


Spring 2022

Madness in Islam: Cultural Dimensions and Medical Knowledge from the Medieval to the Postcolonial

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Recommended Citation

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Madness in Islam: Cultural Dimensions and Medical Knowledge
from the Medieval to the Postcolonial

Senior Project Submitted to
The Division of Social Studies of Bard College

by
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Annandale-on-Hudson, New York

May 2022

Acknowledgments

Thank you to the professors and faculty who I have had the pleasure of working with and learning from during the past four years. Your collective guidance has been invaluable.

Thank you to my advisor Omar Cheta, whose advise and support throughout my time at Bard is incredibly appreciated.

I am especially grateful to my friends and family. Without your kind words and thoughtful encouragement, this process would have been all the more challenging. Thank you.

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Introduction

To define “madness” is quite a complicated pursuit and, despite centuries of attempts, has yet to produce anything precise. Disparities in what constitutes the behaviors that define madness—such as, but not limited to, differing medical ambitions and conflicting treatments or healing mechanisms—are responsible for this complication and reflect the need to interpret madness and mental illness in a rather comprehensive way. I would like to acknowledge that the study of madness is complex and subject to discrepancies. Therefore, I recognize that the findings of this project may provoke differences of opinion.

Madness is a culturally specific reflection of what would more presently be deemed as a kind of mental illness. I do not, however, wish to limit any dialogue of the past according to present understandings, nor do I wish to medicalize conditions such as madness and insanity as “archaic” representations of psychiatric diagnoses such as schizophrenia or psychosis, for example. Therefore, “mental illness,” as well as “mental disturbance,” are used here as broadening, inclusive terms to denote all afflictions related to madness or insanity. I do, however, recognize that madness is not always explicitly perceived as an “illness” in need of treatment. Throughout this project, the term “madness” will be used most often, whereas “insanity” is more commonly applied within discourses of Islamic jurisprudence, which is reflected in my discussion on law and protection.

Discourses around madness—whether legal, religious, or medical—may be considered as a means for legitimizing afflictions, as well as implicating the patient in a process of

“self-making” whereby their existence is rendered according to a comprehensive diagnosis. For centuries madness has been diagnosed for innumerable reasons and healed with a variety of treatments. I decipher madness not as an objective phenomenon but as something malleable, created from a cultural and historical process and manufactured out of the social context of the patient—that madness is determined by the present structures of power and will thus differ accordingly. Attention will be given to the history of the exchange of medical knowledge and the channels through which this knowledge was translated and applied so as to suit the needs of a particular community. My focus will be on the migration of ideas from Ancient Greece to the Middle East and eventually throughout Europe. I will then go on to uncover how knowledge and medical teachings derived from the Graeco-Islamic tradition were upended and implemented by European powers to justify and facilitate their colonial projects.

Chapter I: “Madness and Islam” begins by introducing madness as a condition impossible to typecast by a singular definition, nor as a condition whose diagnoses or treatments can be limited to a singular methodology. Instead, I argue that madness should be surveyed in relation to the environment and the moment in which it occurs. Boundaries between madness and other related phenomena are restricted to the determination set out by a particular society. The line separating insanity from sanity remains invisible except to those intimately related to the patient or to the practitioner tasked with making this very determination. Thus, madness is a phenomenon that exists insofar as a society brings it into being. As Michael Dols states, madness is “any behavior that is judged to be abnormal or extraordinary by a social group at a specific time and place” (136). The chapter continues by exploring the origins of early Islamic medicine and the beliefs and practices that informed its tradition. I situate the encounter between Islam and

Greek medicine as critical to the development of a distinct medical tradition via the translation of significant works into Arabic.

By exploring various understandings of madness, I attempt to highlight the plurality of the Islamic medical tradition. Spirit possession is addressed as a prominent cause of madness, remaining one of the oldest diagnoses through which Muslim patients have been able to confirm their mental disturbances, as well as account for a loss of agency over their mind and body. Using various Qur'anic passages, I trace evidence of possession as caused by the spirits *jinn*. In addition to analyzing possession as a supernatural and religious experience, I present an alternative understanding of spirit possession as a culturally bound syndrome, wherein symptoms originate from a psychiatric disorder rather than a genuine spiritual confrontation.

The following section considers the cases of madness that do not fall under normative interpretation or diagnosis. Instead, madness is accepted or does not require typical treatment methods. In examining these cases, a tolerance of madness is uncovered wherein the protection and care of the individual take precedence over their curing or punishment. Integral to this section is the introduction of Sufism and its belief of madness as evidence of a decision to live according to one's own rule, and maintain one's agency while parallelly seeking union with God. Here, madness is not expressive of a kind of deviance but rather evident of a set of decisions or behaviors unaligned with the "status quo," wherein a greater sense of freedom may be enjoyed.

The final section of this chapter is twofold, situating religion as a channel for healing and law as a form of protection for the mad. Prophetic medicine is introduced as a popular alternative to Graeco-Islamic medicine due to its proximity to God and the traditional practices, treatments, and preventative medicine as pronounced by the Prophet Muhammad. A critical source of

protection for the insane person is attributed to Islamic law, which sets out a comprehensive legal framework for how those experiencing insanity are to be regarded and managed. Islamic law underlines the necessity to provide suitable mechanisms of protection and care for the mentally ill.

Chapter II: “Madness and Translation” begins by outlining the history of the exchange of medical knowledge between Greece and Islam and eventually Islam and Europe, during which translation emerged as a significant project. I provide a brief lineage of the development of traditional Islamic medicine and the phases leading up to its encounter with Europe. Critical achievements during this period include the establishment of the first psychiatric hospital, the translation of an extensive collection of renowned medical texts into Arabic, and the writing and publishing of original medical works by Muslim physicians and scholars.

The second section of Chapter II discusses the diversity in approaches to mental illness and the intersections between European scientific knowledge and Arab-Islamic medicine. By concentrating on the discipline of psychology, or in Islam, the study of the *nafs*—translated as the “self” or the “soul”—I meld together a modern set of explanations with those of classical Islamic thought to demonstrate a developing notion of Islamic subjectivity that incorporates both theological and psychological elements. Psychoanalysis is placed in conversation with Islam so as to reveal an emerging postcolonial theory of the self, wherein religion is no longer thought of as a leading reason for mental disturbance or irrationality. In parallel, the section explores the postcolonial effort to construct an integrative Arabic lexicon of psychoanalysis.

Chapter III: “Madness and Colonialism” acts as a continuation of the encounter between traditional Arab-Islamic medicine and Europe. Despite a century-long transmission of

knowledge, Europe was able to guise their resulting medical system under an impression of modernity, whereby Islam's pluralistic tradition was deemed as "primitive" in comparison. Evidence of madness and ill-health thus stood as justification for colonial intervention. According to its own psychiatric framework, Europe was able to interrogate Arab-Islamic indigenous practices and propagate explicit categories of difference and insecurity.

The second half of Chapter III surveys the colonial encounter between France and Algeria—specifically the implications this encounter had for the health of native patients. Disparities in the quality of care administered by colonial practitioners, the segregation of patients into categories of "civility," and the transportation of madmen to asylums located in France all contributed extensively to the construction and maintenance of a new colonial subjectivity wherein the identity of the patient was eradicated and made anew.

To highlight the ongoing effects of colonization on mental health, in and around the period of decolonization, I examine a specific case of reactionary psychosis recorded by Fanon of a man who, subject to consistent brutality between Algerian forces and the French Army, was left mentally disturbed. A deadly ambush that resulted in the total destruction of village infrastructure and mass murdering of its inhabitants left the patient severely injured. Soon after, his behavior became increasingly abnormal and violent. What developed was an intense belief in the need to protect himself against *everyone*—particularly those he deemed were Frenchman disguised as Arabs—using incessant violence toward Algerian soldiers, nurses, doctors, and fellow patients. The line between enemy and partner became blurred. What is apparent in this case is extreme anxiety, suspicion, and the confusion of identity, where the patient is too

encumbered by the effects of continuous brutality that it becomes the only mechanism through which he knows how to cope.

What you are seeing is the product of many months of research, discussion, and reflection. For centuries scholars and physicians have attempted to make sense of madness, yet still, our study remains imperfect and controversial. I have attempted not to implicate myself in a process of strict determination or to answer any overarching questions on the very cause or meaning of madness. Rather, I have tried to demonstrate an exploration into the various concerns and topics presented in this project and instead open up a meaningful conversation on the study and history of madness—revealing its many rifts, contours, and complexities.

Chapter I: Madness and Islam

Madness and Malleability: Madness as a Contextual Phenomenon

Before any discussion of madness, it is essential to note the ever-changing nature of the practices, ideas, and interpretations of what madness has looked like or how it has manifested over time. Madness may be best understood as a historically contextual phenomenon, thereby determined and classified according to a particular time and place. Thus, scholarship on and around the topic of madness must avoid assessments of appropriateness or accuracy, especially regarding how a community has decided to articulate or treat it.

Assessments of madness require an understanding of it as an affliction determined by one's social and cultural environment. The communities in which one exists are crucial for determining and defining madness and its appropriate treatments. Modern tendencies to classify all cases of mental illness in a strictly clinical manner reject centuries of tradition in which madness has been determined and treated alternatively. Past madnenses are not "petrified entities that can be plucked unchanged from their niches and placed under our modern microscopes" (Midelfort 49). Attempts to situate or even rearticulate past cases of madness within present systems are counterproductive for justifying contemporary attitudes or healing techniques and do little for furthering knowledge on the topics. Experiences of madness are wide-ranging, differing from the enjoyment of an ecstatic sense of holiness to impulses and temptation to suffering through feelings of unending despair (Eghigian 1). Therefore, it is critical to survey such cases from the contexts in which they exist because "an assessment of insanity in any society is

intimately dependent on its social context” (Dols 4). How madness is determined, studied, and treated is thus conditional. In the case of Islam, a distinct set of values and practices govern how madness has been contemplated, defined, and treated. Articulations of madness as common or even acceptable have helped develop diagnoses, name afflictions, normalize patients, and further implement Islamic religious and social values in medicine and the study of mental illness.

Progressive rhetoric used to discuss madness implemented a process whereby justifications for the afflicted and their symptoms emerged (Shoshan 338). Roy Porter’s rationale for madness in early-modern Europe as “medical, or moral, or religious, or, indeed, Satanic” highlights the very malleability of madness as a socio-cultural category that cannot be restricted to a singular cause (14). Madness, as a socio-cultural phenomenon, refers to how the behaviors of the affected individual are conditional to their surroundings, such as the structure of their community, social institutions, and dominant religious and social forces. Such a perspective takes into account how mental processes, symptoms, and behaviors are shaped by one’s cultural, social, and religious background, which makes for a more informed understanding of madness and the circumstances that aid in its development. Madness “could be sited in the mind or the soul, in the brain or the body. It could be good or bad,” and there has never been a precise determination of what constitutes these afflictions (Porter 14). The breadth of this definition warrants a perception of madness and the language used to characterize patients and place them within specific categories as a process through which a culture can confirm its respective norms according to its own medical determinations. This is not to say that the sole intention behind administering diagnoses and treatment is to instill beliefs through medicine so as to confirm authority, but rather to highlight that the process of diagnosis is not always strictly clinical.

