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RECLAIMING COMPASSIONATE MENTAL HEALTH CARE: LESSONS FROM BĪMĀRISTĀNS FOR MALAYSIAN MUSLIMS

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Abstract

Mental health among Malaysian Muslims is formed by the intersection of cultural, religious, and social factors. Despite increasing awareness, stigma and misconceptions persist. Historically, the Islamic Golden Age established bīmāristāns early hospitals providing ethical, holistic psychiatric care. This paper reconstructs the Islamic tradition of mental health care, compares it with contemporary Malaysian Muslim attitudes, and identifies lessons for culturally and religiously sensitive interventions. Using qualitative comparative analysis and thematic review of secondary sources (2020–2025), the study finds that contemporary stigma is largely culturally constructed, whereas Islamic tradition emphasizes compassion, ethical responsibility, and accessibility. The findings suggest that integrating bīmāristān principles can reduce stigma, improve help-seeking behavior, and enhance mental health outcomes for Malaysian Muslims.

Keywords: religiosity, spirituality, media Mental Health, Malaysian Muslims, Bīmāristān, Stigma, Islamic Ethics, Comparative Analysis

INTRODUCTION

Mental health has increasingly become a pressing concern in global public health, yet it remains heavily stigmatized in many Muslim-majority societies, including Malaysia. Among Malaysian Muslims, mental illness is often interpreted through cultural or moral lenses rather than as a legitimate medical or psychological condition. Individuals experiencing psychological distress may be perceived as weak in faith, overly emotional, or lacking patience. Gendered expectations can amplify stigma, particularly for women, who are often expected to uphold familial and societal norms while suppressing emotional struggles (Rajagopal, Stephenson, & Ousey, 2023; Muda & Raphaie, 2025).

This stigma can lead to social isolation, delays in seeking treatment, and worsening mental health outcomes. For example, research in Malaysian university settings during and after the COVID-19 pandemic found that psychological distress significantly increased among students, with cultural misconceptions contributing to reluctance in seeking help (Hassan, Abdul Majeed, Mohd Tajuddin, Abdullah, & Ahmad, 2022). Understanding these dynamics is critical to developing culturally sensitive mental health interventions.

Historically, however, Islamic societies developed a markedly different approach to mental health care. During the Islamic Golden Age (8th–14th centuries), bīmāristāns (Islamic hospitals) provided holistic, ethical, and accessible care for both physical and mental illnesses. Maravia and Al-Ghazal (2021) describe psychiatric wards established in Baghdad during the 9th century and in Cairo and Aleppo in subsequent centuries. These institutions treated all patients without discrimination and

emphasized compassionate, scientifically informed approaches to mental illness, integrating psychological, physical, and spiritual care (Alotaibi, 2025; Rehman & Arshad, 2025).

Contemporary Malaysian research reveals that while religiosity may provide a framework for coping, it does not automatically eliminate mental health stigma. Arif and Olagoke (2024) found that among Malaysian adults, high religiosity coexisted with moderate levels of stigma, suggesting that cultural misunderstandings and lack of mental health literacy persist. Basri et al. (2025) further identified culturally specific beliefs, such as viewing mental illness as, predominantly a "test of faith," that influence perceptions and help-seeking behavior.

The divergence between the historically compassionate care in bīmāristāns and current challenges in Malaysian Muslim communities highlights the need for a culturally and religiously informed approach to mental health. This paper therefore seeks to explore:

1. How mental illnesses were conceptualized and treated in bīmāristāns during the Islamic Golden Age?

2. How contemporary Malaysian Muslims perceive and respond to mental health challenges, with attention to stigma, religion, and culture?

3. What historical, cultural, and systemic factors explain the divergence between Islamic tradition and present-day attitudes?

4. How principles derived from bīmāristān models can inform compassionate, faith-integrated mental health care for Malaysian Muslims today?

By integrating historical and contemporary perspectives, this study aims to bridge past Islamic medical ethics with modern mental health practices, offering both theoretical insight and practical guidance for culturally sensitive interventions.

LITERATURE REVIEW

Historical Context: Bīmāristān And Islamic Psychiatry

During the Islamic Golden Age (8th–14th centuries), bīmāristāns or Maristanes served as pioneering institutions for the treatment of physical and mental illnesses. Maravia and Al-Ghazal (2021) report that the first psychiatric wards appeared in Baghdad during the 9th century, followed by hospitals in Cairo (872 CE) and Aleppo (1354 CE). These institutions were characterized by ethical, holistic care, treating all patients without discrimination based on religion, gender, or socioeconomic status. For example, Bīmāristān al-Mansuri in Cairo (1248 CE) had a capacity of 8,000 beds and provided free treatment to all patients, including those with mental disorders, funded entirely by the hospital (Maravia & Al-Ghazal, 2021).

