumas yra apibrėžiamas arabišku terminu *majnūn*. Šis terminas ne tik apima psichikos sutrikimus kaip ligą, bet kartu prikabina beprotybės etiketę. Taigi, kultūrinių ir medicininių psichikos sutrikimų sąvokos musulmonų visuomenėje yra persipynusios ir dažniausiai išryškėja kaip vientisas darinys.

2. Daugelis sekuliarizacijos teorijos šalininkų teigia, kad moderniame pasaulyje religija neišvengiamai praranda savo vaidmenį. Nors pasak P. Bergerio (1969), sekuliarizacija atskyrė tikinčiuosius nuo Dievo, tačiau modernėjančio arabų pasaulio kontekste religija neabejotinai išlieka kertiniu akmeniu ne tik kasdieniame gyvenime, bet ir formuojant psichikos sveikatos sampratą. Tradicinis religinis gydymas remiasi islamo tradicija, o religija yra integruojama į psichoterapiją kaip teigiamą poveikį gydymui turintis veiksnys. Tačiau kultūriškai sąlygota psichikos sutrikimų samprata ir bendruomenės požiūris į psichikos sutrikimus lemia tradicinio religinio gydymo vyravimą arabų šalyse. Tuo tarpu imamai ir liaudies gydytojai atlieka svarbų vaidmenį formuojant bendruomenių psichologinį klimatą ir iš dalies atlieka psichoterapeuto vaidmenį visuomenėje. Taigi, religija ir dvasiniai lyderiai yra neatsiejama psichikos sveikatos dalis tiek tradiciniame, tiek ir medicininiame psichikos sutrikimų gydyme.

3. Tradicinis religinis gydymas, atstovaujantis liaudies medicinai yra paremtas kultūriniais įsitikinimais. Ši gydymo tradicija ne tik veikia lygiagrečiai su medicininiu gydymu, bet dažniausiai yra pirminis pasirinkimas ieškant psichologinės pagalbos. Daugelis psichikos sveikatos sutrikimų atvejų nepasiekia medicinos specialistų, nes yra gydomi tradicinių liaudies gydytojų. Tradicinio religinio gydymo hegemoniją arabų šalyse lemia kultūros suformuoti įsitikimai, psichikos sutrikimų stigmatizavimas bei nepakankamai išvystyta psichikos sveikatos sistema. Viena iš tradicinio liaudies gydymo problemų, išryškėjusi per Jordanijos atvejį, tai gydymas paverstas verslu, taikant neaiškius gydymo metodus, dažnai prieštaraujančius religinėms normoms, o liaudies gydytojai tapatinami su verslininkais. Vis dėlto, tradicinis religinis gydymas, kurį teikia kvalifikuoti specialistai, laikomas naudingu, nes manoma, kad atitinka pacientų kultūrines vertybes ir įsitikinimus, o kai kuriais atvejais yra taikomas kartu su psichoterapija. Be to, buvo išaiškinta, kad tradicinio religinio gydymo metodas – Korano recitavimas, gali būti veiksmingas ir kitų religijų atstovams. Paaiškėjo, kad tokį gydymo metodą naudoja ir arabai krikščionys Jordanijoje. Modernizacija daranti įtaką tradicinei kultūrai, pasitelkia šiuolaikines technologijas. Tyrimas atskleidė, kad religiniai lyderiai aktyviai naudojasi socialinių medijų

platformomis, siekdami pritraukti jaunosios kartos, kuri yra iš dalies paveikta vakarietiškų tradicijų, dėmesį.

4. Nors psichikos sveikata bei jos gydymas yra stigmatizuojami arabų šalyse, tačiau pastebimas besikeičiantis jaunosios Jordanijos kartos požiūris į konsultavimą. Psichoterapija laikoma ne tik psichikos sutrikimų gydymo metodu, bet ir priemone užkirsti kelią stresui, nerimui bei kitoms pakitusioms psichologinėms būsenoms, kurioms iš dalies turi įtakos modernizacija. Modernizacija yra viena iš priežasčių, dėl kurios jaunoji karta atsiduria kultūrų kryžkelėje, tarp tradicijų, kurių laikosi tėvai, ir sparčios Vakarų kultūros invazijos. Tradicinė kultūra yra veikiama modernizacijos, dėl to silpnėja kai kurie sociokultūriniai aspektai, o tai turi įtakos psichologiniam bendruomenių klimatui. Sekuliarizacijos kontekste, stebint psichosocialinę regiono raidą, atkreiptas dėmesys į šeimos tradicijos, o kai kuriais atvejais ir religijos silpnėjimą. Dėl to susidaro palanki terpė psichoterapijos plėtrai. Nors Giddensas (2000) teigia, kad tradicinėse kultūrose psichoterapija nereikalinga, tačiau akivaizdu, kad modernėjančio pasaulio kontekste psichoterapija yra reikalinga. Šį faktą patvirtina ir pastebimai didėjantis psichoterapijos paslaugų poreikis Jordanijoje. Tačiau, psichikos sveikatos laukas susiduria su iššūkiais, kuriuos skatina sociokultūriniai veiksniai. Socialinė stigma daro įtaką ne tik psichikos sutrikimų sampratai ar gydymo metodo pasirinkimui, bet ir visai psichikos sveikatos sričiai, o taip pat, ir psichikos sveikatos specialisto profesijos pasirinkimui. Dėl to, kyla papildomos problemos – psichikos sveikatos specialistų trūkumas bei didelės paslaugų kainos.

