مركز دراسات التشريع الإسلامي والأخلاق
Research Center for Islamic Legislation and Ethics
عضو في جامعة حمد بن خليفة
Member of Hamad Bin Khalifa University

ISLAM & APPLIED ETHICS

6

ISLAMIC ETHICS AND PSYCHOLOGY

MAMOUN MOBAYED
SAAD EDDINE EL-OTHMANI

COMPILED AND EDITED BY: DR FETHI B JOMAA AHMED

ISLAMIC ETHICS AND PSYCHOLOGY

Mamoun Mobayed
Saad Eddine el-Othmani

Compiled and Edited by:
Dr Fethi B Jomaa Ahmed

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Introduction

In the name of God,
the Most Gracious,
the Most Merciful

The Research Center for Islamic Legislation and Ethics (CILE) is pleased to place into the hands of readers this series of booklets, which contain a collection of research papers that have been presented at events organized by the Center. Through these booklets, we are seeking to build a methodological platform that will contribute to the CILE's key objective, namely promoting radical reform. The type of radical reform that we are calling for is based on a fundamental concept: transformational renovation. This concept transcends traditional renovation and *a posteriori* diligence, which tends to maintain reality and adapt to it, assessing and judging its components through the system of the five categories of laws in Islam; the five categories of ruling values are: Wajeb (required, obligatory); Mandoob (recommended); Mubah (permitted but morally indifferent); Makrooh (discouraged or abominable) and Haram (forbidden or prohibited).

In other words, it is rather an evaluative type of jurisprudence. Transformational renovation goes beyond this intellectual space to create a kind of renovation and jurisprudence that addresses facts critically and explores reality intellectually so as to reform it, or even rebuild it if necessary. Moreover, this transformational renovation process puts forward alternative solutions for the shortcomings of the

current reality, seeking to establish new means, models, and paradigms at all levels that would achieve ethical objectives. Therefore, radical reform purports to go beyond superficial issues and directly into the crux of objectives and ethics, beyond minor details into theoretical foundations and frames of reference.

In order to implement radical reform by means of transformational renovation, religious scholars and scientists should share the responsibility. While religious scholars, in many cases, have been capable of judging reality based on specific facts provided by scientists, the task is different when it comes to diligence and transformational renovation. This is because an endeavor such as this requires an advanced and comprehensive understanding of both religion and reality. Being well-versed in Islamic Sharia sciences and being formally and partially aware of reality alone will not help bring about transformational reform unless it is accompanied with similar knowledge of our reality, and with today's scientific advancement, this is only possible by involving those specialist scientists and practitioners. The process of building reality on the foundation of proper Islamic ethics and values should be based on a deep and comprehensive understanding that will help analyze the reasons behind malice, which drive people to engage in substandard activities. This understanding may lead to alternative solutions and new practices, which are more deeply founded on scientific knowledge. Not to dismiss the sound efforts and evaluative diligence of religious scholars, neither Islamic Sharia scholars nor scientists alone should monopolize knowledge or assume sole responsibility for undertaking reforms in society.

CILE activities are noteworthy for bringing together both religious scholars and scientists. We do not seek to address the evaluative process, which is limited to understanding reality

through judgment and adaptation, drawing on permissions or prohibitions. Rather, CILE events facilitate open dialogue between scholars and expert practitioners, who can collectively propose how best to undertake radical reforms and recommend solutions that are at once inspired by Islamic principles and supported by scientific knowledge.

While the combined work of religious scholars and scientists constitutes a fundamental methodological basis for transformational renovation, it should be coupled with many other elements pertaining to the methods, theories, and objectives of science. For instance, traditional Sharia scientific methods do not preclude the type of renovation desired. At the same time, modern science has failed to focus on ethics, as it has not addressed ethics as a fundamental issue. Rather, science relegates ethics to a secondary position. This raises the issue of the division of sciences into religious or secular sciences, and of their tendency to focus excessively on highly specialized topics without associating them with greater universal themes.

Undoubtedly, this undermines the communication between scientists from various disciplines and thwarts their efforts to work together to develop an epistemological approach that combines their knowledge to serve the important purpose of promoting ethics. Therefore, the challenge set before us is not to persuade scientists belonging to various disciplines and backgrounds to work together. Rather, it is to shake them in their scientific safe havens and drive them to push through the epistemological paradigms governing their own knowledge in order to set up a new system and outline methods toward achieving renovation.

Enhancing its specialized research activities aimed at facilitating and exploring the communication between religious scholars and scientists, the CILE convened a three-day closed

seminar from 22nd to 24th November 2014 in Education City, Doha, to consider the contemporary challenges of and the relationship between Islamic ethics and psychology.

The seminar participants were scholars, intellectuals and experts with theological and practical experience from around the world, including Dr Mamoun Mobayed, Sheikh Dr Saad Eddine El-Othmani, Dr Malik Badri, Sheikh Dr Mohammed Naim Yaseen, Dr Rabia Malik, Sheikh Dr Noureddine Al-khadmi, Dr Colleen Ward, Dr Rashid Skinner, Dr Tariq Ramadan and Chauki Lazhar. The seminar was moderated by Sheikh Yassir Fazaga

The CILE requested the participants to focus on addressing the following questions:

1) How do you evaluate the main approaches to understanding the nature of human being in contemporary psychology and Islamic Heritage?
    a) What are the limits of the moral responsibility of human actions from the perspective of contemporary psychology and Islamic Heritage?
    b) What is the role of the unseen in the psychoanalysis and psychotherapy?
    c) What is the significance of the search for the objectives of psychology and the objectives of *Shariah* in the formulation of a new approach in psychology?
2) What is the position of the ethical pursuit in contemporary psychology and its applications?
    a) What are the main ethical dilemmas faced by the psychotherapist and the patient?
    b) What are the ethical standards for employing technologies that provide a psychological effect on individuals and groups?

c) Is there a role for religion to play in mental health and psychotherapy?

This booklet includes some of the research papers presented in this seminar and is a part of CILE book series which we hope will contribute to our project of transformational renovation.

CHAUKI LAZHAR, *CILE Deputy Director*

About the Authors

MAMOUN MOBAYED graduated with a degree in medicine from Damascus University in 1978. Currently, he is a consultant psychiatrist and director of the Treatment and Rehabilitation department at the Behavioural Health Care Centre (BHC), Qatar, and a professor of psychology at the Community College Qatar. He was trained in psychiatry in Dublin, Ireland, where he practiced for several years, and earned Irish citizenship before moving to Northern Ireland (NI), where he was a specialist in psychiatry, and a lecturer at Queen's University Belfast (1990–2010). He was the first president of the NI Interfaith Forum, and a member of the NI Clinical Ethics Committee, Belfast Health-care Trust. He has a special interest in psychological trauma related to conflicts and disasters. Dr Mobayed has published several psychiatry papers, and ten books on various subjects, including mental illness, parenting, marital communication, the identity of the child, e-consultation and sex education.

SAAD EDDINE EL-OTHMANI was born on January 16, 1956 in Morocco. He is a psychiatrist and obtained his master's degree in Islamic sciences in 1999. He is currently the Head of Government of Morocco and he was General Secretary of the Justice and Development Party (PJD) from 2004 to 2008, and was member of the First Chamber of Parliament from 1997 to 2011. He is the former Minister of Foreign Affairs of Morocco, and member of the Ethics Committee for Biomedical Research in the faculty of medicine in Casablanca. His most recent book is *Religion and Politics: Distinction not Separation* (in Arabic).

Islamic Ethics and Psychology

Mamoun Mobayed

Introduction

This paper attempts to answer a number of questions raised by the Research Center for Islamic Legislation and Ethics (CILE) in a seminar entitled "Islamic Ethics and Psychology." The central question is: "What is the rank of ethics in contemporary psychology and its practices?" The three other subquestions to be asked here are as follows:

- What are the most important ethical problems confronting psychiatrists and patients?
- What are the ethical standards for employing technologies that provide a psychological effect on individuals and groups?
- What role does religion play in mental health and psychotherapy?

In an attempt to answer these questions, I explored the issue theoretically and enriched it with some actual examples. Needless to say, I have changed some data to keep the privacy of people in these case studies.

Pivotal Question

What is the position of ethics in contemporary psychology and its practices?

Various Aspects of Psychology and Mental Health

This seminar on "Islamic Ethics and Psychology" incorporates more than what it is known nowadays as "psychology"; it also relates to mental sciences, mental or psychological health, including psychological medicine currently known as psychiatry, as well as clinical social work. Recently, more awareness and attention were given to mental sides of human life and several areas of specializations in the fields of psychological disorders and mental illnesses that appeared in psychology and psychiatry. The following are examples of these areas of specialization:[1]

- General psychiatry;
- Child psychiatry;
- Old age psychiatry;
- Addiction psychiatry;
- Forensic psychiatry.

Psychology also has its fields including:

- Clinical psychology;
- Educational psychology;
- Criminal psychology;
- Media psychology;
- Military psychology;
- Spiritual psychology.

New schools of counseling also appeared, such as psychological counseling, marital counseling and family counseling. Undoubtedly, their concerns may all come under the title of "Islamic ethics and psychology."

Given that progress and proliferation, it was necessary to develop the ethical principles and criteria to regulate work in such fields of psychology and mental health. In our time, there is almost no psychological scientific authority without a special

division for studying the ethical side of the professional practice, such as the ethical principles of the American Psychology Association,[2] the American Psychiatry Association,[3] the Royal College of Psychiatrists,[4] and the Arab Federation of Psychiatrists.[5]

Multifarious Roles of Practitioners in Mental Health Fields

When discussing the role of psychologists whether physicians or practitioners, we do not only mean their roles in psychotherapy or psychological counseling. Their roles may include further areas such as education, teaching and training as well as preparing psychological and behavioral researches and as expert witnesses in legal cases and other similar roles. It should be remembered that workers in mental health fields have their roles in administration, development of policies, legislations and procedures, and media activities that all necessarily require the availability of ethical principles and standards, especially when there is a conflict, explicit or hidden, between all or some of these different roles.

In the wake of information revolution and wide use of Internet and social media for psychological services whether as psychological, behavioral or familial consultations or by providing psychotherapies via modern media, widely known nowadays as telemedicine, it was, therefore, necessary for these media to commit to ethical rules and standards, as direct contact between clients and psychotherapists may not exist.[6]

Codes of Ethics for Practice

English language makes a distinction between ethics and moral-

ity. Ethics is defined as a field of philosophy that addresses moral issues, problems and moral judgments. Ethics also signifies the set of principles and instructions that governs the behavior in a particular profession. Morality, on the other hand, refers to the rules for recognizing what is right or wrong and what is good or bad. It is necessary for ethics to have plain moral principles. Some define professional ethics as the "assessment of human conduct."[7] In other words, ethical standards can help us judge human conduct: right or wrong, legal or illegal.

Individual Commitment to Ethics

As a general rule, a psychologist, Muslim or non-Muslim, should abide by a code of ethics as part of his/her religion and morals, regardless of people's conduct, good or bad. The Prophet (PBUH) said: "Do not let yourselves be pliably led without will saying, 'If the people are good then we will be good, and if they are wrong then we will be wrong.' You should rather make up your own minds that if the people are good then you are good, and if they are evil, then do not behave unjustly" (narrated by al-Tirmidhi).

The majority of people indeed look forward wishfully to become responsible and achieve goodness by doing good deeds and complying with good conduct and integrity, but in reality there is usually a wide gap between a desired ideal image and the actual human achievement: "You who believe! Why do you say that which you do not do? Most hateful it is to Allah that you say which you do not do!" (Qur'an, 61:2–3).

All human interactions should be committed to ethical principles. This is clear in material dealings: "And give full measure when weigh with a balance that is straight. That is good and ends in better end" (Qur'an 17:35); "So give full measure and

full weight and wrong not men in their things, and do not mischief on the earth after it has been set in order, that will be better for you, if you are believers" (Qur'an, 7:85). Similarly, it should be in relation to professions that deal with man's body and soul, including different medical and psychological professions such as psychotherapy, psychology, mental counseling, and educational and social services, which are worthier than material dealings, whether human being in question is a child or an adult.

This is why medicine as a profession has adhered to ethical principles since the day man discovered diseases and remedies. All newly graduated physicians at faculties of medicine must begin their career with an ethical oath of professional practice. It is known as the Hippocratic Oath, after the name of Hippocrates, the father of medicine who lived in the fifth century BCE when medicine was only taught within members of few families. However, when urgency appeared for greater number of physicians to meet the increasing needs and to avoid misuse, Hippocrates recommended his students to commit to this oath in order to fulfill its rights by due care for the patients' interests.[8]

By exploring the ethical issues pertinent to psychology and psychotherapy, it is possible to connect these areas of specialization with ordinary medical practices, as the relationship between them is close in many aspects. The code of ethics in medicine is part of the ethics that address the physicians' problems with their patients and colleagues. They are a set of rules, regulations and ethics commonly used in the practice of medical treatment, or they are values recognized and adopted by physicians and medical entities throughout the history of medicine according to religious, philosophical and ethical values.

