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Interview

An interview with Professor Malik Badri about his contributions to the Islamisation of psychology

Rahmattullah Khan Abdul Wahab Khan*

A product of the American University of Beirut, internationally well-known clinical psychologist and the author of *The Dilemma of Muslim Psychologists*, Malik Badri was born on February 16, 1932 in Rufaa, a small Sudanese town on the Blue Nile. He obtained his B.A. (with Distinction) and his M.A. degrees from the American University of Beirut in 1956 and 1958 respectively and his Ph.D. from the University of Leicester, England in 1961. He further obtained his Postgraduate Certificate of Clinical Psychology from the Academic Department of Psychiatry of the Middlesex Hospital Medical School of London University in 1966. In 1977, he was elected Fellow of the British Psychological Society and in 1989 he was awarded the title of Chartered Psychologist (C.Psychol) from the same British Society. He was awarded an honorary D.Sc. from the Ahfad University and was decorated in 2003 by the President of Sudan, Omar Albashir with the medal of Shahid Zubair which is the highest award for academic excellence.

His career in clinical psychology took him to a number of African, Asian and European countries. As professor of psychology and senior clinical psychologist in hospitals and clinics, he has worked in

* Rahmattullah Khan Abdul Wahab Khan is a Professor & Clinical Psychologist in the Department of Psychology & Counseling at the Faculty of Education & Human Development, Sultan Idris Education University, Perak, Malaysia. Email: rahmattullah@fppm.upsi.edu.my.

Sudan, Ethiopia, Malaysia, England, Saudi Arabia, Jordan, Lebanon and Morocco. He was a clinical assistant in the Middlesex Hospital Department of Psychiatry of London University's Medical School where he came up with his innovative modifications on Wolpe's systematic desensitisation therapy. Based on his contributions, the World Health Organisation selected him as a member of the Committee on Traditional Medical Practices that extended from 1980 to 1984. At present, he is distinguished professor in the Ahfad University, Sudan, and holder of the Chair of Ibn Khaldun in the International Islamic University Malaysia (IIUM).

I posed some questions to Professor Malik Badri on his contributions in Islamising and culturally adapting psychology, psychotherapy and counselling.

How long have you been interested in Islamisation of psychology?

My experiences in the American University of Beirut:

Ever since I was an undergraduate in the early fifties in the American University of Beirut, I was disenchanted with Freudian psychoanalysis and its absurd claims of attributing all forms of normal and abnormal behaviours to unconscious sexual impulses, but as a young student I could think of no alternative. At that time, Freud was the incontestable hero of psychology. Though Rogers' client-centred counselling was then a popular challenger to psychoanalysis, I felt that its theory and practice were rather vague. I felt that its extreme non-judgmental non-interfering approach and its unconditional acceptance of the client caused the therapeutic process to lose its value, particularly with non-Western clients who come to the healer to give a central focus to their lives and not to wait for them to find their own solutions. It is of interest to state that this is now one of the criticisms levelled by modern Western psychotherapists against this form of therapy (See for example the book by Vitz, 1977).

In the sphere of Islamisation, I was greatly influenced by the writings of Mohammad Qutb, particularly his book titled *Islam: The Misunderstood Religion* and by the writings of Mawdudi. However, all their literature was of a general nature without a clear guide to the Islamisation of psychology and as such I was able to benefit from their contributions in writing my undergraduate term papers. I still

remember some of the titles of these papers. One was titled, "Islam: An Iconoclastic Movement" that I wrote for a course in general education, "Child Development in Islam" for a course in child psychology and "The social structure of the Muslim Brotherhood movement" for a course in social movements.

In the fifties, the American University of Beirut was influenced by the Christian missionary ideology of its early founders. This ideology was at times given directly but mostly as a concealed form of secularism supported by the Western social sciences. In retrospect, I can see that this was for me a blessing in disguise. As a young Muslim from the Sudan I reacted against this "Americanisation" by being cautious and suspicious about what was offered to us in psychology and other social sciences, and was motivated to look for Islamic answers to secular challenges. These were my early efforts at Islamisation.

