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Psychology, Mental Well-Being and Public Health: Translating Depth-Psychological Questions and Culturally Informed Perspectives into Measurable Mental Health Service Quality and Safety

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Abstract

Mental health services are increasingly judged by whether they are safe, effective, person-centred, timely and equitable. Routine quality measurement, however, tends to capture symptoms and service activity while overlooking how patients interpret distress, what gives their lives meaning, and how culture and spirituality shape help-seeking and disclosure. This commentary argues that the enduring value of Freudian and Jungian depth psychology for health-care quality lies not in its treatment claims, which have limited empirical support, but in the questions it raises about concealed motives, self-presentation, identity and meaning. These questions can be translated into testable constructs and measurable service indicators. We distinguish historical concepts from contemporary mechanisms and state the evidence status of each. We consider selected Qur'anic concepts (sakīnah, ṣabr, shukr and tawakkul) as culturally meaningful frameworks, not as psychological equivalents or substitutes for evidence-based care. We then propose a quality and safety framework linking six service domains to practical interventions and example outcome measures, discuss implementation hazards, and outline a prioritized research agenda. Our central message is that culturally informed, person-centred mental health care should be operationalized, measured and tested rather than assumed to be beneficial.

Keywords: Mental Health Services, Healthcare Quality, Patient Safety, Psychological Well-Being, Depth Psychology, Cultural Responsiveness, Spirituality, Qur'anic Concepts, Outcome Measurement

Introduction

The World Health Organization (WHO) defines mental health as a state of mental well-being that enables people to cope with the stresses of life, realize their abilities, learn and work effectively, and contribute to their communities [1]. This definition extends mental health beyond the absence of psychiatric illness and therefore extends the responsibilities of health systems. Quality in health care is commonly framed through six aims: care should be safe, effective, patient-centred, timely, efficient and equitable [2]. The WHO Global Patient Safety Action Plan 2021–2030 similarly frames patient safety as the elimination of avoidable harm across all care settings [3]. In mental health, avoidable harm includes unrecognized suicide risk, missed or delayed diagnosis, disengagement from care because services feel culturally alien, and stigma-related non-disclosure.

Standardized instruments such as the Patient Health Questionnaire-9 (PHQ-9) and the Generalized Anxiety

Disorder-7 scale (GAD-7) are valuable and widely used [4,5]. Yet symptom scores alone do not show how a patient understands their distress, what they are willing to disclose, what gives their life meaning, or which cultural and spiritual resources they draw on. These are the kinds of questions that depth psychology, from Sigmund Freud to Carl Gustav Jung, placed at the centre of the discipline.

Thesis: We argue that the contribution of Freudian and Jungian psychology to healthcare quality and safety is heuristic rather than evidential. Their propositions are largely untested or have limited empirical support, but the questions they pose can be translated into contemporary, testable constructs (for example, implicit processes, self-concealment, identity development and purpose in life). Those constructs can in turn be embedded in service design and outcome measurement. Where culturally embedded spiritual concepts matter to patients, they should be handled the same way: respected, operationalized, measured and tested, and never assumed to be therapeutic or offered in place of evidence-based care.

The commentary proceeds as follows. Section 2 frames well-being as a dynamic, measurable state. Section 3 separates historical concepts from testable mechanisms. Section 4 considers identity, meaning and digital environments. Section 5 discusses culturally and spiritually informed care, including selected Qur'anic concepts. Section 6 proposes a quality and safety framework with practical interventions and outcome measures. Sections 7 and 8 address safeguards and a prioritized research agenda.

Well-Being as a Dynamic and Measurable State

Ryff's [6] model identifies six dimensions of psychological well-being: autonomy, environmental mastery, personal growth, positive relationships, purpose in life and self-acceptance. Psychological health is shaped across the life course by social and structural conditions. Adverse childhood experiences are associated with a wide range of poor health outcomes in adulthood [7], and social isolation is associated with increased mortality risk [8]. Protective factors include supportive relationships, education, meaningful work and community belonging. Because people move between distress and well-being as circumstances change, mental health is better treated as a continuum than a binary state.