It is possible to trace the rise of medical ethics back to ancient times, perhaps starting from Hippocrates and his oath

to old religious teachings. Muslim physicians (e.g. Ishaq ibn 'Ali al-Rahawi who authored *Adaab al-Tabeeb*, i.e. the physician's code of ethics) in the Middle Ages and the beginning of the Modern Age were witnesses to a qualitative advance in professional ethics. The detailed medical ethics, however, had witnessed several developments through years and centuries.[9]

Most works on ethics of medical practices state that physicians and psychotherapist should abide by six essential values in medical ethics. These values are:

- Freedom of choice: patients have the right to choose or refuse treatment;
- Beneficence: practitioner should act in the best interest of the patient;
- Non-maleficence: promoting wellbeing and causing no harm;
- Justice: caring for distribution of rare health resources, and deciding who deserves to get treatment (fairness and equality);
- Keeping patients' dignity: physicians also have the right to keep their dignity;
- Truthfulness and honesty: the concept of informed consent has increased in importance since the physicians' trial of war crimes in Nuremberg held by the USA. It is normal that such moral values may conflict with each other, and the outcome may be an ethical dilemma or crisis. Sometimes, no ideal solution to such dilemma exists and the application of these values conflicts with the values of other individuals.[10]

Why Ethics in Mental Health?

Ethical principles and criteria have their importance in all sides

of human interactions, and such importance gets more weight in the fields of psychotherapy and mental health for many reasons including the following:

1. Mental health is related to very private, personal, familial and social aspects of human life and in return necessitates the patient to reveal very private details on himself/herself as an individual in addition to marital, familial and social details to the psychotherapist;
2. Confusion, misunderstanding and less clarity are still in many people's minds as to psychotherapy and mental health, which may expose them to extortion and bad treatment;
3. Practitioners in mental health, psychotherapy and counseling are relatively few in number when compared to other treatment fields. This encourages those who lack proficiency to work in this field;
4. The existence of some individuals who practice mental treatments, counseling or "spiritual" therapy without receiving appropriate scientific training or who work under no professional supervision to guarantee proficient psychological treatment. Many of those even do not belong to any professional scientific institution or entity to supervise their work and bind them to follow any international standards of treatment;
5. Some ideas and psychotherapies available nowadays have no constant evidence or argument as standard effective medicine. Some types of treatment are also in need of special training but lacked by those who practice and apply them;
6. Some aspects of psychiatry are in close relation with people's lifestyles whether religiously, socially, informationally or even politically. This, therefore, requires high

awareness and caution by practitioners when providing medical services;

7. Some mental disorders and problems may turn a person vulnerable and easily affected by the psychotherapist and his ideas, beliefs and lifestyle;
8. The social stigma of mental diseases is still so strong in our communities, where people rarely discuss their distresses or treatments and thus very little information finds their way to the public;
9. Some psychological disorders and problems pose sensitive issues concerning what is normal and what is abnormal. Religious and social values should affect in answering this question, exposing the person who receives treatment to value influence;
10. Some psychological disorders and problems have legal and judicial aspects pertinent to one's responsibility of work and the limits of legal responsibility for his/her works, which requires clear ethical and professional criteria.

Discussing "the code of ethics and practice" reveals that this code can be defined as "the values and principles that regulate the work rules, explain its conditions, specify the behavior and duties of practitioners and preserve their rights."[11]

Moral situations that come through our way are not always simply clear; white or black, as they may be in the grey area and vague at least in some aspects only. This in turn leaves us in doubts against several choices of which the best is not so clear. However, it is necessary to decide and determine the responsibility, specifically, in practical realities where practical and procedural steps are built in relation to treatments, psychological and behavioral procedures. Such ethical principles must be

practical and applicable to the case in question so that we have a clear ethical stand specifying right and wrong actions.

It is worth mentioning that there are several texts of oaths by medical schools. They differ from country to another according to the religious attitude. For example, the "Code of Honor for Arab Syndicates," the "Medical Oath of the International Conference of Islamic Medicine," the "Ethical and Professional Guide for Family Reformers and Counselors," the "Psychotherapists' Charter of Honor" issued by the Egyptian Association for Psychotherapy and other similar codes. Some medical syndicates in various countries formulated their own oaths for practitioners, such as the medical syndicates of some Arab countries. There are also Christian medical ethics according to the church principles that a doctor or psychotherapist must follow. Some codes of ethics present the medical oath, such as the "Egyptian Physician Oath" introduced by the Egyptian Psychiatric Association that states:

> "I hereby swear by God Almighty
> To commit to God orders in my profession, to safeguard the life of human beings in all its stages under all conditions and circumstances exerting my best effort to save it from suffering and pave the way to its psychological stability;
> To pursue to enroot the values of society and fight against what leads to harm, public or private;
> To preserve people's dignity, not to reveal their private parts and keep their secrets, and be just to them without any exploitation of their needs;
> To render my psychotherapy and care to the close and the distant, to the virtuous and the sinner, the friend and the enemy;
> Not to violate the facts of psychotherapy or treat people

with things forbidden to them by God to the best of my ability;
To tell the truth when speaking, writing or standing as a witness without reporting anything against the truth;
To devote myself to seeking knowledge and offering it for the benefit of human beings and not to harm them;
To honor whoever had taught me and to teach those who are younger than me;
To be a brother to each colleague of mine in the medical profession cooperating on piety and fear of God; that my life would be a confirmation to my belief, secretly and openly, pure from whatever disgraces it towards God and people.
May God Be My Witness."[12]

Relationship between Islamic Ethics and Professional Ethics

Although the seminar title is "Islamic Ethics and Psychology," the question that arises here is on the relationship between Islamic ethics in particular and "human" professional ethics in general. Undoubtedly, some give more importance to one over another and advocates of both trends are there with necessary proofs and justifications. It is also possible to draw a connection between the two systems by means of proper application of sharia higher purposes including the preservice of human life's important aspects such as human soul. What is essentially significant is to have ethical principles and standards as part of the practice of psychological professionals, whether a psychotherapist, a psychologist, or a social and family counselor.

There is a set of ethical principles and standards promoted by professional organizations and institutions including the

organizations of psychiatry, psychology, family counseling and others. It is unquestionably useful for a psychotherapist to know, at first, the ethics governing his/her profession and then to know about the ethics of other professions close to his specialization in order to recognize the common principles. A psychiatrist should then peruse the ethics of psychology, marital and familial counseling and even the legal and judicial counseling in some cases when dealing with psychological cases of some legal dimensions such as psychotherapy, criminal and forensic psychiatry.

Integral System of Professional Ethics

The outcome of ethical principles and procedures largely depends on the integral system of values that should integrate and correlate with the best human standards of accuracy and perfection. We seek perfection indeed but to determine and pursue the required steps is necessary, "Do they not then consider the Quran carefully? Had it been from other than Allah, they would surely have found therein a great contradiction" [i.e. it is perfect] (Qur'an, 4:82). "Allah willed that His book be perfect." In the words of Ibn Rajab al-Hanbali, "Allah willed that perfection be only to His book and a just critic should forgive minor mistakes of another when his right judgments prevail."[13]

Professional ethical standards aim to achieve many aspects including the following:

1. Enhancing the adherence of therapists to mission and career;
2. Enlightening therapists about professional values and ethics;
3. Encouraging therapists to adopt professional values and ethics in their conduct;

4. Helping professional practices dominate psychological treatments;
5. Controlling the behavior of patients and preserving their rights in areas of mental health therapies;
6. Improving the psychological therapies to avoid mistakes and violations that could cause harm to profession, therapists and patients.

Professional ethical principles include many issues, such as:

1. Qualifications of psychotherapists;
2. Personal behavior of psychotherapists;
3. Ethical responsibility of psychotherapists towards profession;
4. Ethical responsibility of psychotherapists towards patients;
5. Ethical responsibility of psychotherapists towards colleagues;
6. Ethical responsibility of psychotherapists towards the institution in which they work;
7. Ethical responsibility of psychotherapists towards community;
8. Ethical responsibility of an institution towards its psychotherapists.

Psychological Practices: A Developing World

There are undoubtedly issues nowadays on psychological practices and therapies never known to communities tens of years ago. It is natural through this history and development to expect our world as a world of developments that may be of quick pace, but the ethics of practice may remain somehow constant. Review of procedures and policies in governance of

practices are necessary in order to absorb new developments in areas of diagnosis and mental therapies.

It is worth noticing that no matter how many ethical principles, standards and procedures we may introduce to address psychological practices, they can neither cover all possible sides and situations nor predict all possible cases and situations, which may hinder our way in areas of psychological therapies and practices. It is the responsibility of every practitioner or psychotherapist to become aware of the general ethics of practice so that when unable to take the better ethical decision, he can research and ask for the best solution for any ethical dilemma he/she encounters: "So ask those who know if you do not know" (Qur'an, 16: 43). Special committees are therefore available in hospitals and psychological institutions to decide on practical ethical issues and to issue recommendations.

Ethics and Psychology: An Example

Some ethical principles are cited here for reviewing purposes. They are stated in the code of American Psychology Association (APA), as guidelines to direct and control the behavior of a therapist in mental health fields:[14]

1. "Do not harm" which is similar to the Prophetic guiding hadith: "Do not harm or reciprocate harm" (right hadith narrated by Ibn Majah and al-Daraqutni);
2. Autonomy: respect the personal freedom and independence;
3. Be just;
4. Be faithful;
5. Accord dignity;
6. Treat others with caring and compassion;
7. Pursue excellence;

8. Be accountable;
9. Be courageous.

First Subquestion: What Are the Most Important Ethical Problems that Face Therapists and Patients?

According to the definition of mental health's ethics, some of the most important ethical issues are presented here. These issues might confront psychotherapists and patients where one must choose only one option from several options available. They should make their choice guided by conscience within their human limits for the best interest of the patient and the public welfare. Different psychological schools and psychiatric institutions have developed their codes of ethics to control and guide the reduction of possible mistakes, misuse or exploitation to the least limit. The professional ethical responsibility continues to be the burden on a professional or a psychotherapist to adopt measures and instructions or ignore them under conscience pressure and legal prosecution possibility.

The types of ethical problems in mental health are going to be reviewed here under the following titles:

1. Patients' rights;
2. Therapist's responsibilities;
3. Treatment procedures.

1. Patients' rights

Therapeutic relationship and confidence

When there is a communication between a therapist and a patient, the relationship should be based on mutual under-

standing to achieve the essential goals of their work in this relationship. The patient thus has the absolute right to know about his treatment, and the therapist will be responsible for explaining the treatment clearly to the patient. Strupp (1975) explores three responsibilities for psychotherapists:[15]

1) Therapeutic function: relieving or eliminating emotional and psychological suffering through understanding, support and ensuring the feeling of safety;

2) Educational function: explaining and clarifying the psychological issues to patients and helping them to get growth, insight and maturity;

3) Technological function: by using different mechanisms and skills to change and adjust behavior.

Case study

Su'ad is a young woman in her thirties. She began feeling anxious and she experienced panic attacks in her office in presence of some colleagues, since she started her new job nine months ago. After some hesitation, she went to visit a psychologist who diagnosed her case as general anxiety and told her that she was going to take only five sessions of treatment to get healed. After the third session, Su'ad felt no improvement. She thus acted in the presence of her doctor as if she completely recovered her natural state and ended sessions.

Confidentiality of information

Confidentiality refers to the general behavior criterion imposed on the therapist not to discuss any information related to the patient with others. This item is involved in therapeutic contract between therapists and patients. In addition, therapists

should not disclose any information about patients, unless in very limited cases that they agreed upon. Some psychological codes such as the American Psychology Association recommend that if a third party asked for some information about a case, "the therapist should only give limited necessary information that helps achieve the goal of the request of information."

One of the main problems of confidentiality is when the health insurance company requests information about a patient who visits a psychiatrist or a psychologist because of experiencing psychiatric disorder. The company will not pay any treatment costs without getting such information. The suitable solution in this case is that the therapist from the early beginning should tell the patient, if he/she wants the insurance company to cover treatment costs in order to permit the therapist to give some information to the insurance company. If the patient wants to pay any costs, then therapists do not need to contact insurance companies. Therapists should inform patients that insurance companies will maintain confidentiality of information, but a therapist do not ensure what will happen after he/she gives any information to insurance companies. Insurance companies can customarily be satisfied with some basic information, such as the patient's name, dates of therapeutic sessions and diagnosis that the patient gets for treatment.

The issue of patients' confidentiality and privacy is undoubtedly one of the most important and critical issues. It is, therefore, significant to give some detailed explanation about it. Some cases and situations may require the psychotherapist or psychologist to give some information about the patient especially in the following situations, which have further explanations in a research submitted to a session entitled: "Professional Confidentiality between Patients' Rights and Society's Safety" held by Social Rehabilitation Center/Qatar, 2013.[16]

In some confidentiality situations, doctors or therapists can explain the issue of confidentiality by confirming the following:

In therapeutic sessions

- In case you seriously endanger the life of another person, I must protect this person and I might be impelled to inform this person or I call the police;
- In case you present a danger for yourself, I might find myself impelled to put you in the hospital or contact your family or anyone who can protect you. In this case, I will discuss these issues with you before taking any procedures unless there is a good reason not to do so;
- In emergency cases when your health suffers a pending danger, I may inform anther professional about your case in order to secure the safety of your life, without your permission, and I will discuss these issues with you if possible;
- When I doubt or conclude that there is a child exposed to abuse due to negligence, assault, beating or sexual harassment, I have to write a special report that allows an official authority to investigate and find facts;
- In such cases, I will disclose only the necessary information in order to protect you or other persons. I will disclose everything that you told me;
- In case you have any opinion about these issues, we can discuss legal matters in detail before you tell me any information on these issues.