My first public lecture on Islamisation:

My first university public lecture was in the University of Jordan in 1963. The lay audience liked it but my colleagues in the Department of Psychology were not happy with it. They prided themselves as scientists being guided by a neutral value-free scientific method in which there was no room for religious "dogma". This was the general opinion of the Arab social scientists of the sixties. They used to sarcastically ask me, "Is there a *fasiq* or evil physics or an un-Islamic chemistry? Then why speak to us about an Islamic psychology? If you do not accept Freudian psychoanalysis, then show us a better way to treat the emotionally disturbed." I knew of no modern psychological answers to such questions until I read the works of the late Professor Hans Eysenck.

The influence of Eysenck and Wolpe

When I read Eysenck's trio of the *Uses and Abuses of Psychology*, *Sense and Nonsense in Psychology,* followed by his third book, *Fact and Fiction in Psychology* (Eysenck, 1954, 1957, 1972), I finally found what I was looking for. Eysenck was a prolific writer with a good sense of humour. With his refined experimental researches and his lucid pen, he was able to expose all the psychoanalytic fallacies and their Freudian deceptive claims. His famous comparative and epidemiological study on 7000 American patients showed with statistical accuracy that only 44% of the patients who received psychoanalysis and psychoanalytically

oriented therapies improved while 72% of those suffering from similar disorders improved though they had received no therapy at all! An unexpected result: it was as if psychoanalytic therapy had no therapeutic effect! This blew up in the face of Freudian psychoanalysis and was appropriately dubbed "Eysenck's bombshell" by modern psychologists.

Eysenck was a gifted theoretician but not a skilful therapist. The practical applications of Eysenck's claims of superiority for his learning theory, later to be widely known as behaviour therapy, had to be carried out by the psychiatrist Wolpe, the real pioneer of behaviour modification therapy. In applying his then new technique of systematic desensitisation, he was able in a few weeks to treat phobic patients who had undergone years of unsuccessful analytic therapy. Though they were secular, these pioneers have unknowingly salvaged Muslim students of psychology from the singular domination of deviant Freudianism. Behaviour therapy, as evidence-based common sense treatment, came with a revolution that helped to pave the way for Islamisation. It is within these circumstances that I decided to travel to London to be trained as a behaviour therapist and to learn about its theoretical background.

Could you please share your interactions with Western psychologists and experiences in London?

I saved money from my salary as lecturer in the American University of Beirut and my visiting professorship in the University of Jordan. I arrived in London in 1966 and immediately fixed an appointment with Professor Eysenck who was then senior psychologist in the Institute of Psychiatry in the Maudsley Hospital. From the impression I got by reading his books, I was expecting to see an extroverted cheerful man. Conversely, I found him to be a reserved rather introverted scholar with a German accent. However, he was very helpful. He informed me that the best trainer in behaviour therapy in England was Dr. Victor Meyer (1971) in the Middlesex Hospital Medical School. He informed me that Meyer would be happy to train me. I realised after seeing him why Eysenck really preferred to write as a theoretician rather than to interact with people as a therapist.

Vic Meyer had just the opposite kind of personality; a humble, sociable and extroverted person. Since he was internationally well-known in his field, I found three other psychologists who came all the way from America and from Holland to receive the same course I had

come to attend. We soon became friends since British psychologists were the first to practise and popularise behaviour therapy at that time.

Since I was a university lecturer in abnormal psychology and psychology of learning, it took me a few weeks to master the theories of behaviour therapy and their practical applications in therapy. Meyer soon referred some of his patients to me and I was happy to see many of them improve or be totally cured. In a few months, we became friends and discussed many issues concerning our specialisation in a critical manner. I expressed my disparagement with the extreme stimulus-response paradigm of the behaviourism of the early sixties that was meticulously followed by all behaviour therapists as though patients were Pavlovian dogs. I said it needed to be "humanised". I informed him that before coming to London, I had already read Wolpe's ingenious therapeutic technique of systematic desensitization but that I made changes to it in treating a Moroccan patient. In this modification, I could combine behaviour therapy with talking and listening to the patient instead of moving him up the hierarchy as if he were an animal to be conditioned. I was surprised to hear from him that my alterations were innovative changes that should be published.

