

## **Directive vs. Non-directive Clinical Approaches: Liberation Psychology and Muslim Mental Health**

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### **Abstract**

Liberation psychology (LP) is a psychological framework that emphasizes social justice as a key component of mental health, defined in LP as the ability of human beings to co-exist, live in harmony, and thrive in community. Muslim mental health as a clinical focus continues to develop, and most writing emphasizes the importance of cultural sensitivity in providing effective care for Muslims, which the literature often relates to the collectivistic nature of Muslim-majority societies. The literature, in turn, often uses collectivistic tendencies and research to support 1-on-1 directive approaches.

This paper questions the use of such directive approaches as potentially recreating a model of hierarchy and dominance that is connected to Muslims' mental health challenges, particularly those of Muslim sub-populations. The authors suggest and discuss several LP-based alternatives, especially the use of group therapy as a more appropriate and culturally responsive model, from both directive and non-directive clinical orientations.

We propose a scientific process committed to the historical reality of the people based on their own problems and aspirations.

– Ignacio Martín-Baró, SJ, 1994

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In psychology, traditional Western European approaches dating back to Freud (1989), Skinner (1974), and other important thinkers have emphasized a scientific approach that prioritized enabling individuals to function successfully in the status quo of Western societies and labeling them as diseased or disordered if they could not (Duran, 2006; Harrist & Richardson, 2014; Pupavac, 2002). Even when they

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acknowledged their own thinking to be culture-bound (Skinner, 1974), the numerous metaphysical and a priori assumptions embedded in their approaches supported the goal of helping individuals function in a social order that European and North American psychologists traditionally theorized as inevitable and unchangeable (Gillespie, 1987; House, 1999; Marcuse, 1966). However, its non-addressing of sexism, heterosexism, racism, colonialism, and Orientalism, as well as the accompanying unquestioned acceptance of the white, male, heterosexual, Christian normative subject, has been highly problematic for a wide range of thinkers (Bazian, 2018; Duran & Duran, 1995; Fanon, 2004; Martín-Baró, 1994, Moane, 2011; Said, 1979; X, 1990).

This critique has included community psychology, postcolonial psychology, and liberation psychology (LP), among others (Duran & Duran, 1995; Martín-Baró, 1994; Moane, 1999; Watkins & Shulman, 2008). LP and psychologists concerned with connecting psychology to larger issues than individual wellness have theorized that the discipline's aims and intentions must include social and environmental justice (Gifford & Stern, 2011; Riemer & Reich, 2011), which is to be realized through individual and community liberation and transformation (Burton, 2015; Mohr, 2019; Watkins & Shulman, 2008). Thus, LP's goal is societal transformation, not just thriving individuals but establishing a world in which all people can thrive.

So then, is mental health a primary or a secondary question in society? If it is a question of individual functioning, then the greater demands of social organization are more primary. In other words, first life itself and then the quality of life (Martín-Baró, 1994, p. 108). However, mental health can also be seen as a primary function of a society that rejects this individualistic model as partial and superstructural (Martín-Baró, 1994, p. 109). If our conception of human beings emphasizes social relationships and people as historical beings, then mental health is something else (Kagitçibaşı, 1995). Additionally, if people are historical beings, then the self is socially and discursively produced and understanding it requires an analysis of the historically contingent arrangements of power through which the normative subject is produced (Mahmood, 2005, p. 33). As Martín-Baró says,

If the uniqueness of human beings consists less in their being endowed with life (that is in their organic existence) and more in the kind of life they construct historically, then mental health ceases to be a secondary problem and becomes a fundamental one. It is not a matter of the individual's satisfactory functioning; rather it is a matter of the basic character of human relations, for that is what defines the possibilities for humanization that open up for the members of each society and group. To put it more plainly, mental health is a dimension of the relations between persons and groups more than an individual state, even though this dimension may take root differently in the body of the individuals involved in these relations,

thereby producing a diversity of manifestations (symptoms) and states (syndromes). (p. 109)

As a logical consequence of a vision for societal transformation, many thinkers have negatively critiqued pedagogical (Freire, 2000; Spivak & Barlow, 2004), sociological (Bringel & Maldonado, 2016; Fals-Borda, 1985), and therapeutic and clinical approaches that focus on individual diagnosis and functioning while re-creating oppressive patterns of dominance, submission, and enforced hierarchy (Duran & Duran, 1995; Jun, 2018a; Martín-Baró, 1994; Moane, 1999; Watkins & Shulman, 2008). There is an urgent need for individual- and community-based interventions that recognize how marginalization and trauma impact the larger population and the inherent strength of communities to heal themselves when given the opportunity and support (Schultz et al., 2016) to do so. Additionally, psychology needs to begin addressing the negative environmental impact of social models that encourage dominance and oppression in society (Stanley et al., 2017).

LP emphasizes a more environmental and systems approach, one that begins to conceptualize these issues as a part of an overall psychological framework. Its approach is highly relevant to Muslim communities and individuals, due to their historical struggles with Orientalism, colonialism, and Islamophobia from without and with cross-cultural struggles with patriarchy, racism, homophobia, and classism from within (Mohr, 2019). Muslims are increasingly speaking out about the need for environmental awareness to play a prominent role in their community's life. Incorporating an awareness of environmental justice in a Muslim mental health model naturally fits this global call (Alkaff et al., 2016).

The prevailing collectivism of Muslim-majority culture makes Muslim mental health naturally attuned to an approach that recognizes the importance of the greater social unit as a primary part of individual wellness. Using LP as its theoretical framework, this paper will question the popular wisdom that cultural competence indicates that clinicians working in Muslim mental health should prioritize 1-on-1 directive approaches due to collectivistic tendencies of Muslim-majority cultures. Additionally, community-based interventions from both directive and non-directive perspectives will be discussed as potentially better solutions to incorporate these tendencies into treatment approaches for Muslims, particularly for Muslim populations affiliated with sub-cultures that are outside traditional or mainstream Islamic norms.