Dealing with courts and judiciary

- In general, if you have a court case, you can prevent me from giving any information you told me. This privilege is always

available for you and you can withdraw it at any time allowing me to speak before court;

- But in some cases, a judge may ask me to testify because he believes court needs some information to reach a fair decision, including:
  1. If your psychological, emotional and mental case is considered important information for the court's decision;
  2. In case of malpractice or in a disciplinary hearing against a therapist;
  3. In case of juridical civil hearing when you may be admitted to a psychiatric hospital;
- When you bring me a court order, we may discuss in detail the confidentiality because you are not required to tell me what you do not want the court to know.

When consulting other professional colleagues

- Sometimes I need to consult another therapist about your treatment. I will not declare your identity and, of course, this therapist is bound to keep confidentiality;
- If I am travelling or out of town, another therapist may act on my behalf caring for the cases I deal with. In this case, I have to tell him/her about my patients including you;
- I am required to keep a record of the work I do with you, authenticating it with the dates of sessions and sometimes the case progress. You have the right to see these records with me unless you think that some written comments bother you; then I will not allow you to read this information but I will explain to you my reasons completely;
- In addition, I may keep my own comments concerning psychotherapy separate from this record, as these comments cannot be read without a special permit.

Insurance companies

- If you enquire about your insurance in order to pay the treatment cost, I have to give some information about the treatment to the insurance company. Usually, they are looking only for diagnosis and dates of appointments. In some cases, they want to know about the treatment plan or, in short, about the treatment to know my fees. I often give you an invoice with some special forms required by the insurance company; therefore, you will recognize what they know about your treatment;
- Insurance companies have no right to disclose any information about the visits to my clinic without your special written approval (release form);
- Of course, I assume that the insurance company is acting ethically and legally but I still cannot control who sees this information in the insurance company office or at any other office. You are not required to submit any further information than this to get your health insurance or to recover any amounts paid.

In procedural cases

- If your employer has referred you to me, I might be asked to give them some information. In this case, let us fully discuss the nature of my agreement with your company before talking about anything else;
- If your debt accumulates without paying to me or reaching a payment plan, I may ask the court to recover the amount due. I will not give courts or lawyers any information except your name, address, the date of your visit for treatment and the amount due.

Child rights during therapy

- Children, under twelve years of age, who get treatment have little legal rights to prevent the information from their parents. I may give them information when required;
- However, 12- to 18-year-old teenagers and the more a person becomes capable of understanding and choosing, the more he/she gains legal rights;
- In this case, you should generally know that most of what you say to me will remain confidential and private, because this will help you get recovered, nevertheless, parents have the right to know general information about some important social matters, or about the progress of treatment, which help them take right decisions with respect to the treatment;
- I may also tell, if necessary, some information on family members that you told me about before.

Spouses in therapy

- If you told me about something that your spouse does not know, I cannot morally agree upon not telling him/her, if missing such information may cause him/her harm. I will help you take the best decision to manage this matter on the long term;
- If you agree with your spouse on child custody or if you have a court custody hearing, I need to know that as this may affect the course of treatment;
- I need your agreement upon that if the psychotherapy/ counselor does not solve your marital difficulties, you then apply for divorce, you should not ask me to testify for any party;

- However, I might be asked by court to give testimony if necessary.

Treating the members of the same family

- If I treat members of the same family, then confidentiality will be very complicated, I will have a combination of responsibilities towards the different family members;
- From the early beginning, we must clarify the objectives of your treatment and my role in caring for your family. According to this agreement, we may solve the problem of limited confidentiality;
- We should also agree which family member will sign a permission of disclosing the documents I write during the treatment.

Group therapy

- If you are in group therapy, you should know that other members are not therapists and the same ethical and legal rules are not applied to them;
- In general, it is difficult to be sure that they will keep the confidentiality of what you say in the group.

Displaying the photos of patients falls under confidentiality and respect of privacy, especially in case of showing or publishing an academic research.

Additional explanations on confidentiality

- Any information you tell outside the treatment sessions will not be considered confidential by court;
- I will not do sound or video recording of any treatment

session without your permission;
- If you want me to send the information of your treatment to another person, you have to sign an authorization allowing me to release the information.[17]

Case study

A psychiatrist diagnosed a case of an eight-year-old child called Rabee' who suffered from some learning difficulties at school. He had to listen to the child's developing story and the story of his family status in order to know about the relationship between the child's parents. The psychiatrist found that Rabee' had been suffering from some emotional difficulties, especially because of a severe and long dispute between the parents and had heard about a possible divorce between them among other family problems. He got an official message from the child's school asking him about "any information about Rabee's problems," and found that the school did not want to know about all details that he had collected. His message was limited to refer to the result of intellectual evaluation conducted to the child and a general description of his case as having "some emotional difficulties within his family."

Patients' options

Patients or those who receive treatments have the right to get their psychiatrists' opinions about any potential diagnosis after assessing the case or any therapeutic procedures plan in as much details as possible. This is to know the nature of the suggested treatment and the available alternatives of psychotherapy, psychological or pharmaceutical treatments. Psychotherapists should explain everything to their patients

in a simple and understandable language. This explanation is not only useful to help the patient respond to the treatment but it also helps the therapist to fulfill his ethical and professional responsibility.

Right to refuse or withdraw from treatment

Patients have the right to balance between potential advantages and any expected disadvantages of a particular method of treatment. He/she therefore is free to refuse a treatment or request an alternative one. Some cases may be excluded from this, for example, when a patient with mental illness is forcibly put in hospital against his/her will in accordance with applicable laws. It usually happens when a patient loses awareness or poses a serious danger to his/her life or to others. When he/she gets the required treatment, he/she then has no right to refuse.

In countries where there is a Mental Health Act (MHA) in effect and a general respect for human rights, there are multiple ethical criteria to control these cases and prevent abuse. We mention here how a forced entry into psychological clinics was an approach applied in some communist countries such as the Soviet Union and other countries. This approach perhaps is still in force in some countries that do not pay much attention to human rights. On the other hand, there might be no option to refuse or accept a treatment for a child who gets admitted to a hospital by his/her parents.

However, it is the duty of a psychotherapist to respect the patient's rights, wishes and choices of treatment goals, treatment methods, number of sessions and type of psychotherapy. This is a very important matter when prescribing psychiatric medications, especially with the availability of information on the Internet. Patients may read about a psychiatric medica-

tion's effectiveness and side effects that may drive them away from receiving certain medications. He/she, therefore, has the right to refuse it.

Case study

Leila is a 60-year-old woman from a rich family. She had to visit emergency due to a pain in her knees. She was able to walk without help. Two days later in the hospital, Leila asked to leave the hospital. This was against her doctor's recommendation. The medical team did not observe a reason to prevent her from discharge except some mild signs of anxiety that indicated modest fears. That day, Leila did not return home. After two days of arduous search by her family, officers found her in a market sitting in a dark corner in a dirty dress and barefoot, with apparent signs of hunger and stress on her face. Leila did not answer any questions that the officers asked her but they recognized her from the description given by her family. Police officers took her back to emergency where all her sons and daughters arrived and felt so sad to see their mother this way.

After a psychological evaluation, the psychiatrist found that Leila had suffered from confusion regarding date and place, a loss of speech ability and a great negligence of herself after being that woman who was very proud of her appearance. Again, Leila refused admission to hospital and asked to go back home. Meanwhile, the psychiatrist advised against that; he diagnosed the case as severe clinical depression with possible beginning of senile dementia (Alzheimer's). He recommended to start her electric-shock treatment, and prescribed her an antidepressant along with anti-psychosis medication. Despite the careful explanation by the psychiatrist, Leila rejected all proposals.

After her sons and daughters' approval, Leila, consequently, was forced into admission to the psychiatry department.

Patients' rights to change therapists or specialists

Patients or clients have the right to change therapists for whatever reason. The need for change becomes greater if the patient feels no benefit from continuing sessions with his/her current therapist. Doctors or therapists, therefore, should respect the patient's right in this change without taking any personal defensive reaction. A doctor should help his/her patients to make it easier to move to another colleague, whether he/she knows this alternative doctor or not.

Patient's rights to know therapist's competence and qualifications

In normal medical treatments for physical and surgical diseases, it is the patient's ordinary right to expect from the therapist to have high and suitable qualifications to treat illness. This goes true with disorders and psychological difficulties. A mental illness patient or a person suffering a mental problem has the right to know the therapist specialization and the various disorders and problems that he/she can cure and deal with. The therapist or practitioner should be ready to show no objection and pay efforts to explain specialization to patients and to anyone seeking help through treatment.

A current ethical problem is that some therapists or psychological counselors do not have the efficiency required, as many Arab and Muslim countries have not adjusted or organized these psychological therapies. It is ethically a problem that psychological treatments have different schools and specialized fields. For example, cognitive behavioral therapy needs appropriate training for at least two years but we find people,

who may have attended one training course for one/two days or read a book on this treatment practice, "treating" some disorders and psychological problems! The same criteria go with other fields of treatment and psychological counseling. It is true that some countries and scientific entities may take time in developing accurate standards and procedures, but this gives no permission to neglect the ethical duty of therapists or psychological counselors.

Case study

Miss Lubna suffered from mental depression for three years. She visited more than one psychotherapy clinic. Every time her doctor described antidepressants, yet she did not like psychiatric medications as she suffered from severe side effects. A psychiatrist advised her to try Cognitive Behavioral Therapy (CBT), a well-known psychotherapy with proved effectiveness in treating depression, as an evidence-based effective medicine which matches medical treatment in many times. Lubna went to visit a psychologist in her city to learn about CBT. He offered to treat her, although he had graduated from a national university where he had studied only general psychology. He had no training in clinical psychology or in this specialized psychological treatment.

2. Therapist's responsibilities

Competence

There are two main criteria required in high psychological treatments to measure the therapist's competence: intellec-

tual competency and emotional competency.[18] Intellectual competency includes knowledge gained by main systematic education, which depends on respected research results and respectable specialized views through practical training and scientific supervision over the use of therapies he/she learns and practices.

Intellectual competency also includes the therapist`s ability to evaluate the case he has and understanding the nature of the problem as well as putting an appropriate therapeutic or procedural plan that ensures the patient's/client's safety. Among intellectual competency's features are that doctors or therapists recognize the limits of what they know or do not know and at which they are skillful or not. A skillful therapist in treating certain psychological issues is not necessarily skillful in other mental disorders. This competency is usually gained by education and training that the therapist receives and by the quality study and certificates obtained through his/her formal and non-formal education.

Emotional competency means that a therapist can tolerate and has a good capability to willingly deal with facts and clinical psychological information that appear in treatment sessions. Furthermore, a therapist should have the required skills that enable him identify the cases and situations when he is partial and is not neutral during work with his/her patient. A therapist should also be able to take care of himself/herself when he gets involved in the difficulties that arise at work during psychological treatments.

Knowing and recognizing these aspects is not a weakness in a psychotherapist. It is quite the opposite. Some therapists working in metal health fields might, due to some physical, social or personal pressures, find themselves obliged to receive any case that comes to their office or clinic to start treatment.

There is no doubt that this does not exempt specialists in mental health from their moral responsibility.

The various procedures and ethical criteria take several forms, such as professional laws and regulations and ethics criteria or guidelines of practices as well as certain criteria required by some entities for covering therapy costs, and the criteria by insurance companies or official licensing procedures by governments. Nevertheless, scientific entities attempt to put things in order to adjust quality and efficiency of psychotherapy practices, but they have no impact on providing proper evaluation of such practices. So far, it seems that all efforts have failed to provide suitable evaluation of those practices, which confirms, once again, the importance of therapists' moral obligation. This is why such a leading seminar held by CILE is clearly important.

When we talk about competency, of course, we do not mean perfection as there is perhaps no perfection in this world. The ethical criteria usually refer to what might be called (good enough therapist) according to the evaluation of professional colleagues and practitioners who understand the nature of mental disorders and illnesses and recognize the appropriate criteria for treatment and the expected improvement or recovery.

Case study

'Abeer, a psychologist, practiced individual psychotherapy for a number of years on cases of stress and depression, as she had a good expertise in this area through her university education and then in a two-year training program on individual cognitive behavioral therapy under the supervision of an accredited trainer and psychotherapist in this field. During her continu-

ing education, she attended a half-day training course in family therapy and then began announcing herself practicing family therapy and marital therapy with her clients. She also continued reading on family therapy whenever possible.

Prophet Mohamed (PBUH) briefed the ethical responsibility of a therapist by saying, "Whoever practices medical treatment without knowledge will be held accountable for any loss incurred" (Abu Dawud and al-Nasa'i). According to another narrator: "Whoever practices medical treatment without being known for his knowledge of medicine will be held accountable for any loss incurred" (Abu Dawud, al-Nasa'i, Ibn Majah and al-Hakim). A therapist, whether a doctor nor not, is held responsible for his/her work. Muslim scholars explored this issue in details taking a moderate stand far from excessiveness and negligence, being the causers of suffering to humankind.