Could you briefly explain this new technique in simple language?

Systematic desensitization was and still is one of the most popular behavioural therapeutic techniques. It aims at gradually habituating the patient by utilising his ability to imagine graded scenes or a hierarchy of the things or situations that cause him anxiety and emotional disorder. For example, if he had a phobia of high places, the graded scenes starts with the first floor and ends with the patient looking down from the balcony of the 30th floor.

Following this, the patient is trained in the ability to deeply relax by training in muscular relaxation, deep abdominal breathing or other methods. When the patient is fully relaxed, he is asked to silently imagine the least anxiety-provoking scene in the hierarchy. In classical systematic desensitization that is still followed by therapists, imagination continues for a fixed time. In my time, some therapists used a stop watch. This is repeated until he reports no anxiety and is then transferred to the next item. If during the course of treatment he experiences anxiety, he would report that by raising his index finger and the therapist would bring him back to an earlier item and would help him to relax and later present the

same item until he overcomes his anxiety and is ready for the next scene in his vertical trip until he completes the hierarchy.

The innovative alterations to Wolpe's systematic desensitization therapy I applied in 1965 when treating a Moroccan patient included:

Instead of silently imagining anxiety-provoking scenes as prescribed in Wolpe's method, I asked the patient to loudly voice in detail what she was imagining. This enhanced her involvement and her ability to imagine vividly. This was helpful since research in the field reported that many patients fail to imagine vividly and are embarrassed to inform the therapist of their inability (Badri, 1970).

Secondly, in place of restricting the therapy to the agreed upon hierarchy that represents only a sample of feared items, I encouraged the patient to "horizontally" imagine and speak about other scenes of comparable anxiety provoking instances. This was done to facilitate a transfer from clinic to real life. It turned out to be one of the earliest attempts at transforming classical behaviour therapy to cognitive therapy. Whenever she reported much anxiety, I discussed it with her and helped her to change her negative thoughts. In doing so, and without knowing it, I actually used cognitive therapy that was introduced years after the publication of my article.

Thirdly, as an alternative to the unreliable instruction of raising a finger to signal anxiety, I used a quicker and more reliable instruction of simply asking the patient to stop talking whenever she experienced much anxiety. Raising the finger is unreliable because the therapist may fail to notice it in time and patients, as other researches have shown, may not raise a finger even when their faces express much anxiety (Badri, 1966). In my method, I often notice anxiety in the tone of voice of the speaking patient even before she stops talking. I think that the idea of raising a finger in itself is evidence that Wolpe and the early behaviorists who followed him were extreme in avoiding speech with the patient.

Fourthly, in combining the gradual approach of desensitization with cognitive therapy, behaviour rehearsal and spiritual therapy, I have shown how this combination can be of special significance in treating Muslim patients.

With the encouragement of Dr. Meyer, I wrote up my contribution in an article that was published in the American *Journal of Psychology,* in

1966 under the title, "A new technique for the systematic desensitization of pervasive anxiety and phobic reactions" (Badri, 1966). Dr. Meyer was happy to recommend my technique in his lectures and started using it with his patients. He informed me that he found it superior to the classical technique of Wolpe and he gave it the name "behavioural psychotherapy" but I preferred to call it, "Cognitive systematic desensitization" (Badri, 2014a). He later referred to it in his book *Behaviour Therapy in Clinical Psychiatry* that was published in 1970. After my paper was published, it was referred to by a number of well-known psychologists such as Martin Seligman and Steven Hollon (Rehm, 1981).