5. Psichikos sveikatos srityje yra taikomi tarptautiniai standartai. Tačiau vakarietiška psichoterapija negali būti pilnai adaptuota skirtinguose kultūriniuose kontekstuose, o islamo psichologijai iki galo išvystyti trūksta teorinio pagrindo, kuris atitiktų arabų šalių sociokultūrinę sistemą. Taigi, psichoterapijos inkultūracijos problema išryškėja keliais aspektais: pirmas – ne visi terapijos metodai atitinka kultūros ir religijos tradicijas, antras – ne visi terapijos metodai gali būti sėkmingai inkultūruojami. Todėl islamo psichologija, kuri remiasi religija, iškyla kaip atskira konsultavimo šaka, o islamo psichologai savo darbo praktikoje daugiausia dėmesio skiria religiniam aspektui. Tokiu atveju psichoterapija įgauna religijos apvalkalą ir vyksta resakralizacija.

6. Sugretinus vakarietišką ir islamo psichoterapiją, išryškėjo ne tik jų skirtumai, bet ir sąlyčio taškai. Skirtumai pasireiškė per sociokultūrinius veiksnius, tokius kaip bendruomeniškumas ir vakarietiškas individualumas, kai nepriklausomybė virsta tarpusavio priklausomybe; galios santykį, kuris pasireiškia per šeimos hierarchiją. Išryškėjo kultūros nulemti skirtumai ir panašumai terapeuto ir paciento santykiuose bei terapijos procese. Tradicinio

religinio gydymo ir vakarietiškos psichoterapijos sąveika leidžia daryti išvadą, kad kultūriškai korektiškai ir jautriai derinami du gydymo metodai – tradicinis religinis ir vakarietiška psichoterapija, papildo vienas kitą ir gali veikti kartu.

ABOUT THE AUTHOR

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LIST OF PUBLICATIONS ON THE SUBJECT OF DISSERTATION

Valaitė, Dovilė (2019). "Psichikos sutrikimų samprata, tipologija ir gydymas tradicinėje islamo kultūroje", *Būdas*, *3*(186), pp. 30–37. ISSN 2669-0403.

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CONFERENCE PRESENTATIONS ON THE SUBJECT OF DISSERTATION

21 October 2017. "Tradicinių psichikos sutrikimų samprata, tipologija ir gydymas islamo kultūroje" (The concept, typology and treatment of mental disorders in Islamic culture), Republican conference "Tradicinės ir naujos civilizacinių sąveikų sistemos", Lithuanian Culture Research Institute, Vilnius, Lithuania.

13–15 April 2018. "Modern psychotherapy in Islam: The problems of adaptation and inculturation", The Third Baltic Alliance for Asian Studies (BAAS) Conference "Dynamic Asia: Shaping the Future", University of Latvia, Riga, Latvia.

27 April 2018. "Vakarietiška psichoterapija islame: inkultūracija ir jos problematika" (Modern psychotherapy in Islam: The problems of adaptation and inculturation), 15th Conference of Young Scientists in Psychology "Jaunasis mokslininkas tarp tradicijų ir naujovių", Vilnius University, Vilnius, Lithuania.

18–20 September 2019. "Tradition of dream interpretation in Islam: Origin, conception and typology", 9th International Conference of Young Folklorists "(Ir)relevance of Classical Folkloristics in the 21st Century", The Institute of Lithuanian Literature and Folklore, Vilnius, Lithuania.

5–7 March 2020. "The conception of mental disorders in contemporary Islamic world: Between tradition and modernity", The Fourth Baltic Alliance for Asian Studies (BAAS) Conference, Vytautas Magnus University, Kaunas, Lithuania.

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