Good relationship and no exploitation

A patient who seeks psychotherapy or counseling due to some emotional or personal disorders is vulnerable to exploitation by the therapist. Undoubtedly, a therapist has a stronger position in this situation as he/she controls therapeutic processes while patients or seekers of counseling are keen to please the therapist and meet his/her needs thinking that all therapist's specific requirements are only to help overcome current problem.

The therapeutic relationship may thus become more complicated, as it is expected from sessions of psychotherapy to give rise to a phenomenon widely known as "transference." In this case, the patient feels that the therapist is an important person in his/her past just like father, mother or others and begins to act toward this therapist as so in this phenomenon of transference expressing himself/herself as if a fact in this

relationship. Conversely, a therapist or a psychotherapist may also fall in counter-transference when he/she starts acting and reacting towards the patient as if he/she is responsible for his/her private and familial life just like a parent with children. Therapists in this case should be aware regarding the patient' transference and their own counter-transference.

Doctors or psychotherapists should be careful not to extort the patient's vulnerability resulted from psychological or emotional state. They should not exploit patients financially, sexually or in service nor should they make use of their patents public relationships. Therefore, what is ethically required from psychotherapists, pursuant to statements of ethical regulations developed by professional associations of mental health, is to assess relationships with patients in therapeutic processes based on mutual trust. Any error in this relationship may incur grave unexpected consequences.

Good conduct with people from different classes and cultures

A psychotherapist usually provides services of psychotherapy and psychological care for different sectors of clients, which could be called "trans-cultural treatment." Most concentration was previously shed on ethical measures adopted by the doctor or the therapist when dealing with people from different cultures. Recent orientations of the optimal treatment with clients coming from different backgrounds include many differences and distinctions among various minorities, such as differences of ethnicities, races, nationalities, gender of clients: male or female, and elderly and those who belong to a religious minority different from the therapist's, as well as patients with disabilities or special needs and AIDs-positive persons.

Some standard ethics have been developed for trans-cultural treatments including the following:[19]

1. Cultural differences are considered private, complex and dynamic specificities;
2. Good therapeutic relationships should first appropriately start with treating outstanding cultural differences between both parties;
3. Discussing the common grounds may pave the way for better dealing with dissimilarities and differences;
4. Appropriate timing for discussing the issue of cultural differences is essential to avoid interrupting the optimal communication between both parties;
5. Cultural differences could be powerful factors and good sources to strengthen therapeutic relationships;
6. Meaning and significance of cultural differences may be deeply affected by the course and content of therapeutic sessions;
7. Understanding the patient's culture, history and background may play a significant role in determining and diagnosing the current psychological difficulties, and will help in planning the therapeutic goals;
8. The therapeutic relationship is originally implied in the general cultural framework, which may affect this relationship;
9. The cultural competency of a doctor or a therapist may greatly affect the way of dealing with differences;
10. It is necessary to note that discussing cultural differences in therapeutic sessions may affect the course of a patient's cultural context.

Therapist's rights to refer a patient to an alternative therapist

Many reasons exist for therapists to refer their patients to another doctor or therapist. They may find it so difficult to treat the problem confronted, because it falls outside their specialty or due to other problems that a therapist cannot handle. For example, the patient's several attempts to commit suicide or threats to hurt himself/herself, missing many treatment sessions, refusal to pay for treatment in a private clinic, harassment by so many calls, day and night, or disturbing the therapist's family.

Case study

Dr Adel, a consultant psychiatrist, began treating a 32-year-old young man who, over five years, suffered bipolar affective disorder. During treatment, this man went through a state of mania when aggressive ideas appeared with paranoia essentially directed against the psychiatrist. Over some more months, his state deteriorated and the psychiatrist did nothing but increase the drug dosage. The patient began to act aggressively towards the psychiatrist and broke some furniture in his office. When the psychiatrist attempted to refer him to another therapist, his reaction became violent and he refused the referral, so the psychiatrist ended the therapeutic relationship, as he thought this could end the issue, but he was surprised to find out that his patient rented an apartment opposite to his house to spy on him and his family. He also called them by telephone at any time, day and night.

In this case, the psychiatrist failed to recognize that his patient began to lose control and the former was not able to cure

him. Eventually, the case deteriorated to a dangerous extent. When the psychiatrist realized the dangerous situation, it was too late. The case was taken to the police and court, where the judge's report stated, "The psychiatrist continued medication despite his competency was not enough to offer the optimal treatment for the dangerous case of his patient. The psychiatrist thus, directly or indirectly, led to the deterioration of the patient's state. He had to seek the support of more competent entities at an earlier time to deal with this patient."

Therapists' duty to know the scope of their abilities and potentials

It is no doubt that a doctor or a therapist, regardless of his/her expertise and knowledge, may face a difficult case to treat, due to difficulty of diagnosis or complicated mechanism of treatment. The problem may also fall outside the psychiatrist's/doctor's area of specialization, who must know the patient's right to know of this fact and thus to seek available alternatives, for example, consulting another colleague or referring the patient to another doctor with more experience on the area of need.

Case study

Mr Mahmoud began to receive psychological treatment from a psychiatrist for anger fits that erupted from time to time while with his family. Apparently, Mahmoud had the symptoms of paranoia. The psychiatrist thus advised him to be admitted to a psychiatric hospital, an advice which Mahmoud refused. For him, it was his right to decide on this point and his case was not that dangerous to his life or others. The psychiatrist continued

his treatment and therapeutic sessions despite his belief that it was better for Mahmoud to be in a hospital.

End of treatment/sessions when a patient reveals no improvement

It is the duty of a psychiatrist, when a patient shows no improvement after a period of therapeutic sessions, to inform the patient that the state showed no improvement despite the efforts made and it might be better to consult another psychiatrist whose treatment may prove more effective and efficacious.

Case study

Two years ago, Mr Nizar began visiting a psychotherapist two times a week. Although his psychological state had shown much improvement a long time ago, his doctor continued giving him appointments without any advice, at any phase, to stop medical appointments. Nizar became fully connected and dependent upon his psychotherapist, who believed that "as long as the patient needs more sessions, so why not!"

Cooperation with entities capable of supervising and assessing therapists

It is the duty of a psychotherapist or psychiatrist to cooperate with entities capable of controlling the work quality and integrity with patients and others in need of treatment or mental counseling as usually practiced by entities issuing medical licenses for practices. For example, the ministry of health and other scientific entities in charge of monitoring the professional standards of psychological therapies including the societies of

psychiatrists and psychotherapists and similar entities.

Some of these entities request the practitioner to fulfill specific requirements of periodic training, which in turn necessitates the therapist to attend a specific number of training hours and practical activities to stay in touch with the most up-to-date developments and discoveries that help him/her to offer the best treatment for cases presented. This necessary cooperation makes it mandatory to cooperate with any complaint presented by a patient, his/her family or a third party when concerns arise about some practices, treatments or their outcomes.

Therapist's ethical responsibility towards entities requesting information about patients

The same abovementioned criteria on confidentiality and respect of patients' privacy should also be in force here. Therapists should reveal no information that may help recognize the patient or his/her family. The same goes true for any third party that may request any information directly or indirectly, such as insurance companies, as stated above when exploring the issue of privacy, and different media as well as the company where the patient in question works.

Therapist's personal stands, beliefs and thoughts

Mental disorders and problems normally leave a person vulnerable to others, including therapists. It is the duty of a therapist to respect the patient's ideas and beliefs; and she/he should not exploit a patient's vulnerability or disorder to influence her/his religious, political or social ideas. Undoubtedly, this needs much care and awareness by the therapist.

Therapist's relationship with pharmaceutical manufacturing and sale companies, and medical equipment companies

Pharmaceutical companies as well as other companies of psychiatric medications and medical equipment will normally try to promote their products by providing some material exhortations or services to physicians and therapists with an aim to encourage them to promote the use of these products whether internationally or unintentionally. Some companies may offer free air tickets or meals to some psychologists and psychotherapists driving them to promote their drugs at the expense of other companies' drugs and products. It matches the popular saying: "there is no such thing as a free lunch."

3. Treatment procedures

Permission field, explicit permission and informed consent (especially child protection)

It is the informed consent, conscious or informed confession, as the patient needs to know the procedures of treatment, nature and limits of effects and side effects expected. It should be all expressed in a clear language by a therapist using an easily understandable and ordinary language to patients. It is appropriate to offer some verbal and written information or through some available means like video and useful websites. Based on my experience for a number of years, as a member of the medical ethics committee (medical ethics committee for hospitals in Belfast, Northern Ireland), I can say that many practitioners of medicine, surgery, psychiatry and mental counseling, by help of appropriate training and supervision, have normal professional lives apart from ethical crises and challenges of

professional practices. However, when an incident takes place, we are held in wonder for the little awareness of ethical professional procedures and the way to observe and address them.

It may partly be referred to the absence of teaching and training in fields of professional ethics of practice in academic faculties and graduates' training programs. It recalls the reconsideration of the subjects educated for those students to guarantee a proper number of educational hours on medical ethics and the ethics of professional practice that suit the area of specialization, be it psychotherapy, psychology or social service. (I taught part of medical ethics at Belfast University.) Many of the ethical questions proposed to ethics committees affiliated to specialized bodies come late and only help better reform and rehabilitation, not prevention. Awareness about these ethical standards may help earlier solution, when a case is suggested before occurrence for the sake of prevention, not cure.

Case study

In a clinical periodic discussion where therapists exchange views, a psychotherapist consultant related that he was in a therapeutic session with a 20-year-old man who suffered from some psychological and behavioral problems most likely caused by child molestation at the hand of his adult elder brother. At the end of the session, the psychotherapist mentioned that the patient said that his younger brother, only 11 years old, was now suffering the same sexual molestation by the same elder brother. The psychotherapist mentioned nothing more.

I then asked this colleague whether he could do anything after knowing that an 11-year-old child was suffering sexual abuse by his adult brother. It was evident that the colleague had

no idea about any ethical or legal principle to consult for help in this situation. He felt his duty was to inform some authorities about the danger to which the child was exposed and the child's safety was his paramount consideration.

Confidentiality and exceptions

This issue has been discussed above under the title patient's rights.

Group therapy and problems of confidentiality and privacy

Group therapy may prove useful in some cases of psychological disorders or problems, as it may help the patient reach satisfaction and change ideas and situations in a better way by sharing therapeutic group sessions. Addiction is one of the states where group therapy is always recommended, such as the cases of "AA" or alcoholics anonymous, general anxiety, phobia and others.

Group therapy inevitably exposes some problems, particularly the issues of confidentiality and a patient's privacy, which differ from one society to another according to the limits of openness within a society. Finally, patients' desire must be respected and their consent to have this therapy is necessary.

Case study

I personally supervised the treatment of a number of young girls who had suffered sexual abuse. At a certain point, I felt it was useful for those girls, all of whom were over twenty years, to have group therapy in order to learn from one another and exchange skills of adaptation with hard emotions and life dif-

ficulties. Negotiating the issue with each of them individually was a desire I respected and no group therapy was held, as only two accepted while two apologized and expressed respectfully their desire to keep the details of their lives confidential. Individual therapy thus continued.

Documentation and archives

Like other medical treatments, it is necessary in psychiatry to document the work of psychiatrists and record the details of psychological sessions including symptoms and indicants, the phases of treatment and rate of responsiveness and the decisions taken to address the patient's emergent situations as well as the procedures adopted by the therapist. Benefits of this documentation are many and proved necessary for several considerations.

The duty of a therapist is to preserve these archives safe in form and place that no one can review. Only the therapist and, perhaps, his/her honest secretary in charge of keeping the archives can review when needed for writing something or preparing a report. This is equally applied on written and digital archives.

Therapeutic contract

Therapeutic relationships between patients and therapists must comply with regulations and procedures clearly known to both sides to make sure that things go in the right way and reduce the possibilities of future differences and deviation from the way intended by psychotherapy. Although the concept of "therapeutic contract" is not new, no clear discussion explored it until the 1970s of the last century.[20]

It is an ethical error for the therapist not to tell the patient about some basic matters from the very beginning of psychotherapy, such as:

- Diagnosis of case presented, even if tentative (a therapist may need more than a session to determine the proper diagnosis);
- Suggested therapy and possible alternatives (if any);
- Aims desired and expected from therapy;
- Nature of therapeutic process and the patient's expected role and responsibility;
- Number and approximate concurrency of sessions;
- Doctor's/psychotherapist's role and responsibility;
- Possibilities and manners of communication between sessions;
- Potential or expected side effects;
- Possible limits of professional confidentiality (refer to the issue of confidentiality stated above and when to overlook it);
- The way a therapist would keep the patient's private file and he/she should answer the patient's questions in this regard;
- Nature of relationship and limits of responsibility when the patient is under eighteen.