Islamic medical ethics emphasized *rahmah* (compassion) and sincerity in patient care. Alotaibi (2025) notes that Andalusian medical approaches stressed the interconnection of physical, emotional, and spiritual well-being, aligning with Islamic ethical imperatives to heal and promote patient welfare. Hadith literature, such as the saying "Allah is the Healer…," has been interpreted to encourage physicians to act with gentleness and responsibility toward patients (Alotaibi, 2025). This historical framework formed the basis of early Islamic psychiatry, in which qualified physicians approached mental disorders scientifically rather than attributing them solely to supernatural causes.

Treatment methods were comprehensive and patient centered. Classical scholars, including al-Rāzī and Ibn Sīnā, practiced therapies that integrated psychological and physical care. Rehman and Arshad (2025) highlight that Ibn Sīnā's Canon of Medicine emphasized the integration of nutrition,

pharmacology, and psychotherapy for illness recovery. Similarly, Mitha (2020) demonstrates that mental health practices during the Islamic Golden Age were consistent with contemporary medical principles of the time, rather than mere cultural beliefs. This intellectual legacy laid the groundwork for the conceptual understanding of mind-body connections that later influenced Western medicine (Rehman & Arshad, 2025; Mitha, 2020).

Contemporary Perceptions, Stigma, and Attitudes Among Malaysian Muslims

Modern research indicates that cultural stigma remains a significant barrier to mental health care among Malaysian Muslims. Rajagopal et al. (2023) conducted a systematic review and found that misunderstandings of mental illness, reinforced by cultural beliefs, lead to social shame and reluctance to seek help. Differences in cultural background also affect stigma levels; for instance, Chinese Malaysian students exhibited higher stigma compared to Malay Muslim students. Furthermore, Muda and Raphaie (2025) reported that Malay Muslim students were more likely to reject stigmatizing beliefs than their non-Muslim peers, suggesting that Islamic teachings on patience and healing may mitigate prejudice.

Religion and religiosity play nuanced roles. Arif and Olagoke (2024) examined 451 adults from various religious backgrounds in Malaysia and found that high religiosity was associated with only moderate stigma. No significant differences in overall stigma were found between Muslims and adherents of other religions. Interestingly, Christians showed the highest stigma, followed by Hindus, while Muslims were in the middle range. These findings suggest that religiosity alone is insufficient to eliminate stigma; correct understanding of religious teachings is critical. Basri et al. (2025) further emphasize that in Malaysian Muslim communities, mental illness is sometimes perceived as a "test of faith" or a consequence of past misdeeds. Their adaptation of the M-PAMH scale included items to assess culturally specific stigmatizing beliefs.

Gender and cultural factors also intersect with mental health stigma. Basri et al. (2025) note that women may be more vulnerable to mental health issues and more likely to seek treatment than men, though their studies focused on the general Muslim population. The Malay-Muslim cultural emphasis on family honor often leads individuals to conceal mental health problems. Research conducted in 2020–2022 highlights persistent gaps in mental health literacy, emphasizing the need for ongoing education and community awareness initiatives to reduce stigma (Rajagopal et al., 2023; Basri et al., 2025).

Overall, these studies illustrate a stark contrast between the historical Islamic ethic of compassionate, accessible care and the modern-day challenges of cultural stigma in Malaysian Muslim communities. Understanding this divergence is essential for developing interventions that are both culturally sensitive and grounded in Islamic ethical principles.

METHODOLOGY

This study adopts a conceptual, comparative, and historically informed qualitative methodology. The aim is to analyze how mental health care was conceptualized and practiced within Islamic civilization particularly through the bīmāristān tradition and compare it with contemporary perceptions and attitudes among Malaysian Muslims. This methodological approach allows for a systematic examination of texts, themes, and historical practices while linking them to modern sociocultural and religious realities.