### **Liberation Theology: The Background of LP**

Most practitioners trace LP's origin to liberation theology, a Catholic movement based on the belief that the role of God and faith communities is to emphasize liberation from social, political, and economic oppression, as well as the transformational power of inclusive grass-roots spirituality and community-based organization (Brown, 1993). Its spiritual understanding is built on the individuals and

communities' interpretation and conceptualization of the scriptures as a result of group reflection. Worship is not limited to adoration, but involves action designed to create spiritual virtue in the community's life, namely, confronting oppression and injustice as well as providing life-sustaining resources for all of its members with an emphasis on empowering the most marginalized.

There is some debate about liberation theology's exact origin. Most religious scholars consider it a direct result of responses to Vatican II (1962-1965) by Catholic bishops in Latin America and the work of priests in the 1960s who began envisioning the church's work as engagement with the poor (Gutiérrez, 2004; Montero, 2007). This work was theorized as an alternative to the church's unquestioning support of the upper classes and the economic status quo in response to the horrific conditions facing the indigenous populations of Central and South America, as well as the historical tradition of the Roman Catholic Church as the bestower of divine right on the monarchy of Spain (Gutiérrez, 2004). This demand for shifting the theological perspective, along with emphasizing accessible language and praxis, was articulated by Latin American theologians at the Episcopal Councils held in Medellín (Colombia) and Puebla (Mexico) (Montero, 2007). The work of thinkers such as Gustavo Gutiérrez and Leonardo Boff was in direct response to concepts that are explicitly present in Vatican II documents, such as *Lumen Gentium* and *Gaudium et Spes* (Gutiérrez, 2004).

A primary focus of liberation theology was the preferential option for the poor [hereinafter the preferential option], or the soteriological action of the church grounding itself in real-life engagement with the poverty, oppression, and suffering of Latin America's masses and the systems that created and maintained their poverty (Gutiérrez, 2004). This preferential option also involved an eschatological vision of transforming history in the here and now, as opposed to the traditional passive and patient waiting for the Messiah to descend from the sky to bring God's will to Earth (Gutiérrez, 2004). The role of sin and evil were expanded to include systems of oppression and injustice on a societal level and not based solely in individual transgressions to be confessed and forgiven (Gutiérrez, 2004).

Additionally, its theology prioritized orthopraxis over orthodoxy and conceptualized the church's work as dynamic engagement with its parishioners, most of whom were victims of oppression and marginalization (Gutiérrez, 2004). In short, it was a theology of change, a revolutionary vision of a transformed, renewed world created by, for, and with the community of believers and a caring and involved God.

Another historical perspective is that liberation theologies arose simultaneously around the world in response to the *weltanschauung* of the 1960s (Rieger, 2017). This theory proposes that these diverse models, including feminist (Rueher, 1972), black (Cone, 2010), Muslim (Dabashi, 2008; Demichelis, 2014; Esack, 1997), deaf (Lewis, 2017), and other liberation theologies were all responses to

the rising consciousness of the 1960s in threads that represent a kind of convergent evolution (Rieger, 2017). While this is certainly possible, South and Central American liberation theology was clearly the predecessor of most of the movements and that all liberation theologies drew on the work of Latin American theologians at some point in their development. The emphasis on social justice, a God who cares about the poor, and the importance of praxis over theory as the essence of piety are universal in all liberation theologies.

### **The Influence of Ignacio Martín-Baró in Defining LP**

This above historical context is relevant to LP's development, specifically because LP developed simultaneously in a variety of geographic localities and communities despite the current trend to give the main credit for the movement to Ignacio Martín-Baró, a Jesuit priest heavily influenced by liberation theology. Thinkers such as Geraldine Moane (1999, 2006, 2010) in Ireland were working with a LP framework prior to the dissemination of his work and trace their roots directly to feminist liberation theologians such as Mary Daly and other radical feminists. Moane (1999) also based her work on post-colonial thinkers such as Franz Fanon (2004), who discussed many of the ideas found in Martín-Baró's work from an independent intellectual tradition primarily disconnected from him. Post-colonial thinkers such as Eduardo Duran (Duran & Duran, 1995) and others who later engaged with his thought were working from the same starting critiques as Martín-Baró in their writings on psychology, but not necessarily from those written by Martín-Baró himself.

With all that acknowledged, Martín-Baró is now credited by most with developing the concept of LP. He drew heavily on Latin American liberation theology because he lived there, was a Jesuit priest, and wrote about its direct influence on his work (Martín-Baró, 1994; Torres-Rivera et al., 2014). Martín-Baró was also influenced by liberation theology's immanent Christology, eschatology, and soteriology, all of which were based on a God of life and justice, in that he conceptualized serving the poor (the preferential option) and the immediate radical transformation of society (orthopraxis over orthodoxy) as primary goals of both religion and psychology (Gaztambide, 2014; Martín-Baró, 1994; Torres-Rivera et al., 2014). All of these tenets are present and clearly discussed in Dr. Farid Esack's *Quran, Liberation, and Pluralism* (1997), in which he discusses liberation theology from an Islamic perspective. He talks about the Quranic commands of justice and the prohibition of *zulm* as reflections of an involved and concerned God, the importance of orthopraxis as jihad and struggle being a primary mandate of Islam, and how this is all actualized by engaging with the poor and the Other (Esack, 1997).

