

tingkat depresi, stres kronis, dan isolasi sosial—meminta pendekatan yang mengintegrasikan dimensi biologis, psikologis, sosial, dan spiritual kesejahteraan manusia. Studi ini kembali meninjau kerangka kerja biopsikologis Abū Zayd al-Balkhī (850–934 M), yang diuraikan dalam *Maṣāliḥ al-Abdān wa al-Anfus*, untuk mengevaluasi relevansinya terhadap tantangan kontemporer. Dengan mengacu pada tinjauan literatur kualitatif dan analisis komparatif, penelitian ini menyoroṭi bagaimana klasifikasi al-Balkhī tentang *ḥuzn* (kesedihan/depresi), *waswasah* (perenungan obsesif), dan *fazaʿ* (panik) memiliki kesamaan konseptual dengan kategori diagnostik modern, sementara strategi terapinya—termasuk refleksi kognitif, regulasi perilaku, pengabdian spiritual, dan persahabatan sosial—menunjukkan orientasi integratif yang selaras dengan, namun tidak dapat disamakan dengan, terapi kontemporer seperti Terapi Perilaku Kognitif (CBT), psikologi positif, dan mindfulness. Artikel ini juga menyoroṭi tantangan epistemologis dan klinis dalam mengadaptasi kerangka kerja al-Balkhī saat ini. Ini termasuk perbedaan ontologi dan metodologi, ketidaksesuaian terminologi dengan sistem DSM/ICD, kurangnya validasi empiris, dan risiko dekontekstualisasi jika pemikirannya diterapkan tanpa adaptasi kritis. Namun, studi ini berargumen bahwa sintesis al-Balkhī antara teologi Al-Qurʿan, kedokteran Greco-Arab, dan rasionalisme filosofis menawarkan sumber daya berharga untuk mengembangkan model perawatan yang resonan secara budaya dan berlandaskan etika. Warisan al-Balkhī dapat memperkaya diskursus kesehatan mental di konteks mayoritas Muslim dan masyarakat pluralistik, asalkan diterapkan secara reflektif, kritis, dan dalam dialog dengan bukti klinis kontemporer.

Kata-kata Kunci: *Abū Zayd al-Balkhī, Adaptasi Budaya, Kesehatan Mental, Model Biopsikosial-Spiritual, Psikologi Islam.*

Introduction

In the modern age, mental health challenges have reached unprecedented levels across the globe. The World Health Organization (World Health Organization (WHO) 2023, 15) reports that over 280 million people suffer from depression globally, making it a leading cause of disability. Stress-related disorders, including generalized anxiety and burnout, have become widespread, particularly among youth and working professionals (American Psychological Association (APA) 2022, 42). Social isolation accelerated by the COVID-19 pandemic and the ubiquity of digital communication has been linked to heightened risks of depression, suicide, and cardiovascular disease (Holt-Lunstad, Smith, and Layton 2010, 235; Killgore, Cloonan, Taylor, Lucas, et al. 2020, 68).

While these conditions are often approached primarily from biomedical or psychological perspectives, growing evidence suggests that such fragmented approaches are insufficient to address the complexity of modern mental health crises. Mental health cannot be disentangled from broader human dimensions—physiological processes interact with emotional regulation, while social belonging and spiritual meaning significantly influence resilience and recovery. Thus, the current reality calls for an integrative paradigm that recognizes the interconnected nature of human physiology, emotions, spirituality, and society, offering a

more holistic foundation for prevention and intervention.

While biomedical models have advanced significantly, their tendency to isolate biological causes often leaves emotional, spiritual, and social dimensions underexplored in earlier stages of psychological science (Engel 1977, 132; Ghaemi 2010, 24). George Engel's biopsychosocial model provided an important alternative by advocating for a holistic approach to illness that incorporates psychological and social factors (Borrell-Carrió, Suchman, and Epstein 2004, 578). In recent decades, psychology as a discipline has made significant progress, with courses such as biopsychology, social psychology, and psychology of religion/spirituality becoming common in many academic programs (Killgore, Cloonan, Taylor, Lucas, et al. 2020, 105). Nevertheless, contemporary approaches often remain plural and fragmented, lacking a unifying framework that fully integrates biological, psychological, social, and spiritual dimensions. Within this context, Muslim scholars have increasingly turned toward Islamic intellectual heritage to retrieve neglected but relevant paradigms for mental health, particularly those that integrate body, mind, and soul.

Among the important contributions to early understandings of mental health is that of Abū Zayd al-Balkhī (d. 934 CE), a 9th-century polymath associated with the Balkh School of Knowledge in the Abbasid era (Haque 2004, 332). His major work, *Maṣāliḥ al-Abdān wa al-Anfus (Sustenance for Body and Soul)*, demonstrates a sophisticated attempt to integrate physical and psychological well-being within a single framework. Al-Balkhī categorized mental illness in ways that bear striking resemblance to contemporary understandings of depression (*ḥuzn*), obsessive thoughts (*waswasah*), and anxiety (*faza'*) (Badri 2013, 45; Rassool 2016, 118).

However, it is important to situate al-Balkhī within the broader intellectual context of the Abbasid era, which was marked by extensive translation and engagement with Greek philosophical and medical texts. Thinkers such as Hippocrates and Galen had already provided naturalistic accounts of mood, temperament, and mental disturbance, and their works—along with those of Plato and Aristotle—were widely circulated and studied (Gutas 2014, 87). Al-Balkhī's contribution, therefore, is not isolated or wholly unprecedented, but rather represents an original synthesis that combined inherited Hellenistic medical theories with Islamic spiritual and ethical insights. Crucially, he advocated preventive care and lifestyle management, suggesting diet, rest, cognitive reframing, spiritual practices, and social companionship as therapeutic tools (Gutas 1998, 55; Nasr 1996, 144).

Al-Balkhī's classification of psychological ailments and his emphasis on non-pharmacological treatments have led some contemporary scholars to describe his model as a precursor to modern cognitive behavioral therapy (CBT) (Haque et al. 2016, 289; Keshavarzi and Haque 2013, 141).

While such parallels are illuminating, it is important to approach them cautiously. CBT, as developed in the twentieth century by Aaron Beck and others, emerged within a specific epistemological and clinical tradition rooted in Western psychology (Foa, Hembree, and Rothbaum 2007, 492). In contrast, al-Balkhī's methods were embedded within the ethical and spiritual worldview of classical Islamic thought. His recommendations—such as countering negative automatic thoughts through gratitude (*shukr*) and remembrance of God (*dhikr*)—indeed bear conceptual resemblance to CBT's focus on restructuring maladaptive cognitions (Nesse 2019, 15). However, these similarities should be understood as *convergent insights* across distinct intellectual traditions, rather than evidence of direct historical continuity.

This absence reflects not a lack of relevance but rather the historical marginalization of Islamic intellectual contributions in the dominant narrative of modern psychology. Its recent rediscovery is driven by the need for paradigms that resonate culturally and spiritually with Muslim populations, where Western secular models may not fully capture the ethical and metaphysical dimensions of suffering (Hedayat-Diba 2000, 159; Chavarria et al. 2023, 215). By ethical dimensions, al-Balkhī emphasizes the cultivation of virtues such as gratitude, moderation, and social responsibility as part of psychological healing. By metaphysical dimensions, he situates mental health within the human relationship to God and the pursuit of ultimate salvation, thus embedding treatment within a transcendent teleology. In this sense, al-Balkhī's model is distinctly Islamic: although informed by Hellenistic science, it integrates body, mind, and soul through Qur'anic values and spiritual practices, producing a synthesis that cannot be reduced to Greek medical paradigms (Fernando 2010, 96; Badri 2000, 54).