When I visited the US in the eighties, I asked the late Professor Ismail Al-Faruqi, then professor in Temple University in Philadelphia, to arrange for me to meet Professor Joseph Wolpe who was professor of psychiatry in the same university (Badri, 2014b). He invited me to lunch, presented me with his latest papers and offered me membership in his Association for The Advancement of Behaviour Therapy. However, he did not show wholehearted acceptance regarding my alterations to his systematic desensitization. Like Eysenck, he was a staunch behaviourist who worked hard to shape psychology into a hard exact science. The Stimulus-Response Pavlovian paradigm was most suited for this endeavour. No talking about subjective aspects such as mind, consciousness, unconsciousness, or other cognitive aspects; and of course, the human soul was out of bounds. So, ideally and in contradistinction to traditional psychotherapy that influences the mind to indirectly relieve the symptoms, the behaviour therapist does just the opposite; he should find the maladaptive pathological habit causing the symptom in his patient's behaviour and directly decondition it as if he were a surgeon removing a tumour.

As a psychologist aspiring to Islamise psychology, I refused this behaviouristic extremism because it was based on an animalistic and a mechanistic conception about human nature influenced by Darwinism and secular humanism. It is in direct conflict with the Islamic belief about human nature and its spiritual *fitrah.*

Behaviour therapy as they developed it has now given its priority seat to cognition. The name is now "cognitive behaviour therapy"; in short, CBT. Cognitive therapy stresses that it is our thinking and beliefs that cause our emotional responses, whether they are normal or disordered. So to treat a psychologically disordered person, you cannot

directly apply unlearning and conditioning except in simple and mono-symptomatic disorders that lend themselves to a stimulus-response paradigm such as a phobia in a normal person caused by a car accident. But in the vast majority of other cases, particularly those mixed up with depression, you have to change the thinking and beliefs that generate the emotional disorder of the patient. This obviously opened the door widely to the major role of beliefs and thought and hence to the Islamisation of psychology.

Was it this research of modifying systematic desensitization that urged you to write your popular book, *The Dilemma of Muslim Psychologists*?

No, not exactly. The book was not limited to psychotherapy but to a criticism of secular Western psychology in general and to the blind reception of Muslim psychologists to its theories and practices. However, I could not have written that book without the experience I acquired from teaching psychology in Sudan and Saudi Arabia and without the numerous case studies of the patients I had treated in these countries. After being certified as a behaviour therapist in 1966, I was eager to Islamise and apply what I have learnt on Muslim patients. I worked as a senior clinical psychologist in the Clinic for Nervous Disorders in Khartoum where I had a good chance to apply my Islamised therapy on patients with a variety of disorders. Professor Taha Ba'shar, the chief psychiatrist of Sudan at the time, was our boss. He challenged me to treat the 5% of patients whom he and other therapists failed to help. He said to me, "Let us see whether your new "magic" can do anything with our failures". He was happy to see most of them improving, but little did he know that it was not the behaviour therapy per se that did the "magic", but in reality the greater benefit to them came from the spiritual Islamic adaptation of its application.

In 1971, I joined the University of Riyadh as a professor and established the first psychological clinic in the University. I also worked in the psychiatric section of Riyadh Central Hospital. The years I spent in Riyadh were indeed the most productive in my Islamisation efforts. It was during this time that I was invited to the annual conference of the Association of Islamic Social Scientists in Indianapolis in the USA. It was at this conference that I read my famous paper, "Muslim psychologists in the lizard's hole". The way the lecture was received by

Muslim psychologists astonished me. The "lizard's hole" title comes from the famous Hadith of the Prophet (PBUH) that prophesised that in the future, Muslims are going to blindly emulate the ways of life of the Jews and Christians. He said that they will follow them even if they get themselves into a lizard's hole. The title became a catchphrase and was used by other authors. My widely distributed book *The Dilemma of Muslim Psychologists* was only an expanded form of my lizard's hole article.

Another area of Islamisation that was opened for me in the University of Riyadh was the contributions of early Muslim physicians and scholars to psychology. I briefly mentioned this topic in my book, *The Dilemma of Muslim Psychologists* but as I continued reading after that, I was astonished to find that our early scholars and healers had already mastered cognitive behaviour therapy (CBT) and used it in treating the emotionally disordered. I realised that, had the modern Muslim psychologists read into the works of al-Ghazālī, al-Balkhī, Ibn Qayyim al-Jawziyyah, Ibni Sina, Arrazi and similar great scholars, they would have come up with these so-called modern technologies many years before Europe. They could have been the pioneers and teachers instead of being the blind followers.