To put it simply, Martín-Baró (1994) believed that both the existence of a just world and a new vision of a new human being in a new society required a new praxis and a new epistemology:

What is needed is the revision, from the bottom-up, of our most basic assumptions in psychological thought... This done, truth will not have to be a simple reflection of data, but can become a task at hand: not an account of what *has been done*, but of what *needs to be done*. (p. 23)

His words turned out to be prophetic, for he fell victim to the very military oppression and imperialism he had fought so hard to dismantle. He was tragically assassinated in 1989 at El Salvador's Jesuit University, where he taught.

A specific set of premises about psychology's goals and methodology are common to LP thinkers. One of the primary critiques is of individualism, which emphasizes the individual and his/her having an ontological existence separate from that of the community. This critique is grounded in the transhistorical and ahistorical subject of Western European psychology (Dykstra, 2014; Martín-Baró, 1994) and the universalizing language and framework of its psychological theories. Martín-Baró (1994) critiqued this universalizing tendency with the famous words:

The prevailing scientism leads us to consider human nature as universal, and to believe therefore, that there are no fundamental differences between, say a student at MIT and a Nicaraguan campesino, between John Smith from Peoria, and Leonor Gonzales from Cuisnahuat, El Salvador. (p. 23)

The supposed universal concept of the self is the result of a view of the human person that presupposes a metaphysics that is specific to the Western European and North American worldview and ontology of the human person (Rothman & Coyle, 2018; Martín-Baró, 1994).

LP also critiques positivism and scientism (Martín-Baró, 1994). Positivism is the scientific standard that states that facts that are untestable and unmeasurable in concrete terms, such as soul and spirit, are neither real nor relevant – an assumption that increased within psychology due to many practitioners' attempt to advance their own thinking and the field in general as a science (Martín-Baró, 1994; Watkins & Shulman, 2008).

Scientism is the attempt to make the study of the person scientific and erase the inclusion of subjective bias. Again, it is derived from materialistic ontological assumptions about the self, an epistemology that reinforces the idea of an ahistorical, transhistorical self, as mentioned above (Martín-Baró, 1994; Watkins & Shulman, 2008). In fact, it is based on a specific epistemic grounded in the metaphysics of the scientific revolution, materialism, and Newtonian physics (Skinner, 1971). This perspective, which includes a focus on the universality of human development, emotion, and reactivity (including modern Behaviorism),

dismisses the unique characteristics and perspectives formed by the diverse experiences of each individual, as well as the structural and functional determinants of marginalized or oppressed peoples' common and collective realities (Borda, 1979).

From an LP perspective, therefore, the preferential option is a commitment to a functional psychology that demands justice for those individuals and communities whose experience is silenced and deprioritized by the traditional assumptions of theology, psychology, and Western European ontologies of the self (Martín-Baró, 1994; Moane, 1999). In response to psychology assuming that societal realities are the necessary results of the universal, biological, and instinctual tendencies of individual human beings (Marcuse, 1966), LP's environmental approach recognizes the impact of systems of power and hierarchy and assumes that individual well-being cannot be achieved in a vacuum. In terms of women, the poor, and colonized people, LP proposes that the Western European psychology's fundamental conceptualization of the self needs to be critiqued and reworked from indigenous perspectives that honor voices that are not Western European, Christian, heterosexual, rich, male, gender normative, or in other ways reflective of privilege and hegemonic discourses (Duran, Firehammer, & Gonzalez, 2008; Martín-Baró, 1994; Moane, 1999).

In response to scientism and positivism, LP questions the idea that psychology can exclude categories of spirit and soul and still remain accurate and relevant. This reconceptualization of the self, which is central to LP, in the context of societal forces is postulated as a praxis of societal transformation based on the interests of the poor, marginalized, and oppressed in terms of achieving justice in the world and moves traditional Western psychology's assumptions away from an orientation based on maintaining the current status quo (Dykstra, 2014; Dykstra & Moane, 2017).

Martín-Baró eloquently critiqued the prevailing notions about how to define mental health and mental illness. When he critiqued individualism, he spoke of how the ideas that conflict and war were assumed to be inevitable presupposed the concepts of us and them, as well as an objectified Other that reinforced all the basic problems facing humanity. In his time, Latin America was at war everywhere you looked. He discussed the idea that the assumptions driving war and conflict were in fact a societal mental illness; proposed that mental health be redefined to include a vision of collective health, one in which co-existence was not only possible but also the basis of a vision for a new society; and argued for a new epistemology and new praxis that reflected these ideas (Montero, 2011).

### **Conscientization, Paolo Freire, and LP**

One thinker who influenced liberation theology and LP was Paolo Freire, whose approach represented for Martín-Baró a possible framework for this new episte-

mology and praxis. Freire (2000) was an educator who critiqued those pedagogical approaches that reinforced oppressive societal systems and constructed an alienated consciousness through education. He proposed that instead of a banking method, according to which teachers deposit information in students and then withdraw it at test time, education should involve a dialogue focused on conscientization or consciousness raising. This idea of fostering the development of consciousness is akin to Islamic models, including that of the Prophet (PBUH) as *murabbī*, a teacher who nurtured his community's development of understanding and insight (Alwani, 2019).

In terms of Martín-Baró's work, Freire's approach was applicable to the therapeutic process, because the therapy of an expert treating a sick individual was replaced by an engagement with individuals that connected their suffering to the larger social picture surrounding them (Tate et al., 2013). Of course dialogue has historically been a central part of psychological treatment, but the concepts that Freire opened up can be applied to the clinician-client relationship so that it becomes more empowering and respectful. For Martín-Baró (1994),

the horizon of conscientization assumes an important change in the profession's way of conducting its work. It does not entail giving up the technical role the psychologist now performs, but it does involve scrapping theoretical assumptions about adaptation and intervention made from a position of power. (p. 44)

LP goes from theoretical imaginings to practical impact when it manifests in the tangible engagement with the mental wellness of individuals and communities. Connecting such wellness to a theoretical reflection on social justice, environmental justice, and the ontology of the self has to be combined with practical engagement so that it can become a praxis of transformation. This praxis has been focused in a variety of settings, including liberation arts (Simms, 2019), participatory action research (O'Neill, 2018; Payne & Bryant, 2018), and the ongoing work of individuals and community organizations and groups to apply liberatory models and approaches to creating and supporting wellness and challenging privilege and power.