Case study

'Abdulrahman was 20 years old and a religiously committed young man. He visited a psychotherapist seeking help and treatment as he had a problem of being attracted to male youth and men, especially men who were 10 years or more older than him. 'Abdulrahman did not feel good about this attraction to the same sex and wanted to get rid of it and become "normal,"

he said, as inspired by his religious motives with hopes of future marriage and family, which was also his mother's deep hope for her only boy among five sisters.

The professional psychotherapist decided that 'Abdulrahman suffered a problem concerning the acceptance of this sexual attraction due to the pressures of his conservative community and his attempts to please his mother while he was deeply unwilling to change. Consequently, the psychotherapist started psychological sessions with the aim of helping 'Abdulrahman to accept his attraction to members of the same sex, simply because this was the psychotherapist's conviction he received during his psychological education and training that sexual attraction to members of the same sex was "natural" and inborn character where one has no choice.

Psycho-education

Appropriate therapeutic practices should not be restricted to the treatment of symptoms of disease or disorder but a therapist should also enlighten his/her patient about the disease's causes, symptoms, possible therapies and ways to prevent deterioration or at least to reduce it. If this is the case with physical diseases like ulcer and myocardial infarction, the same goes true for mental disorder like depression, phobia, panic attacks, schizophrenia and other mental diseases.

I say that the social stigma continues to hinder open and liberal disclosures on these issues, especially in our Arab Muslim communities where public culture on mental illnesses is weak (refer to the issue of social stigma below). It is the duty of psychotherapists to work on promoting the public awareness of mental issues culture and to work on reducing the social stigma on mental illnesses.

Side effects of treatment

Undoubtedly, it is the ethical responsibility of therapists to inform their patients of any possible side effects of taking any drugs or using any other form of therapy, especially in a time when information on drugs and therapies are very common and no longer restricted to professional physicians or therapists.

Pharmaceutical companies, indeed, pursue to prevent any legal action by writing pamphlets issued with mental drugs recording all possible effects, even if an effect occurred only once amid a thousand times of use. The long list of side effects may cause some patients to worry, particularly worrisome persons. It is thus the duty of a therapist to explain the matter and the side effects of frequent occurrence and those of scarce occurrence. It is said that "each poison is medicine and each medicine is a poison," so it depends upon the optimal use and dosage of a certain substance for the cure of a certain state.

Case study

'Abeer visited a psychotherapist after suffering obsessive memories for years since she was exposed to sexual abuse by a family member. She suffered from panic attacks, depression, and loss of self-confidence, sleep disorder and nightmares. The female psychotherapist used Cognitive Behavioral Therapy while she had no training about the way to treat the victims of sexual abuse. She failed to expect the side effects and thus made no warning about them. 'Abeer began to suffer paranoia and her family had to interfere to stop these sessions and took her to a specialty hospital.

Social stigma

It is impossible to fully separate psychological therapeutic practices from the stigma of mental illnesses and mental health patients that may also extend to the patient's family, mental therapies generally and mental physicians and psychiatrists. Our communities are still suffering this stigma and the patients and their families pay for it. Patient only come for treatment when it is too late and their states are so bad that therapy becomes more complicated and requires longer times.[21]

Professional competency

It is worth remembering the quality addition by early Muslim scientists and physicians who introduced the concept of *hisbah* and set the principle that a doctor or a practitioner must have enough training and experience. I had taught a course on the history of Islamic medicine at Queen's University, Belfast, and saw the admiration that students revealed when they knew about the Muslims' contribution to this area.[22]

The ethical problems of some mental health practices have undoubtedly risen because some "therapists" or "psychological guides" may not comply with the strict criteria imposed by other physicians, who are required to achieve a certain level of education, training, expertise and practice under supervision and follow-up before getting the medical license of practice. The same goes true for physical doctors, surgeons and psychotherapists.

Physicians and psychiatrists are usually members of scientific organizations or syndicates or work under the supervision of ministries of health or other representative authorities. Psychotherapists may not submit to the same standards of com-

petency and supervision, where people may not recognize it especially when many of them cannot differentiate between a specialized psychiatrist, licensed and permitted to practice, on one hand and a "psychotherapist" who has no equal expertise or training on the other hand. Persons with very limited experience that may not exceed one-day/few-days course on some mental issues may practice "psychotherapy" in some countries, especially in the third world and they introduce themselves as "specialist psychotherapists"![23] Hopes are pinned on Arab countries to develop some regulating standards for those undertaking the mission of "psychotherapy or psychological counseling" to guarantee the safety of individuals and community and preclude the occurrence of ethical and legal problems that only patients pay for their costs.

Physicians or therapists are also required to keep their competency to maintain a good degree of coping up with the latest developments, new inventions and therapy technologies in their fields. It is unacceptable that a physician keeps apart from medical developments, specifically in his/her area of specialization. Ignorance of new discoveries and therapies is even penalized by law and the same goes true for mental therapies as a therapist should keep continuing professional education required by some scientific and health bodies that grant medical licenses for practice.

Before renewing the license, it is necessary for a doctor to prove that he/she attended training and lectures for a number of hours throughout the year, which helps him/her keep professional competence; otherwise, license renewal could be refused. A number of researches proved the positive effect of this training and sustainable education on improving competency and therapist's experience.[24] It is also hoped that entities and authorities in charge of issuing licenses in the Arab and

Muslim countries should enact laws binding therapists to continue training.

What is normal and abnormal?

This is one of the most important grounds of difference between the Arab and Muslim world on one hand and the West more generally and the non-Muslim world. The goal is to specify the normal human affair versus abnormal, whether we call it illness, disorders or otherwise. What is "good" or "not good." The optimal example of this case is the gender identity disorders.

In 2010, I presented a research paper entitled "Homosexuality: Should we treat it or not?" to the conference of Arab Federation of Psychiatrists held in Khartoum. The participants, psychiatrists and psychologists were almost in unanimous agreement on the importance of this issue, which it is forbidden to think of or be mentioned in Arab countries. It even happened that a psychiatrist in a European country spoke about aiding those in need to change their gender but he had to face a legal action filed against him to remove his name from the physicians licensed to practice psychotherapy.

Ethics of psychiatry researches

No one denies the urgency for academic psychological researches to help us understand the psychological symptoms, whether natural or pathological, which in turn help us discover the optimal treatment and procedure for these psychological phenomena. However, it is necessary for these research measures to be in conformity with strict ethical criteria that guarantee the right of an individual involved in scientific experiments,

protect the researchers and ensure scientific objectivity.

It is enough to mention one of the serious criteria in medical and psychological researches, namely, the Nuremberg Code (1947) which is the constitution of medical research ethics.[25] In countries that respect scientific researches and human rights, a researcher who conducts a medical or psychological research should first get the approval of the ethics committee entrusted to approve such researches. Sometimes the committee may deny the request for permission, if the research conflicts with human rights or safety criteria guaranteed for the patient and others involved in experiments.

The Nuremberg code includes a number of principles on the ethics of medical research and emphasizes the human rights guaranteed for persons willing to participate in scientific experiments. The code includes the following points:

1. Voluntary consent of the subject person is absolutely essential;
2. Experiment should be such as to yield fruitful results for the good of society;
3. Experiment should be so designed and based on the results of previous animal experimentation or any other logical justification;
4. Experiment should be so conducted as to avoid all unnecessary physical and mental suffering and injury;
5. Degree of risk to which a voluntary person may be exposed should never exceed interests expected from a research;
6. Experiment should be conducted only by scientifically qualified persons;
7. During the course of experiment, the person of interest should be free to end the experiment with no need to present any justifications.

To know about possible ethical obstacles and problems that may hinder the psychotherapists' work, it is useful to review the unprecedented quality survey studies conducted by the American Psychological Association in 1922. It asked 1319 professional psychotherapists of its members to describe ethical situations and problems that they had in their practices and formed an ethical challenge to them. Among them 679 responded and described 703 situations classified in 23 types, as the following table shows:[26]

	Type of problem	**Number**	**Percentage**
1	Confidentiality and privacy	128	18%
	Possibility that a third person may be exposed to danger	38	
	Child abuse	23	
	HIV-positive person	8	
	AIDS-positive person	6	
	Elderly abuse	1	
	Internal conflict whether or not to disclose private information	79	
2	Keeping the professional relationship and interests of conflicting relationships	116	17%
3	Payment of money/place of work	97	14%
4	Methods of education/academic place/problems of training	57	8%
5	Legal/ forensic-led psychology	35	5%
6	Researches and studies	29	4%
7	Colleagues' behaviors	29	4%

8	Sexual matters	28	4%
9	Psychological assessment	25	4%
10	Using insecure or unsafe drug	20	3%
11	Competency	20	3%
12	Ethics of practice/ethical committees	17	2%
13	Psychology: schools and teaching	15	2%
14	Publication	14	2%
15	Helping the poor and the needy	13	2%
16	Supervision	13	2%
17	Ads and misrepresentation	13	2%
18	Industrial psychology/companies	9	1%
19	Legal–medical issues	5	1%
20	End of treatment	5	1%
21	Racism	4	1%
22	Therapy archives	4	1%
23	Miscellanies	7	1%

Second Subquestion: What Are the Ethical Standards for Employing Technologies That Provide a Psychological Effect on Individuals and Groups?

Psychotherapists have several mental therapies available to use. For example, psychotherapies may be verbal, behavioral, individual, group or dual in addition to pharmaceutical therapies and electric shock therapies. A psychiatrist or psychotherapist may use all therapies except pharmaceutical therapies and electric shock therapies, which can only be prescribed by a psychiatrist who received knowledge and training about pharmaceutical therapies as part of his/her general medical training before psychiatric training.

The pharmaceutical therapies are thus excluded while other psychotherapies may be used under the general medical code of ethics. Electric shocks are also excluded, which are usually used under general anesthesia. It is highly effective in cases of severe depression and it is very different from the stereotyped image displayed in movies, which is typical of torture, not therapy.

Here, we elaborate on therapies used for psychological effect on a person, for example:

- Psychological therapies based on direct dialogue between a therapist and patients or clients, such as cognitive psychotherapy and psychoanalytical therapy;
- Behavioral therapies with several technologies such as biofeedback, stress management, aversive therapy, operant conditioning, classical conditioning and other physiological interventions.

Except for the aversive therapy that had ethical objections and thus rarely used, other behavioral therapies are widely used. All these therapies normally need specialized training that a therapist has to take before using them in mental therapies to realize the dimensions of the psychological school standing behind these technologies and the range of their desired effect and their potential side effects.

Applying these therapies presumes that the patient has self-control and can control his/her environs while submitting to these therapies. The use of these therapies is generally accomplished by the patient's effective cooperation and prior consent and he is free to end them when he/she wants it. The ethical problem appears in some cases and situations when a person under treatment is unable to approve or refuse treatment, such as the unconscious patient suffering severe psychosis or severe mental disorder or retardation. In such cases, a therapist must

resort to a third independent side to get approval of these therapies such as the opinion of a specialized scientific committee or a court order.

The rise of media impact and social attention is natural upon using some behavioral technologies in certain environments, such as schools and prisons in an attempt to reform and adjust behaviors. Examples of these behavioral technologies include the deprivation of some advantages for the adjustment of negative behavior and the enhancement of positive behaviors. A behavioral therapist is required to abide by the ethical criteria and principles for controlling these practices and there should be direct regulatory mechanisms to observe these practices lest they should go beyond the rational ethical limit of psychological behavioral therapies.

Case study

In a hospital specialized to teenage patients who suffer mental retardation and severe emotional disorders, a psychiatrist developed a way of behavioral therapy exposing a teenager to a light electric shock whenever the teenager banged his head against a wall. This teenager had already lost an eye and was about to lose his second eye because of forceful and repeated beating of his head against the wall for no reason known to the team of therapists. All trials to stop him from this dangerous behavior failed. Although the psychiatrist had the approval of his parents to use this therapy, a specialized scientific committee of ethics did not approve continuing this behavioral therapy.

Third Subquestion: Is There a Role for Religion to Play in Mental Health and Psychotherapy?

Since Sigmund Freud and other psychologists wrote on the neurotic/pathological effect of religion on mental health when he suggested that religious people are more liable to mental diseases than others,[27] many of those worked in mental health during the 20th century were badly affected by this negative view of the relationship of religion with mental health. Many of them had negative, sometimes aggressive, views of religion to the extent that some claimed that religious beliefs are responsible for the loss of confidence, depression and even schizophrenia.[28]

However, research studies conducted during the last two decades led to a drastic change in this view as their findings proved this relationship to be more positive, specifically the positive effect of practicing religion and worships on mental health.

A significant study of the last two decades' literature on the impact of religiosity from the psychological, psychiatric, medical and mental health and sociological perspectives proved that the impacts of religiosity and religious worships are generally useful and preventive.[29]

Further findings that lent support to these studies include the development of various measures of religiosity, faith or spirituality. These studies proved that religiosity helps man endure psychological, physical and social shocks particularly in cases when a person involved suffers a fatal disease.[30] It also helps man have stronger immunity and better resilience. Many studies exploring the relationship of religiosity, faith or spirituality with mental health state, find it as a relationship that is generally positive on both sides, that is, faith and religiosity

enhance mental health, whereas persons with good mental health enhance and strengthen their feelings of faith.[31]

Faith and practicing religion reduce the rates of mental disorders including anxiety, depression, suicide trials, addiction and forbidden drugs. Many therapies for these disorders speak of the positive role that faith and worship play to bring about security, self-assurance and nervous and muscular relaxation, which have positive reflection on improving the conditions of mental health.