The present study seeks to revisit the biopsychosocial wisdom embedded in al-Balkhī's writings and assess its relevance for contemporary psychological issues. Here, the biopsychosocial is not understood in purely secular or mechanistic terms, but within the ethical and metaphysical paradigm of Islam, where the body (*jism*), soul/self (*nafs*), intellect (*'aql*), and spirit (*rūḥ*) are viewed as interdependent dimensions of human existence. This framework situates health not only as functional balance but also as moral cultivation (*akhlāq*) and alignment with ultimate spiritual purpose. The central research questions include: (1) What are the key biopsychosocial elements in al-Balkhī's model? (2) How does his approach address present-day disorders such as depression, stress, and social isolation? (3) How might his model be adapted within modern Islamic psychology or integrated into mental health frameworks?

A qualitative literature review was chosen to explore these questions. This includes primary analysis of al-Balkhī's in *Maṣāliḥ al-Abdān wa al-Anfus (Sustenance for Body and Soul)* (Balkhī 2004, 74), alongside classical

Islamic medical writings such as Ibn Sīnā's *al-Qānūn fī al-Ṭibb* (Sīnā 1999, 152) and al-Rāzī's *Kitāb al-Ḥāwī* (Rāzī 2000, 88). Secondary literature from contemporary Islamic psychology and modern mental health theory is also engaged (Rassool 2023). Comparisons with the biopsychosocial model (Wade and Halligan 2017, 998) and emerging Islamic psychological frameworks (Haque et al. 2016, 42; Weatherhead and Daiches 2010, 230) help contextualize al-Balkhī's relevance in current therapeutic discourse.

The urgency of this work is made more pressing by global mental health data. Despite decades of biomedical and cognitive-behavioral advances, Western models of depression remain limited in scope, often criticized for reducing complex suffering to neurochemical imbalances or individual maladaptive cognitions (Mascella 2013, 64; Van der Kolk 2014, 115). Large-scale reviews show that pharmacological treatments alone frequently fail to prevent relapse and are less effective when applied cross-culturally (Arroisi, Muhsinin, and Fadlilah 2024, 41). These limitations highlight the need for frameworks that integrate biological, psychological, social, and spiritual resources in culturally resonant ways. Within the Islamic intellectual tradition, numerous scholars from al-Rāzī to Ibn Sīnā and al-Ghazālī addressed the interplay of body, mind, and soul. Among them, al-Balkhī stands out as one of the earliest to provide a systematic classification of mental disorders and an integrative set of therapeutic tools (Mitha 2019, 88). His writings demonstrate a nuanced awareness of how prolonged grief or anxiety could deteriorate bodily health or escalate into suicidal ideation, and he proposed preventive strategies through lifestyle balance and spiritual cultivation. By situating psychological healing within ethics and metaphysics, al-Balkhī offers a paradigm that complements modern therapy with Islamic values (Nasr 2003, 114; Al-Attas 1980, 67).

One of the most critical areas where al-Balkhī's thought intersects with contemporary crises is social disconnection. Modern psychology has extensively examined loneliness as a determinant of poor mental health, linking it to depression, anxiety, and even physical morbidity (Holt-Lunstad, Smith, and Layton 2010, 235). Recent studies confirm that chronic loneliness and the erosion of community ties are particularly acute among digital-native youth (Turkle 2010, 122; Twenge, Spitzberg, and Campbell 2019, 185). Al-Balkhī emphasized similar concerns centuries earlier, warning against harmful companionship and highlighting the importance of *ṣuḥbah* (good companionship), purposeful routines, and spiritually meaningful activities. While these insights parallel principles in modern positive psychology and behavioral activation (Seligman and Csikszentmihalyi 2000, 12; Layous and Lyubomirsky 2014, 129), al-Balkhī frames them within an Islamic moral and metaphysical context, where companionship and community are not only psychological resources but also ethical duties and spiritual practices.

This study also recognizes the epistemological and methodological differences between al-Balkhī's context and modern clinical paradigms. His framework was shaped by a synthesis of Qur'anic anthropology and the intellectual heritage of late antiquity, including Greek medical and philosophical traditions. The Qur'an itself speaks of the human being in multiple dimensions—*jism* (body), *nafs* (self), *rūḥ* (spirit), *qalb* (heart), and *'aql* (intellect/reason)—yet these categories are not presented as a systematic model. Muslim scholars of the Abbasid era, building on both Qur'anic terminology and Hellenistic philosophy, elaborated these dimensions into a more integrated anthropology (Murata and Chittick 1998, 37; Nasr and Leaman 2001, 112). Within this synthesis, al-Balkhī articulated an understanding of the human being as a composite of body, self, spirit, and intellect. Modern scholars argue that such traditional Islamic psychology offers complementary insights that can enrich existing therapeutic models, especially when adapted thoughtfully (Keshavarzi and Haque 2013, 145).

Theoretical Framework

The theoretical underpinning of this study is constructed on two intersecting paradigms: the modern biopsychosocial model of mental health and the classical Islamic psychological model, as exemplified by Abū Zayd al-Balkhī. This comparative framework seeks to demonstrate how al-Balkhī's integrative view of the human being—encompassing body, soul, and society, and grounded in ethical-spiritual values—can complement and enrich modern approaches to psychological disorders such as depression, chronic stress, and social disconnection. Through this integration, the study advocates for a biopsychosocial-spiritual model, particularly suited to Muslim contexts and culturally diverse therapeutic settings.

1. The Biopsychosocial Model in Modern Psychology

The biopsychosocial model, introduced by George Engel in 1977, was formulated as a corrective to the reductionist biomedical paradigm, which had long defined illness primarily in biological terms (Engel 1977, 132). Since then, Engel's model has become influential in clinical psychology, psychiatry, and psychosomatic medicine, underscoring that illness arises from the dynamic interplay of biological, psychological, and social factors (Borrell-Carrió, Suchman, and Epstein 2004, 578).

In the case of depression, for example, contemporary research consistently shows that no single cause suffices. Rather, depressive disorders emerge from a convergence of biological predispositions (e.g., neurotransmitter imbalances), psychological tendencies (e.g., negative thought patterns), and social stressors (e.g., isolation, unemployment, trauma) (Mascella 2013, 64; Van der Kolk 2014, 115). This recognition

represents a significant advance beyond purely biomedical explanations.

Nevertheless, critics have pointed out that even the biopsychosocial model often stops short of addressing spiritual and existential dimensions of human health, which remain central to the lived experience of many patients worldwide, particularly in religious contexts (Sulmasy 2002, 26; Mohr 2012, 289). In response, scholars have proposed the biopsychosocial-spiritual (BPSS) model, which explicitly incorporates spirituality and religiosity as protective and restorative factors influencing resilience, recovery, and quality of life (Cook and Powell 2022, 110; Puchalski et al. 2009, 887).

2. Islamic Psychology and al-Balkhī's Integrative Model

In Islamic psychology (*‘ilm al-nafs*), the human being is understood as an integrated system of body (*jism*), spirit (*rūḥ*), self (*nafs*), and intellect (*‘aql*). While this anthropology resonates with earlier philosophical traditions, including Greek medical and Stoic thought that emphasized the rational regulation of passions, the Islamic framework embeds these faculties within a Qur’anic and prophetic worldview oriented toward ethical refinement (*tazkiyat al-nafs*) and spiritual transcendence (Murata and Chittick 1998, 37; Nasr 1968, 112).