Basically, if we define mental illness as the societal frame of reference that constructs a frame for all human endeavor and relationship based on war and conflict, then individual functioning is a level of intervention that does not address the true mental illness. Mental health needs to be co-created and envisioned collectively so that the actual problems with how people process reality, the basic filters, are re-evaluated and restructured to make possible the true health of a society that is not destroying just individuals, but also families, communities, and the environment. Martín-Baró used Freire's approach of conscientization as a model to envision how psychologists could actualize mental health by challenging the societal mental illnesses that drive war and injustice. He proposed that conscious-



ness raising ought to be central and stated that psychologists need to be creative and innovative in the models they utilize to create solutions and a better world. Freire's approach to education was a natural fit for Martín-Baró and others who have theorized about LP, because the psychologist's role then emphasizes empowerment and consciousness raising toward a more just society, as opposed to conformity with the current status quo.

Transforming psychology into LP involves changing the logic of the Other as an external entity in conflict with the normative subject and demands that the question of being in community be taken seriously for any real liberation to occur (Sands, 2018). These questions look different and more urgent when posed from the position of the colonized Other fighting for liberation because it is a situation of significantly more urgency. Therefore, they have been widely considered and theorized about in the global South, particularly in Africa (Seedat, 1997; Seedat & Lazarus, 2011; Sands, 2018) and Latin America (Montero, 2007), where Freire wrote and worked.

For example, the community psychology program at Palestine's Birzeit University, where dialogue was used to raise awareness of the structural roots of mental health problems, employed the model of using conscientization as a method of community intervention (Makkawi, 2015). Drawing on Freire's model, as well as South American and South African psychological theories, the program was conceptualized as follows:

The quest for a critical community psychology program in occupied West Bank and Gaza Strip was derived from the assumption that the individual's psychological well-being is to a large extent an outcome of ongoing occupation, oppression, repression, and exploitation. The program therefore aimed to train students to examine how the ongoing occupation, military violence, the creation of the colonialist separation wall, checkpoints, economic embargo, poverty, imprisonment and torture, assassination and killing, school closures, and the systematic destruction of Palestinian community's infrastructure produced a psychosocial dynamic and contextual background affecting Palestinian people's mental health. The program wanted to understand the social determinants of delinquency, child labor, aggression, domestic violence, school violence, substance abuse, and high-risk behaviors. The program, emphasizing critical conscientization, aimed to skill graduates to work with groups and communities within this oppressive colonialist context, and is by and in itself a process of psychological liberation and mental health promotion. (Makkawi, 2015)

The question, then, is what are some of the possibilities for new approaches and new methodologies based on an epistemology for psychology that equates harmony and co-existence on a societal level with mental health? How can LP inform Muslim mental health specifically in creating space for Muslims to exist peaceful-

ly, happily, and sustainably? What would mental health treatment look like for them if interpersonal harmony and co-existence with other Muslims, non-Muslims, and the environment were core principles of mental health?

### **Muslim Mental Health and Cultural Humility**

Due to its emphasis on how society impacts the individual, questioning of embedded Western European assumptions, and focus on social and environmental justice, LP is uniquely suited to be considered within the realm of Muslim mental health and Islamic psychology. Additionally, its emphasis on empowerment through conscientization is well suited to Muslims in many contexts, as they have been silenced and marginalized often as a result of colonialism and Islamophobia. Additionally, LP's primary role of constructing a negative critique of ahistorical and positivist models of the self aligns well with many people working in both realms (Haque et al., 2016; Rothman & Coyle, 2018).

Many thinkers have discussed the need to create an indigenous ontology of the self, one that reflects an Islamic worldview for a truly Islamic psychology to evolve (Badri, 1979). The concept of the Islamization of Knowledge calls into question the acceptance of Western Europe's Enlightenment-era metaphysics, scientific materialism, and/or post-modernism and recognizes that the basic premise of its ahistoricism is problematic (Al-Faruqi, 1986). Muslim mental health and Islamic psychology as they exist in 2020, reflected by the current literature (at least in English) and people working in the field, acknowledge many of the same basic critiques highlighted by LP, as well as adopt many of the latter's solutions. Additionally, as mentioned above, emphasizing the group due to the collectivistic nature of Muslim-majority cultures makes a psychological approach that prioritizes human relationships and societal wellness a natural fit.

There has been a well-documented increase in the utilization of and need for mental health among Muslims living in the West ever since 9/11, culminating with the presidency of Donald Trump. His enactment of the Muslim Ban, along with the Republican right's mainstreaming of Islamophobia in the United States and by conservatives in Europe, has led to more mental health problems, as well as increased research on mental health among Muslims (Moffic et al., 2019).