Faith and worship may also improve the physical health including the relief of cardiovascular diseases, for example, blood pressure. It is also found that a person involved in practicing worship sessions even once a week lives seven years more than others who attend no worship sessions.[32] Interpretation for these positive effects suggests that religiosity gives man a higher goal of life and thus boosts the morale at times of distress. It also helps an individual to join a worship gathering, which makes him/her feel socially affiliated and associated.

It is no doubt that relationship of religion with mental health is important, particularly when we remember that religiosity and faith are highly important, in a way or another, for the majority of people. Studies indicate that 90% of people practice some forms of religious sessions and worships and they find them helpful for them to adapt to life pressures and difficulties including sickness and other plights.

A number of studies also discovered that many of the patients desire to discuss religion and faith with them. Religiosity and practicing religion also help to improve family relationships and marital relations and thus positively affect mental health, specifically when reminding of the grave effect of family and marital problems and difficulties on the mental health. This is equally true with regard to parents, spouses and children. In my

endeavors to explain the nature and mechanism of religiosity's positive effects, the following mechanisms are recommended:

- Healthy practices followed in religion. Islam in particular includes many of these teachings, traditions and ethics;
- Social support given by believers and mass worships;
- Psychological resources and sources enhanced by religion, such as self-respect and self-esteem and the feeling a religious person has of the ability to change and influence the world;
- Faith grants psychological aids such as self-assurance;
- Cognitive side inside religious people that they have a complete and integral worldview, so life is no longer a puzzling dilemma;
- Mindful awareness and focus on current state of religious people in sincere and pure attention;
- *Salah* (prayers) grants the feeling of connection with God, and that man is not alone even if people around him are very few;
- Repentance and revived return to God, which permit man to start again and again regardless of mistakes and sins: "All the children of Adam are sinners, but the best of sinners are those who repent often" (classified as a good hadith by Al-Albani).

To sum up, ethical duties of therapists or psychotherapists include that they must respect the beliefs of patients and those seeking counseling; they should not underestimate the patient's religious deeds and interests, whether individually or in group, and should declare their respect to patients' beliefs even if therapists are not bound to believe the patient's religion or ideas.

Another ethical duty of therapists or psychotherapists is

that they should not exploit the patient's vulnerability resulting from suffering emotional or mental disorders, especially as the patient is generally eager to please the treating doctor within their relationship as mentioned above.

Conclusion

In this paper, I attempted to answer the three questions presented. For the sake of avoiding protraction, I did not explore some important issues a psychiatrist or others, of those offering psychological therapies, may practice or need to give counseling about them. Examples of these issues include, but not limited to the following:

- Ethics on psychological studies, especially those including experiments on people, on which I talked briefly above;
- Ethics of psychotherapists in academic areas such as lecturers, teachers and trainers;
- Ethics of therapists' dealing with audio, video and social media;
- Ethics on writing and publication.

Some medical practices concerning procedures of contraception as to those who suffer severe mental retardation. This material is studied in general medical fields.

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Ethics, Religion and Psychology: Toward an Alternative Relationship Comments on Mamoun Mobayed's Paper on Islamic Ethics and Psychology

Saad Eddine el-Othmani

It is not easy to comment on Dr Mamoun Mobayed's paper in view of the scholarly status of its author, who is a renowned specialist in the field of psychiatry, and also on account of the comprehensive nature of his presentation. The following comments aim to examine some of the concepts raised in the paper and to formulate some general thoughts which constitute the framework of the discussion of ethics and psychiatry.

Ethics in Contemporary Culture

The word "ethics" in the Arabo-Islamic culture refers specifically to moral principles (morality), the set of criteria specified by the principles of right and wrong, more than being attached to the standard of benefit and harm.

However, there is today a growing tendency to differentiate between morality and ethics, as the latter is concerned with the establishment of logical standards which help in the making of right decisions in given situations. Therefore, it functions as a process for the conceptualization of morality, and it aids in taking moral positions in specific cases.

Despite the differences among specialists regarding the definition of the two levels and the differentiation between them, the selection of the levels of morality and ethics is more practical and beneficial.

One of the important differences between the two levels lies in the fact that values and morality are absolute, relatively

limited and static, whereas ethics are practical, preponderant and subject to development. However, they are based on morality, which is mostly innate and intuitive, while ethics are the product of collective thoughts which aim to apply morality to situations which become increasingly complex by virtue of the passage of time and the complexity of human life.

There are also work ethics or rules of professional conduct (professional ethics), characterized as codified ethical rules, which are agreed upon in a particular profession and about which a decision of the competent authority has been issued in the said profession. For instance, one talks about the rules of conduct in the profession of medicine, engineering, etc.

Though legal and ethical rules intersect in several respects, they are distinguished from each other in some. For instance, there are types of behavior which can be legal but without being ethical, and vice versa. A given act may also be ethical but without being legal. Examples of the latter include assistance provided to refugees in an illegal situation, an act deemed ethical but which may be illegal.

Before coming into existence and becoming generalized in any given society, ethics are often preceded by the stage of their adoption as legal rules. The ethics stage is useful in the elaboration of the necessary social entente and the ancillary culture to adopt the legal base. To exemplify, the defense of animal rights was carried out in its early stage at the ethical level, and it required decades to enact laws preventing animal abuse. The same thing could be said about the protection of the environment, traffic regulations, among others.

Research in ethics has witnessed significant development in recent decades, and ethics has become a theoretical and practical concept appertaining to the ethical values of certain practices. It aims to prevent this valuation from being subjected

to the person's intuition or the prevailing habits, etc. Rather, it subjects it to reflection, discussion and criticism. Ethics covers areas of human activity and all kinds of professions, as there exist journalism ethics, market ethics, political and electoral ethics, sports ethics, etc.

At the levels of practice and scientific research in medicine, ethics have evolved in a significant way and become an integrated system for which ad hoc committees and specialized bodies have been designated, and for which charters and resolutions containing the guidelines and the governing rules have been established.

Nowadays, no medical association in the world would be recognized by the international medical bodies before it commits itself to the ethical rules of the medical profession and the specialization under which it operates. Moreover, it is not possible today in law-abiding countries to undertake biomedical research without being granted approval by an accredited ethics commission.

Islamic Ethics in the Context of Contemporary Ethics Development

There are extensive Islamic texts which reveal that, being a common human value, morality is an inherent system originating in different nations and cultures, and that it is only befitting to adopt common human concepts. People agree on the fundamentals of these ethics, given that honesty, generosity, loyalty and justice are commendable concepts in all human values, in the same way as the opposite values, like lying, being unjust, bearing false witness, etc., convey reprehensible meanings.

In underscoring values and ethics, the Qur'an addresses mankind and not exclusively believers. The verse which sums

this up is: "O mankind, indeed We have created you from male and female and made you peoples and tribes that you may know one another. Indeed, the most noble of you in the sight of Allah is the most righteous of you." Moreover, there is an authentic Hadith (*Sahih*) which confirms that Islam came in the context of the ongoing constructive achievements of humanity. Prophet Muhammad (PBUH) said: "I was sent but to perfect good manners." Commenting on the ten commandments mentioned in the verses 151 and 152 (Surat Al-An'aam), Abdullah bin Abbas said: "These are the 'precise verses' that God mentions in Surat Aal-Imran unanimously endorsed by the laws of mankind, and which have never been abrogated in their applications among other beliefs and doctrines."

One of the most prominent Islamic ethicists who have confirmed this fact is *Muhammad Abdullah Draz whose work, "*The Moral World of the Qurʾan,"[1] references the scholarly output of renowned modern thinkers in the area of ethics. He benefited from these ethicists by comparing between their perspectives and what is stated in the Glorious Qur'an regarding ethics, documenting several instances of compatibility. *Draz, in particular, examines* Immanuel Kant's assertion that the source of moral obligation exists "in that supreme kingdom in the human psyche which exists independently of both desire and the outside world."[2] He notes that it is "not only an axiomatic but, in my opinion, it is totally compatible with the concept extrapolated from the Qur'an. The Holy Book has taught us that awareness of good and evil was, in its initial composition, instilled into the human soul (And [by] the soul and He who proportioned it – And inspired it [with discernment of] its wickedness and its righteousness)."

Elsewhere in the work, Draz commends Kant's statement that "his deep and palpable intellectual probes have helped him

realize the significant difference that essentially sets off ethics from all other practical rules."[3]

Draz states in his introduction that, based on the above, his thesis is "a kind of composition wherein the ethical ideas of the East meet with their Western counterparts within a comparative framework, which is conscious, neutral and devoid of any preconceived notion or whim of fanatic adherence to a particular school." In his important conclusions, he wonders if "this rapprochement among the different cultures should not serve as a practical prelude to be followed by greater understanding and a wider tendency towards human fellowship, whereby the wellbeing of nations brings people closer to each other."[4]

The practical conclusion of this important process is that in the subject of ethics in general, and in medical ethics in particular, we find that the common human interest is the most predominant. Muslims, therefore, can be part of the current global ethical drive, interact with it positively and contribute towards its better rationalization. They do not need to isolate themselves from others on exclusivist grounds.

Fundamentals of Ethics in Psychiatry

Since human beings were first exposed to medical practice, doctors have been concerned with the establishment of its ethical standards. Hence, the Hippocratic Oath was introduced by doctors to express this moral concern. Medical ethics have been influenced by the philosophical and social changes which advocate passage from the "paternalistic" doctor–patient relationship to a contractual one based on partnership and dialogue. The doctor–patient relationship is equally based on the understanding that care for the patient does not reside merely in showing concern about the illness, but also about the pain

felt by the patient. After all, the sick person should be seen from a holistic perspective and essentially dealt with as a human being, hence the growing insistence on the need to respect the basic principles of moral reasoning, which generally consist of the following:

1. Showing goodwill towards the patient by safeguarding his interests;
2. Observing the dignity and independence of the patient;
3. Granting the right to information;
4. Offering the consensual and judicious approval for treatment.

These principles ramify into several ethical rules and rights which frame the doctor–patient relationship and the treatment process.

Psychiatry is a branch of medicine which focuses on the study of mental illness, its classification, diagnosis and treatment. Its greater objective is to alleviate the psychological and social sufferings of man. Being a branch of medicine, the ethical developments taking place in the field of medical ethics apply to it in their totality.

Because of the abuse of psychiatry and its exploitation for political ends in the former Soviet Union, in dealing for instance with opponents as psychiatric cases, the World Psychiatric Association adopted, in 1977, the Declaration of Hawaii, including the required guidelines for ethics in psychiatry, which have been subsequently updated through stages. The document stipulates that the adopted guidelines represent the minimum required ethical standards for the profession of psychiatry. In brief, the following guidelines are some of the most important ones:[5]

1. The psychiatrist should treat the patient in consistence with accepted scientific knowledge and ethical prin-

ciples, and he shall also be concerned for the common good and should make a just allocation of healthcare facilities;
2. The psychiatrist aspires for a therapeutic relationship with the patient that is founded on mutual agreement, trust, confidentiality, cooperation and mutual responsibility;
3. The psychiatrist should inform the patient about the nature of his/her condition, the therapeutic procedures, including possible alternatives and the possible outcomes;
4. No procedure shall be undertaken or treatment administered against the patient's own will or without his/her consent, unless because of the mental illness, the patient cannot make a judgment as to what constitutes his/her best interest, and on the condition that this treatment shall not provoke serious impairment to the patient or others;
5. The psychiatrist must never use his/her professional position to violate the dignity or human rights of any individual or group, and he/she should never allow inappropriate personal desires, feelings, prejudices or beliefs to interfere with the treatment;
6. The informed consent of the patient must be obtained before presenting his/her case as a research sample, taking all reasonable measures to protect the anonymity and reputation of the patient, who reserves the right to withdraw at any time from the clinical research program, as he/she had the initial right to participate in it, and this should not influence the psychiatrist's efforts to help and treat the patient;
7. The psychiatrist should stop all therapeutic, teaching

or research programs which may prove contrary to the principles of this Declaration.

Thereafter, the General Assembly of the World Psychiatric Association (WPA) issued the Madrid Declaration in 1963, which was subsequently elaborated in a number of international conferences.[6] The WPA developed these general guidelines to provide further details and clarify the ethical position concerning a number of emerging situations faced by the psychiatrist.

Commitment to these ethical principles and guidelines is essential in the practice of psychiatry so as not to leave the patient at the mercy of the bona fides of his doctor. This does not imply the exclusion of the religious, cultural and social considerations of different peoples and civilizations, for these must be entertained and integrated – as much as possible – within the international conventions ratified in this field. Today, according to the guidelines of WPA, an association specialized in psychiatry cannot join WPA unless it complies with its ethical principles and the Hawaii and Madrid Declarations.

Specificities of Ethics in Psychiatry

In his paper, Dr Tawfeeq Mamoun Mobayed has expatiated on a number of ethical issues, and I would like to examine here the ethical norms and attitudes which characterize psychiatry and emphasize their implications for ethicism in the field of medicine.