This has a direct implication for quality improvement: a single assessment at intake is insufficient. Brief, repeatable instruments such as the WHO-5 Well-Being Index [9] can track change in well-being, complementing symptom scales and allowing services to detect deterioration or recovery earlier.

Historical Concepts and Testable Mechanisms

Freud proposed that behaviour is shaped by unconscious processes, early experience and internal conflict, and those individuals manage anxiety through defence mechanisms [10]. His structural model described interaction between the id, ego and superego [11]. Jung, working initially within the psychoanalytic movement, developed analytical psychology, which introduced the collective unconscious, archetypes, shadow, persona and individuation as central concepts [12,13].

These frameworks should be treated as historical and interpretive. Many classical propositions are difficult to falsify, and educational summaries of psychodynamic theory acknowledge that empirical support for many components is limited (American Psychological Association [APA], n.d.). It is important not to conflate this with the evidence for contemporary psychodynamic psychotherapy, which has its own trial literature and is assessed on its own merits [14]. The classical theories describe a conceptual lineage; they do not validate current clinical practice.

Domain (quality aim)	Quality or safety gap	Practical intervention	Example outcome measures
1. Suicide and self-harm risk (safe)	Distress may be concealed or expressed through culturally specific idioms; screening is inconsistent	Structured risk screening and safety planning by trained staff; culturally sensitive interview prompts; clear escalation pathways [33]	Proportion screened with a validated tool; proportion of at-risk patients with a documented safety plan; follow-up contact after discharge
2.Measurement-based, collaborative care (effective)	Symptoms and well-being not routinely tracked; treatment not adjusted to progress	Routine PHQ-9, GAD-7 and WHO-5 with stepped and collaborative care models [31,32]	Proportion with baseline and follow-up scores; response and remission rates; time to treatment adjustment

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3. Cultural and spiritual responsiveness (patient-centred)	Patients' explanatory models and spiritual preferences are not elicited	Brief cultural formulation; optional spiritual history [23]; interpreters; referral pathways to spiritual care when requested	Patient-reported experience measures; documentation of patient preferences; treatment drop-out by cultural group
4. Literacy and stigma reduction (timely)	Delayed help-seeking; low recognition of early warning signs	School, workplace and community literacy programmes with clear referral routes [34]	Mental health literacy scores; time from symptom onset to first contact; stigma scale scores
5. Social connection (equitable)	Loneliness and isolation not assessed; vulnerable groups under-reached	Screening for loneliness and linkage to community programmes [8]	Validated loneliness score; completion of community referrals; access and outcome differences by group
6. Digital environments in youth services (effective, safe)	Problematic use, sleep disruption and online stressors not routinely asked about	Routine questions on digital use, sleep and online experiences in adolescent assessment; family and school engagement [19]	Screening rate; sleep and WHO-5 scores; patient-reported online harms

Table 1: From historical concepts to testable constructs and quality relevance.

Note: The table describes conceptual correspondences for service-design purposes. It does not imply that the historical concepts have been validated.

Three translations follow. First, patients do not always report what is clinically relevant, whether from avoidance, stigma or lack of language for distress. Services should therefore use structured, repeated and culturally sensitive enquiry rather than rely on spontaneous disclosure. Second, the gap between experienced and presented self, which Jung described through the persona, corresponds to well-documented concealment and impression management. Stigma reduces help-seeking, and this is a measurable access and equity problem [16]. Third, identity and meaning are legitimate subjects of assessment because they are components of psychological well-being [6], provided they are measured and not merely assumed.

Identity, Meaning and Digital Environments

Young people construct identities through family, education, peers, religious and cultural traditions, and increasingly digital platforms. The WHO Regional Office for Europe reported an increase in problematic social media use among adolescents in the 2021/2022 Health Behaviour in School-aged Children survey compared with 2018 [18]. Evidence on the mental health effects of digital technology use is mixed, however: reviews describe associations that are generally small and inconsistent, and causal direction is uncertain [19]. We therefore do not suggest that social media causes mental illness. The more modest and defensible point is that the persona concept offers a useful prompt for clinicians, who can ask how young patients present themselves online, whether online comparison affects self-esteem, and how digital life affects sleep and relationships.