One result has been more research on religion and spirituality as protective factors for mental well-being in women (Mohr, 2017), Muslim college students (Tanhan & Strack, 2020), the elderly (Hafeez & Rafique, 2013), and many other Muslim sub-groups (Koenig & Shohaib, 2012). Islamophobia's impact is greater when individuals feel that their mental health problems are sources of stigma, a perception that is increased due to the absence of indigenous cultural values and the imposition of dominant cultural models in the context of mental health care (Laird, 2017). A review of the literature's discussions on environmentally triggered mental health needs reveals an overwhelming call for culturally sensitive

approaches to best meet the needs of affected Muslims (Abu-Raiya, 2012; Laird, 2017; Moffic et al., 2019; Padela et al., 2012; Rothman & Coyle, 2018; York Al-Karam, 2018). This is often framed in terms of cultural competency, based on the concept that clinicians who have a better understanding of Islam and Muslim-majority communities and countries will be better equipped to understand and provide appropriate therapeutic services (Hodge & Nadir, 2008; Koenig & Shohaib, 2014). While it is true on one level that this could help clinicians avoid major errors and misconceptions, it is a problematic solution due to the pitfalls of cultural competency, as defined and practiced currently in psychology (Rothman, 2018).

In their groundbreaking work on cultural humility as an alternative to cultural competence, Tervalon and Garcia (1998) analyze the potential mistakes that clinicians can make when they gain some information and deem themselves culturally competent. In their famous example, an African American nurse refused pain medication to a Latino patient because she had been taught that Latinos overexpress their pain. They describe the situation thus:

To be avoided, however, is the false sense of security in one's training evidenced by the following actual case from our experience: An African American nurse is caring for a middle-aged Latina woman several hours after the patient had undergone surgery. A Latino physician on a consult service approached the bedside and, noting the moaning patient, commented to the nurse that the patient appeared to be in a great deal of post-operative pain. The nurse summarily dismissed his perception, informing him that she took a course in nursing school in cross-cultural medicine and knew that Hispanic patients overexpress the pain they are feeling. The Latino physician had a difficult time influencing the perspective of this nurse, who focused on her self-proclaimed cultural expertise. (pp. 118-119)

In any given situation, when clinicians focus on their self-perceived cultural expertise, commonly as an outsider but also as an insider, there is a danger of assuming that one has a specific insight, based on the client's culture, that in actuality is totally inaccurate (Rothman, 2018). After all, there are as many worldviews, family cultures, and intercultural differences as there are people.

This idea that the efficacy of some current cultural competency training may be imperfect does not mean that the common wisdom of advising non-Muslim mental health professionals working with Muslims to educate themselves about Islam is wrong (Ahmed & Amer, 2012). Rather, increasing one's awareness of Islam can help a practitioner in this regard, as long as the limits of such generalized information is contextualized with the awareness that treating the world's nearly 2 billion Muslims as a stereotyped entity may be ineffective and problematic (Al-Krenawi et al., 2009; Mohr, 2017; Rothman, 2018). At a minimum, non-

Muslim clinicians and professionals should acknowledge and place the larger sociopolitical culture of Islamophobia in its proper context and understand how it, both consciously and unconsciously, affects and biases their relationship with Muslim clients (Ahmed & Amer, 2012).

Tervalon and Murray-Garcia (1998) propose that self-reflection and life-long learning are the essential elements of cultural humility. They state that life-long learning about cultures is an essential component of a mental health providers' continuing education, which needs to be balanced with ongoing self-reflection and self-exploration so they can be flexible and humble enough *to say that they do not know when they truly do not know* (p. 119). Self-reflection includes not only the provider's professional knowledge about the other culture, but also a keen awareness of one's own underlying cultural beliefs, biases, and assumptions. Biases may result in erroneous judgments and misconceptualizations that will interfere with his or her efficacy as well as render the essential tasks of creating trust and rapport impossible.

### **Directive Approaches, Cultural Humility, and Collectivistic Culture**

One of the biases based on the popular wisdom and the culturally competent approach to Muslim mental health is related to directive approaches. In reference to Muslim mental health and Islamic psychology there is popular wisdom, no doubt based in knowledge of specific cultural traditions, that Muslim-majority cultures are generally far more collectivistic than Western European cultures (Kesharvarzi & Haque, 2013; Kesharavzi & Khan, 2018). Collective societies evaluate a particular act or course of action at the family or community level, meaning that its value and success or failure is determined by its impact on the community's greater good. This emphasis, as well as surveys of Muslims engaged in mental health care, have suggested that directive approaches in mental health are methodologically congruent with the collectivist tendency in many Muslim-majority communities.

Studies have also reflected that many Muslims state that they are more comfortable with directive approaches (Kesharvarzi & Haque, 2013; Mir et al., 2015). However, even within this popular wisdom the literature acknowledges that depending on directive interventions must be tempered with awareness of the therapeutic process' importance of self-exploration and self-awareness (Kesharvarzi & Haque, 2013).

Directive approaches describe a set of theories and methodologies in psychological intervention that were traditionally based on a medical model according to which human development and behavior is assumed to be universal, unchanged by environment, and best managed by an external expert who is hierarchically above the client. While such approaches are wide in scope and include Psychodynamic, Behavioral and Medical models, according to the critiques of

many de-colonial and LP theorists (Moane, 1997) their core beliefs are generally similar in that they tend to emphasize the provider's agency in treating the clients and patients' problems and pathologies.

Directive approaches have major problems, among them a tendency for clinicians and medical health providers to use a directive or paternalistic style with older and less educated clients (Smith et al., 2017), whether or not it is a fair and accurate choice in intervention. Less educated clients may assume that they prefer a directive approach simply because they have not been given the chance to participate and co-create their own healing process. As the logical expansion of a Muslim society's collectivistic nature remains undeveloped, it would make sense to propose that the identified target of change in such societies or groups who have suffered a trauma or oppressive system together should be the community, as opposed to the individual. This would involve a focus on long-ignored community-based interventions, which have been found to have positive multi-level outcomes (O'Niell, 2018; Smith et al., 2017).