Early Islamic medicine and its initial formulations can be traced back to the influences of Greek and Roman physicians and scholars and their respective thoughts regarding appropriate and effective medical practices. The majority of the concepts and literature produced by early Islamic scholars on medicine and the effects of mental disturbance can be attributed to the inspiration derived from such scholarship. Greek medical works proved influential to the development of Islamic medicine and remain vital for understanding how Islamic medical traditions were cultivated and eventually transmitted elsewhere. The reception of Greek medicine as an adequate system to be accepted in early Muslim society was primarily due to the works of Islamic medical writers, physicians, and translators who tasked themselves with making more accessible the teachings of Galen, along with other influential physicians. Medical concepts developed from these works were first translated into Arabic and circulated amongst the public. The total synthesizing of this knowledge into Arabic was a process of the medieval era—a period marked by incredible cultural and scientific achievement. An alternative to the practices gleaned from Greek-based medicine are those of Prophetic medicine or, in Arabic, *al-tibb al-nabawi*. However, these medical traditions did come into contact and should not be considered completely unconnected from one another. Greek-based medicine employed Prophetic medicine and vice-versa to explain God's involvement with the health of the human body and to “compliment religious practices with healing practices” (Afacan 22). The medical system of the medieval period and onward unfolded as an amalgam of various fields of knowledge. A diverse set of medical traditions were to coexist, thus contributing to Islam's plurality of techniques and healing.

The works produced by Muslim physicians were eventually implemented by European scholars, who translated their synthesized works into Latin to inform European medical teachings and aid in the development of modern medicine in Europe (Saad, Azaiezh, and Said 475). In the borrowing from earlier Graeco discoveries, Islamic scholars expanded upon previous knowledge to inform their writings. Through Islam's expansion of these previous discoveries coupled with its respective theoretical and religious principles, a distinct system of medicine was produced, accepted, and eventually followed. Initial understandings of madness and other mental afflictions expressed in early Islamic medicine are due primarily to the transmission of Graeco medical understandings into Arabic, though in most cases altered to accord with Islamic doctrine. Muslim scholars contributed an array of concepts that extended beyond those of the prominent Greek humoral theory, even in some instances pointing to its flaws or suggesting alternative explanations. Additionally, interest in psychoses played a major role in the development of the notion of madness in Islam outside theological explanation. The succeeding work of medieval Islamic medical writers produced a robust system of medicine that fit Islam's religious and cultural demands, altering foreign discoveries and adding the expertise of physicians and scholars to create a new tradition in line with its respective customs.

Possession as Madness: Jinn and The Qur'an

Early Islamic medicine is motivated by the customs and principles of the religion and legitimated by its reflection of Islam, as it was first represented in the text. Belief in the veracity of the Qur'an and the healing power of the divine is the principal mode of coping with both prolonged mental affliction and isolated or repeating instances of insanity. Though Greek

medicine forms the basis of inspiration for Islamic written medical knowledge, the revelations found within the Qur'an, as well as its overgrowths such as the *hadiths* or the *Sunnah of the Prophet*¹, are responsible for further informing Islam's medical tradition and for propelling developments that allowed for the creation of its own distinct system (Werth 1).

One of Islam's most prolific justifications for cases of madness is the belief in spirit possession. Possession is one of the longest-standing explanations for mental disorder and, along with Islam, is a phenomenon found in Hinduism, Buddhism, and Judaism (Dein and Illaiee 290). Professor and anthropologist I.M. Lewis defined the possessed person most candidly as someone deemed to be in a state of possession as determined by their own culture (40). By this definition, possession is confirmed according to the cultural context of the afflicted person. Cultural context is the very thing that will ultimately determine if one is thought of as possessed by a spirit or instead experiencing a state of psychosis. Possession is a "culturally specific way of displaying symptoms of psychosis, dissociation, social anxiety, etc.," and it is up to a particular community and the nature of their medical system to declare the causes of mental or bodily affliction (Dein and Illaiee 291). Here, a distinction is made between a religious diagnosis of possession and one based on a clinical diagnosis like psychosis.

Possessed states are most commonly attributed to the *jinn*, the supernatural spirits of God, and are particularly prominent figures throughout the early Meccan portions of the Qur'an. Jinn are said to exist alongside humans yet remain invisible to the naked eye when in their original form. They are able to see humans and discern their actions, but humans are devoid of the power to see them. The Arabic term for madness is *junoon*, with its etymology meaning "hidden" or

¹ The Sunnah of the Prophet is comprised of traditional social and legal practice in Islam as layed out and followed by the Prophet Muhammad.

“invisible” (Tzeferakos and Douzenis 3). Alternatively, jinn may take on the form of an animal: dogs, cats, camels, monkeys, owls, scorpions, and in particular, snakes. They may also assume appearances of something rather inhuman, misshapen, or figures imagined as “monstrous hybrid beings” (Werth 13). According to popular belief, jinn may be male or female though they do not inherently exist by individual identities. Their sex is distinct, though jinn do not adopt specific names or personalities that differentiate them from one another (Werth 13). Rather, they represent the same essential force and are often referenced collectively within the context of possession.

Within the spiritual world, jinn are positioned lower than angels and, in some cases, associated with demons and Satan, or *Shaytan*—a figure within their realm. Despite their demonic comparisons, jinn are said to be capable of pursuing both good and evil and can decipher between what is right and what is wrong (Dein and Illaiee 291). They maintain qualities similar to human beings, such as intellect and freedom, which are essential qualities of humankind. Jinn live alongside humans but arrange themselves in a world distinct from ours. Regardless of exercising mortal qualities, God derives the jinn from something much different from humans: “He created man from hard clay, like bricks. And created the jinn from a fusion of fire” (Qur’an 55:14-15).² The difference in origin between the human and the jinn may be assumed to reflect their respective statuses. The man derives from earthly material, while the jinn are birthed from fire and flame—an element that is piercing upon contact and often deemed “hellish.” Because the jinn originate from flame, it is worth noting that recorded symptoms during fits of madness include delusions of fire and flames (Dols 77). Islamic physician Ibn Sina

² All succeeding translations of the Qur’an are done by Talal Itani (b. 1961) and are taken from the “Tanzil Quran Navigator.”

(c. 970-1037) declares signs of madness as “irritation, jumping about, and sparks flying before the eyes” (Shoshan 331). The fact that these symptoms involve hallucinations of the very origin of the thing that possesses them is compelling when contemplating the strength of possessive states and the effect of the jinn over the mind and body. The jinn are an essential figure within Islam’s approach to madness. Belief in the jinn and other supernatural entities influence Islam’s treatment of mental disturbance and the course of a patient's diagnosis.

There are several ways in which someone may be more or less prone to possession. A prominent explanation of possession is a weakness in religious conviction or a tendency toward doubtful thoughts about God and his authority. Individuals' actions inspire their susceptibility to possession and cause the jinn to become provoked—attacking those weak in religious conviction. Other ways a human might be vulnerable to possession, as suggested by Islamic scholar Ibn Taymiyyah (c. 1263-1328), is due to the presence of sensual desires or obsessive love. Jinn may also cause possession out of pure evil or “horseplay,” with no particular reason for dispute with the possessed (Werth 16). According to Ibn Taymiyyah, the most common cases involve explicit disputes on behalf of the jinn in which they believe to have been wronged or harmed by a human and seek vengeance upon them. Humans unknowingly harm the jinn—pouring hot water on them, urinating on them, or killing them—and become possessed despite not realizing the jinns’ presence when committing these acts: “the jinn are by nature very ignorant, harsh, and volatile in their behavior, so they may vengefully punish human much more severely than they deserve” (Werth 16). If we are to assume spirit possession as unprovoked or random, it may instead be interpreted as a condition preventing a Muslim from worshipping God full-heartedly. Rather than a consequence of weak religiosity, possession may be understood as

the very thing encouraging this weakness to continue. Possession remains one of the most popular explanations for abnormalities in behavior amongst Muslim patients, wherein appropriate treatments include but are not limited to: “remembrance of God and recitation of the Qur'an; blowing into the person's mouth, cursing and commanding the jinn to leave; and seeking refuge with Allah by calling upon Allah, remembering him, and addressing his creatures” (Khalifa and Hardie 351). Possession can occur regardless of if one follows appropriate preventative measures. In this case, the jinn are capable of tempting even the most devout and driving them into states of madness, marked by repeated misbehavior.

According to a psychiatric frame of reference, jinn possession may indicate an altered state of consciousness. Psychiatric researchers Najat Khalifa and Tim Hardie present three theoretical frameworks through which states of possession may be otherwise understood. First is the *dissociation theory*, based on Freud’s conception of the unconscious. According to this theory, a state of hysteria is brought about when the ego is overwhelmed by unconscious thought, thereby resulting in a state of disassociation (352). The ego is responsible for maintaining the skills necessary to function in the world: impulse control, perception, evaluation, and judgment. The unconscious is that part of the mind that “stores feelings, thoughts, and urges unaware to the individual” (“Psychoanalytic Terms & Concepts Defined”). Second is the *communication theory*, whereby the person displaying possession symptoms exhibits similar effects to someone experiencing oppression. They assume a “sick role” to receive attention (Khalifa and Hardie 352). The third and final theory is the *sociocultural theory*, which accounts for possession as a “culturally sanctioned phenomenon” that a community is exposed to from an early age. A person will thus anticipate that they will, at some point, be exposed to its effects (Khalifa and Hardie

352). When exploring such theories, the fundamental interaction between traditional cultural formulations and contemporary psychiatric methods becomes visible. Regardless of any prominent system underlying the practice of a particular clinician, the reality of possession, as revealed and held by the patient, must take precedence. Maintaining such an approach will help determine appropriate treatment pathways (Khalifa and Hardie 353). I mention these frameworks so as to indicate a psychiatric alternative to the understanding of possession as a religiously-bound affliction. The concept of jinn possession has entered into contemporary Western medical discourses over the last century and, for some clinicians, has presented a considerable dilemma. I bring attention to this again so as to highlight the clinical belief in spirit possession as a culturally specific way of displaying psychoses. Such a belief points to an essential rift between Islamic spiritual explanation versus conflicting psychiatric methods, which could affect the quality of care delivered by Western practitioners to patients of a Muslim background.

That spirit possession causes madness is a widely familiar notion in Islam and can be first traced back to the Qur'an, for example:

Those who swallow usury will not rise, except as someone driven mad by Satan's touch. That is because they say, "Commerce is like usury." But God has permitted commerce, and has forbidden usury. Whoever, on receiving advice from his Lord, refrains, may keep his past earnings, and his case rests with God. But whoever resumes—these are the dwellers of the Fire, wherein they will abide forever. God condemns usury, and He blesses charities. God does not love any sinful ingrate. Those who believe, and do good

deeds, and pray regularly, and give charity—they will have their reward with their Lord; they will have no fear, nor shall they grieve. (2:275-277)

According to these verses, one afflicted by madness cannot decipher what is forbidden or considered evil from what is good and acceptable under God. God permits commerce but prohibits usury. Those who go against rules set by God and continue participating in sinful acts will be punished and, upon the Day of Resurrection, resume the form of someone driven into madness. Here, madness is a punishment delivered by the “touch” of the demon. Those able to break free from patterns of misbehavior and remain pious will prove their loyalty and shall be given a chance at redemption. Their case will rest with God, and He will at once protect them from the evil-doings of Satan. If sinful acts resume and the possessed do not change their course, they will abide forever in the “Fire.” One must follow the advice and warnings delivered by God. If not, one will jeopardize their sanity and become vulnerable to possession by the jinn.