The same caution applies to meaning and purpose. Positive associations between purpose in life and well-being are documented [6], but such associations do not show that interventions targeting meaning improve clinical outcomes. This is a research question and a reason to measure, not an assumption to build services on.

Culturally and Spiritually Informed Care

Cultural responsiveness

People interpret symptoms through cultural beliefs about health, illness, morality, family and spirituality, and services that ignore this context may create barriers to care. Cultural competence is better understood as an ongoing, critical practice than as a fixed body of knowledge about groups [17]. Culturally adapted psychological interventions show moderate benefits in meta-analysis [20]. Cultural responsiveness does not mean accepting every traditional belief uncritically. It means respecting identity, undertaking proper scientific assessment, recognizing culturally specific coping, communicating appropriately, protecting against stigma, safeguarding patient autonomy and ensuring access to evidence-based treatment.

Spirituality and mental health

Freud generally interpreted religion through a critical psychoanalytic lens, whereas Jung gave greater weight to religious symbolism and spiritual experience. Contemporary research does not need to choose between these positions.

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Reviews report associations between religiousness or spirituality and better mental health outcomes, though the relationships are complex, context-dependent and, in some forms such as religious struggle, can be negative [21,22]. A short spiritual history, such as the FICA tool, can help clinicians identify whether spiritual beliefs are important to a patient's coping and what role they wish them to play in care [23].

Selected Qur'anic concepts

We discuss a small number of Qur'anic concepts as examples of culturally meaningful frameworks through which Muslim patients may interpret adversity and well-being. They are not psychological constructs, and we do not claim equivalence with them. Verse references follow the standard chapter:verse system and should be read in an authoritative translation [24]. Transliterated terms are italicized.

- Sakīnah denotes divinely bestowed tranquillity and reassurance, and is mentioned, for example, in relation to the hearts of the believers (Qur'an 48:4). It should be distinguished from the closely related notion of hearts finding rest or peace (ṭuma'nīnah), which is the term associated with the remembrance of God in Qur'an 13:28. The original manuscript linked 13:28 directly to sakīnah; this has been corrected here.
- Ṣabr, commonly translated as patience or perseverance, appears in contexts such as Qur'an 2:153 and 39:10. It may be considered alongside resilience and adaptive coping, but it must not be interpreted as passive acceptance of abuse, illness or injustice, or as a reason to defer treatment.
- Shukr, or gratitude (for example, Qur'an 14:7), has conceptual links with appreciation and positive psychological functioning.
- Tawakkul, or trust in God (for example, Qur'an 65:3), may help believers distinguish personal responsibility from circumstances beyond their control, alongside taking appropriate action.

These concepts could be treated as hypotheses for research on perceived stress, emotion regulation and subjective well-being. Systematic reviews of Qur'an-based practices (listening, recitation, memorization) and of Qur'an-based interventions report potentially favourable outcomes but also considerable heterogeneity and methodological limitations [25,26]. The better-studied field of mindfulness and meditation offers a useful comparator: meta-analyses show modest benefits for some outcomes, such as anxiety, depression and pain, but not superiority over established treatments [27,28]. Qur'anic terminology and verse references in this commentary should be reviewed by a qualified specialist in Islamic studies before clinical or educational use.

A Quality and Safety Framework for Mental Health Services

Table 2 translates the preceding discussion into six service domains, each linked to one or more of the Institute of Medicine (2001) aims [2], a practical intervention and example outcome measures. The framework is consistent with the biopsychosocial tradition, which treats biological, psychological and social factors together [29,30]. It is a proposal for local adaptation and testing, not a validated model. It builds on established components, including measurement-based care and collaborative care [31,32], structured suicide-risk assessment Posner [33], and community mental health literacy [34].