Additionally, these collectivist tendencies may be expressed differently across the extremely diverse global Muslim community. Assuming that specific cultures lie on a spectrum between individualistic and collectivistic does not mean that all the individuals within a given population rigidly follow these prescribed social norms. In such marginalized communities as the differently abled, women, youth, and LGBTQ+ (a group increasingly accepted by mainstream Muslims at least in the United States) (Aslan & Minhaj, 2015; Bayyah et al., 2016; Mahomed & Esack, 2017), the tendency to feel loyal to multiple in-group affiliations may create a higher tendency to use the therapeutic context for self-exploration, for the ability to conform to norms may be challenged (Triandis, 1989).

Individual Muslims may be more or less oriented toward collectivistic values, given certain sub-group affiliations, despite their collectivist cultural tendencies. This may create conflicts with directive approaches. In terms of LP, these approaches run the risk of reinforcing power structures that prevent the development of true mental health by denying marginalized groups the ability to be in charge of meaning-making and agency in the therapeutic context (Oliver, 2004). If the goal of mental health is to enable the individual to function successfully within the societal status quo, then perhaps the directive approach would be perfect. But if the goal is humanizing relationships and developing models of co-existence for all people, then this thought needs to be explored further.

There is an obvious danger of culturally competent mental health professionals assuming that directive approaches will resonate with Muslims without considering either their individual needs or how psychology should evolve in collective communities, many members of which have had no previous experience with its individualistic perspectives and goal of personal well-being outside the context of a societal unit (Tervalon & Murray-Garcia, 1998). Directive approaches

also might reinforce hierarchy and models of dominance and submission (Moane, 1997), as well as place the definition of disease and wellness inside an individual but outside the scope of the community's discourse.

Although there are possibilities for directive approaches, a real danger is that they could recreate the dynamics of oppression in the clinical environment in a way that mirrors and supports various power differentials, including gender, ethnicity, sexual orientation, identity, and so on (Jun 2018b; York Al-Karam, 2018). These approaches are increasingly dangerous for marginalized, silenced, or socially erased people, such as women (Sarkar, 2001) and LGBTQ+ individuals (Reading & Rubin, 2011), due to the danger of clients feeling blamed or mistrustful of authority (Reading & Rubin, 2011). However, potentially group-based directive models might be able to incorporate some of group therapy's effective components, such as group cohesiveness (Marmarosh et al., 2005; Yalom & Lleszcz, 2005), more easily with Muslims due to their collective cultural tendencies.

These definitions and narratives can be limiting and close down possibilities, including that of client-led directive approaches. Directive approaches could potentially still allow space for the client to be an expert on his/her own life and use his/her intellect and life experiences while receiving directive guidance. Community-based interventions in the American Muslim context have often come from imams at the *mimbar*, trusted expert speakers at conferences, community gatherings, barbershops, kitchens, front porches, *halaqas*, and *iftars*. In addition, significant work has been undertaken to raise the awareness and skills of Muslim faith leaders around issues of mental health, as well as a growing awareness of the imam's importance as the first-line responder to the community's mental health needs (Abbasi, 2016). Potentially, this could be leveraged by groups being co-led by mental health professionals and religious leaders. Information can be disseminated in a directive approach to the collective while still leaving room for the individual.

In Islam, the community (*umma*) is considered one body. Researchers have suggested that less individualistic models aimed at the community are needed in places like Palestine (Makkawi, 2015; Shawahin & Çiftçi, 2012). When one part of the *umma* hurts, all of its other parts hurt as well. This model of interconnectedness could enable talking about illness and ills through the lens of collective responsibility without shame and stigma for those struggling with mental illness, addiction, or trauma. Community connectedness has been an effective treatment for trauma through group work a Latino and American Indian/Alaska Native communities (Schultz et al., 2016), and has tremendous potential as an intervention for Muslim communities.

If directive approaches are suited to the collectivistic nature of Muslim-majority communities, developing and implementing models focused on group healing on the community level, collective healing, and wellness should be em-

phasized. Group approaches have proven effective for female survivors of sexual abuse, and group models have been reported to reduce the experience of stigma, isolation, and shame in this population (Sayın et al., 2013). Group approaches have also proven effective for female survivors of incest due to reduced isolation and shame (Margotta & Asner, 1999). Interpersonal learning as a result of group therapy has effectively enhanced self-esteem for women recovering from eating disorders (Gallagher et al., 2014).

Group approaches have been shown to help LGBTQ+ asylum seekers with trauma, stigma, shame, and low self-esteem (Reading & Rubin, 2011), as well as to be effective for Muslim women recovering from sexual trauma in Turkey (Welkin et al., 2015). Stigma is a consistent challenge due to Islamophobia (Kunst, 2012; Samari, 2016), and mental health challenges make this more pronounced (Laird, 2017). Thus, using a group approach that reduces stigma by group dynamics makes a tremendous amount of sense.

Part of what could potentially make group approaches the most effective approach to a Muslim community would be for the group's facilitator to identify as part of the group (Mir et al., 2015; Walpole et al., 2013). Client-counselor matching has not been conclusively shown to improve outcomes in all cases (Walpole et al., 2013); however, some research does suggest that it has a positive effect on group therapy (Fiorentine & Hillhouse, 1999; SAMSHA, 2005; SAMSHA, 2014). Especially with recent immigrants, research indicates that cultural matching is particularly important (SAMSHA, 2005). In addition, a co-facilitator who identifies more closely with the group's members can provide support to the more clinically trained facilitator if the primary facilitator does not understand the specific population's problems and strengths and can serve as a role model to assist the clinician (SAMSHA, 2005). Group safety and trust is further enhanced when there is a common understanding or shared experience (Rotgers et al., 2006). Research has shown that when a facilitator who vulnerably shares helps model a deeper level of healing in a group setting and can contribute to the development of identification, universalism, and the instillation of hope (Yalom & Lleszcz, 2005).