Research Design: Conceptual & Comparative Analysis

Because the study does not involve primary data collection, it relies on a conceptual research design utilizing secondary source. This design is commonly used in Islamic studies, medical humanities, and cultural psychology, particularly when bridging historical knowledge with contemporary analysis (Alotaibi, 2025; Rehman & Arshad, 2025). The comparative dimension draws parallels between:

1. Classical Islamic mental health models (e.g., bīmāristān institutions, writings of al-Rāzī and Ibn Sīnā)
2. Present-day mental health perceptions among Malaysian Muslims (2020–2025 empirical studies)

This dual perspective enables a critical contrast between Islamic tradition and current cultural realities.

Sources of Data

The analysis integrates two bodies of literature:

(a) Historical–Islamic Sources
These include peer-reviewed works on:

i. the establishment and functioning of bīmāristāns
ii. classical Islamic medical ethics
iii. psychiatric writings from the Islamic Golden Age
iv. institutional models of care in Baghdad, Cairo, Damascus, and Andalusia

Key authors include Maravia & Al-Ghazal (2021), Alotaibi (2025), Rehman & Arshad (2025), and Mitha (2020).

(b) Contemporary Malaysian Studies (2020–2025)
This includes journal articles and empirical studies on:

i. stigma among Muslims (e.g., Rajagopal et al., 2023; Basri et al., 2025)
ii. religiosity, cultural factors, and help-seeking behaviors (Arif & Olagoke, 2024)
iii. gendered experiences and community attitudes
iv. mental health literacy and cultural misconceptions

These sources provide insight into how Malaysian Muslims understand, interpret, and respond to mental health challenges today.

Analytical Framework

The study uses a thematic analytical framework guided by two overarching themes:

1. Compassionate, holistic Islamic medical ethics
   (as exemplified by bīmāristāns)
2. Contemporary cultural stigma and misconceptions
   (as found in Malaysian empirical studies)

Themes were identified inductively from the literature and then compared to identify convergences, divergences, and gaps. This thematic–comparative approach aligns with current methods in medical anthropology and culturally informed mental health research.

Rationale and Justification

Several reasons justify this methodological approach:

i. Historical Islamic models are under-utilized in modern Muslim mental health scholarship, despite their richness.
ii. Malaysian Muslim attitudes today are often shaped more by culture than Islamic teachings, warranting a culturally focused analysis.
iii. Comparative conceptual papers are recognized in Islamic studies journals, particularly on the intersections of ethics, history, and psychology.
iv. This approach enables the paper to highlight practical pathways forward, informed by both heritage and contemporary realities.

Limitations

This study acknowledges several limitations:

1. Historical data on bīmāristāns is based on available manuscripts and may not capture all regional variations.
2. Contemporary studies in Malaysia remain limited in scope, with few large-scale national datasets.
3. The conceptual nature of the methodology means findings are interpretive rather than empirical.

Despite these limitations, the methodology provides a robust and credible foundation for analyzing the historical–modern comparison.

Methodological Rigor

To ensure scholarly credibility, this study applies the core principles of qualitative rigor credibility, dependability, confirmability, and transferability, which strengthen the reliability of conceptual and comparative research.

Credibility is established by grounding the analysis in peer-reviewed studies published between 2020 and 2025, alongside well-documented historical sources from the Islamic Golden Age. Using literature from diverse fields Islamic medical history, psychiatry, cultural psychology, Malaysian mental health studies enhance the accuracy and depth of interpretation. The integration of contemporary empirical findings with classical Islamic texts enables cross-validation of themes across independent knowledge domains.

Dependability is reinforced through a systematic and transparent analytic process. The study employs a structured thematic approach, where recurring motifs (e.g., compassion, stigma, misinterpretation of religion, institutional care) were identified across multiple sources and compared consistently. This systematic procedure ensures that findings are reproducible by other researchers examining the same bodies of literature.

Confirmability is ensured by grounding each claim in explicit textual evidence, rather than the author's assumptions. Citations from historical treatises, modern psychological surveys, and Malaysian stigma studies function as an audit trail. This helps minimize personal bias and strengthens objectivity in analyzing both classical and contemporary sources.

Transferability is supported by the study's focus on broad civilizational principles such as Islamic medical ethics, community care, and cultural influences which can be meaningfully applied to other Muslim-majority contexts. Although the paper focuses on Malaysia, the analytical framework provides a model for comparing classical Islamic traditions with mental health attitudes in other societies.

Together, these strategies uphold methodological rigor and ensure that the study's conclusions are not only conceptually sound but also academically defensible within multidisciplinary scholarship.