Abū Zayd al-Balkhī in *Maṣāliḥ al-Abdān wa al-Anfus (Sustenance for Body and Soul)* represents one of the earliest systematic attempts within the Islamic tradition to classify psychological illnesses alongside physical ones. Rather than treating them as secondary to bodily dysfunction, al-Balkhī emphasized their equal importance, diagnosing conditions such as sadness (*ḥuzn*), anxiety (*faza’*), obsessive thoughts (*waswasah*), and stress (*ghamm*), while prescribing medical, cognitive, behavioral, and spiritual remedies (Badri 2013, 45; Haque 2004, 289; Rassool 2016, 118).

Importantly, cognitive restructuring strategies—such as challenging negative thoughts through reflection, gratitude, or remembrance of God—were not unique to Islam, since Stoic philosophers like Marcus Aurelius and Epictetus had similarly advocated rational exercises to reframe distressing cognitions (Long 2002, 76). What distinguishes al-Balkhī, however, is the integration of these cognitive techniques within an explicitly Islamic metaphysical and ethical framework, where healing is linked to spiritual trust (*tawakkul*), patience (*ṣabr*), and moral responsibility to the community. In this sense, his approach represents a synthesis: drawing from universal insights into human psychology, but embedding them within the ethical-spiritual anthropology of Islam.

These strategies parallel modern interventions such as Cognitive Behavioral Therapy (CBT) and positive psychology (Keshavarzi and Haque 2013, 141; Haque et al. 2016, 292). Thus, al-Balkhī's model provides both historical depth and cultural resonance, offering a bridge between global psychological science and Islamic intellectual heritage.

3. Synthesizing Classical and Contemporary Approaches

The proposed theoretical framework builds not on a wholesale fusion but on a critical dialogue between Engel's biopsychosocial paradigm and al-Balkhī's integrative psychology. The aim is not to conflate the two but to highlight their respective strengths and identify areas of complementarity. Engel's model contributes scientific validity, clinical structure, and an empirically grounded account of biological–psychological–social interactions (Engel 1977, 132). Al-Balkhī, in contrast, contributes an early Islamic articulation of mental health that situates psychological well-being alongside bodily health and embeds both within an ethical–spiritual horizon (Balkhī 2004, 74; Haque 2004, 289).

Al-Balkhī's unique contribution lies in his systematic classification of psychological disorders—such as sadness (*ḥuzn*), anxiety (*faza'*), obsessive thoughts (*waswasah*), and stress (*ghamm*)—and in his prescription of cognitive, behavioral, lifestyle, and spiritual strategies for prevention and healing (Badri 2013, 45; Rassool 2016, 118). These include reframing destructive thoughts, regulating sleep and diet, engaging in healthy social companionship (*suhbah*), and cultivating spiritual practices such as remembrance (*dhikr*).

In this study, broader Islamic concepts such as *ibtilā'* (trials), *tawakkul* (trust in God), and *tazkiyah al-nafs* (moral-spiritual growth) are acknowledged as part of the wider intellectual context of Islamic psychology, but they are not directly attributable to al-Balkhī's text. Distinguishing between al-Balkhī's own contributions and the broader Islamic tradition avoids conflation and maintains the clarity of the object of study.

By placing Engel's and al-Balkhī's frameworks in conversation, the study proposes a biopsychosocial-spiritual model that both preserves clinical rigor and integrates cultural–religious meaning. Such a model responds to contemporary calls for culturally adapted psychotherapy that draws authentically on indigenous epistemologies rather than merely “Islamizing” Western constructs (Weatherhead and Daiches 2010, 230; Fernando 2010, 96).

4. Application and Justification of the Framework

This study applies a biopsychosocial-spiritual (BPSS) analytical framework, constructed through a critical dialogue between Engel's biopsychosocial paradigm and al-Balkhī's integrative psychology. The BPSS framework serves as the interpretive lens for examining how al-Balkhī's ideas speak to present-day challenges in mental health. Specifically, it enables systematic mapping of al-Balkhī's insights—biological (diet, rest, exercise), psychological (cognitive reframing, emotional regulation), social (companionship, community), and spiritual (remembrance, moral cultivation)—onto contemporary categories of mental health care.

Using this BPSS framework, the study explores three current challenges: depression, conceptualized here as not only biochemical imbalance but also rooted in cognitive distortions and existential emptiness; stress, interpreted as not merely physiological arousal but also exacerbated by spiritual disconnection and information overload; and social disconnection, recognized as a driver of anxiety and depression due to fragmented relationships and loss of meaningful community (Turkle 2010, 122; Twenge 2017, 185).

By clarifying that the BPSS model is both an interpretive tool and an outcome of synthesis, the study positions al-Balkhī's framework not as a relic but as a living resource. In doing so, it underscores that healing is not only cognitive or pharmacological but also social and sacred, aligning therapeutic practice with ethical and metaphysical dimensions meaningful to Muslim patients.

Abū Zayd al-Balkhī: Life, Works, and Psychological Contributions

1. Historical Context and Intellectual Background

Abū Zayd Aḥmed ibn Sahl al-Balkhī (850–934 CE) was a polymath, philosopher, geographer, and pioneering figure in early Islamic psychology and medicine. He was born in the city of Balkh, in what is today northern Afghanistan, a region known as Khurasan during the Abbasid Caliphate. The intellectual atmosphere of the Abbasid era, particularly under the patronage of Caliph al-Ma'mūn, was marked by an openness to diverse forms of knowledge, especially the translation of Greek philosophical and medical texts into Arabic (Gutas 2014, 55). Within this milieu, Hellenistic rationalism, Galenic medicine, and Aristotelian psychology provided important categories for analyzing human nature, which Muslim scholars engaged, critiqued, and reinterpreted through the lens of Islamic revelation. Al-Balkhī was deeply influenced by this environment and became one of the leading scholars associated with the Balkh School, a tradition noted for its integration of rational sciences (*'ulūm al-'aql*) and religious disciplines (*'ulūm al-dīn*).

A student of the philosopher al-Kindī, al-Balkhī's intellectual lineage reflects a confluence of Qur'anic anthropology, Hellenistic thought, and empirical observation (Haque 2004, 289). His scholarship spanned multiple fields, including medicine, geography, ethics, politics, theology, and psychology. In mental health, his most enduring contribution was his systematic treatment of psychological well-being in his seminal book *Maṣāliḥ al-Abdān wa al-Anfus* (*Sustenance for Body and Soul*), where he articulated an integrative vision of human flourishing that combined medical knowledge with ethical and spiritual practices.

2. Overview of *Maṣāliḥ al-Abdān wa al-Anfus*

Maṣāliḥ al-Abdān wa al-Anfus (*Sustenance for Body and Soul*) is widely regarded as one of the earliest Islamic treatises to explicitly integrate psychosomatic and psychological health. While much of premodern Islamic medical literature emphasized physical ailments, al-Balkhī divided human well-being into two interdependent domains: the body (*al-abdān*) and the soul/self (*al-anfus*) (Badri 2013, 45). He argued that just as the body may fall ill and require treatment, so too can the soul experience dysfunctions such as anxiety, depression, fear, and obsessive thoughts, which equally demand diagnosis and care.