There are plenty of instances in the Qur’an of warnings against the effects of evil spirits and the threat that spirit possession or temptation poses to Muslim piety. In the very last Sura of the Qur’an, we can find an example in which God is referenced as the ultimate source of refuge against these kinds of threats, “Say, ‘I seek refuge in the Lord of mankind. The King of mankind. The God of mankind. From the evil of the sneaky whisperer. Who whispers into the hearts of people. From among jinn and among people’” (114:1-6). As a prayer provided to Muslims, followers are encouraged to protect themselves against devilish tempters—who whisper evil into the hearts of believers and cause disarray—by acknowledging God’s primary attributes. That God is the lone sustainer of the protection of Mankind against the forces of evil and that there exists no other authority by which one can be rescued against the coercive efforts of evil’s

recurring suggestions. Complications may include loss of concentration during ritual prayer, obsessive reprehensible thoughts, and compulsive behavior, especially during acts of spiritual purification (Parker and Siddiqui 41). Vulnerability to such influences does not subside. The only way to limit one's susceptibility to being led astray by sin requires an understanding of God as the absolute authority in determining their protection. Notable here is the reference to both jinn and man as the potential sources of evil. The "whispering" of evil is not exclusive to Satan. Thus, in reciting and adhering to this prayer, followers may seek refuge from the evils of both jinn and man. The only way to protect oneself from temptation is to follow the will of God, "since any other spirit or essence whispering to mankind is whispering the will of Satan (Iblis)" (Werth 12). In recognizing God as the essential ruler of humankind and as the exclusive Being to be worshiped—assuming the position of a loyal servant—one is less vulnerable to the mischiefs of evil and, in turn, less susceptible to possession.

Alternative Madness: Trial, Tolerance, and Mania As Privilege

The onset of madness may be understood as the unfolding of a sort of punishment against the occasional sinner, whereby a disobedient individual becomes burdened with a "divine punishment" intended to encourage them to change their ways. It is not until they correct their behavior that God may free them from their ailments. Alternatively, bouts of madness are evidence of a divine blessing rather than solely a kind of punishment. Suffering caused by illness is considered a "spiritual test from the Almighty Creator, Allah [God], a test of faith in Him, in the meantime expunging sins and misdeeds" (Hussein, Albar, and Alsanad 62-63). For devout Muslims, prescriptions of madness reveal themselves as a test against their piety, as an

opportunity to prove they are worthy of salvation and be given priority against their less devout counterparts. The reason for affliction, in any of its forms, may thus be presumed as a “trial or blessing for the believer” (Dols 245). Rather than thinking of madness as a condition caused by the coercion of devious beings such as the jinn, one may consider God as the originator of such distress, in which He intends for His trials to leave the Muslim patient chastening or expiatory (Dols 245). Here, God is the agent of mental affliction or ill-health. He determines the condition of the individual, and it is up to them how they decide to proceed.

Islam established attitudes toward the mentally ill according to a basis of tolerance and understanding. Such tolerance is observed in the setting up of protections or healing methods. Rather than neglecting or desocializing the mentally ill—rendering them outcasts unable to function alongside the “sane”—Islam presents a sort of road map for believers, directing them to a set of adequate responses to their ailments via heightened religiosity. Such attitudes underline the “moral necessity for the protection and care of the vulnerable individuals, as dictated by God himself” (Tzeferakos and Douzenis 1). Despite still witnessing social prejudice, which is to be expected of any society and its treatment of the mentally ill, there is a distinct religious and moral responsibility in Islam to support those encumbered by affliction.

Contrary to understanding madness as an affliction necessary to be treated or healed, a body of knowledge exists in which associated conditions and behaviors are accepted and understood as rational responses to one's present circumstance. According to Sufi tradition, disturbance or irregularity in one's behavior is understood as a decision to go against the status quo. Symptoms of what would regularly be termed madness are instead the result of one who challenges societal norms, is original and rejects conformity, or “attempts to find alternatives to a

static and stagnant mode of living” (Okasha 378). Contrary to the concept of possession as something uncontrollable, madness is instead brought about by choosing how to live according to one’s own set of principles, to do and say things beyond the social pale. According to professor and psychologist Marwan Dwairy, there is a historical tendency for Muslims not to overly pathologize themselves. Only the extreme cases are considered *junoon*—or madness, while other cases of emotional distress are often regarded as normal (Dwairy 118). Dols contends that medieval Islam “permitted a much wider latitude to the interpretation of unusual behavior than does modern Western society and much greater freedom to the disturbed, non-violent individual” (4). Dols rationalizes alternative cases as the “excessive love in the otherwise sane, the wisdom of the fool, or the divine love of the mystic,” each of them with their own logic for why they need not be treated under a normative sense of madness (Dols 12). Greek medical theories existed alongside these popular notions in medieval Islam and combined to form a solid medical model for understanding madness. Each case is of a cultural type, indicating Islamic societies' diverse concepts of madness, the relative closeness between madness and sanity, and a growing tolerance of deviant behavior (Al-Issa 50).

A person exhibiting excessive love assumes the appearance of someone experiencing a state of madness. Dols points to a critical distinction in the excessive love of the otherwise sane or “romantic fool.” On one end, the “intense emotion of the discreet, chaste lover was a cultural ideal,” and on the other, “it was a moral and religious dilemma” (12). Such a distinction highlights the discrepancy between intense love as a favorable condition versus a condition that reflects a state of madness, presenting a concern for one’s morality and religiosity. The separation between these two understandings is critical for exposing the differing views of

excessive love, or the Arabic term '*Ishq*, as described particularly in the works of Muslim writers. The positive view defines this love as "a complex and exceedingly interesting but mysterious human experience," where excessive love is not a malady to be dealt with but rather a legitimate consequence of one's existence (Dols 314). Their condition is honorable and displays intense emotionality. Along with this definition, the romantic fool represents a "social ideal of passionate chaste love" (Al-Issa 50). Such an approach posits the romantic fool and their behaviors as an ideal, regarded as a condition worthy of acceptance or even encouragement. That is not to say that the romantic fool is not mad, but rather that their madness is tolerated and even envied.

It is important to note that within literature and other artistic mediums, interpretations of the mad person were dependent upon the Muslim's particular interests and understanding. A negative understanding of excessive love, or '*Ishq*, amongst Muslim writers was again based on the belief that it presented a threat to one's moral or religious status. In this sense '*Ishq* was thus comparable to lust, a sin long-held as "detrimental to Arab male pride" (Dols 314). On the other hand, excessive love is considered admirable. Wherein lust or passion is celebrated rather than looked down upon as a sign of weakness or mental deficiency. As purported by physician Ibn Sina, the physical and mental effects of love madness are a general state of delusion with symptoms similar to melancholia: fear, sadness, delusions, and hallucinations (Al-Issa 47-49).

Other tolerable madmen are the "wise fool" and the "holy fool." Both represent a harmless, though eccentric, literary archetype in existence for centuries. The wise fool was frequently presented in medieval literature and regarded as foolish due to his tricky demeanor and unexpected or unconventional behavior. According to Dols, the wise fool could be a joker, a

court jester, or an intrepid social critic (12). Despite being thought of as foolish, he is an essentially intellectual figure with the keen ability to provide insight and communicate the truth. The archetype of the wise fool is presented in modern Arab cinema as one who can confront social injustice and oppression on behalf of the government. Similarly, in contemporary Arabic novels, he is represented as the unfortunate victim of objectionable circumstances, though involved in a commentary that reproaches these injustices (Dols 12). Typically uncovered as a clever or worldly figure, the mystery or absurdity of the wise fool is challenged and reconsidered.

The “holy fool,” or the “fool for God’s sake,” is an individual who surpasses societal conventions, as does each of these madmen, and devotes his entire being to the worship of God. In this case, the holy fool is characterized according to excess in sacred or profane love and is defined by an intense devotion to God, or as the mystic who seeks absolute union with God (Dols 13). Because of the sheer intensity of his devotion, his behavior is judged as abnormal rather than as a regular expression of Muslim religiosity. Instead of assuming madness as evidence of possession, the behavior of the holy fool was imagined as a sort of “divine infusion,” whereby they are experiencing a “privileged mania” (Dols 370). The holy fool was not possessed by evil spirits but was madly in love with God—however, he appeared foolish to the world. The holy fool allows for a more inclusive understanding of religious experience, thereby encouraging greater tolerance of intense piety and the mad behaviors it might embody.

Protecting and Healing: Religion, Medicine, and Law

Throughout the medieval era, religious healing emerged as the most common response to those experiencing symptoms of madness and mental disturbance. There exist plenty of channels for healing such afflictions, including instilling total trust in God and his capacities or developing a more active religious life, resorting to Galenic medicine, or turning to the accounts of the Prophet Muhammad on matters of health and wellness. Though medical practices varied depending on region, Prophetic medicine was widely accepted and exercised amongst all classes of people (Gallagher 800). The choice one made for their appropriate treatment foremost depended on the type of illness, the resources they had available, and the skillsets of their local practitioners (Dols 8). As previously stated, alongside the increasing prevalence of Graeco medical theories following the rise of Islam, an alternative genre of medical literature emerged around the ninth century as an alternative to strict Greek-based medical systems (Savage-Smith 141). By adopting pre-Islamic notions of health, Prophetic medicine situated itself according to an appreciation of Prophetic tradition over the medical practices integrated from Hellenistic society. Authors of the treatises of Prophetic medicine were typically clerics rather than physicians who advocated for the return to traditional practices of the Prophet (Savage-Smith 141). The establishment of these treatises was interpreted as a direct reaction to the development of a strong Graeco-Islamic medical tradition and intended to represent a sort of parallel practice. The work done by clerics was considered “hostile to the medical ideas assimilated from Hellenistic society” (Ragab 1). Nonetheless, the work disseminated by Prophetic practitioners succeeded alongside medicine and literature derived from the Greek humoral system.

Although the Qur'an is believed to be a principal guide for matters of health and wellness, there is no explicit reference to medical healing within its pages. To discern adequate advice on matters of illness, devout Muslims sought out guidance contained in the *hadiths*. The *hadiths* acted as an amalgam of extra-Qur'anic advice originating from the Prophet Muhammed, listened to and recorded by first-hand witnesses. Due to Muhammad's divine stature and closeness with God, he is an esteemed source of instruction and guidance. Instruction on matters of health and wellness was gleaned from these records and established as legitimate.

The essential purpose of Prophetic healing is to offer fellow Muslims a “set of values and a scheme of behavior regarding physical well-being, including everyday etiquette...based on the life of the Prophet and his pronouncements” (Dols 244). The popularity of Prophetic medicine is attributed to the belief in God as the originator of both illness and health and as the sole deliverer of all healing. Because of this, the divine healing revealed by the Prophet took precedence over the normative instructions found within Islamic medicine—which is much broader and initially inherited from mostly Greek sources and later incorporated knowledge from Persia, Syria, India, and Byzantine (Hussein et al. 65). Islamic medicine is a much more scientific and analytical discipline, whereas Prophetic medicine operates according to its theological and doctrine contents (Hussein et al. 65). The collection of *hadith* outlining the proper methods for restoring and maintaining one's health is comprised of the methods confirmed by the Prophet, compiled and commentated on by Muslim jurists. Dols defines Prophetic medicine as a collection of folk medicine of the Arabian Bedouin, Galenic medicine, and the principle of divine causation (Dols 248). All of which—coupled with textual tradition—supply pious Muslims with an appropriate guide for handling disease and illness. Prophetic medicine thus became the principle over

Graeco-Islamic medicine and placed methods supported by doctors or traditional familial cures inferior to that of the remedies and rituals declared by the Prophet. According to Ibn Qayyim al-Jawziyya (c.1292-1350), the Prophet provides “a kind of medicine the doctors can barely understand or reach by their experimentation, hypothesis and theories” (16). For treating madness, a few of the healing techniques under Prophetic medicine include prayer, incantations, blood-letting, and purges, among others (Dols 245). Although God has appointed a suitable remedy for each infirmity, some of the most salient and widely applied treatments under Prophetic medicine include the consumption of honey, cupping³, and cautery, which should be avoided or used only infrequently (Browne 12). For many Muslims, Prophetic healing and intense prayer achieve what physicians and secular medicine cannot.

