Why Western psychotherapy cannot be of real help to Muslim patients?

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Western psychotherapy cannot be of real help to Muslim patients for a number of reasons. In verifying this we will start by the broad general substantiation and proceed to the specifics. Firstly, in dealing with people, psychology itself cannot stand to the cross-cultural guidelines of exact sciences. In comparison to the universal consistent laws that govern matter and pure biological processes that validate itself irrespective of nationality or culture, the psychological study of people is by nature inconsistent. Compare in this respect between variables concerning the density of metals, the physical disorders which are caused by specific chromosomal aberrations and the surgical treatment of appendicitis, compare these with some of the psychological variables like human anxiety, introversion, arousal or love.

Moreover, psychotherapy as a branch of psychology and psychiatry is among the most vague and nebulous branches of these sciences. Some topics in psychology that lies in the no-man's land with other exact sciences like chemistry and biology such as genetic psychology, physiological psychology and psycho-pharmacy can claim to be admitted under the prestigious umbrella of science, but psychotherapy cannot claim such a position. Some of its perspectives can even be viewed as an art influenced by philosophy. That is why the efficacious treatment of psychologically disturbed patients in the same culture by the same psychological perspective and the same psychotherapist must be partly or wholly adjusted to suit the needs of each patient. This then is the first general issue challenging the universality of the application of the theories and practices of Western psychotherapy to Muslim patients.

Secondly and more specifically, it was found that human culture has a great influence on the nature of the psychological disorders its people can be afflicted with and how they are expressed and accordingly how they can be treated. As early as the beginning of the last century, Kraepelin found that among Javan

patients, melancholia and mania were scarce and that depressive reactions were rarely associated with sinfulness and quilt (Kiev, 1964). Similarly, in modern times, (Kleinman, 2004) found that Nigerians do not show extreme feelings of remorse and worthlessness when depressed. He also reported that Chinese are more likely to report physical symptoms when they are emotionally disordered.

Greater evidence for the influence of culture in shaping the experience of psychological disorder comes from researches into culture-bound syndromes. For example, *Amok*, characterized by sudden rage and indiscriminate homicidal attacks is a culture-bound syndrome common in Malaysia and Thailand. Women in the same South Eastern Asian region, when under stress, may suffer from *latah* which is a hysterical disorder accompanied by echolalia. Other culture-bound disorders and syndromes exhibiting all sorts of uncommon symptoms such as the extreme fear of shrinking of penises and disorders that alter consciousness such as the *zar* observed in Ethiopia, Sudan and Egypt are clear examples of the influence of culture in creating unique symptoms that require new forms of psychotherapies.

On the other hand, some of the disorders listed in the DSM like anorexia nervosa seem to have affected only those living in the West. It is only after women in non-western countries had been influenced by the European taste of slimness as a standard for female beauty that this disorder started to emerge. However it is still absent or very rare in African countries in which fat women are preferred to skinny ones. Thus evidence for this cultural influence is becoming so convincing that it is challenging the claimed globalization of the famous gospel of modern psychiatry; the Diagnostic and Statistical Manual of Mental Disorders.

Thirdly and still more distinctively, is that Western psychotherapy is built on influential theories about the nature of man developed by the pioneers of the main perspectives of this field. Though some of these pioneers claim that their therapeutic perspectives are scientific in nature, in fact they are nothing more than the secular philosophy and the arm-chair thought of the founders. None of these founders, be it Freud, Watson, Rogers or Ellis had closed himself up experimenting in a laboratory to come out with 'results' denying the existence of the human soul and his consciousness or to arrive at his claim that man is by nature aggressive, selfish or governed by his unconscious motivation; or that his nature is fully shaped by conditioned stimuli in his environment or that he has a good nature but needs to be actualized according to the values and ethical norms of Western modernity.

All these theories and their practices are fully influenced by the Western godless worldview of secular humanism. This materialistic soulless concept of human nature that became like a religion of irreligiousness became the rock on which Western psychotherapy is built. The pioneers and followers of different theories and their healing practices continue to have bitter arguments and emotional criticisms among themselves but they all unequivocally agree on this materialistic nature of a soulless psychology studying a soulless man.

Accordingly, in dealing with Muslim patients, Westerners or Western-minded therapists would not only find themselves facing a different culture with possible different symptomatology but also persons with contradictory philosophies of life, dissimilar ethical standards, opposing conceptions about the nature of man, conflicting religious orientation and epistemologies that are poles apart.

Psychology and its therapeutics cannot rid itself from philosophy. Metaphysical aspects about what is real can consciously or unconsciously influence both therapists and their patients. Belief or unbelief in the real existence of spirituality, angels and Jinn can shape the nature of man and his symptoms and can promote or hinder therapeutic endeavors. Epistemological issues about knowledge and how we know it can also be of paramount importance in the process of therapy. One who holds revealed knowledge in the highest esteem cannot have a harmonious interaction with one who considers such an epistemological aspect in the lowest status. Furthermore, ethics as a philosophy decides upon what we ought to do. So if a patient and his therapist have contradictory standards they may be at odds. One may believe that one can happily do as he pleases if he does not break the law even if this includes homosexuality abortion or euthanasia. The other is governed by what is good and what is sinful as dictated by religion and *shari'a*.

Unlike other religions, Islam is not a faith that restricts its followers to perform a few rituals and then choose how to live according to their needs in their societies. It is a way of life with a fully fledged worldview that guides the Muslim in all facets of his life according to the teachings of the Holy Qur'an and the role model of Prophet Muhammad (PBUH). The Prophet of Islam was not a dreamy sublime figure such as Buddha or Jesus (PBUH) as portrayed by Christianity, but a man who lived as a parent, a husband, the General of his Muslim army, a founder of a state, and above all a Messenger of Allah and a spiritual role model truthfully living the ethical values of Islam .

Hence, with the exception of the symptomatic treatment of disorders caused by minor environmental traumas or mono-symptomatic phobias that may not need the therapist to deal with deeply rooted cultural and spiritual issues, the treatment of all other psychological disorders may not bring about improvement because of this cultural, spiritual, and ethical conflicts. In fact, as I have shown in a number of studies such as (Badri, 1978 & 2009), disregard to these differences may hamper the therapy or even end up in exacerbating the symptoms of Muslim patients. The author can illustrate the adverse effects of unmodified Western psychotherapy to Muslim patients and the importance of Islamically adapting psychotherapy by a number of case studies. This adaptation is the real meaning of the term ***"Islamization"***.

Indeed, re-shaping psychotherapy into an Islamic perspective cannot be avoided in the treatment of many disorders of Muslim patients. For example, how can a modern therapist help a patient who complains from a phobia of *jinn* or ghosts without discussing the complaint from the point of view of Islam? What about a patient who has a phobia of death? Can he improve without seeking help from the Islamic belief of the immortality of the soul and life after death? And can a therapist avoid an Islamic approach when counseling a young man who hates his father and refuses to help him? And finally can a marriage counselor help a couple on the verge of divorce without discussing the Islamic rights of the wife and the husband and who will be given the custody of the children without knowledge of Islamic family law?

If Western and Westernized psychotherapists do not take these issues into consideration, their therapeutic efforts may not be of real benefit to Muslim patients.

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