It is important, however, to contextualize these claims. Al-Balkhī did not develop his ideas in isolation: the medical-philosophical traditions of Hippocrates and Galen had long emphasized the mutual influence of body and mind, and Stoic thinkers such as Marcus Aurelius had already reflected on cognitive and emotional regulation (Long 2002, 76). What distinguishes al-Balkhī's contribution is not absolute originality but the synthesis of this Greco-Roman heritage within an Islamic intellectual framework, where psychological health was directly connected to spiritual and ethical well-being (Arroisi, Mustopa, and Djayusman 2024, 20; Haque et al. 2016, 289).

This “dual approach” of body and soul can be fruitfully placed in dialogue with the later biopsychosocial model. Strictly speaking, al-Balkhī articulated a biopsychological framework—emphasizing physical and mental interdependence—yet within his text, references to companionship (*ṣuḥbah*), social environment, and spiritual practices (*dhikr*, *tawakkul*) suggest that his vision was implicitly social and spiritual as well. Thus, while Engel's model categorized “bio–psycho–social” as separate domains, al-Balkhī's approach anticipated a more integrative view in which physical, psychological, social, and spiritual factors were inseparably intertwined (Rassool 2016, 118).

3. Classification of Mental Illnesses

Al-Balkhī was among the earliest Islamic scholars to classify mental disorders into systematic categories, a task he undertook in his *Maṣāliḥ al-Abdān wa al-Anfus*. In this treatise, he emphasized that disorders of the soul require the same diagnostic attention as disorders of the body (Balkhī 2004, 74). His classifications include:

1. *Ḥuzn* (Sadness or Depression): Al-Balkhī distinguished between *ḥuzn 'āridī* (reactive sadness caused by external events such as bereavement) and *ḥuzn lāzim* (enduring sadness without an apparent cause). This anticipates, though does not fully align with, the modern distinction between reactive and clinical depression (Haque et al. 2016, 145). His therapeutic advice included moderation in grief,

spiritual consolation, and companionship.

2. *Waswasah* (Obsessive Thoughts): He described *waswasah* as intrusive, irrational ideas that repeatedly trouble the mind, preventing inner peace (Balkhī 2004, 88). Modern clinicians would associate this with obsessive-compulsive symptoms, but unlike contemporary CBT approaches that emphasize cognitive-behavioral restructuring, al-Balkhī combined rational reflection with spiritual practices such as *dhikr* (Keshavarzi and Haque 2013, 141).
3. *Faza'* (Panic or Sudden Fear): Al-Balkhī observed that sudden fear can strike without warning, manifesting in palpitations, trembling, and breathlessness (Balkhī 2004, 92). This is strikingly similar to modern descriptions of panic attacks. However, whereas modern psychiatry may prescribe anxiolytics, al-Balkhī recommended behavioral regulation, gradual exposure, and strengthening reliance on God.
4. *Ghamm* and *Hamm* (Stress and Worry): He differentiated *ghamm* (general distress) from *hamm* (anticipatory worry), a distinction that demonstrates conceptual overlap with what is now termed generalized anxiety disorder (GAD) (Badri 2000, 112). Al-Balkhī's remedies included cognitive reframing, maintaining daily routines, and engaging in communal life.

In each case, al-Balkhī's therapeutic strategy integrated cognitive, behavioral, social, and spiritual dimensions. Unlike punitive or stigmatizing approaches found in some premodern settings, his model emphasized restoring balance (*i'tidāl*), emotional regulation, and cultivating *tawakkul* (trust in God). This integrative orientation highlights both the originality and the contextual limitations of his work: while it resonates with certain strands of modern psychology (e.g., CBT), it also reflects a distinctly Islamic metaphysical anthropology, which modern secular paradigms often exclude (Rassool 2016, 118).

4. Therapeutic Strategies and Preventive Mental Health

In *Maṣāliḥ al-Abdān wa al-Anfus*, al-Balkhī explicitly emphasized preventive mental health (*ḥifẓ al-ṣiḥḥah*) centuries before such ideas were formalized in modern psychology. He argued that just as one adopts habits to preserve physical health, one must proactively protect the soul from harmful thoughts and emotions (Balkhī 2004, 76). He recommended balanced daily routines, moderation in diet, meaningful companionship, and spiritual devotion as forms of psychological hygiene.

His therapies included:

1. Cognitive Reframing: Al-Balkhī advised individuals suffering from sadness to reason with themselves by recalling divine wisdom and reminding their hearts of the ultimate purpose (Balkhī 2004, 88).

This use of self-talk and rational–spiritual reflection parallels aspects of cognitive restructuring in CBT, though unlike secular CBT, it anchors rationality in Qur’anic anthropology and metaphysical hope (Haque et al. 2016, 289).

2. Behavioral Regulation: He emphasized *intizām al-a’-māl* (regularity in actions) such as maintaining daily structure, physical movement, and purposeful engagement to combat lethargy and loneliness (Balkhī 2004, 93). This anticipates modern behavioral activation, though al-Balkhī linked it to cultivating discipline as an ethical virtue, not merely as symptom reduction (Seligman and Csikszentmihalyi 2000, 12).
3. Spiritual Healing: Al-Balkhī encouraged prayer (*ṣalāt*), remembrance (*dhikr*), and Qur’anic recitation to stabilize emotions and restore balance to the soul (Balkhī 2004, 101). While some modern psychotherapies may use mindfulness or meditation, al-Balkhī’s approach was grounded in Islamic theology, viewing spiritual acts as both worship and therapy (Nasr 1989, 144; Al-Attas 1993, 67).
4. Social Support: He strongly emphasized companionship (*ṣuḥbah sāliḥah*) and community interaction as preventive measures against isolation, warning that solitude without purpose can intensify distress (Balkhī 2004, 112). This overlaps with current research on social capital and its protective effects against depression and suicide (Holt-Lunstad, Smith, and Layton 2010, 235).

Al-Balkhī did not reject biological explanations or physical treatments. On the contrary, he advised physicians to assess both internal (psychological) and external (physical/environmental) causes of illness. His statement that “a wise physician must heal both body and soul” (Balkhī 2004, 115) illustrates his holistic vision. Compared to modern psychology, which often compartmentalizes biological, cognitive, and social interventions, al-Balkhī integrated them within a unifying spiritual–ethical framework.

5. Legacy and Modern Relevance

While al-Balkhī’s *Maṣāliḥ al-Abdān wa al-Anfus* was recognized in its own time within Islamic medicine, his psychological insights did not significantly shape the genealogy of Western psychology, which developed largely from Greco-Roman and Enlightenment roots. As a result, his contributions remained marginal in mainstream global psychology until their rediscovery in the late twentieth century (Haque 2004, 289).

In recent decades, however, scholars of Islamic psychology have begun to re-examine al-Balkhī’s ideas, not as direct precursors to modern therapies, but as part of an indigenous Islamic framework that can inform culturally adapted care for Muslim populations (Rassool 2023,

110). This revival reflects broader efforts to challenge the hegemony of secular, Western paradigms that often marginalize moral, religious, and communal dimensions of mental health. Instead of being treated merely as historical curiosities, al-Balkhī's categories of sadness (*huzn*), anxiety (*faza*), and obsessive thoughts (*waswasah*) are increasingly referenced as resources for building context-sensitive interventions in Muslim societies (Keshavarzi and Haque 2013, 141).

Al-Balkhī's legacy is thus best understood not as a forgotten "founder" of CBT, but as an early Islamic thinker whose integrative vision—linking body and soul, reason and faith, individual and community—offers a valuable parallel to modern holistic approaches. In an era marked by rising stress, anxiety, and social disconnection, his framework underscores the importance of embedding psychological care within ethical and spiritual worldviews.