The protection and care of those vulnerable to conditions of madness and insanity can be attributed to Islamic law—or Sharia law. In medieval Islam, “insanity”—the disorder responsible for barring a citizen from successfully existing within society, lacking restraint, or impairing sound judgment—is determined as the immediate concern of the state and its laws. Concern lay not in ensuring the insane be healed or their freedom honored but instead that their property and community be protected (Dols 13). The dominant interest of Islamic law was not in evaluating one’s mental condition and determining their ailments and how to heal them, but rather in protecting the patient, his environment, and those around him from the consequences of his behaviors, as well as making assessments on how to best preserve the value of his property. Under Islamic jurisprudence, what constitutes insanity is quite ambiguous and is considered a “catch-all” expression for various forms of unusual behavior (Shoshan 332). It is a flexible term

³ Cupping, or *hijama*, is a remedy advocated for by the Prophet Muhammad to treat and prevent various ailments. The term in Arabic refers to the process of suctioning the skin and returning the body to a normal state of internal balance.

without an official definition, whereby determinations are made ad hoc to administer appropriate protection to the individual when necessary. The issue of dealing with the insane is an exclusive category existing outside the general proceedings of Islamic law. However, it can be generally classified according to three categories: absolute or continuous, intermittent, and partial (Tzeferakos and Douzenis 3). Each of these categories determines how the insane will be dealt with within legal matters, though they remain contended. According to the Maliki school—one of the four Sunni law schools—there shall be no legal difference between the intermittent or permanent cases. Whether bouts of insanity are recurring or permanent, the afflicted person must comply with judicial interdiction and surrender all capacities to an appointed guardian, which acts as the major legal instrument secured for his protection (Dols 13). For the Maliki school, the judicial decision on whether one's illness was insanity or not was required for following through with guardianship, while for other schools, it was not. Typically, the law outlined within the other schools accorded all responsibility of the insane to his family. In some cases, the insane person became the dealing of the local judge and, in default of a judge, ruled by the collective decisions of his community (Dols 438). The mad person is made void of any legal authority and is stripped of all faculties necessary to handle matters of marriage and divorce, the profits of his estates or property, and a host of other affairs. He is thus rendered a similar status to that of a child.

The distinction between intermittent and permanent insanity is unique in cases dealing with criminal responsibility. Suppose one is burdened with insanity only during certain moments. In that case, it must be proven whether insanity was active at the time of the criminal act if the accused person is to be determined guilty (Tzeferakos and Douzenis 3). Governed by compulsion, the permanently insane are void of soundness and are without the capacity to

decipher between right and wrong. It is impossible for the insane to sin or commit a crime sincerely without free will; hence they could not be held responsible. Intention, or *niyya*, in Islamic law is critical, particularly as it relates to the Latin concept of *mens rea*—or the “mental aspect” associated with one’s intention to commit a crime (Chaleby 78). One cannot be judged as guilty until their intention is fully examined. The mentally disturbed or mad person is recognized as incapable of possessing an intent to commit a crime and is therefore not liable. Despite differences in the categories of insanity under Islamic law—absolute or continuous, intermittent, and partial—forensic psychiatrist Kutaiba Chaleby posits that there are no disagreements about the rule of insanity and criminal responsibility. The insane individual will not be culpable for “any action he or she might commit.” However, there are various definitions of what insanity actually is, which will affect the determination of whether or not someone is protected by this rule (Chaleby 80). I wish to shift focus to the concept of competence under Islamic jurisprudence, especially as it relates to the protection of the insane as delivered by the state. As I mentioned, Islamic law declares that the insane individual lacks the capacity to handle regular affairs—he lacks reason and deliberate intent and is therefore liable to legal incompetence (Chaleby 71). For example, the insane person is generally not allowed to make a contract, especially those involving risking their money or property. However, because insanity fluctuates in intensity and duration, whether one is considered competent or not will also fluctuate.

It is valuable to look back at instances of madness or insanity as they were understood during a particular moment. Cultural definitions of madness clarify a society’s approach to mental illness—a critical cultural topic when considering the development of said culture and the

environment created for its citizens. Conducting a holistic survey of Islamic medicine and the forms in which it has been articulated, whether that be through modes of law, religious text and practice, or medical pronouncement, demonstrates the pluralism of healing and protection administered within Islam. In doing so, one can also decipher Islam's general position within the sphere of mental health.

Chapter II: Madness and Translation

An Essential Exchange: Traditional Arab Islamic Medicine and its Contact with Europe

There exists a long history of exchange of medical knowledge between majority Muslim societies and Europe. The middle and latter half of the medieval era was marked by a significant flow of medical and scientific expertise, during which a considerable collection of Arabic works were translated and disseminated. Arabic works were first translated into Latin for an audience majorly comprised of the social elite and the highly educated. It was not until these works were translated into vernacular languages that a much larger readership was able to access them, understand them, and apply their information. Approaches to mental health and well-being became popular points of reference and provided a basis for European practices. As mentioned, Muslim medical writers, scholars, and physicians involved themselves in translating Greek medical writings, which helped inform the very beginnings of Islam's distinct medical tradition. A synthesizing of medical knowledge, coupled with medical guidance derived from the language and lessons of religious texts, produced a precise system for preventing, treating, and healing maladies of the mind and body. I find Al-Rawi and Fetters' definition of traditional Arab and Islamic medicine particularly salient in its ability to encapsulate its overall essence:

as a system of healing practiced since antiquity in the Arab world within the context of religious influences of Islam and to be comprised of medicinal herbs, dietary practices, mind-body practices, spiritual healing and applied therapy whereby many of these elements reflect an enduring interconnectivity between Islamic medical and Prophetic

influences as well as regional healing practices emerging from specific geographical and cultural origins. (164)

Also notable is their mentioning of its continued practice, calling for greater recognition of the traditional system within contemporary clinical practices. Traditional Arab and Islamic medicine reflects a melding of systems. Synthesized theories and practices—majority Greek, but also of Chinese, Persian, and Ayurvedic origin—joined together with Prophetic medicine to produce a comprehensive, well-informed medical tradition. Understanding the significance of traditional medicine for Arab and Muslim patients will allow clinicians a more holistic and culturally sensitive approach to providing care. Traditional systems and their procedures cannot be neglected if the patient is to be cared for ethically and without the clinician penetrating their own notions of health onto the patient (Al-Rawi and Fetters 168). An acknowledgment of traditional medical systems is paramount if a patient is to receive sufficient medical care. Suppose a clinician is caring for a society or community in a location where they are not native. In that case, it is their responsibility to be familiar with the traditional system of medicine with which the majority of their patients identify. By following through with this approach, clinicians will be better able to anticipate adequate healing methods for their patients and thus administer them accordingly (Al-Rawi and Fetters 168).

Traditional medicine is defined as a totality of knowledge, skills, and practices derived from the “theories, beliefs and experiences indigenous to different cultures, whether explicable or not, used in the maintenance of health as well as in the prevention, diagnosis, improvement or treatment of physical and mental illness” (World Health Organization 8). The term “indigenous,” specifically when applied to medicine or notions of health, can be understood as intimately

related to matters of geography and colonization (Anderson 144). Anderson explains that such references to indigeneity are typically implicative of a place or geography assumed as marginal or thought of as in need of development, predicated upon a “history of colonization and dispossession, with consequent resistance and adaptation to invaders and settlers” (Anderson 144). Rendering “indigenous,” or traditional, medical understandings as insignificant to healing processes delivered by European clinicians risks othering a majority of current or potential patients, as well as creating and maintaining health disparities among the colonized.

That notions of madness and mental health are understood as indicative of socio-cultural differences is worth mentioning once again to emphasize that there is no single authoritative classification or treatment. Dwairy provides a comparative model between modern Western cultures with medieval and South or Eastern cultures, particularly in the area of science and medical difference. The former’s scientific approach is “dualistic,” which is often characterized by the belief that the mind and the body are separate entities and that the self is independent from the body (Dwairy 209). As for the latter, the scientific approach is deemed “holistic” and instead believes there are no clear distinctions between the mind and the body, and that true health derives from a unity between the mind, body, and the soul (Dwairy 209). As for behavior toward mental illness, modern Western cultures have tended to a process of psychologizing distress and making sense of mental affliction according to psychiatric diagnoses. Through the holistic approach in medieval and South or Eastern cultures, mental illness is recognized as being manifest in subjective terms, whereas the dualistic approach tends not to recognize subjective experience as presenting any legitimate concern (Dwairy 210). Fundamental differences such as these point to the relative likelihood that a Western approach to treating native Arab and Muslim

patients using their psychological methods or psychotherapeutics may present misunderstanding and maltreatment via the implementation of unsuitable practices.

The development of traditional Arab and Islamic medical knowledge and its eventual contact with Europe may be best understood according to its phases, first beginning in the eighth century, during which a fundamental encounter with Greek science, philosophy, and mathematics took place. Translation became a critical project, and a collection of Greek works were translated into Arabic to be made widely accessible. By virtue of this first period of translation, Muslim physicians and scholars attained prestige in medical science that surpassed their predecessors. Christians lost their monopoly over medicine, and the work of Muslim translators came to be considered equal to those of the Greeks (Saad et al. 476). Hospitals and medical schools were established and rendered important sites for teaching and delivering medical expertise to the public. The earliest recorded psychiatric hospital was built in Baghdad, Iran, around the early ninth century and eventually served as a model to be replicated throughout the Islamic world (Ragab 4). According to numerous scholars, the final phase of development started in the twelfth century and is credited as the beginning of a confrontation between Europe and Arabic medical knowledge.

Translations of the work of philosopher and physician Ibn Sina into Latin—or better known in the West by his Latinized name Avicenna—dominated medical instruction in European universities until the eighteenth century (*The Stanford Encyclopedia of Philosophy*). First translated into Latin in the twelfth century, Ibn Sina's *The Canon of Medicine* became a particularly authoritative work for helping teach medical science throughout Europe. Sixteen editions were published by the fifteenth century, with one in Hebrew used by the Jewish

communities in Europe. Twenty editions were published by the sixteenth century, and a few additional versions were completed in the seventeenth century (Saad et al. 476). Alongside Ibn Sina, an abundance of secondary Arabic medical works were produced and would eventually be instated into Europe. Arab-Islamic medicine significantly influenced the eventual development of modern European medicine. The translation of such works into Latin provided critical information for European philosophers and scholars and informed much of the basis for their first institutionally recognized medical knowledge. Such medical practices are an amalgamation of tradition and technique: transferred, translated, and disseminated across Europe. Such texts as *The Canon of Medicine* became standard medical references up until the period of colonization. The period of colonization of the Middle East, by predominantly British and French forces, spanned between the early nineteenth century into the late twentieth century. A burgeoning European interest to establish authority over various territories of the Ottoman Empire remains culpable for the onslaught of occupation and a “long and cruel colonization” (Merabet 4). One after the other, Islamic countries were colonized and thus placed under new leadership.