The idea that group models should be the focus for Muslims harmonizes with an LP approach because even in a directive group therapy model, dialogue and the consciousness raising model share power and emphasize agency within society. What if the directive model were implemented in a model that facilitated healing through dialogical engagement with mental health and wellness? This modality would honor both the community and the individual process, including making Muslim community spaces like mosques more welcoming (Bagby, 2017). The idea that a qualified community member could facilitate conversation through group dialogue and consciousness raising would be an LP approach rooted in Muslim community models and culture. This could be combined with the best

practices approaches for group interventions and those factors found to enhance the efficacy of group psycho-therapy (Yalom & Lleszcz, 2005), as well as culturally sensitive models that incorporate religiously relevant models and information, similar to other spiritually modified interventions based on the protective effects of spiritually integrated approaches (York Al-Karam, 2018; Zidan et al., 2017).

### **Non-directive Approaches and LP**

The concepts of conscientization and consciousness raising in LP focus further on using the therapeutic process to dismantle oppression when applied in a non-directive model. Non-directive psychological theories and methodologies are frequently described as client-based, for these interventions are assumed to be strength-based, client-led, and based on the unique interplay between the individual and his/her environment. None of this has to always be pitted against the family of origin and culture. Taking into account the effects of colonization, racism, and other forms of oppression is important, for doing so enables providers to acknowledge them in the shaping of families and intergenerational trauma.

Unquestioned assumptions about hierarchy can have a negative effect on therapeutic outcomes, and self-reflection is an important part of the clinician's role in treating populations effectively from a multi-cultural perspective that takes the importance of cultural humility seriously (Jun, 2018a). When viewing the change process through the lens of LP, the mental health professional's role shifts away from that of an expert on etiology and healing to that of a process expert (Torres-Rivera et al., 2013).

The concept of liberation theology relates to this approach. Assuming that God is a god of mercy and justice, that the oppressed and marginalized are a priority of religious action and life, and that our actions in this world toward justice and against *zulm* are religious mandates is central to a Muslim mental health approach. Helping these people attain self-actualization is a priority and a religious duty (Esack, 1997), as well as a duty for Muslim mental health clinicians. Obviously, the elision of liberal progressive agendas within Muslim mental health approaches can potentially reflect an epistemic of post-modern relativism, due to its fundamentalist locating of freedom in unlimited individual choice that is, in turn, deeply rooted in the exact logic of power relations that LP questions, namely, the unquestioned normative frame of reference of the Western European epistemological tradition (Mahmood, 2005).

However, non-directive approaches potentially represent an opening to ways of understanding agency based on the exploration inherent in conscientization. Such approaches acknowledge, at the level of process, that reworking these power relations requires questioning the ability of any particular psychologist's training to prepare the mental groundwork for creative change that operates outside the presupposed ontologies of Western European psychology. The concept



that help can actually be doled out like supplies from a food pantry needs to be overcome. As Freire (2000) states,

False charity constrains the fearful and subdued, the rejects of life, to extend their trembling hands. True generosity lies in striving so that these hands, whether of individuals or entire people's, need be extended less and less in supplication, so that more and more they become human hands which work, and working, transform the world. (p. 45)

What this liberation would be in actuality remains to be created, for at this point in time we cannot say what it would look like, how it would function, or how these transformed and humanized relations would be actualized.

Freire (2000) described the key elements of conscientization, and they are eminently applicable to a model of group intervention for mental health. His ideas of using generative themes could be a starting place for discussion groups. Additionally, how he juxtaposes the four-part processes of oppression versus liberation relates to developing conscientization-based mental health models. He describes oppression as being based on conquest, divide and rule, manipulation, and cultural invasion, whereas dialogical action is based on cooperation, unity, organization, and cultural synthesis. These differing frameworks also could form the basis of models of therapeutic interaction and for formulating group approaches that utilize a non-directive and liberatory dialogical model.

### **Conclusion: Complementary not Contradictory, Harmony not Conflict**

This paper sought to contribute to exploring the directive/non-directive dichotomy in Muslim mental health, particularly in reference to LP's implications for the conversation, and specifically conscientization. One cannot take dogmatic stances on the issues, for one must remain open to the nuances and variations of the ideas being discussed, as well the wide range of possibilities as to how different approaches might incorporate both reflection and engagement in a praxis of psychology that supports social justice and individual and community wellness.

All of these ideas, as well as the greater realities of global philosophical thought, exist on a spectrum and represent variations in perspective that, while often portrayed as being in opposition, are in fact possible to harmonize and integrate. It is not a question of liberation psychology versus behaviorism, Islamic psychology versus Western European psychology, and ultimately Islam versus the West. There is a long history of Muslim scholars believing that European law and living according to the Sharia were compatible (Frykholm, 2015) and that Islamic psychology and Western psychology in many ways often harmonize and can inform each other. Islam, and thus Islamic psychology, is naturally a component of globalization and not necessarily in conflict with secularism as such (Yom, 2002).

While it does not immediately solve every conflict for Muslim mental health practitioners, many are theorizing an alternative frame of reference beyond

the oppositional-conflict model of Islam versus post-modernity as an inevitable reality of our time. The medical model's failure to address the spirit is one of the critiques of LP, the critique of scientism and positivism. Another view, that of mysticism, is a holistic and harmonious view that sees the materialist reality as a layer within a greater reality of Being. As Wilber (1998) states in his *The Marriage of Sense and Soul*, all the layers of mind and elements are reflections of the Great Nest of Being, which he contends has three levels: the gross level (matter and body), the subtle level (mind and soul), and the causal level (spirit) (p. 10). He freely criticizes the global North's scientific materialism that has reduced the finer and subtler levels of consciousness to the gross layer of matter.