Contemporary Relevance of al-Balkhī's Biopsychosocial Model

Mental health challenges in the 21st century have become increasingly complex. The World Health Organization (World Health Organization 2023, 15) reports that over 280 million people suffer from depression globally, making it a leading cause of disability. The COVID-19 pandemic further escalated rates of anxiety, post-traumatic stress, and social isolation (American Psychological Association (APA) 2022, 42). These problems are compounded by digital alienation, fragmented communities, and a rising sense of spiritual emptiness (Turkle 2010, 122; Twenge 2017, 185).

Despite advances in biomedical psychiatry and pharmacotherapy, critics argue that these approaches remain incomplete, lacking the moral and spiritual dimensions through which many individuals—especially in religious or traditional societies—interpret suffering and healing (Ghaemi 2010, 24; Mohr 2012, 289). Engel's biopsychosocial model marked an important advance by emphasizing the interplay of biological, psychological, and social factors (Engel 1977, 132). Yet its limited engagement with spirituality and ethics has led to calls for models that also address the metaphysical aspects of the human condition (Sulmasy 2002, 26; Rassool 2023, 110).

Within this broader search, Abū Zayd al-Balkhī (850–934 CE) provides a significant historical perspective. His treatise *Maṣāliḥ al-Abdān wa al-Anfus* (*Sustenance for Body and Soul*) explicitly linked bodily and psychological health, while also incorporating spiritual practices and ethical balance as integral to well-being (Balkhī 2004, 82; Badri 2013, 45). Rather than claiming direct precedence over modern theories, his work can be read as an early Islamic articulation of a biopsychological framework expanded into social and spiritual domains. In this sense, al-Balkhī's model resonates with and enriches modern holistic approaches,

while remaining rooted in an Islamic metaphysical and ethical worldview (Haque 2004, 289).

Depression and al-Balkhī's *Ḥuzn*

In *Maṣāliḥ al-Abdān wa al-Anfus*, al-Balkhī distinguished between *ḥuzn ṭabīʿī* (natural sadness following identifiable losses) and *ḥuzn ḡhayr ṭabīʿī* (persistent or disproportionate sadness without clear cause) (Balkhī 2004, 82). This bears a conceptual parallel to modern distinctions between reactive depression and major depressive disorder (Mascella 2013, 64; Arroisi et al. 2024, 50). Al-Balkhī proposed interventions such as rational self-talk, gratitude (*shukr*), prayer, positive reframing, and cultivating supportive companionship (Balkhī 2004, 85; Keshavarzi and Haque 2013, 141). While these approaches resonate with CBT and Behavioral Activation Therapy (Seligman and Csikszentmihalyi 2000, 12; Layous and Lyubomirsky 2014, 129), they differ in grounding: CBT frames depression in cognitive-behavioral dysfunction, whereas al-Balkhī ties it to ethical-spiritual imbalance and the restoration of *i'tidāl* (inner balance) through faith and practice.

Stress and *Waswasah*

Al-Balkhī defined *waswasah* as intrusive, repetitive thoughts that dominate the mind and cause psychological distress (Balkhī 2004, 88). He recommended strategies such as counter-thoughts (*mu'ākasah*), remembrance of God (*dhikr*), and regulating sleep and environment (Balkhī 2004, 93). These methods show partial resonance with contemporary approaches like CBT, mindfulness, and lifestyle restructuring (Haque et al. 2016, 141). The key difference lies in epistemology: whereas modern therapies emphasize cognitive-behavioral mechanisms, al-Balkhī's interventions are embedded within a spiritual teleology where intrusive thoughts are also moral-spiritual trials.

Social Isolation and *Ṣuḥbah* (Companionship)

Modern neuroscience demonstrates that chronic loneliness damages brain function, immunity, and emotional resilience (Holt-Lunstad, Smith, and Layton 2010, 235). Al-Balkhī similarly warned against prolonged isolation, stressing that healthy companionship (*ṣuḥbah ṣāliḡah*) is essential for psychological well-being (Balkhī 2004, 112). He advised cultivating purposeful community ties, both for emotional stability and for ethical-religious growth. While this overlaps with modern community-based interventions and group therapy models (Twenge, Spitzberg, and Campbell 2019, 185; Killgore, Cloonan, Taylor, and Dailey 2020, 68), al-Balkhī's framing differs in seeing companionship not only as a social resource but also as an ethical duty and spiritual safeguard.

Spiritual Healing and Meaning-Making

In *Maṣāliḥ al-Abdān wa al-Anfus*, al-Balkhī emphasized that emotional well-being cannot be separated from spiritual orientation. He recommended practices such as remembrance of God (*dhikr*) and trust in divine decree (*tawakkul*) as therapeutic tools for calming distress and restoring balance (Balkhī 2004, 101). While existential psychotherapy and religious coping studies (Pargament 2001, 47) affirm the importance of meaning-making in resilience, al-Balkhī situates these practices within an explicitly Qur'anic and ethical teleology. Unlike secular therapies where spirituality is treated as an optional coping resource, his model integrates it as constitutive of health itself (Nasr 1996; Al-Attas 1980, 67).

Preventive Mental Health and Holistic Resilience

Al-Balkhī also advocated preventive self-care, emphasizing sufficient sleep, moderation in eating, and regulation of harmful thoughts and emotions (Balkhī 2004, 115). He warned against exposure to excessive grief or destructive social environments, framing prevention as part of both medical wisdom and ethical discipline. This anticipates but also differs from contemporary public health approaches to resilience training and mental hygiene, which focus on biological and cognitive mechanisms but often lack explicit metaphysical grounding (Rassool 2016, 118; Van der Kolk 2014, 115).

Application in Clinical Settings

The renewed interest in al-Balkhī highlights his potential relevance for culturally adapted mental health care in Muslim-majority contexts. Concepts such as *ḥuzn* (sorrow) and *waswasah* (obsessive thoughts), when used in therapeutic dialogue, provide patients with familiar cultural categories that enhance therapeutic alliance and clinical outcomes (Haque et al. 2016, 141). However, it is important to distinguish which terms are explicitly from al-Balkhī (e.g., *ḥuzn*, *waswasah*, *faza'*) and which belong to the broader Islamic intellectual tradition (e.g., *ṣabr*, *tazkiyah*), to avoid conflation.

Efforts by scholars such as Malik Badri, Rania Awaad, and institutions like the International Association of Islamic Psychology (IAIP) have sought to integrate Islamic concepts into psychotherapy, often citing al-Balkhī as a historical reference point but developing new clinical applications beyond his original scope (Badri 2000, 112; Rassool 2023, 110). Thus, al-Balkhī's work functions less as a ready-made therapy and more as a foundational resource for building contemporary Islamic psychology.

Philosophical Dimensions of al-Balkhī's Contribution

Beyond clinical observations, al-Balkhī's paradigm must be understood within the philosophical anthropology of Islam. Whereas modern biopsychosocial frameworks operate within a naturalistic ontology that views the human being primarily as a psycho-biological organism, al-Balkhī grounds his analysis in a Qur'anic metaphysics that conceives the human as a composite of body (*jism*), self (*nafs*), intellect (*'aql*), and spirit (*rūḥ*) (Balkhī 2004, 74). In this sense, his work embodies an epistemology of integration (*tawḥīd al-ma'rifah*), where medical knowledge (*tibb*) and spiritual wisdom (*ḥikmah*) are not opposed but mutually reinforcing (Balkhī 2004, 115).