The Canon of Medicine, completed in 1025, has been regarded as one of the most celebrated medical encyclopedias, comprising five separate volumes that chronologize a mass of Ibn Sina’s medical discoveries recorded throughout his career. Known in Arabic as *Qānūn fī at-Ṭibb*, *The Canon of Medicine* represents “the culmination in Islamic medicine of the long period of translation, study, and reformulation of primarily Galen's works...[and] was part of an even longer process of systematization of Greek medicine that had begun in late antiquity” (Dols 62). Alongside a comprehensive synthesis of Greek philosophy and medicine, *The Canon* is fortified by Ibn Sina’s own contributions and medical wisdom. He recognizes disease as being

due to an imbalance in mental function and categorizes them as the “disease of temperament, humor and structural patterns,” whereby causes may be understood as “inner and environmental; congenital and obtained; organic and functional; physical and emotional” (Masic 996). The humoral theory posits that one’s temperament and health are dependent upon the excess or deficit of four bodily fluids: black bile, yellow bile, phlegm, and blood, each with their corresponding maladies. For example, Ibn Sina was the first to report on the syndrome *sabari*, an excessive madness caused by yellow bile. The victim of *sabari* suffers from regular sleep disturbance and persistent insomnia, increased agitation, hyperventilation, and forgetfulness (Al-Issa 48). Humorism assumed a central role in early and medieval Islamic medicine until its decline due to the gradual development of modern natural sciences. Eventually, it was no longer a standard method for identifying and treating illness by the second half of the nineteenth century (Ormos 601). Ibn Sina defined madness as a “mental disorder of reason,” in which “reality is replaced by fantasy,” and he locates its origin in the middle part of the brain (Mohamad 6). The physician tasked with administering treatment must, according to Ibn Sina, “know how to arrive at conclusions concerning (1) the causes of illness and the individual signs thereof; (2) the method (most likely to) remove the disorder and so restore health”, and when the illness is obscure, the physician must “be able to assign to them their duration, and recognize their phases” (33).⁴ The physician is thus placed in an especially valuable position, where the patient’s probability of recovery or the duration of their illness depends on the physician's ability to locate its causes and determine appropriate treatment methods.

⁴ *The Canon of Medicine* by Ibn Sina, translations by O. Cameron Gruner, M.D., . *A Treatise on the Canon of Medicine of Avicenna* (1930). This translation is based on the Latin versions published in Venice in 1595 and 1608, as well as the Arabic version published in Rome in 1593.

Understanding the Self: Islam, Subjectivity, and the “Science of the Soul”

According to medieval physician Ishaq Ibn Imran (c. 900), there is an inherent difficulty in determining diagnoses, in that the causes of mental disturbance are incredibly diverse and may warrant confusion for the doctors who often do not have an exact knowledge of the illness “because of the variety in the symptoms of the soul [*nafs*]” (Dols 73). Medieval Islam has a history of analyzing mental illness according to scientific knowledge, which developed in tandem with religious Islamic and Prophetic medicine. Ibn Sina was able to reconcile religious interpretations of health and ill-health with rationalism while maintaining that psychology is “the science which treats of the soul and its operations” and should therefore be the real foundation of medicine (Gruner 9). The study of psychology in Islam is coined as the science of the “*nafs*.” The origin of the term may be traced back to classical Islamic thought, which encompasses a tradition in which the *nafs* is directly linked to the body and the spirit (Shakry 42). *Nafs* is most commonly translated as either the “soul” or the “self” (*Encyclopedia of Islam, Second Edition*). A robust analysis of the *nafs*—as an integrative pursuit fixed on synthesizing Islam’s notion of the self—emerged as a postcolonial effort by psychologists of the twentieth and twenty-first centuries. Specifically, around the mid-twentieth century, the topic of the self as it relates to the “other” became quite central to the discourses of psychology happening at the time, in which critiques over the egocentricity present within Western philosophical ideas about the self and its place within society were acknowledged (Shakry 36). Rather than focusing on the self from a solely inward perspective, without consideration for how the self is implicated in the outside world, there is a preference amongst postcolonial thinkers to instead focus on the collective nature of selfhood. Studying the *nafs* uncovers not only the essence or capacities of the singular

self but also the nature of the self within a collective, and the associations that materialize between the self and society. Despite an emphasis on the movement along the *nafs* as a process rooted in individualism, still underlined in the Qur'an are the common origins of humanity and the effect that a single soul can have on the collective conditions of a community. Al-Yagout states, "when we transform ourselves, we transform the lives of others, one by one...[and] when we deny the presence of shadows within us, the darkness extends outward to our community" (40). Thus, one's progress along the stages of the *nafs* will affect those around them positively. When one is willing to confront portions of the self that are in need of improvement, they will ward off the potential for evil or negativity to encroach into not only their own life but into the larger community. The common origins of humanity are declared in Sura 4:1: "O people! Fear your Lord, who created you from a single soul, and created from it its mate, and propagated from them many men and women. And revere God whom you ask about, and the parents. Surely, God is Watchful over you." Referenced here is the "single soul," or the totality of human beings as determined by God. This Sura serves as a sort of reminder that all beings stem from one. Placed under the authority of God, the self exists merely as a single component of a much larger endeavor.

Shakry challenges the notion that psychoanalysis⁵ and Islam have forever existed in isolation from one another. This notion has long motivated a West versus East mentality within modern discourses of subjectivity, with psychoanalysis representing the Western world and Islam representing the Eastern world. She encourages an undoing of our assumptions of the secular

⁵ Psychoanalysis was founded and developed by Austrian neurologist Sigmund Freud around the early 1890s. According to the Oxford English Dictionary, psychoanalysis is: "a system of psychological theory and therapy which aims to treat mental disorders by investigating the interaction of conscious and unconscious elements in the mind and bringing repressed fears and conflicts into the conscious mind by techniques such as dream interpretation and free association."

subject of analysis and to think about religion and selfhood more productively as a “creative encounter of ethical engagement” (Shakry 2). In doing so, we open ourselves up to the intellectual history of the non-European world and reveal the emergence of a new psychology, or “science of the soul,” that is fundamentally linked to Islam. Freudianism and other psychoanalytic traditions coupled with the writing of leading classical Islamic physicians Ibn Sina, Abu Hamid al-Ghazali (c.1058-1111), Fakhr al-Din al-Razi (c.1149-1209), and Ibn ‘Arabi (c.1165-1240), produced a blending of concepts through which postwar Egyptian thinkers were able to reimagine a theory of the self, “in concert with and also heterogeneous to European analytic thought” (Shakry 2). Particularly responsible for the blending of psychoanalysis and the French tradition of philosophy with classical Islamic concepts is professor and psychologist Yusuf Murad, who helped formulate an Arabic lexicon of psychoanalysis and introduced “*al-la-shu’ur*,”—a mystical term first coined by medieval Sufi philosopher Ibn ‘Arabi meaning “the unconscious.” Unconsciousness is a concept prominent in the mystical tradition (Shakry 21). Known as a “philosopher of integration,” Murad was concerned with recovering Arabic tradition into his translations of contemporary psychological terminologies by consistently utilizing terms resonant within earlier Arabic literature (Shakry 22). Murad’s use of the term *al-la-shu’ur* for translating the Freudian concept of the unconscious is representative of this. Freud traversed postwar Egypt, sharing his philosophy to incite discussion in the Arab world over his ideas about the unconscious and other psychoanalytic theories (Shakry 1). This process would soon come to influence modern Arabic thoughts on subjectivity and selfhood.

The *nafs* is a primordial feature of Sufi psychology and derives a rich history according to Sufi religious tradition. In an attempt to move away from modern assumptions of selfhood as

normatively secular, Shakry determines Sufism as a suitable point of entry for uncovering the relationship between religion and psychoanalysis. Some European analysts of the nineteenth and early twentieth century considered religion as an “expression of the infantile in mental life,” that religious practices were responsible for procuring obsessive neurosis and compared religious experience to infantile regression, confusions in sexual feelings, and even catatonia and schizophrenia (Shakry 5). Early understandings of psychoanalysis as secular have surfaced as controversial to the validity of religious experience and instead marked such experiences as imbalances or disturbances in one’s mental state. The relationship between religion and psychology has long been controversial. Freud believed religion was directly related to neurosis and irrational behavior and associated religiosity with the repression of instincts, intrapsychic conflicts, and obsessional neurosis (Al-Issa 3). Conflicting accounts figure religion as having a positive relationship with psychopathology, whereby religion has assisted in controlling impulsive behaviors leading to suicide or excessive alcohol consumption. Additionally, the exceeding quality of mental health of the religious individual is said to be on account of the “availability of social support, companionship, and the presence of a sense of identity and belonging” (Al-Issa 4). Sufism’s tolerance of madness is crucial, wherein religious conviction does not denote a lack of consciousness or control. Instead, the religious individual represents a kind of agency, a desire to be free from constraint.

Postcolonial attempts at reworking the encounter between psychoanalysis and Islam are critical for the construction of a more comprehensive understanding of selfhood in former colonies, as well as locating resonances in knowledge production and postwar writings between Europe and Islam. Murad’s formulation of a contemporary Arabic lexicon of psychoanalysis, and

recovery of traditional Arabic terminology in his translations, is also apparent in his decision to adopt *nafs* as a key term of reference for him and his fellow scholars (Shakry 24-25). Murad's "integrative subject" of analysis is considered an agent of synthesis, embodying a certain cultural multiplicity. Murad denied understanding the subject according to an "ego" type of psychology based in a Freudian construction of the mind (Shakry 24). Rather, Murad used *nafs*—a term etymologically ingrained in religion—as a kind of Arabic signifier of contemporary psychological terms such as "ego" or "psyche." The integrative subject embodied a notion of the self not merely as being made up of a body or psyche, but rather "*wahda nafsiyya, jismiyya, ijtima 'iyya,*" meaning the unity of psychic, bodily, and societal aspects" (Shakry 24).

Sufi notions of the self embody multiple forces, varying in number depending on the thinker from which a particular notion originates (Shakry 46). Abu Hamid al-Ghazali advances an extensive pre-modern definition of the term as it pertains to Sufism:

the term *nafs* has two meanings. The one relates to that entity in man in which the power of anger and the power of desire are found. This use is the most prevalent among the Sufis. For them *nafs* means the element in man that includes all the blameworthy qualities...The second meaning is [that of] the subtle entity...that is man's true reality, soul (*nafs*) and essence. (Shakry 47)

The *nafs* is most commonly divided into three stages, each understood as a progression of the other. With self-realization as a necessity for the spiritual success of all Muslims, understanding the *nafs* is eminent to one's forward movement along the Path. The "Path" is a mystical notion of the steps leading toward God, along which all Sufi's should walk (Schimmel 98). Movement along the Path can be understood as a constant struggle against the *nafs*. It is the

traveler's responsibility to separate the *nafs* from its evil elements in order to replace them with the peaceful and praiseworthy attributes necessary for their progression (Shimmel 112).

According to Shimmel, the *nafs* is the "cause of blameworthy actions, sins, and base qualities" (112). The Arabic lexicon presents three different stages of the self: *nafs al ammara bil su*, *nafs al lawwama*, and *nafs al mutmainah* (Al-Yagout 11). According to Rothman and Coyle,

discussing the *nafs* in relation to its various stages is significant in that they "impart a dynamic element to the framework and indicate a natural progression of the soul toward growth" (1732).