This critique has been widely accepted and addressed by including spirituality in psychology in a nearly endless variety of iterations, including making assessments of the bio-psycho-social-spiritual and of course the American Psychological Association's (APA) Institution of Department 36 in 1976. Martín-Baró (1994) described this as the conflict between rat psychology and psychology with a soul.

Basically, now in 2020 some are proposing a new version of the same long-term problem within the medical establishment. The concept that the Islamic worldview conflicts with psychological ethics is a misunderstanding of reality in the sense that the APA's ethics were originally grounded in gross levels of matter and do not conflict with the subtler and finer layers of Being. There is a deep harmony between the universal ethical principles found in the APA's code of ethics and Islam. Martín-Baró (1994) discusses the problem of false dilemmas and talks about how juxtaposing worldviews often leads to dismissing possibilities and options instead of expanding understanding and insight.

Treating Muslims who disagree with traditional Islamic norms relates to including an Islamic perspective in LP and, specifically in this paper, to doing mental health work with cross-cultural awareness. Martín-Baró (1994) discussed how conflict becomes natural in society in reference to the polarizing effects of war, war as a prevailing culture and the displacement of groups towards opposite extremes. (p. 112). He states:

...polarization exacerbates differing social interests and in the end, implicates the whole scope of existence...Thus, the basis for daily interaction disappears. No frame of reference can be taken for granted as valid for everyone; values no longer have any collective validity, and even the possibility of appealing to common sense is lost, because the assumptions of coexistence themselves are being put on trial. (p. 113)

The idea that Muslim mental health professionals cannot work responsibly with LGBTQ+ clients and follow the APA code of ethics, or with feminists or other Muslim sub-populations who follow less traditional norms, is based on an idea that Islam and secularism are necessarily in conflict (Elzamzamy & Keshavarzi,

2019). In the therapeutic setting, instead of rejecting the ethics of the APA or the National Association of Social Workers, simply remaining clear about the implications of mental health work for Muslims in terms of the afterlife, in reference to the lifespan as understood by Islam, would refocus this debate more constructively (Rothman, 2018).

In terms of ethical approaches that prioritize the community's health, thinking in terms of conflict, war, and opposition is problematic for many reasons, one being the frame of reference that sees war as the basic truth of human experience. There is another option. Finding ways to foster collective mental health makes tremendous sense as a Muslim mental health directive, given the beautiful emphasis that traditional Muslim-majority societies have placed on the group. As Martín-Baró (1994) said,

...we must work hard to find theoretical models and methods of intervention that allow us, as a community and as individuals, to break with the culture of our vitiated social relations and put other, more humanizing, relationships in their place. (p. 120)

He goes on to say:

If the foundation for people's mental health lies in the existence of humanizing relationships, of collective ties within which and through which the personal humanity of each individual is acknowledged and in which no one's reality is denied, then the building of a new society, or at least a better and more just society, is not only an economic and political problem; it is also essentially a mental health problem. (p. 120)

The chapter's concluding words are, "The challenge is to construct a new person in a new society" (p. 121). Franz Fanon concludes his *Wretched of the Earth* with a similar call:

But what we want is to walk in the company of man, every man, night and day, for all times...The Third World must start over a new history of man which takes account of not only the occasional prodigious theses maintained by Europe but also its crimes, the most heinous of which have been committed at the very heart of man, the pathological dismembering of his functions and the erosion of his unity, and in the context of community, the fracture, the stratification, and the bloody tensions fed by class and finally on the immense scale of humanity, the racial hatred, slavery, exploitation, and above all the bloodless genocide whereby one and a half billion men have been written off...if we want humanity to take one step forward, if we want to take it to another level than the one where Europe has placed it, we must innovate, we must be pioneers. For Europe, for ourselves and for humanity, comrades, we must make a new start, develop a new way of thinking, and endeavor to create a new man. (pp. 238-239)

For psychologists, this means being willing to question conventional methods and theories. To go a step further, this means that clinicians must engage in self-reflection. If the prevailing mindset is one that views conflict as a natural and necessary state seeps, as it inevitably will, into all of a society's core belief systems, and if clinicians do not notice or question its influence, clinical approaches will be unable to move individuals and society beyond it. Thus, as Fanon says, "Fighting for the freedom of one's people is not the only necessity. As long as the fight goes on you must re-enlighten not only the people but also, and above all, yourself on the full measure of man" (p. 219).

There are many ways that research and practice can develop new models for how this can happen. Focus groups based on participatory action research that discuss empowerment and what people think mental health would even look like are a possibility. Community think tanks could bring together community members to discuss what a new society with a sustainable future would look like and how mental health clinicians can help bring it into reality. Of course, this research suggests as well that Muslims' mental health would benefit from group therapeutic approaches and that the multiple options for what this could look like need to be explored.

Martín-Baró asked what happens when psychology starts from the experience of the masses, of the multitude. The task implies both respecting people's autonomy of thinking and action, as well as challenging them to reveal their humanity as the ultimate act of self-liberation (Rahman, 2004). Research needs to continue developing models for bringing these visions to the academic and professional worlds of psychology from the roots of society, models that really elevate the entire work of psychology – all the way from providing band-aid solutions to unsolvable dilemmas to a key that opens doors to new ways of being and a new society. The ongoing self-reflection and commitment to learning arising from an attitude of humility, harmony, and co-existence will no doubt be crucial to finding new options (Rahman, 2008; Jun, 2018a). The commitment to being pioneers of new ways of thinking, not thinking in terms of conflict but working toward solutions that allow Muslims to live their religion in a spirit of unity with each other and the Other, means realizing that individual wellness requires a commitment to social justice and working for a praxis of to make this a reality for all.

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