The field of psychiatry is characterized by a number of specificities which have significant impacts on the methods and limits of the application of ethics, given the effects of mental disorder on the patient's freedom of choice and the vulnerability which may characterize the person. Thus, the difficulties

encountered in the application of ethical principles in the general medical practice are critical in the field of psychiatry and constitute only few of the problematics witnessed in psychotherapy. These problematics are not found in the other areas of psychology which deal with people who do not suffer from psychological disorders (or illnesses), even though they might suffer from psychological problems but which do not amount to "disorder" or "illness." Moreover, in the medical field, it is rare to find a patient whose physically illness does not affect him mentally. This, however, does not categorize the patient's illness as a mental one.

I will discuss below three topical issues related to the ethical dimension of the doctor's treatment of the mentally ill: patient information, informed consent and direct access to the patient's file.

Informing the Patient as a Prelude to his Informed Consent

Providing the patient with adequate information about his health, and taking informed consent prior to performing medical consultation and treatment are two things which form the backbone of the ethical practice and are inextricably related. The consent is only deemed acceptable if it is done foresightedly and if the patient receives sufficient information. These two stages, however, pose several problems in psychiatry. On account of the psychological state of the mentally ill person, informing him about his condition or some of its aspects might have dire consequences for his health or for his status at the family, professional or social levels.

Impact of Informing the Patient

Informing the patient means providing him with information related to his health condition and the treatment possibilities. The doctor is required, from an ethical point of view, to ensure such information is confirmed and documented in accordance with up-to-date scientific knowledge. It must also be constantly evoked that the provided information is the result of scientific knowledge which is subject to change and development, but which the patient often sees as definitive truth. This, in general, raises several problematic issues such as:

1. In psychiatry, disorders affect the psychological mechanism at the level of thought, emotion or behavior. Identifying the illness and determining its effects on this mechanism have social manifestations which may be articulated using expressions that are perceived offensive. Some circles, restrained as they might be, still use the phrase "doctor of fools" or "doctor of madmen" to refer to the field of psychology. How can the patient be informed about his illness without fearing this could lead to backlash and rejection, perhaps even a state of agitation which impedes treatment, or in the best scenario confusion that perturbs the patient?
2. The diagnosis of mental illness always brings up the issues of cause and responsibility. The patient seeks, as does his family, to find the causes of his mental state and the party which bears responsibility thereof. In this respect, the prevalent culture meddles with the information "offered" by whoever encounters the ill person or his family, including stories of witchcraft, Jinn, evil eye, etc. The psychological fragility of the patient is one of the factors which complicate the answer to the cause

and responsibility question. It has been documented that families have fallen apart and conflicts arisen from these erroneous manifestations;

3. Evaluating the future of the illness and its development constitutes mostly the source of the patient's anguish, on the one hand, and misunderstanding, on the other one. It is often difficult to predict the evolution of the illness and its impact on the patient's level of perception and his mental and intellectual abilities. The fact that the illness is chronic makes it difficult for the patient to accept it, thus prompting him to look for alternative therapies, which at times may cause confusion in the doctor's treatment and at others complicate the illness.

These difficulties may not all be exclusive to psychiatry, but they take special dimensions in it as they interact with erroneous popular perceptions, especially those claiming that mental illness relates to the person's self and his mental and emotional specificities.

Information and Understanding

If, by providing the patient with information on his illness, it is meant to make him understand it better, which in turn helps in the treatment, this is not often the case among mentally ill patients. The manifestations in the patient's mind have a negative effect on at least the following four levels:

- The illness may affect the cognitive abilities and the intelligence of the person, thus restraining his ability to understand;
- The illness may include deliriant disorders which make the ill person interpret and distort the information presented to him;

- The patient may understand the information in a way that could exacerbate his pessimism and loss of hope during sharp mood disorders, thus increasing the risk of suicide;
- The patient may be affected by the social manifestations of the diagnosis submitted to him, which leads him to deny the illness and refuse medication, and possibly reject treatment altogether for fear of being classified as a fool or a madman, or judged as being inept to bear certain social responsibilities and be prevented, for example, from getting married.

Thus, it becomes clear that the general ethical rules concerning the patient's right to adequate information about his illness do not altogether apply to the psychologically ill person, for these require an accurate estimation as they are embedded in the context of the evolution of the doctor–patient relationship and they adapt to the patient's condition.

Barriers to Informed Consent

It is agreed upon that the best treatment is the one which receives the foresighted approval and active participation of the patient. In psychiatry, there are constraints which make it difficult to adhere to this sublime ethical principle. The mental illness relates to the self that perceives, understands and judges things, matters which form the basis of an individual's freedom of choice and decision-making. This is reflected in the words of Henri Rey, a renowned modern psychiatrist: "mental illness is an ailment which affects the freedom of the individual."

Accordingly, there is a special way of dealing with the principles of dignity and independence of the patient in the field of psychiatry, given that sometimes interest requires the imposi-

tion of restrictions upon the mentally ill and the dispensation of obtaining consent for treatment or hospitalization. In normal situations, the doctor remains the main reference and, at times, is the unique decision-maker. Thus, applying the ethical rules becomes relative, on the one hand, and is subject to variations in the assessment, on the other one.

Therefore, psychiatry refers to the special concept of "the ability to provide consent" instead of the consent as such, and the ability to approve often varies according to the condition of the illness and its development. In deliriant or mood disorders, the ability to provide consent does not occur in the same degree, as it increases or decreases with the intensification of the disease or its improvement, and with the appearance or disappearance of the disease.

The challenge that informed consent poses for the mentally ill person is linked to his ability to recognize that he is ill and that he requires treatment, as well as the realization that a timeframe is needed for treatment, which may extend across the entire lifespan.

In psychiatry, however, the doctor is confronted with special illness cases, such as patients under the effect of addiction who lack the will to detoxify, the deliriant patients whose psychotic thoughts make them perceive reality differently, the severely schizophrenic patients who completely deny the illness and refuse any treatment, or the depressed patients whose closed minds make them engage in negative thoughts and perturbed feelings. In such cases, the therapist's adoption of a neutral position, by leaving the patient alone and "free" in his decisions, is in truth tantamount to leaving the patient prey to psychological disturbance, while being unable to unravel the reality of the illness.

There are three things which reflect this special situation:

weakness in the ability to differentiate, the risk of suicide and the risk of harming others.

Inability to Provide Consent: Weakness in the Ability to Aifferentiate

Psychiatrists treat patients who are characterized by psychological fragility, whereby their ability to understand things, perceive their consequences and take the relevant decisions is uneven and weak. True, this vulnerability does not altogether prevent the search for a cure that serves the interest of the patient and upholds his human dignity. However, it is clear that psychological fragility may affect the patient's ability to think, act independently, communicate and understand information about the illness. It may also affect his competence to provide foresighted consent for the treatment in his case.

From an ethical perspective, the patient's exclusive situation requires that the physiatrist observe some important matters, which consist of the following:

- Deploying more effort in engaging the patient in dialogue and helping him overcome the abovementioned aspects of vulnerability, especially that several of the pathological cases have levels of understanding and perception nearing more or less those of a psychologically healthy person. Contingent upon the patient's consent, sometimes the doctor may consult the patient's family members or friends;
- Prescribing treatment which affects in the least possible way the patient's freedom of choice, as recommended by the Madrid Declaration: "Psychiatrists should devise therapeutic interventions that are least restrictive to the freedom of the patient";

- Avoiding the consideration of compulsory treatment as a perpetual goal; on the contrary, the psychiatrist should regard the treatment as intended to restore the level of awareness and understanding, and the ability to judge things and decide in a way which makes the patient return to the participatory and contractual therapeutic relationship. Thus, in many of the cases characterized by lack of awareness of the illness, endeavoring to create this awareness must be prioritized in the treatment plan, because it is essential for an effective treatment and is necessary for a healthy relationship between the therapist and the patient. This should have a positive medical and ethical effect on the quality of the treatment and the improvement of the patient's condition.

Suicide Risk

Fear that the psychologically ill person may commit acts harmful to himself reaches its highest proportion with suicide attempts, which is one of the main obstacles to granting the mentally ill patient the right to independence in decision-making and in accepting treatment.

In many cases, the illness carries the risk of suicide, and in others this may pose a threat to his family, such as what happens in cases of mass suicide wherein the patient, in the event of severe depression, kills his children or his wife before taking his own life. The search for this risk among patients with depression is considered a key part of the psychological examination, as is not detecting it or not taking it seriously an act of professional negligence.

Risk of Harming Others

In other illness conditions, the patient may represent a danger to others. He may use violence against them, resulting in some cases in homicide, whether these conditions concern paranoia, severe schizophrenia or other illnesses.

It is clear that we are dealing here with psychiatric emergencies whose risks should not be underestimated, and which require that we take the necessary decision to provide treatment in the relevant legal context of each country. Of course, this requires the doctor to observe, within the limits of what is possible, ethical standards, and he should gradually make the patient aware of his pathological state and the necessity to undergo treatment, as well as protecting him from succumbing to suicide or from assaulting others. In these two cases, the psychiatrist takes himself the decision to treat the patient or to admit him into hospital against his will. This decision is seen from the perspective of emergency intervention to save a patient in a critical condition rather than from that of depriving him of his freedom.

Striking a balance between the two levels is considered the backbone of the daily routine of the psychiatrist and his main concern as he endeavors to develop and improve.

Privacy and Confidentiality

This is an extremely important ethical principle in medicine in general and in psychiatry in particular. It is so that all ethics documents stipulate the necessity for doctors and health institutions to protect the privacy of the patient, the confidentiality of the information about him, the diagnostic tests, the treatment and the medical records after obtaining the consent of

the patient or of his legal guardian, and to prevent misuse. It is not allowed for anyone but the medical team to have access to the patient's medical file; otherwise, the patient's explicit and informed consent is required.

In psychiatry, this issue is particularly important given the nature of the information exchanged between the patient and the doctor. The Madrid Declaration stresses that "information obtained in the therapeutic relationship is private to the patient and should be kept in confidence and used, only and exclusively, for the purpose of improving the mental health of the patient. Psychiatrists are prohibited from making use of such information for personal reasons, or personal [or academic] benefit." The specificity of psychiatry is such that the patient may represent danger to himself or to others, which requires informing the relevant authorities within the framework of the laws in place. The Document emphasizes that "Breach of confidentiality may only be appropriate when serious physical or mental harm to the patient or to a third person would ensue if confidentiality were maintained; whenever possible, psychiatrists should first advise the patient about the action to be taken. [The breach of confidentiality may only be appropriate when required by law] as in obligatory reporting of child abuse."

This section includes the patient's right to have direct access to his medical file and its contents. He also has the right to request copies thereof. For psychiatric patients, this right is conditioned by the extent of their awareness and their differentiation ability so that they can use the medical information in the right way. This is more so in the case of patients admitted into hospital against their will, and their families must be consulted and their access to the medical file should be carried out with the assistance of a doctor of their own choice.

Avoiding Exploitation

One of the particularities of psychotherapy is that the fragility of the patient makes him vulnerable to exploitation by the therapist. Ethical conventions require that the relationship between the patient and the doctor be objective and balanced, and it should not be based on financial or moral profit, except as stipulated by the legal conventions of remuneration. Moreover, the psychiatrist should refrain from establishing personal relationships with the patient, which could underlie sexual exploitation or physical abuse in any form.

Religion and Mental Illness

From the perspective of professionals, modern studies demonstrate that the relationship between religion and the treatment of mental illness moved in the first half of the twentieth century from the direct and extensive use of religious methods to total apprehension of the perception that religion is a significant element in the therapy. Today, the practitioners are calling for action which could lead to the establishment of equilibrium between theory and practice in this regard. Dr Mamoun Mobayed elaborated on the evolution of recent studies which have started attributing to religion, in terms of belief and practice, an importance in the mental health of the individual. Here, I would like to add two things:

First, there is a growing interest in religion within psychiatric institutions. A resultant feature is the interest the World Psychiatric Association demonstrated in the subject matter by establishing a special section entitled "Religion, Spirituality and Psychiatry," both to reveal its importance and to encourage scientific thought and research in it. A book collecting the views

of dozens of specialists from all over the world was published in 2009, in which all of the authors express their conviction – as stated in the Foreword to the book – that deepening the study in the interaction of psychiatry and religion will offer "significant benefit and aid, and is one of the critical tools for thought and practice in psychiatry."[7] The authors confirm that religiousness and spirituality contribute to the improvement of the quality of life. They say, for example, that "we cannot imagine that religion and spirituality would not affect the way of life and the psychological and social stability of people in general and patients in particular." In the Preface, the authors recognize that "psychiatry has taken considerable time to discover such a simple yet complex truth," adding that "for a long time, psychiatry has ignored the fact that the silent attitude towards hatred of religion has had a negative impact on the theory and practice of psychiatry," in addition to its negative effect on the consecutive classifications of psychiatric disorders.

In the same context, the *International Journal of Psychiatry*, organ of the World Psychiatric Association, published a supplementary issue in February 2013 entitled: "Understanding and addressing religion among people with mental illness."[8] The lead article concludes that there are good prospects in psychological studies to help psychiatrists gain a greater understanding of the interactive relationship between religion and psychiatry.