To spiritually or physically advance, one must be well-acquainted with their inner-self. An adherence to this progression fosters both personal and collective growth. Understanding the *nafs* helps one better understand the nature of the self and the scope of human potential in Islam.

Every believer has potential, but the success one has at fulfilling this potential is dependent on the nature and disposition of the soul.

In an attempt to demonstrate the origins of the *nafs* and its relation to early medieval philosophy and psychology, it is worth breaking down the stages as well as surveying particular Qur'anic selections in which each is referenced, as Sufi psychology is based on the pronouncements and ideas found within the Qur'an. The *nafs* is considered the "lowest principle of man," and surpassing the *nafs* is the *qalb*, "heart," and the *ruh*, "spirit" (Shimmel 191). Again, as Porter pointed out, madness can be located in the mind or the soul (14). Hence, an investigation into the *nafs* is a critical step for deciphering the relative likelihood for one to experience madness—at which stage or under what condition of the soul, and for what reason.

The first stage, *nafs al ammara bil su*, can be translated as the commanding soul or the lower self and that which incites ones to evil. At this stage, the self can be interpreted as having

an intense attachment to the material and psychical world, through which personal desires take precedence (Al-Yagout 15). *Nafs al ammara bil su* is mentioned in Sura 12:53: "...The soul commands evil, except those on whom my Lord has mercy. Truly my Lord is Forgiving and Merciful." There is a certain level of ignorance at play, and the person experiencing *nafs al ammara bil su* is presumably unaware of how their actions or behaviors affect themselves and those around them. The prioritization of personal desire and or a general dismissal of God's divine superiority leads one to the condition of being *nafs al ammara bil su*. At this stage, one is most inclined to commit wrongdoing or sin, yet this is also the stage that marks the beginning of the process toward purification (Shimmel 112). In order to move onto the second stage, one must fully recognize the power of divine guidance and seek within God a total authority:

Say, "Shall we invoke besides God something that can neither benefit us nor harm us, and turn back on our heels after God has guided us; like someone seduced by the devils and confused on earth, who has friends calling him to guidance: 'Come to us'?" Say, 'The guidance of God is the guidance, and we are commanded to surrender to the Lord of the Universe.' (Qur'an 6:71)

Here, one is advised on how to answer those nonbelievers who treat religion as folly, who do not wish to overcome habits of disobedience or refrain from sin, and who will be without protection. If one is to turn away from God, they shall assume a status similar to those whom the devils have tempted. Rather than being commanded to evil—a familiar concern for the *nafs al ammara bil su*—the believer is commanded to God. Once they have fully surrendered, they may proceed along the *nafs*.

The second stage is referred to as *nafs al lawwama*; the self-incriminating soul or the soul that regrets itself (Andopa and Yunita 139). This stage, mentioned only once throughout the Qur'an, is located in Sura 75:1-2: "I swear by the Day of Resurrection. And I swear by the blaming soul." God has sworn an oath to the existence of the Day of Resurrection as a means of granting certainty that all are and will be subject to judgment. Early Sufis long existed under the ongoing threat of the Last Judgment until discovering the "promise of mutual love between God and man" (Shimmel 25). They were able to locate this divine love among the various stages of the *nafs*, between the "soul that commands evil" and the "soul which is at peace with God" (Shimmer 25). That God "swears by the blaming soul" in connection to the Day of Resurrection may indicate His belief in one's ability to transcend their lower self and transform unfavorable conditions in order to alter their fate. Or that in judgment, the soul is able to ascend and come back to life (Al-Yagout 33). *Nafs al lawwama* can be understood as the "inception of our spiritual awakening." That true freedom is not having the faculties to openly indulge in our desires, but instead "freedom *from* our desires, addictions, greed, vanity, lust, and arrogance" (Al-Yagout 33). Thus, true freedom from the commanding self relies on *freedom from* rather than the *freedom to do*. Every time darkness overcame *nafs al lawamma*, "divine light illuminated it and it reproached itself for its evil desires" (Shakry 48). In reproach, there is often guilt over past transgressions, which in result, may encourage a kind of fear of God. *Taqwa*—mindfulness of God and self-awareness rooted in absolute piety—is a catalyst for overcoming the lower self (Al-Yagout 35). And, *taqwa* is incomplete without fear. Also relevant on the Path from the lower self onward is the concept of *tawakkul*, or complete trust in God and a self-surrender to Him (Shimmel 117). Those who remain loyal and pious will not be harmed by those who deviate from

God's word. How an individual behaves against desire or deviancy will determine the protection they receive. Hence, it is up to the self to demonstrate a strict disavowal of all evils. One will not be held accountable for the sins of others, nor with their ascension across the stages of the *nafs* be affected.

The final stage is *nafs al mutmainah*, the self which is at peace or the tranquil self, freed from the "prison house of the body" (Shakry 48). This stage indicates an arrival at purification, in which one reaches a "clear and bright soul by remembering God and eradicating the influence of lust and despicable qualities" (Andopa and Yunita 158). *Nafs al mutmainah* is referred to in Sura 89:25-28, "On that Day, none will punish as He punishes. And none will shackle as He shackles. But as for you, O tranquil soul. Return to your Lord, pleased and accepted." The soul is called home to its Lord, to where it originates. Achieving *nafs al mutmainah* suggests a full, uncompromised belief in God and intense loyalty to His divine instruction, no matter the personal sacrifice. Along the *nafs*, absolute adherence to one's faith safeguards against any and all interference from reaching purification. Inherent acknowledgment of God and His divine salience will assist in eliminating the despicable qualities that impede one from reaching the peaceful and satisfied self, *nafs al mutmainah*. Devoid of lust or drama and without the need for material possessions or sensual pleasures, the self may in its ideal state. Immoral desires are replaced with devotion; desires become aligned with God and his aspirations for man. According to a string of interviews with relevant Islamic informants on the theory and development of the soul in Islam, it was found that the final stage of the *nafs* was discussed as more so an ideal to strive for than a condition that is likely or expected to be achieved (Rothman and Coyle 1737). Regardless, *nafs al mutmainah* remains significant in that it represents an objective in the

development of the self “that all participants seemed to feel was an integral aspect of the Islamic conception of the soul” (Rothman and Coyle 1737). The last stage of the *nafs* functions as a sort of final destination that all Muslims should work toward for the sake of satisfying God, notwithstanding how arduous it may be to get there.

For Sufis, the struggle against the *nafs* has long been a topic of profound discussion. The process of understanding the self is understood as being incumbent upon a Muslim at all times (Tekke 2). According to the Sufi model of the self, one is able to preview the “invisible dimension of human being,” which encompasses the realm between God and man. At the same time, the Sufi model provides insight into the “Muslim understanding of human consciousness,” which both resonates with psychoanalytic models as well as provincializes them (Shakry 49). As stated, the initial translators of Freud into Arabic concluded that the concept of the unconscious had a considerable connection to the *nafs*. Such ideas surrounding the unconscious turned out to be rather influential in forming modern discourses of subjectivity in the expanse of areas such as psychology, Islamic philosophy, and law. A prominent intellectual of postwar Egypt, Muhammad Mustafa Hilmi, declares a fundamental connection between Sufism and psychology, whereby Sufism is an inquiry into existence, a kind of social order, and most prominently, an “exploration of inner affects or emotions” (Shakry 54). Thus, postwar mystics were interested in uncovering the *nafs* and studying the path to purification as this would help decipher the inner workings of the self, mental or physical power, the potential for illness and in turn the adequate treatment methods.

Chapter III: Madness and Colonialism

Regulating the Colonial Body: Medical Intervention and The Institution

Prominent postcolonial efforts to bridge the gap between psychoanalysis and religion significantly altered normative theories of the self in Islam. Egyptian thinkers departed from the strict adherence to secular European psychoanalytic thought and instead instated a melding of traditional Islamic concepts. For Murad, studying psychoanalysis made possible an understanding of the historical ruptures and persistent violence engendered by colonialism (Shakry 12). From this understanding, Murad could uncover such cruelties, interrogate them, and make space for anti-colonial psychoanalysis. Murad and his colleagues published the first journal of psychology in the Arab world in 1945, titled *Majallat 'Ilm al-Nafs*, which invested itself in sharing with its audience a disciplinary space for psychology and introducing its major concepts to the Egyptian public. Despite efforts by Murad and other postcolonial writers to develop an integrative and self-reflexive discipline, it is important to consider more in depth how these medical traditions were first appropriated to further colonial endeavors and render indigenous practices as grounds for improvement alongside other pretenses for intervention, as well as situate psychiatry as a discipline implicated by colonial sentiment.

As detailed, Arab-Muslim societies have long held their own intricate and well-advanced medical system, though their practices were at once marked unsound and underdeveloped as a means for justifying European intervention starting in the eighteenth century. A critical tension between traditional Arab-Islamic medicine and European modern psychiatric medicine thus

culminated. Islam's theological medical reasoning and pluralistic treatment methods were used as an acceptable justification for control, considered backward or primitive in comparison to the European scientific approach: "modern medicine claims its title to superiority by its successes, and judges the medicine of the past by its failures" (Gruner 16). By being placed under the guise of modernity, medical intervention became a channel through which the European empires could interrogate Arab-Islamic indigenous practices, establish the conditions of bodies according to their own psychiatric framework, and begin to spread their control elsewhere. They were able to justify their ventures by contending that Western medical intervention improved the overall health of the colonized. Medicine thus became a device used by authorities for penetrating local societies and administering new practices (Gallagher 799). Modern psychiatric knowledge and its corresponding methods were implemented and used as tools for furthering Europe's imperialist aims. The issue of madness and its treatment in colonial and postcolonial societies is a critical topic in the study of medical history and deserves our attention. As Keller states rather eloquently, because psychiatry is immersed in a space between both the social and natural sciences, it presents a crucial "locus for study of the relationship between knowledge and power in colonial domination" (296).

Foucault declares that mental illness is not a natural phenomenon but a cultural construct. A society's attitude and approach toward the mentally ill demonstrate a process of social control, in which said society constructs concepts of sanity or insanity and so places them on either end of a spectrum. The history of mental illness and medicine may thus be understood as an account of "control, power, knowledge and freedom beyond a history of a disease and its treatments" (Afacan 1). Narratives of madness or insanity go beyond a standard history of the condition and

treatment and instead involve a process of manipulation, wherein the rehabilitation of patients is not the primary concern. The treatment or management decided for the ill person uncovers much about the behaviors of a power holder at a certain time and within a specific community, especially during moments of colonization. Foucault believes that the modern medical positivism that emerged by the end of the eighteenth century was responsible for the ensuing objectification of madness into an instrument for control. When considering the institutions that madness came to be affiliated with, this objectification is moreover presumed as responsible for initiating a new mode of social control (Foucault xvi).