Domain (quality aim)	Quality or safety gap	Practical intervention	Example outcome measures
1. Suicide and self-harm risk (safe)	Distress may be concealed or expressed through culturally specific idioms; screening is inconsistent	Structured risk screening and safety planning by trained staff; culturally sensitive interview prompts; clear escalation pathways [33]	Proportion screened with a validated tool; proportion of at-risk patients with a documented safety plan; follow-up contact after discharge
2. Measurement-based, collaborative care (effective)	Symptoms and well-being not routinely tracked; treatment not adjusted to progress	Routine PHQ-9, GAD-7 and WHO-5 with stepped and collaborative care models [31,32]	Proportion with baseline and follow-up scores; response and remission rates; time to treatment adjustment
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4. Literacy and stigma reduction (timely)	Delayed help-seeking; low recognition of early warning signs	School, workplace and community literacy programmes with clear referral routes [34]	Mental health literacy scores; time from symptom onset to first contact; stigma scale scores
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6. Digital environments in youth services (effective, safe)	Problematic use, sleep disruption and online stressors not routinely asked about	Routine questions on digital use, sleep and online experiences in adolescent assessment; family and school engagement [19]	Screening rate; sleep and WHO-5 scores; patient-reported online harms

Table 2: Proposed quality and safety framework with practical interventions and example outcome measures.

Note: Measures are examples and should be selected, validated and, where necessary, translated for the local population. Balancing measures (for example, clinician time and patient burden) should be monitored alongside outcomes.

In practice, services should select a small number of indicators, co-design them with patients and families, pilot them in a defined setting, and review them through routine quality improvement cycles. Equity analysis, which disaggregates indicators by language, nationality, gender and age, is essential in multicultural health systems.

Hazards and Safeguards

Introducing psychological, cultural and spiritual perspectives into services creates its own risks, which quality and safety frameworks should anticipate:

- Unvalidated theory driving clinical decisions. Historical psychoanalytic interpretations should not replace structured assessment or evidence-based treatment.
- Imposition of belief. Spiritual enquiry must be voluntary, non-directive and documented only with consent. Clinicians should not assume that a patient's religion determines their preferences.
- Delay in treatment. Concepts such as ṣabr or tawakkul must not be used to discourage help-seeking or to minimize illness, abuse or injustice.
- Negative religious coping. Religious struggle can accompany distress and may require specific clinical attention [21].
- Stereotyping. Cultural information should inform enquiry, not replace it. Cultural humility and individual assessment remain essential [17].
- Measurement burden. Excessive instruments can reduce engagement and distort practice; indicators should be few and meaningful.

A Prioritized Research Agenda

Rather than a long list of topics, we propose six priority questions, each with a suggested design:

1. Does routine elicitation of explanatory models and spiritual preferences improve engagement and patient-reported experience? (Pragmatic or stepped-wedge trial.)
2. Do culturally adapted interventions that incorporate concepts such as ṣabr, shukr and tawakkul improve outcomes compared with standard care, and for whom? (Randomized trial with validated religious coping measures and fidelity assessment.)
3. Can the constructs in Table 1 (for example, concealment, purpose in life, identity) be validly measured in Arabic-speaking and multicultural populations? (Psychometric validation.)
4. How do digital identity and online experiences relate to well-being and help-seeking in young people over time? (Longitudinal cohort studies.)
5. Does screening for loneliness with linkage to community services improve well-being and service use? (Hybrid effectiveness–implementation study.)
6. Do the indicators in Table 2 reduce disparities in access, engagement and outcome? (Quality improvement studies with equity analysis.)

Conclusion

Freud and Jung directed attention toward concealed motives, early experience, symbolism, identity and meaning. Their specific theories have limited empirical support and should not guide clinical decisions. The questions they raised nevertheless identify blind spots in conventional quality measurement: what patients conceal, how they present themselves, what gives their lives meaning, and how culture and spirituality shape their understanding of distress.

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When translated into testable constructs, these questions can inform safer, more person-centred and more equitable mental health services [35]. For Muslim patients, concepts such as sakīnah, ṣabr, shukr and tawakkul may be meaningful resources, to be respected, studied and used with consent, as a complement to evidence-based psychological and medical care and never as a replacement for it.

We propose the following working definition for service planning: mental health is the capacity to understand oneself, regulate emotion, maintain meaningful relationships, adapt to adversity, experience purpose and participate constructively in society, and health services should be designed, measured and held accountable accordingly.

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