Second, inspired by the role of faith in the treatment of mental illness, a number of Islamic scholars and preachers have written about religious psychotherapy, the use of religion or the Qur'an in psychotherapy.

Some, however, confuse between mental illness and illness of the soul which has a religious or moral character, while others consider faith enough for the prevention of mental illness,

accounting for the incidence of mental illness as evidence for weakness in faith. These and similar ideas pose obstacles for the proper and positive attitude towards mental disorders and illnesses. Therefore, it is important to stress some of the determinants of the relationship between faith and religion, on the one hand, and mental illness, on the other, including the following:

1. There is a major difference between mental illness, which is usually treated by medical specialists, and the "illness of the soul" (or what some Islamic scholars call the illness of the heart), which implies the human deviation from the right path or from religious teachings.

Mental illness, which falls under the specialization of doctors, is governed by laws outside of the human will and, as is the case with organic diseases, it affects the believer and the unbeliever, the obedient and the wicked, as long as its causes exist.

The second type, known as "illness of the soul" in the religious sense, is an illness which appertains to the human will and impulse, such as selfishness, arrogance, the evil intention towards others, etc. It entails the person's volitional choice to adopt a similar type of behavior. Its treatment should be undertaken by all categories of educators. Ibn Qayyim al-Jawziyyah was among the early scholars to disambiguate the concepts by differentiating between two types of illness of the soul:

"The first type does not cause the sufferer immediate pain …. such as the illness resulting from ignorance, doubt, suspicion, desire, etc., and its treatment has been prescribed by prophets and their followers who are the doctors of this type of illness."

"The second type inflicts on the sufferer immediate pain, such as distress, grief, sadness and anger, and the causes of this

type can be treated using either regular medication or anything that serves as an antidote to the causes, and whatever overrides such causes when they exist …"[9]

2. A distinction should be drawn between psychological problems or symptoms, on the one hand, and psychiatric illnesses, on the other hand. The former are symptoms experienced by human beings as a result of life pressure and inefficient adaptation therewith. They are not considered psychiatric illnesses, but they are symptoms which persist for short periods of time and they do not usually have an important effect on the competency of a person or his productivity in life. Creating moral and social support, as well as improving one's lifestyle and exercising, among other activities, can be helpful in overcoming them. Faith and religious practices are beneficial in relieving stress and anxiety. Mental illnesses, or "mental disorders" as popularly called in modern psychology, are like organic diseases which require objective treatment, though faith can help mitigate them but in the same degree it does in the case of organic diseases, with variation in the degree of mitigation.

On the whole, specialists distinguish between psychiatric symptoms and mental illnesses, using standards associated with the presence of symptoms which reflect a disruption in thinking, emotion or behavior and in the sharpness, the duration or the negative impact of the pain felt by the individual on his social integration or his professional performance.

3. Like organic diseases, psychiatric illnesses of an objective nature generally resemble them in terms of their causes and interactions. They also have their own factors which may be numerous and overlapping. However, in a given period of time or for a specific case, they may not be recognized or under-

stood, but they do exist and they could be studied, thus ruling out their attribution to metaphysical forces such as the jinn or the like.

Psychiatric illnesses are involuntary occurrences; therefore, the patient does not often assume responsibility for his illness, except in specific cases such as drug addiction, while other cases are the result of the interaction of several genetic, organic, biological, psychological and environmental factors, as is applicable to any organic disease. The way the psychiatric illness and the organic one respond to the treatment is generally the same.

4. The claim that faith prevents mental illness, in the medical sense, is not accurate. It might relieve the impact of some of its kinds or ease the acuteness of developing new ones, but it cannot stop it as it cannot prevent the organic disease. Just like the rest of humanity, the believer could be a healthy or unhealthy creature who is subject to God's universal laws. Therefore, it is normal for "righteous" people or some of their relatives to be afflicted with a mental illness when the factors causing the latter are present. Some of those who are afflicted, for example, with depression, are often surprised by the illness despite the fact that they are "pious and virtuous believers" who observe prayer, its schedules and requirements. This category of people makes the illusion that depression does not affect a person who possesses strong faith. The fact of the matter, however, is that depression is not subject to the impulses and ideas of the individual or strength or weakness of his faith, since this illness is governed by mechanisms and factors which transcend that. In contrast, affliction with depression does not distort or decrease the person's faith. On the authority of A'ishah bint Abi Bakr, Al-Bukhari narrated that Prophet Muhammad (PBUH) said:

"No fatigue, nor disease, nor sorrow, nor sadness, nor hurt, nor distress befalls a Muslim, even if it were the prick he receives from a thorn, but that Allah expiates some of his sins for that." This Hadith shows that it is possible for a Muslim to undergo these psychological afflictions, but it does not mention that they affect his faith to any extent at all.

Since its inception, the Muslim community has witnessed the presence of members known to be afflicted with what was formerly known as "madness," for example, but nobody ever claimed that the affliction was due to the victim's lack of faith. However, it is commonly known in Sharia that this type of person is not considered an assignee because he does not possess the ability to differentiate. Today, there are many mental illnesses which affect human societies to a similar extent although the extent of their religious observance varies significantly. For instance, statistics show that schizophrenia affects nearly 1% of all societies, regardless of their religion or the degree of their faith. Thus, like all other preordained acts, mental illness is an Act of God whose objective causes do not differentiate between the believer and the disbeliever. Moreover, the person's mental illness does not impugn or decrease his faith.

5. The concept of the role of faith in the treatment of mental illness in its medical sense is often flawed in several respects. Undoubtedly, faith, religious remembrance and Qur'anic recitation play a major role in relieving the Muslim's mental illness, opening for him the door of hope and promise and consoling him for any loss he suffers as a result of the illness with compensation in the Hereafter. This, however, does not dispense the patient from using the required medical treatment. Some people often cite Hadiths about the role of *Ruqyah* (incantation), but an examination of the cited Hadiths reveals that they

concern patients who suffer from organic diseases, on whom *Ruqyah* has a positive effect. An example of these Hadiths is Anas Ibn Malik's in *Sahih Muslim* in which he reported that Prophet Muhammad (PBUH) authorized the use of *Ruqyah* to treat the impact of the evil eye, the scorpion's sting and pustules. Imran ibn Husayn reported that Prophet Muhammad (PBUH) said: "No spell is to be used except for the evil eye or a scorpion sting." Explaining this Hadith, Imam Hussein bin Masood Al Baghawi (d. 516 AH) said: "It does not include denial of the permissibility of *Ruqyah* for other purposes, for it is permissible to use it in the remembrance of Allah Almighty in all pains."[10] The cited Hadiths prove the legality of *Ruqyah* in case of a scorpion's sting, ulcer, etc., which are organic diseases. No one, however, said that reading Al-Faatiha or performing *Ruqyah* to heal someone who is stung by a scorpion or who suffers from ulcer dispenses him from using medical treatment. If this is true in the case of organic diseases, it must equally be so in that of mental illnesses.

Is There any Special Islamic Approach to Psychology?

I talked earlier about the role of religion in psychotherapy, which is the practical side of the relationship between religion and psychology, but what about the theoretical side? Is there any special Islamic perception of psychology and its relevant subjects?

For decades, there have been persistent endeavors to develop an Islamically oriented vision in the domain of psychology, especially in the context of the overall trend known as "Islamicity of knowledge." This proposes the use of the Qur'an to steer scientific research in the field of psychological studies, or to extrapolate knowledge from the Qur'an to enhance scien-

tific knowledge, both of which make up the body of psychology. Some scholars believe in the possibility of creating new trends inspired by the Qur'an to transcend those prevalent in Western psychology.

Other scholars, however, refer to this process as an Islamic rooting of psychology, which consists of "establishing a science based on the Islamic conception of man, the principles of Islam and the verities of Sharia law, to the extent that the subjects of this science and its inherent concepts and theories become consistent with the principles of Islam, or at least, not be in conflict with it."[11]

An in-depth analysis of these trends requires special studies, but suffices it here to reflect on the main findings of these extensive endeavors in this field:

1. The attempt to elicit precise information from the Holy Qur'an regarding the meaning, nature and interactions of the human psyche, as well as its normal and pathological aspects, is an old practice. In fact, the various scientific endeavors across the centuries reveal the difficulty of creating consensus on the fundamentals in this area, and whatever extrapolations or opinions put forward are only interpretations of religious texts which evolve through time and in conjunction with the development of human knowledge. Any similar endeavors are but presumptive notions which cannot override the facts in psychology, even if the latter were in themselves conjectural.

2. The attempt to derive an "Islamic conception of man, society and existence," which many consider the basis for the effort to establish the "Islamic rooting" process, begs the traditional question asked by many scholars throughout history: Are we going to come up with novel ideas unknown to the Predecessors, i.e. the prophet's Companions and their Successors,

or are we merely going to reiterate their own perceptions? If, however, what we intend to offer today is different from or is ancillary to what they knew, does this not mean that knowing it is not specific to religion, given that it is knowledge attached to "self" and "history" which is soon "abrogated" by another scholar who will propose other conceptions?

3. The attempts to draw from religious texts the foundations for the understanding of the human psyche and its interactions have confirmed the existence of numerous discrepancies at the level of interpretation, which do not allow for the elaboration of concepts, even when there is agreement on the basis. In any similar event, there can be no alternative to Western psychology and its methodological and cognitive repertoire.

4. The presence of facts extrapolated from religious texts, which impact the results of scientific knowledge in psychology, presupposes the possibility of their being subjected to the methodological and cognitive standards common in a particular scientific field. However, in case the objective behind this effort is to filter the existing psychological knowledge and purify it from whatever could be contrary to Islamic credence and legislation, then the Muslim is only obligated to comply with the drawn scientific deductions and applications without having to create a new science as such. All scholars, Muslim as well as non-Muslim, may have obligational principles in their scientific work, but these do not require them to establish new scientific disciplines.

5. Science is, by nature, neutral and its deductions are either accurate or inaccurate. Its rudimentary principle, however, is that it only proves accurate when undertaken by specialists.

If this is the case, then science should normally be compatible with the provisions of Sharia; otherwise, there must be an error in understanding either Sharia or science.

6. Many of the studies in Islamic rooting have not kept pace with the methodological and cognitive developments in psychology. In the last quarter of the nineteenth century, psychology shifted from being a division of philosophy, subjected to preconceived theories, to an independent science which, like many other branches of science, is subject to the methodological process of verifying a priori theories against practical experience, which either endorses it or refutes it. Its basic condition is the possibility of re-experimentation conducted by any observer who masters the experimental methodology which initially validated it. However, the transition was neither general nor possible except through stages and over an extended period of time. The influence of preconceived philosophical notions remained strong in many theories of psychology throughout the first half of the twentieth century. Then, scientific research witnessed significant methodological development characterized mainly by the adoption of precise diagnostic criteria and statistical methodology in psychological studies. This was followed by the momentous breakthroughs in the fields of neurobiology (neural chemistry and neural imaging), neuropsychology and genetics, among others. These new developments changed the approach to psychological life, in general, and to mental disorders, in particular, at various levels: interpretation, classification, diagnosis and treatment. The argument in our case, however, is that most of the attempts to Islamize psychology did not take into account these massive transformations, thus appearing as though they were reactions to schools or to obsolete interpretations.

7. Finally, the attempts made so far have not been successful in ascertaining the feasibility of an independent science, or an independent branch thereof, called "Islamic Psychology." Moreover, the consecutive studies have not been able to answer the question regarding the necessary theoretical and practical approaches or perceptions which Muslim scholars should take into consideration when dealing with psychology. Therefore, is the idea of "Islamization" or "Islamic rooting" fundamentally incorrect, or is the adopted methodology and the tools inappropriate? In my opinion, psychology is a science whose formulations are conducted through its own tools, and Muslims should use these methodological tools or develop them. In addition, Muslim scholars should contribute directly to the development of science, not create yet another science or an independent branch thereof.

Notes

1 A graduate of Al-Azhar University, Muhammad Abdullah Draz wrote "The Moral World of the Qur'an," as a doctoral thesis at the Sorbonne University in 1947.
2 Ibid., p. 26.
3 Ibid., p. 61.
4 Ibid., p. 18.
5 This is not a verbatim translation of the Declaration, but a paraphrase of its most important points. See the entire text of the Declaration of Hawaii on the website of the World Psychiatric Association: http://www.wpanet.org/detail.php?section_id=5&content_id=27.
6 See the website of the World Psychiatric Association, which is available at: http://wpanet.org/detail.php?section_id=5&content_id=48.
7 World Psychiatric Association, *Religion and Psychiatry*, 2009, p. 1.
8 The article is available on the website of the World Psychiatric Association, at: http://arabpsynet.com/Journals/WJ/ArabicWP-Feb2013.pdf.
9 Ibn Qayyim al-Jawziyyah, Ighathatou Al-Lahfan fi Massa-id ich-Chaytan: 1/18.
10 *Sharh Assunnah*: 12/162.
11 Muhammad Uthman Najati, "Minhaj Ata'aseel al Islami fee 'Ilm Annafs," Majalatu Al Muslimi Al Mu'asir, 57 (1411 AH): pp. 21–45.