Medical positivism, in brief, is a theoretical approach committed to locating and gathering scientific evidence on the likes of medicine and health, focusing specifically on cause and effect and analyzing physical elements. Positivist practitioners tend to see the social through psychological terms, such as “seeing how people’s estimations and expressions of pain differ by age, sex, or race” (Alderson 1008). There are major ethical concerns if a clinician is to decipher pain thresholds depending on such attributes. Yet, it is incredibly difficult to define positivism as it has many nuances according to differences in the methodology adopted by various positivist philosophers and sociologists. However, moving away from medical positivism is favorable for fostering healthier patient-clinician relationships based on a heightened sense of understanding and empathy, wherein first-hand, subjective accounts of affliction are considered in line with physical observation. In order to better understand the pain or mental disturbances one is experiencing, clinicians have to think in non-positivist ways: “to accept patients’ subjective views and see pain as more than physical, involving the mind as well as the body” (Alderson 1008). Pain is not restricted to immediate physical suffering, nor does pain exist solely in forms

observable to the human eye. In addition to the body, judgments of pain should encompass those located in both the mind and the soul. The medical positivism Foucault refers to points directly at the “modern phase” arising at the end of the eighteenth century, in which madness became an exclusive object of medical perception (xviii). Madness was thus rendered a strictly clinical epidemic and was to be dealt with in accordance with the colonial systems introduced. Control over medicine and health was marked by a general intrigue by colonizers to establish authority over indigenous bodies and regulate them according to newfound health policies. Colonial medicine was undoubtedly responsible for making universalizing claims and for creating and reproducing racial and gendered discourses of difference detrimental to the health and security of the native population (Marks 210). Doctors and police imposed laws that regulated women’s reproductive capabilities, soldiers’ bodies, the vaccination of children, and the decision to incarcerate the physically or mentally ill (Gallagher 800).

The institutionalization and treatment of the mad leading up to and during the period of colonization in the Middle East are worthy of consideration, especially as it relates to systems of exclusion and the creation of new forms of subjectivity. The clinic is often a “literal theater for colonial conflict” (Keller 161). Thus, examining the hospital, in any of its forms, will reveal much about the relationship between the violence and trauma engendered by colonialism and mental illness (Keller 161). Long before any colonial encounter, it may be contended that Islam was the first to establish mental hospitals, thought to be initially built in Bagdad, later in Cairo, and eventually in Damascus (Murad and Gordon 28). An incredibly meaningful contribution to Islamic medicine was the development of an institutional system of care for the mentally ill provided by the establishment of the hospital, or *bamaristan*—meaning a place for the sick in

Persian (Al-Issa 55). Hospitals were built for the sole purpose of caring for and providing relevant treatment to patients rather than to seclude the afflicted individuals from society. Thus, their intention was not to isolate the sick but successfully cure them using appropriate treatments and medicines. Initial treatments of the medieval era included baths, fermentations, compresses, bandaging, cupping, massage, bloodletting, and cauterization (Al-Issa 56). Medications administered to patients included sedatives, stimulants, and various antidepressants. A particularly standout medication of the medieval era is *mufarrih al-nafs*—translated as “gladdening of the soul”—and was predicted to change a patient's sadness into joy (Al-Issa 56). The extent of one's religious affiliation may have also had an effect on the level of satisfaction of the patient. A belief in the authenticity of God as the deliverer of medicine made Muslims more prone to adhere to treatment (Sabry and Vohra 3). Treatment methods were thus considered a gift to be cherished, for God does not bestow an illness upon his people without also delivering its respective remedy. However, there is some disagreement as to whether or not the initial Islamic hospitals were outright religious in their day-to-day operations. Claims have been made that the first hospitals established in the West were religious institutions, while the Islamic hospital was inherently secular (Al-Issa 56).

The burgeoning interest to hospitalize the mentally ill resulted in the medicalizing of abnormal or disturbing behavior, as well as delimiting symptoms according to medical terminology. Mental illness was considered in line with organic pathology—based on scientific understanding of the cause and effect of illness rather than being fixated on theological reasoning. Additionally, though, the involvement of rulers or officials concerned with satisfying their religious obligations thought of the hospital as a tangible channel through which they could

provide charity to the poor and needy (Al-Issa 56). Thus one may argue that the *bamaristan* was not secular, as it was intentionally embedded in charitable and pietistic endeavors and implicated in religio-social traditions of philanthropy and community engagement (Ragab xiv). In relation, the religiosity of community members has been debated as the reason for their positive treatment of the insane. Another impression of the Islamic hospital was that it was *relatively* secular. Rather than being run by religious leaders or scholars, all operations were managed by state officials and non-Muslim physicians, particularly Galenic physicians (Ragab xi). Also worth noting is the value of the *bamaristan* as a hub of medical education, committed to teaching and leading training efforts for those within the institution and the greater public (Ragab xi). The reality of the medieval Islamic hospital was one of compassion and concern for the disturbed. Normally organized in the center of cities rather than on the outskirts, the sick were not to be kept from society but to be incorporated so as to be in regular contact with the surrounding community (Ragab xi). Inpatients were able to socialize with relatives and friends frequently and move freely throughout the institution. The hospital was to be treated as a social center in the interest of reducing feelings of isolation among the patients. Whereas the intention behind European asylums was to “confine patients, isolate them, and render them essentially harmless” (Millon 82). As for majority Muslim societies, incidents of mental illness emerged as an opportunity for the community to come together, “to show social support and be charitable to other Muslims who were in distress” (Al-Issa 57). The mad were cared for unconditionally—respected, given shelter, and administered the best treatment per their relevant affliction.

The contrast in the conditions of mental institutions functioning in majority Muslim societies versus those in Europe is quite stark. As stated, patients of the *bamaristan* were treated relatively humanely. While Europe dealt with the mentally ill by condemnation and punishment, Muslim citizens were treated with the principle intent to heal. During the middle ages in Europe, the insane were sometimes burned to death or, more often, subject to punitive laws directed against the patient—treated as if they were idlers, vagrants, or criminals (Millon 82). A rather crucial difference between the European asylum with that of the *bamaristan* is that the former thought of the ill as criminals, in need of extreme discipline for the purpose of controlling and thus forcefully manipulating them into powerless beings. Convinced that repeated harsh treatment would alter the disposition of patients and ultimately benefit them, clinicians remained unwavering in their abuse. Early literature suggests that few Muslim patients were agitated or dangerous enough that they required restraints, whereas, in Europe, patients deemed as dangerous were routinely restrained or kept in small rooms or stalls referred to as “lunatic boxes” (Millon 82). Accounts circulated by scholars on the conditions of European mental institutions contradicted the realities found in Islamic mental institutions: “[they] were neither the dungeons described by Foucault (1965) nor the bedlams whose inhabitants were objects of curiosity” (Al-Issa 56-57). In line with Al-Issa’s claim that the European asylum maintained religious understandings of mental illness, Millon confirms that until around the sixteenth century, supernatural explanations for the mentally ill were standard. Such medieval superstitions and their resulting inhumane treatments were founded upon the belief that the mentally ill were encumbered by devilish forces or evil spirits (Millon 81).

Around the sixteenth century, these religious interpretations were gradually replaced by psychological concepts. However, transitions into a more medicalized understanding of the ill were not met with any immediate changes in treatment, and care remained both “callous and brutish” (Millon 83). Around the turn of the eighteenth century, a shift occurred among European practitioners in which they began to understand patients as “sentient human beings” whose madness could potentially be treated and eventually cured (Millon 92). The *bamaristan* became to be perceived as being demonstrative of Muslim barbarity. The French saw this as an opportunity to install their psychiatric profession, spread their expertise, and thus use the North African colony as a place in which they could experiment and put their ideas into practice (Vaughan). For Foucault, regardless of the development of madness from an ignominious disease to a medicine of the soul to a psychiatric concern, each phase has presented a new mode of exclusion whereby social control is exerted according to the present system of thought.

Colonial Psychiatry and Madness During Decolonization: The Case of France and Algeria

I wish to shift focus to the case of Algeria and the effects that the era of colonization had on its people. Starting in 1830, France invaded and conquered Algeria and remained for over a century. By the seven-year Algerian War of Independence in 1954, France was finally removed. The colonization of Algeria and its conclusive war lead to deep instability on both sides. Though, Algerian decolonization marks a significant turning point—the end of France’s colonial Empire and the birth of the Algerian republic. Algeria is unique in that it was implicated in formal colonization quite early in comparison to other North African and Middle Eastern countries. It wasn’t until 1881 that France established a protectorate over Tunisia, and eventually over

Morocco in 1912. The Empire did not secure mandates over former Ottoman territories such as Syria and Lebanon until after the First World War (Merabet 7). The subsequent encounter between Algeria and France was characterized by incipient violence, misunderstanding, and intense destruction of native social forms (Fanon 39). Throughout the period, the French were responsible for establishing numerous colonial institutions that housed both European and indigenous communities. By 1838, a law was passed mandating the internment of all “lunatics” in every French department—Oran in the West, Constantine in the East, and Alger in the center (Keller 313).

The first official psychiatric hospital in Algeria was built in Blida-Joinville in 1933, and has been considered most prolific for its association with Fanon, who worked there during the 1950s. During his time at Blida, Fanon attempted to remove the chains from his patients, introduce culturally sensitive therapeutics, and generally revolutionize treatment mechanisms found within the hospital (Keller 163). Overall, Fanon sought to humanize the hospital. Following Algerian independence, it was renamed the Franz Fanon Hospital in his honor (Al-Issa 105). Prior to independence, there existed only three mental hospitals in the country, yet by 1987 that number had increased to ten. Another transformation was the addition of outpatient psychiatric clinics and psychiatric wards that were integrated into the main general hospitals (Al-Issa 105). This allowed greater freedom for the patient and the ability to exist outside the immediate confines of the hospital.

A lack of local facilities prompted French authorities to transport those Algerians diagnosed as insane to French asylums. This evidently only worsened their mental health, leaving them both incredibly disenfranchised and unfamiliar with the surrounding culture and

civilization, as well as isolated from their loved ones for long periods of time (Keller 314).

Practiced as part of the colonial agenda in Algeria was the method of the “colonization of settlements,” in which populations coming from the colonial metropolis were established within the occupied territories, where they are able to receive a plethora of privileges at the detriment of the local people (Merabet 5-6). This method of colonization is involved in changing the identity of local territories and their inhabitants through asserting new identity forms in line with their colonial aims. Ever since first contact with European colonizers, native populations have generally become sicker and have died younger than non-native inhabitants of the same colony or state (Anderson 144). Thus, colonial psychiatrists have historically been more invested in caring for their European patients than those native to the lands they uprooted and established control over. The cure rate for North African Muslims confined within the colonial hospital was recorded as five percent. Meanwhile, French patients received a cure rate of around thirty percent (Keller 314). Such a statistic points to an evident disparity between the quality of care administered between native patients and those that were members of the colonizing force. This begs one to question whether or not curing the insane was the main ambition of the physician, or rather something else—to isolate and construct the patient into an innocuous, unemotional being who did not pose a threat to the colonial project in Algeria.

In 1873, a psychiatrist from the Aiz asylum in France disclosed that the average annual mortality rate for Muslim patients was forty-nine percent, while the mortality rate for Europeans was between thirteen to fourteen percent (Keller 314). Inequalities between patients were extreme. Native Algerians were barred from receiving social welfare and services in education and health and were left without necessary protections (Al-Issa 102). North African Muslim

patients were long segregated from French patients within the hospital, which allowed such disparities to go unnoticed. French settlers believed the native people of Algeria to be quite superstitious, amoral, violent, and pathological people based on factors such as their climate and race (Gallagher 806). Such a position contributed to the colonizers' decision to separate the more “civilized” settlers from the Algerians, particularly within the boundaries of the hospital so as to prevent them from getting into disputes, as they were assumed to be fundamentally incompatible with one another (Gallagher 806). Segregation within the mental hospital may be one relevant explanation for the upholding of a certain mode of subjectivity, in which the colonized patient believes themselves as genuinely less than by way of continuous ostracization, confinement, and punishment. A patient’s sense of self is likely confused, as “colonialism forces the people it dominates to ask themselves constantly: “In reality, Who am I?”” (Fanon 250). The colonial psychiatry unholding these institutions has assaulted the very subjectivity of the colonized (Keller 165). Psychiatry has fixed Algerians according to subversive tropes—slackers, liars, robbers, criminals—and thus successfully presented them according to a primitive nature, needing to be helped, fixed, and made “healthy” and “civilized.”