Could you provide concrete examples about the contributions of these early scholars to psychology?

To give a detailed account about the scholarly psychological and therapeutic works of these knowledgeable scholars would take us beyond the space and time of this interview. So, I will limit my treatise to one of their greatest thinkers. This is is Abū Zayd al-Balkhī who was an encyclopaedic genius. His insightful contributions covered many fields that seem to be unrelated to each other. Though his fame as a great scholar came from his original works in geography, he wrote more than 60 books and manuscripts painstakingly researching disciplines such as theology, philosophy, poetry, astronomy, mathematics, ethics, sociology and other disciplines. The only manuscript he wrote on medicine and psychological therapy was the one titled *Sustenance of Bodies and Souls*. I have translated the psychotherapeutic section of the manuscript. It was published by the International Institute of Islam Thought (IIIT) in 2013.

His contributions to psychiatry and clinical psychology in this manuscript are really remarkable. In the 9th Century, he was perhaps the

first physician to clearly differentiate between psychoses and neuroses, i.e., between mental and psychological disorders. Furthermore, he was able to classify emotional disorders in a strikingly modern way, classifying the neuroses into four disorders: fear and panic, anger and aggression, sadness and depression, and obsessions. Not only that, he has also written in great detail how cognitive and behaviour therapy can be used to treat each one of his classified disorders. The belief that it is our thinking that leads to our emotional state is as old as the ancient Greek Stoic philosophers. However, it was al-Balkhi who developed this into a refined cognitive therapy.

He has clearly shown that faulty thinking leads to emotional pathological habits of anxiety, anger and sadness. In a preventive endeavour not mentioned by modern cognitive therapists, he advised normal persons in their relaxed state to "store" in their consciousness rational and healthy thoughts from which to draw to counteract any emotional pathological thought that may be generated by the unforeseen future emotional reactions of life experiences. He compared this with the first aid boxes or kits that people keep in their houses for physical emergencies.

Al-Balkhī, was also a pioneer of psychosomatic medicine. In his manuscript, he continuously compares physical with psychological disorders and beautifully shows how they interact with each other to form psychosomatic disorders, not forgetting to highlight the individual differences between patients in this respect. With his perceptive clinical observations, he could differentiate between disorders that are caused by psychological factors and those that have a biological aetiology. Remarkably, he differentiated between normal sadness that afflicts everybody, depression that has a clear environmental cause like the death of a near relative or financial loss, and the endogenous depression that has a biological bodily causation and which cannot be pinned down to a specific reason.

So, modern Muslim psychologists failed to benefit from the works of their early scholars but what about the Western historians of psychology who claim to be rigorous and unbiased in documenting their history?

The original contributions of Muslim scholars and physicians during the Middle Ages are largely ignored by modern Western historians of

psychology and science. In writing the history of these disciplines, they start by honouring prominent early Greek philosophers, such as Pythagoras, Socrates, Plato, Aristotle and Euclid who lived from the sixth century B.C. to the early fourth century B.C. and then they leap centuries to the Renaissance and the European Enlightenment. Thus, when Western scholars write about the history of cognitive behaviour therapy, they follow the same trend.

Do you think that the Islamisation and adaptation of cognitive behaviour therapy is the main, or the only, task that a Muslim psychotherapist can do?

It is true to say that cognitive behaviour therapy has become the psychological treatment of choice in all parts of the world, including many Arab and Muslim countries, in spite of the fact that many older generations of psychologists and psychiatrists are still holding to inefficacious and outdated psychodynamic therapies. These fossilised psychologists will soon be replaced by younger graduates from institutes that certify psychologists in CBT. But this does not mean that cognitive behaviour therapy is the final goal of psychological therapy and that Islamising it is the ultimate objective of Muslim psychologists.