Philosophically, this raises three key contrasts with modern paradigms:

1. Ontological foundation – For al-Balkhī, health and illness are not only physiological or psychological states but conditions of harmony (*i'tidāl*) within a divinely ordered cosmos. In contrast, secular psychiatry generally confines itself to material causality.
2. Epistemological method—al-Balkhī's model synthesizes rational reflection, empirical observation, and scriptural revelation. This tripartite epistemology contrasts with the empiricist reductionism of modern psychology, which tends to marginalize metaphysical and scriptural sources.
3. Axiological aim the ultimate goal of healing in al-Balkhī's paradigm is not merely functional recovery but moral-spiritual flourishing (*tazkiyah al-nafs*). Therapy thus has an ethical telos, linking mental health with virtue and eschatological purpose.

These philosophical underpinnings clarify why al-Balkhī cannot simply be reduced to a precursor of Engel's biopsychosocial model or modern CBT. His work represents an Islamic metaphysical synthesis, weaving together body, psyche, society, and spirit into a unified vision of human well-being. Recognizing this context allows contemporary scholars to appreciate al-Balkhī not merely as a historical clinician but as a philosopher of the human condition whose insights enrich current debates on the limits of secular psychology and the importance of integrating ethics, metaphysics, and spirituality into the science of the soul.

Challenges and Criticisms of Applying Abū Zayd al-Balkhī's Biopsychosocial Model Today

While Abū Zayd al-Balkhī's biopsychological framework demonstrates an integrative approach to mental health within the Islamic tradition, its application to contemporary psychology is not without challenges. Key issues include epistemological differences, contextual gaps between premodern and modern societies, institutional limitations, and the need

for empirical validation in clinical settings. Recognizing these challenges is crucial to avoiding romanticizing the classical model and ensuring that its adaptation is both critical and constructive.

1. Epistemological and Temporal Distance

One of the primary challenges in reapplying al-Balkhī's model is the epistemological distance between classical Islamic psychology and modern clinical psychology. Al-Balkhī's theories were not produced in a secular scientific vacuum, but in the synthesis of three knowledge traditions: Qur'anic theology, Greco-Arabic medicine, and philosophical rationalism.

From the Qur'anic and theological side, his framework was shaped by concepts such as *nafs*, *qalb*, *rūh*, and *'aql*, which offered a moral-spiritual anthropology of the human being. Healing was therefore not merely symptom reduction but also a process of aligning the self with divine order and ultimate purpose.

From the Greco-Arabic medical tradition, al-Balkhī inherited Galenic and Hippocratic ideas about humoral balance, psychosomatic interaction, and the importance of diet, environment, and regimen (*ḥifẓ al-ṣiḥḥah*). Yet he reinterpreted these within an Islamic framework by treating psychological illnesses (*amrāḍ al-anfus*) as equally deserving of medical attention as bodily illnesses (*amrāḍ al-abdān*) (Balkhī 2004, 74).

From the philosophical tradition, especially the rationalist lineage of al-Kindī and Hellenistic psychology, al-Balkhī employed reason and reflection as therapeutic tools, echoing Stoic cognitive strategies but embedding them in Qur'anic metaphysics. His use of rational self-talk and counter-thoughts (*mu'ākasah*) reflects this fusion of logic and theology.

These three foundations—Islamic theology, Greco-Arabic medicine, and philosophical rationalism—set his model apart from modern clinical psychology, which privileges empirical science, evidence-based interventions, and neuroscientific validation (Haque et al. 2016, 2014; Ghaemi 2010, 24).

While al-Balkhī's categories of *ḥuzn* or *waswasah* may resonate with modern classifications such as depression or anxiety, terminological and conceptual differences risk oversimplification if directly translated into DSM-5 or ICD-11 categories. Moreover, modern clinicians, trained largely within secular paradigms, may find al-Balkhī's holistic integration of spiritual causality, divine will (*qadar*), and soul purification (*tazkiyah al-nafs*) unfamiliar or even inaccessible (Mohr 2012, 289).

2. Lack of Empirical Operationalization

Yet these parallels should not be mistaken for equivalence. The techniques are embedded in distinct epistemological frameworks: CBT frames them as cognitive-behavioral mechanisms for symptom reduction,

whereas al-Balkhī grounds them in an integrative anthropology where restoring *i'tidāl* (balance) involves the body, soul, intellect, and spirit (Balkhī 2004, 82).

This epistemological difference explains why interventions that look alike in practice may not be identical in meaning or outcome. For al-Balkhī, techniques such as self-talk or regulating routines were not only pragmatic but also moral–spiritual disciplines oriented toward cultivating resilience, virtue, and proximity to God. In contrast, secular therapies often bracket out metaphysical or ethical ends.

Furthermore, although al-Balkhī did recommend religious practices like *dhikr* and *tawakkul*, these were not his sole or primary methods. Rather, they formed part of a wider therapeutic repertoire that also included diet, sleep hygiene, emotional regulation, and rational analysis of thoughts (Balkhī 2004, 115). Modern discussions risk reducing his model to “religious coping,” whereas his own framework treated spiritual practices as complementary tools within a holistic system of prevention and cure.

The lack of empirical operationalization remains a barrier for modern integration. Quantitative research, clinical trials, and psychometric instruments are needed to test whether interventions inspired by al-Balkhī—when contextualized within his broader integrative paradigm—can achieve measurable outcomes in contemporary clinical settings (Haque et al. 2016, 289).

3. Cultural and Institutional Barriers

A major challenge in re-engaging al-Balkhī’s model today lies not only in practical limitations but in paradigmatic cultural barriers. Modern psychology, as institutionalized in universities and health systems, largely operates within a secular epistemology that sidelines theological and metaphysical categories. In many Muslim-majority societies, this has produced a gap: while there is cultural familiarity with concepts from Islamic psychology, professional training and clinical curricula remain heavily modeled on Western paradigms, often without integration of indigenous intellectual traditions (Rassool 2016, 118).

This epistemic imbalance creates institutional resistance to models like al-Balkhī’s, which rest on Qur’anic anthropology and Greco-Arabic medicine rather than purely materialist assumptions. As a result, even where cultural resonance exists, frameworks like al-Balkhī’s are often dismissed as “non-scientific” or “pre-modern” because they do not fit neatly into evidence-based criteria shaped by secular biomedicine (Hedayat-Diba 2000, 45).

Such barriers are paradigmatic rather than merely practical: they reflect a broader intellectual hegemony that privileges secular reductionism while marginalizing integrative, spiritual, and ethical

approaches. Addressing this requires interdisciplinary collaboration between psychologists, theologians, and historians of medicine, as well as the development of new research methodologies capable of accommodating non-material epistemologies. Without this paradigmatic shift, al-Balkhī's contributions risk remaining symbolic rather than genuinely transformative for contemporary psychological science.

4. Risk of Idealization and Decontextualization

To apply his model uncritically in the present would risk producing frameworks that are anachronistic or overly rigid in theological orientation. For example, some of his medical recommendations—such as diet and humoral balance—reflect Greco-Arabic medicine that no longer aligns with contemporary biomedical science. Similarly, his integration of Qur'anic metaphysics, while invaluable for Muslim patients, cannot be transplanted wholesale into pluralistic or secular contexts without careful adaptation.

Acknowledging these limitations does not diminish al-Balkhī's legacy but safeguards it from apologetic overstatement. Rather than presenting him as a "precursor" of modern psychology, it is more accurate to recognize his thought as a historically situated synthesis that can inspire contemporary frameworks, provided it is critically contextualized, empirically tested, and ethically adapted to modern clinical realities. This reflexive approach avoids the risks of romanticization and ensures that al-Balkhī's insights remain relevant without being decontextualized or absolutized.