Algerian Muslims were aware of the implications of the asylum as a form of abusive state control. It became a normal belief among Algerians that those admitted into the hospital would eventually die there. Thus it was unlikely for patients to voluntarily enter as it was better to die at home among their loved ones than to die inside the hospital. Hence, Algerians would do anything they could to avoid committing themselves or their family members unless it was absolutely necessary (Gallagher 806). As a result of Algeria’s independence, the rate of cases of mental illness only multiplied as people flocked to the hospital and attempted to cope with the

distress leftover by colonial abuse. The resulting social, psychological, and cultural changes following the withdrawal of France played a significant part in the mental health of the Algerian individual and further influenced the severity of mental illness:

Social changes brought about by the destruction of traditional village life during the colonial era and migration to cities after independence may have deprived Algerians of social support and communal living, and thus increased their insecurity and isolation.

(Al-Issa 109)

The isolation of the native community is a common feature of colonial encounter, though the end of an explicit colonial presence in Algeria did not resolve feelings of seclusion or dissociation among its people. Feelings of isolation left over by France's presence are said to be connected to the prevalence of paranoid delusions among psychiatric patients. Mental illness in present Algeria may be classified in a few different ways, such as chronic delusional psychoses, confusional psychoses, and "bouffées délirantes"⁶ (Al-Issa 106). Chronic delusional psychoses are often considered the "delusion of passion," with some associated afflictions being erotomania⁷, delusions of jealousy, and delusions of revendication⁸. The next are confusional psychoses, which involve complications with one's consciousness, temporal-spatial disorientation, anxiety, and dream-like experiences. Such states are often treated in the hospital once a patient has already attempted to deal using traditional treatment methods (Al-Issa 107). The final disorders are the bouffées délirantes, characterized by sudden effects such as vivid hallucinations,

⁶ Bouffées délirantes is a historically French psychiatric diagnostic term often used to describe short-term psychoses. *Bouffée* can be translated as a "waft" or "puff," while *délirante* is translated as "delusional" or "incoherent."

⁷ Erotomania is a condition in which someone experiences the delusion that another person is intensely in love with them.

⁸ Delusions of revendication include making claims of damages, scientific discovery, and of political or mystical ideologies.

delusions, clouding of consciousness, and rapid mood swings. Bouffées délirantes is a disorder rampant in former French colonies with common themes of delusion connected to religion, sexuality, jealousy, poisoning, forced marriage, sexual abuse, and incest (Al-Issa 108). The prevalence of each of these disorders has been debated as the result of years of trauma left over by colonialism. As it was diagnosed and regulated by colonial physicians, madness has emerged as a determining factor for the maintenance of continuous control and violence. Psychiatry, or the process of psychiatrization, is thus the force responsible for preserving this authority. Psychiatry, as Keller declares, has been a “biopolitical machine for the regulation of colonial order” (162). Colonial bodies were determined according to psychiatric terms and aims—a technique for regulating and declaring the colonized as an entity desperately in need of governing. Native Algerians were rendered incapacitated, too deficient for their own achievement and self-rule (Keller 170-171). The discourse surmounting out of psychiatric diagnoses thus served to pathologize the colonized in a way most suitable for maintaining French interests.

The period of decolonization, despite any initial successes, remains a violent phenomenon marked by complete disorder. The mass withdrawal of French psychiatrists and nurses left Algerian hospitals without the resources necessary to provide adequate care to thousands of their patients, nor were they appropriately equipped to handle the psychological consequences left over by an incredibly violent war. I do not wish to focus specifically on decolonization as a total process but rather consider how the onset of decolonization relates to and has affected the mental health of the colonized individual. In both colonial and postcolonial settings, I believe it may be worth noting how Fanon posits the subjectivity of the colonizer in relation to the colonized as a kind of dual process of self-making: “it is the settler who has

brought the native into existence and who perpetuates his existence” and the settler “owes the fact of his very existence, that is to say, his property, to the colonial system” (36). One would not exist without the other. Each is involved in this process, and the stipulations of their involvement are what I wish to give notice—that the colonial world is a world cut in two (Fanon 38). The gradual and eventual separation between these two factions reveals much about the consequences of colonial encounters and their residual effects, especially in the area of mental health and, more specifically, delusional acts of violence. Violence was and remained a particularly salient feature to the colonial situation in Algeria. Decades of forceful exposure to torture and brutal discriminatory behavior left Algerians deeply damaged. Intense aggression percolated into communities and thus bred a series of pathological behaviors. Fanon argues that, perhaps due to this link, violence is an essential aspect of the anticolonial struggle (Abi-Rached).

Fanon surveys a number of cases of reactionary psychoses whereby the experience of the patient is understood as a situational response to a particular event that has given rise to the disorder—“the bloodthirsty and pitiless atmosphere, the generalization of inhuman practices, and the firm impression that people have of being caught up in a veritable Apocalypse” (251). The case studies Fanon puts forth are a collection of observations that span the period from 1954 to 1959. The majority of patients were examined in Algeria in hospitals or as private patients outside the institution. Other cases involve patients who were cared for by the health divisions of the Army of National Liberation.

Particularly stand out is case study No. 2: “Undifferentiated homicidal impulses found in a survivor of a mass murder.” This case involves a patient whose village happened to be a constant site of conflict between Algerian forces and the French army ever since the onset of the

war. Thus, the patient was a frequent witness to death and the heavily wounded—still, he remained personally removed from politics and was uninterested in involving himself in the conflict. However, a deadly ambush that occurred close by resulted in enemy forces to arrive at his village. The patient was shot twice by French soldiers yet woke up to being treated by members of the National Liberation Army⁹. Prior to being shot in both his right arm and left leg, the patient observed the brutal destruction of occupied homes, as well as the collective murder of fellow villagers.

Following initial treatment, the patient began to exhibit signs of intense aggression, “with violent phases of agitation, accompanied by screaming,” declaring his intention was to “kill everybody” (Fanon 260). His behavior was to become increasingly abnormal. Soon, he demanded a gun. He was suddenly intent on “defending” himself—stealing a gun and firing on sleeping soldiers, attacking fellow patients with makeshift weapons, and threatening nurses and doctors. The patient stated: “God is with me...but he certainly isn't with those who are dead...I've had hellish good luck...In life you've got to kill so as not to be killed” (Fanon 261). Here, it is clear the patient is encumbered by delusions that warrant violence against *everyone*. Such a statement proves that violence, as a consequence of colonization, is an incredibly permeable response and that when faced with such terrible conditions, God is no longer a veritable source of protection.

Particularly notable is the patient's incessant belief in the presence of Frenchmen who have disguised themselves: “There are Frenchmen in our midst. They disguise themselves as Arabs...All these so-called Algerians are really Frenchmen...and they won't leave me alone. As

⁹ The National Liberation Army (ALN) was the constitutionally legal party in Algeria directing the war of independence against France from 1954 to 1962.

soon as I want to go to sleep they come into my room...” (Fanon 261). The line between enemy and ally is blurred. The inclination to kill even those who appear to be on his side, or who look like him, emerges out of an extreme need to protect oneself so as to ensure one's own survival. This case points to a delusion of identity as a symptom of an unending colonial trauma, where the afflicted individual struggles to comprehend their positionality.

Fanon does not present a critique of the violence displayed during the liberation movement but instead posits it as an anticipated response, part of an attempt to rebuild and cure oneself of a colonial neurosis, “...this irrepressible violence is neither sound and fury, nor the resurrection of savage instincts, nor even the effect of resentment. It is man recreating himself” (Butts 1018). Violence is thus as a manifestation of a colonial neurosis or madness. Colonialism and its resulting traumas encourage and enable an abandonment of the self through the insertion of new identity forms so as to devise a community of obedient subjects. Violence on behalf of the patient may then be understood as an attempt to re-establish identity and to make space for the self outside of the institution.

Conclusion

“...whether madness is described as a religious or philosophical phenomenon (an experience of inspiration, a loss of mind, etc.), or as an objective medical essence (as in all the classifications of types of madness that have been developed by psychiatry), these conceptions are not discoveries but are historical constructions of meaning” (Foucault xiv)

A general fascination with cultural approaches to mental illness—through differing modes of treatment, healing, and protection—inspired this project and is what led to my discovery of the fundamental interaction between the medical systems of Ancient Greece, Islam, and Europe. My initial approach to this project was to account for the translation and dissemination of medical knowledge by focusing specifically on notions of madness while maintaining Islam as the locus of study. Madness, as a phenomenon whose history is marked by continuous change and disruption and whose very meaning has remained contentious, appeared as a promising topic full of nuance and cultural implication, wherein there does not exist a singular meaning.

I’ve found studying madness to be quite an intimate pursuit in that it deeply familiarizes oneself with the existential particularities of a specific community—it forces one to question who they are, if they belong or to what extent they belong. Under madness, understanding of one’s own subjectivity and selfhood is defined according to the system in control at that particular moment, especially through the nature of their diagnoses and the conditions of their institutions. The role that a society assumes in the management of madness and mental illness tells us a lot about its intentions—whether that be to actually heal the affliction person or to

confine them and control them. Whether diagnoses or descriptions of madness are religious and spiritual, or scientific and psychiatric, they remain historical constructions of meaning—whereby the dominant culture or medical system is able to determine relevant categories of identity: mad, insane, psychotic, schizophrenic, and so on.

I decided to think about the transmission of medical knowledge as a sort of three-part historical process. The first part covers the encounter between Ancient Greek medical theory and Islam roughly between the eighth to the eleventh century, the translation and synthesis of Greek texts to produce original Arabic works, and the development of a distinct Arab-Islamic medical system. The second part deals with the contact made between Islam and Europe starting in the twelfth century lasting until the seventeenth century, during which European physicians became familiar with Islamic medical teachings that would thus inform the basis of their medical practice. The third and final phase involves a critical point in this historical process where knowledge is appropriated and used to condone colonial projects in the Middle East and North Africa. Modern scientific medicine emerged and became critical for shaping how madness was defined and treated. However, I will note that I did not trace these three moments in a rigorously linear manner but instead moved along the timeline in a way that I deemed most logical in order to best demonstrate points of convergence and divergence.

In moving forward with studying madness and its history, a few things surface as suitable points for further examination, particularly with regard to the contents of this very project. In order to make a more sound analysis of the transmission of medical knowledge, it would be beneficial to more closely survey the actual instances of translation that are involved. This could entail an examination of the structures involved in the work of medical translation, as well as

examining the very translators themselves. Doing so will allow for a better understanding of the cultural and social implications involved in the development of notions of mental illness, as well as their decided upon treatments. Giving greater attention to translation might also reveal critical points of conflict between medical systems, for example, the relationship between religious textual tradition with that of scientific reasoning for explaining evidence of madness.

Additionally, a rethinking and reimagining of what it means to be “sane” appears to be a promising approach for conducting more meaningful research on madness. Questioning what constitutes someone as sane might put into perspective how and why categories of madness came to exist and how those categories may be propagated and upheld by corresponding judgments of sanity.

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