For one thing, cognitive behaviour therapy is itself facing a third wave of drastic changes that bring it nearer to spiritual therapy. The first wave was the launching and success of behaviour therapy that changed the face of traditional psychodynamic psychotherapy like a revolution. However, its emphasis on the stimulus-response paradigm of behaviourism required that this extremism be moderated. So the second wave was its "marriage" with cognitive psychology and its accent on thinking and beliefs. So, CBT came to life. Now, the emerging third wave is taking cognitive behaviour therapy to mindfulness that has its roots in Buddhist tradition of acceptance and commitment that reminds us of the religious acceptance of predestination. In mindfulness the person is advised to meditate and focus on his present emotions, thoughts, and sensations. It is a sort of meditation on accepting one's feelings and thoughts from outside himself. Acceptance and commitment simply means that one should accept what is not within his control and commit himself to do what can improve and enrich his life.

Doesn't this look like the advice that a Muslim cleric gives to a young stressed man? Don't we as Muslims carry out these spiritual

activities in our spiritual contemplation and *tasbeeh*? And doesn't our belief in predestination and the overpowering command of Allah (SWT) help us to accept what we have no control over and pray for what we can do to help ourselves? I believe that with the new influence of positive psychology and emotional intelligence, a fourth wave of spiritual therapy is imminent.

Moreover, to Islamise cognitive behaviour therapy cannot be the final aim for an Islamising psychologist since a number of other therapeutic perspectives can be of great help to emotionally disordered Muslim patients. We have limited much of our interview to cognitive behaviour therapy because it is the major perspective of modern therapy but there are other approaches that lend themselves to an Islamic oriented therapy. Victor Frankl's logotherapy is a good example. Frankl was a follower of Freud but his experience in a concentration camp in Germany convinced him that the major cause of neuroses and emotional disorders is lack of meaning for existence in this life. His motto is that if a person has a *why* to live for, he can cope with almost any *how*. He treats his patients by helping them to discover a meaning for their life and for their suffering. The Islamising psychologist will need very little work to Islamise this technique.

My final question is related to non-Muslim patients who come for treatment at the hands of a practicing Muslim therapist. Can he be of help even if the patient wants a religiously oriented therapy?

Since the cognitive aspect of treatment in CBT depends on the beliefs of the patient, then, if religion is a major part of his or her beliefs, the therapist cannot avoid integrating religion in his therapy. The age of the so called non-judgmental approach that avoids religion is gone! Once you sit as a therapist and the client faces you as a patient, you have become judgmental.

I used the same integrative technique with an Italian Catholic patient in the Middlesex Hospital in London. She had what we used to call at that time a hysterical eye-blinking and shutting of the eyes disorder. An ophthalmologist referred her to our clinic after finding no physical problem with her eyes. They blink and shut completely in the most embarrassing situations such as when crossing the street or getting into a bus, so she was carrying a white stick like a blind woman. She was referred to me and I found that, many years ago, after the death of

her son, she went for help to a Catholic priest in a nearby church. He asked her whether she came to mass prayers and she confessed that she doesn't. He ordered her out of the church and told her that God will not accept her prayers.

When this symptom afflicted her in 1966 after a traumatic experience, she became depressed and was so sad believing that God does not accept her. I told the senior psychiatrist at that date, Professor Arthur Crisp, that I need an understanding priest to tell her that the first priest was wrong and that God loves her. At that date, integrating psychotherapy with religion was unacceptable. Professor Crisp gave me that one-sided English smile that expresses polite disagreement and ridicule but he agreed and on his suggestion, a young doctor by the name of Chessor brought the right priest. The woman met the new priest who falsified what the earlier cleric said. She wept uncontrollably in an emotional cathartic response. The next morning her symptom improved greatly and with a little of my new method she went home without her stick. Now, with the increasing acceptance of spirituality, no CBT training program should avoid this integrative approach in its curriculum.

Professor Badri, thank you for your answers. I wish you well in your blessed efforts at Islamising psychology.

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