Conclusion

In revisiting the psychological framework of Abū Zayd al-Balkhī, this study has shown that classical Islamic thought continues to offer meaningful perspectives for addressing contemporary mental health challenges. Al-Balkhī's biopsychological model, articulated in *Maṣāliḥ al-Abdān wa al-Anfus*, integrates body (*al-abdān*), self/soul (*al-anfus*), intellect (*'aql*), and spirit (*rūḥ*) into a holistic vision of well-being. His classification of disorders such as *ḥuzn* (sorrow/depression), *waswasah* (obsessive rumination), and *faza'* (panic), together with therapeutic strategies that combine cognitive reflection, behavioral regulation, social companionship, and spiritual practices, demonstrates a synthesis of Qur'anic anthropology, Greco-Arabic medicine, and rationalist philosophy.

At a time when global mental health crises are intensifying—marked by rising depression, chronic stress, and social disconnection—al-Balkhī's framework highlights dimensions often overlooked by purely biomedical or secular psychological models, particularly the integration of ethics, community, and spirituality. His emphasis on preventive care, resilience, and moral cultivation resonates with, though is not identical to,

contemporary approaches such as holistic medicine, resilience-building, and positive psychology.

Nevertheless, this study also recognizes the limits of applying a 9th-century paradigm directly to 21st-century clinical practice. Al-Balkhī's concepts were historically situated, shaped by humoral medicine and Qur'anic metaphysics, and must therefore be adapted critically rather than idealized. Differences in epistemology, language, and methodology necessitate contextual interpretation, empirical validation, and ethical scrutiny to ensure relevance in modern clinical and multicultural settings.

For this reason, the paper calls for a balanced approach—one that honors the intellectual and spiritual contributions of al-Balkhī without romanticization, while engaging rigorously with modern clinical science. Future work should prioritize interdisciplinary collaboration among Islamic scholars, psychologists, clinicians, and social scientists to operationalize his insights into culturally sensitive interventions. Such efforts may include clinical trials, qualitative studies, and curriculum development that bridge classical Islamic wisdom with contemporary therapeutic standards.

In conclusion, al-Balkhī's framework does not function as a direct precursor of modern psychology but as a historically rooted synthesis that offers valuable resources for rethinking mental health in holistic, ethical, and culturally resonant ways. By situating his contributions within both their 9th-century context and today's clinical discourse, his work can inspire more integrated models of care that restore balance to individuals and communities in a fragmented world.

REFERENCES

- American Psychological Association (APA). 2022. "Stress in America 2022: A National Mental Health Crisis." 2022. <https://www.apa.org/news/press/releases/stress>.
- Arroisi, Jarman, Aflatun Muchtar, Farhah, and Firda Inayah. 2024. "Relasi Pengetahuan dan Perilaku (Tinjauan Pemikiran Fakhruddin Al-Razi)." *Kalimah: Jurnal Studi Agama dan Pemikiran Islam* 22 (2): 217–34. <https://doi.org/https://doi.org/10.21111/klm.v22i2.12373>.
- Arroisi, Jarman, Husain Zahrul Muhsinin, and Ahmad Rizqi Fadlilah. 2024. "Self-Transcendence in Transpersonal Psychology: A Critical Review from the Perspective of the Islamic Worldview." *International Journal of Emerging Issues in Islamic Studies* 4 (1): 69–81. <https://doi.org/https://doi.org/10.31098/ijeis.v4i1.2432>.
- Arroisi, Jarman, Rodhi Hakiki Bin Cecep Mustopa Mustopa, and Royyan Ramdhani Djayusman. 2024. "Coping with the Discrepancy between Moral and Intellectual Achievement: The Model Integration of Higher Education and Modern Islamic Boarding Schools in Indonesia." *Indonesian Journal of Islam and Muslim Societies* 14 (2): 231–57. <https://doi.org/10.18326/ijims.v14i2.231-257>.
- Attas, Syed Muhammad Naquib al-. 1980. *The Concept of Education in Islam*. Kuala Lumpur, Malaysia: International Institute of Islamic Thought and Civilization (ISTAC).
- . 1993. *Islam and Secularism*. Kuala Lumpur, Malaysia: International Institute of Islamic Thought and Civilization (ISTAC).
- Badri, Malik. 2000. *Contemplation: An Islamic Psychospiritual Study*. Edited by Abdul-Wahid Lu'lu'a. London, Washington: International Institute of Islamic Thought (IIIT).
- . 2013. *Abu Zayd Al-Balkhī's Sustainance of the Soul: The Cognitive Behavior Therapy of a 9th Century Physician*. London, Washington: International Institute of Islamic Thought (IIIT).
- Balkhī, Abū Zayd al-. 2004. *Maṣāliḥ al-Abdān wa al-Anfus*. Edited by Mālik Badrī. Riyāḍ: Markaz al-Malik Fayṣal li al-Buḥūth wa al-Dirāsāt al-Islāmiyyah.
- Borrell-Carrió, Francesc, Anthony L. Suchman, and Ronald M. Epstein. 2004. "The Biopsychosocial Model 25 Years Later: Principles, Practice, and Scientific Inquiry." *Annals of Family Medicine* 2 (6):

576–82. <https://doi.org/10.1370/afm.245>. Department.

Chavarria, Victor, Blanca De La Puente, Laura Gimenez, Cristina Pou, Carlos Peña-salazar, Isabel Grimal, and Josep Maria Haro. 2023. "Spirituality, Religiosity and Mental Health: A Clinical-Care Approach." *National Library of Medicine* 51 (6): 281–82. <https://doi.org/https://pubmed.ncbi.nlm.nih.gov/38321718/>.

Cook, Christopher C. H., and Andrew Powell. 2022. *Spirituality and Psychiatry*. Cambridge: Cambridge University Press.

Engel, George L. 1977. "The Need for a New Medical Model: A Challenge for Biomedicine." *Science* 196 (4286): 129–36. <https://doi.org/https://doi.org/10.1126/science.847460>.

Fernando, Suman. 2010. *Mental Health, Race and Culture Second Edition*. Edited by Jo Campling. New York: Palgrave Macmillan.

Foa, Edna B, Elizabeth A Hembree, and Barbara Olasov Rothbaum. 2007. *Prolonged Exposure Therapy for PTSD: Emotional Processing of Traumatic Experiences*. Edited by David H Barlow. New York: Oxford University Press.

Ghaemi, S. Nassir. 2010. *The Rise and Fall of the Biopsychosocial Model: Reconciling Art and Science in Psychiatry*. Baltimore: Johns Hopkins University Press.

Gutas, Dimitri. 1998. *Greek Thought, Arabic Culture*. London: Routledge.

———. 2014. *Avicenna and the Aristotelian Tradition: Introduction to Reading Avicenna's Philosophical Works*. Edited by Hans Daiber, Anna Akasoy, and Emilie Savage-Smith. Leiden, Boston: Brill.

Haque, Amber. 2004. "Psychology from an Islamic Perspective: Contributions of Early Muslim Scholars and Challenges to Contemporary Muslim Psychologists." *Journal of Religion and Health* 4 (43): 357–77. <https://doi.org/https://doi.org/10.1007/s10943-004-4302-z>.

Haque, Amber, Fahad Khan, Hooman Keshavarzi, and Abdallah E Rothman. 2016. "Integrating Islamic Traditions in Modern Psychology: Research Trends in Last Ten Years." *Journal of Muslim Mental Health* 10 (1): 75–100. <https://doi.org/http://dx.doi.org/10.3998/jmmh.10381607.0010.107>.

Hedayat-Diba, Zari. 2000. "The Islamic Tradition and Clinical Psychology."

APA Bulletin, 2000.

- Holt-lunstad, Julianne, Timothy B Smith, and J Bradley Layton. 2010. "Social Relationships and Mortality Risk: A Meta-Analytic Review." *PLoS Medicine* 7 (7): 1–20. <https://doi.org/10.1371/journal.pmed.1000316>.
- Keshavarzi, Hooman, and Amber Haque. 2013. "Outlining a Psychotherapy Model for Muslim Clients: Integrating the Classical Writings of Muslim Scholars with Modern Psychotherapy Approaches." *Psychotherapy* 50 (3): 372–77. <https://doi.org/https://doi.org/10.1037/a0029823>.
- Killgore, William. D. S, Sarah A Cloonan, Erin C Taylor, Dakota A Lucas, and Natalie S Dailey. 2020. "Loneliness: A Signature Mental Health Concern in the Era of COVID-19." *Psychiatry Research* 29: 113–17. <https://doi.org/https://doi.org/10.1016/j.psychres.2020.113117>.
- Killgore, William D S, Sara A Cloonan, Emily C Taylor, and Natalie S Dailey. 2020. "Letter to the Editor Loneliness: A Signature Mental Health Concern in the Era of COVID-19." *Psychiatry Research* 290 (May): 113–17. <https://doi.org/10.1016/j.psychres.2020.113117>.
- Kolk, Besser Van der. 2014. *The Body Keeps the Score: Brain, Mind, and Body in the Healing of Trauma*. 1st ed. New York: Penguin Books.
- Layous, Kristin, and Sonja Lyubomirsky. 2014. "The How, Why, What, When, and Who of Happiness: Mechanisms Underlying the Success of Positive Activity Interventions." In *Positive Emotion: Integrating the Light Sides and Dark Sides*, edited by June Gruber and Judith Tedlie Moskowitz. New York: Oxford University Press. <https://doi.org/10.1093/acprof:oso/9780199926725.003.0025>.
- Long, Anthony Arthur. 2002. *Epictetus: A Stoic and Socratic Guide to Life. Philosophie Antique*. USA: Oxford University Press. <https://doi.org/10.4000/philosant.7388>.
- Mascella, Vivian. 2013. "Depression: Causes and Treatment." *Estudos de Psicologia I Campinas* 2 (30): 23–25. <https://doi.org/10.1590/S0103-166X2013000200016>.
- Mitha, Karim. 2019. "Islamically Integrated Psychotherapy: Contextualising Psychotherapy for Muslim Clients." *Psychotherapy and Politics International* 17 (1): 14–18.
- Mohr, Sylvia. 2012. "Spirituality and Mental Health: A Clinical Perspective." *The Journal of Nervous and Mental Disease* 200 (7): 548–52. <https://doi.org/10.1097/NMD.0b013e3182400000>.

[doi.org/https://doi.org/10.1097/NMD.0b013e31825bfb20](https://doi.org/10.1097/NMD.0b013e31825bfb20).

Murata, Sachiko, and William C Chittick. 1998. *The Vision of Islam*. Edited by Roger Corless and R. Ninian Smart. St. Paul, Minnesota: Paragon House.

Nasr, Seyyed Hossein. 1968. *Man and Nature: The Spiritual Crisis in Modern Man*. London: Unwin Paperbacks.

———. 1989. *Knowledge and the Sacred*. New York: State University of New York Press.

———. 1996. *Religion and the Order of Nature*. New York: Oxford University Press.

———. 2003. *A Young Muslim's Guide to the Modern World*. Chicago: Kazi Publications, Inc.

Nasr, Seyyed Hossein, and Oliver Leaman. 2001. *History of Islamic Philosophy*. London and New York: Routledge.

Nesse, Randolph M. 2019. *Good Reasons for Bad Feelings: Insights from the Frontier of Evolutionary Psychiatry*. New York: Dutton.

Pargament, Kenneth I. 2001. *The Psychology of Religion and Coping: Theory, Research, Practice*. New York, London: The Guilford Press.

Puchalski, Christina, Betty Ferrell, Rose Virani, Shirley Otis-Green, and Pamela Baird. 2009. "Improving the Quality of Spiritual Care as a Dimension of Palliative Care: The Report of the Consensus Conference." *Journal of Palliative Medicine* 12 (10): 885–904. <https://doi.org/10.1089/jpm.2009.0142>.

Rassool, Goolam Hussein. 2016. *Islamic Counselling: An Introduction to Theory and Practice*. London and New York: Routledge.

———. 2023. *Islāmic Psychology: The Basics*. London and New York: Routledge. <https://doi.org/10.4324/9781003312956>.

Rāzī, Abū Bakr Muḥammad ibn Zakariyyā al-. 2000. *Al-Ḥāwī fī al-Ṭibb*. Edited by Muḥammad Muḥammad Ismā'īl. Beirut: Dār al-Kutub al-'Ilmiyyah.

Seligman, M. E. P., and M. Csikszentmihalyi. 2000. "Positive Psychology: An Introduction." *American Psychologist* 55 (1): 5–14. <https://doi.org/https://doi.org/10.1037/0003-066X.55.1.5>.

Sīnā, Abū 'Alī al-Ḥusayn ibn 'Alī Ibn. 1999. *Al-Qanūn fī al-Ṭibb*. Beirut: Dār

al-Kutub al-‘Ilmiyyah.

- Sulmasy, Daniel P. 2002. "A Biopsychosocial-Spiritual Model for the Care of Patients at the End of Life." *The Gerontologist* 43 (3): 24–33. https://doi.org/https://doi.org/10.1093/geront/42.suppl_3.24.
- Turkle, Sherry. 2010. *Alone Together: Why We Expect More from Technology and Less from Each Other*. New York: Basic Books.
- Twenge, Jean M. 2017. *IGen: Why Today's Super-Connected Kids Are Growing Up Less Rebellious, More Tolerant, Less Happy—and Completely Unprepared for Adulthood*. New York: Atria Books.
- Twenge, Jean M., Brian Spitzberg, and W. Keith Campbell. 2019. "Less In-Person Social Interaction with Peers among U.S. Adolescents in the 21st Century and Links to Loneliness." *Journal of Social and Personal Relationships* 36 (6): 1892–1913. <https://doi.org/http://dx.doi.org/10.1177/0265407519836170>.
- Wade, Derick T, and Peter W Halligan. 2017. "The Biopsychosocial Model of Illness: A Model Whose Time Has Come." *Sage Journals* 31 (8): 995–1004. <https://doi.org/https://doi.org/10.1177/0269215517709890>.
- Weatherhead, Stephen, and Anna Daiches. 2010. "Muslim Views on Mental Health and Psychotherapy." *Psychology and Psychotherapy: Theory, Research and Practice* 83 (1): 75–89. <https://doi.org/https://doi.org/10.1348/147608309X467807>.
- World Health Organization. 2023. *World Mental Health Report 2023: Transforming Mental Health for All*. Switzerland: WHO Press.
- World Health Organization (WHO). 2023. "Depression Fact Sheet." 2023. <https://www.who.int/news-room/fact-sheets/detail/depression>.

This Page is Intentionally Left Blank