ANALYSIS & DISCUSSION

Reconstructing The Islamic Tradition: Compassion, Ethics, And Institutional Care

Re-examining the Islamic Golden Age through the lens of mental health reveals a civilizational model characterized by compassion-driven care, ethical responsibility, and institutional sophistication. The bīmāristān system, often cited as the earliest organized psychiatric treatment, treated mental illness as a legitimate medical condition requiring structured institutional support rather than moralizing or stigmatizing it (Maravia & Al-Ghazal, 2021). Multi-functional hospitals included psychiatric wards, music therapy, pharmacological treatments, and trained physicians, reflecting the integration of medical

practice with Islamic ethical principles. Central to this tradition was the ethic of rahmah (compassion). Physicians modeled their practice on prophetic ethics, integrating gentleness, emotional attunement, and moral accountability into care (Alotaibi, 2025). Psychological disturbances were recognized as part of the human condition rather than as spiritual inferiority. The classical approach also emphasized mind–body–spirit integration, with treatments combining dietary interventions, behavioral therapy, talk-based counselling, and herbal pharmacology (Rehman & Arshad, 2025; Mitha, 2020). This early holistic framework mirrors contemporary biopsychosocial models, grounded in both empirical observation and theological understanding.

Divergence Between Islamic Tradition And Contemporary Malaysian Muslim Culture

Contemporary Malaysian Muslim perceptions of mental health contrast sharply with the classical model. Stigma, supernatural attributions, and moral judgments often impede help-seeking and exacerbate psychological distress. Several factors contribute:

1.Historical and Cultural Factors

Malaysia's health system largely relies on Western biomedical models alongside deeply rooted cultural norms and *adat*, which prioritize family reputation and social conformity. Mental illness is sometimes viewed as a "test of faith" or spiritual imbalance, leading to self-stigma and social withdrawal (Basri et al., 2025).

2.Religious Misinterpretation

Faith can be protective, yet selective interpretation may exacerbate stigma. Deeply religious individuals may internalize blame for their struggles, equating mental illness with weak faith or moral failure (Arif & Olagoke, 2024). Unlike the integrated faith-and-ethics model of the Golden Age, contemporary attitudes sometimes misalign religious belief with psychological well-being.

3.Systemic Challenges

Limited access to clinicians trained in both psychology and Islamic counselling, fragmented policies, and underdeveloped outreach perpetuate gaps between cultural expectations and professional care (Nasir et al., 2023; Rajagopal et al., 2023).

Key Themes Derived from Comparative Analysis

1. Ethical and Compassionate Care
Classical Islamic psychiatry prioritized dignity, mercy, and professional ethics, ensuring inclusive care for all patients (Maravia & Al-Ghazal, 2021). In contrast, contemporary Malaysian Muslim communities often experience judgmental attitudes, highlighting the need for culturally congruent training that integrates Islamic ethics into modern mental health practice.

2. Holistic Integration of Mind, Body, and Spirit
The bīmāristān model treated mental illness with dietary, pharmacological, psychological, and spiritual interventions (Rehman & Arshad, 2025; Mitha, 2020). Modern Malaysian care, by contrast, is often fragmented, separating psychological, religious, and community support. Embedding holistic frameworks can reduce stigma and improve therapeutic engagement.

3. Accessibility and Community Engagement
Historically, bīmāristāns provided free care to all patients, supported by waqf endowments (Alotaibi, 2025). Today, financial, logistical, and cultural barriers limit access, particularly in rural areas (Nasir et al., 2023). Faith-based education programs, mosque partnerships, and community initiatives can normalize help-seeking and expand equitable care.

4. Professional Competence and Policy Alignment
Bīmāristān physicians combined medical knowledge with spiritual literacy. Contemporary Malaysia can emulate this dual competence by training professionals in both psychology and Islamic ethics. Policy-level interventions guidelines, public awareness campaigns, and curriculum integration can harmonize modern practice with Islamic principles, ensuring culturally sensitive care.

Synthesis and Key Findings

The comparative analysis demonstrates that contemporary Malaysian Muslim mental health challenges are shaped more by cultural, social, and systemic factors than by Islamic principles. In contrast, the classical bīmāristān model exemplified a compassionate, ethical, and holistic approach that treated mental illness as a legitimate medical condition rather than a moral failing or spiritual deficiency.

Key insights from this study, illustrated across key dimensions and supported by evidence, include:

Aspect	Islamic Golden Age (Bīmāristān)	Contemporary Malaysian Muslim Context	Implications / Lessons
Accessibility	Free treatment for all; no discrimination by religion, gender, or wealth	Limited access; financial, cultural, and social barriers	Policies should ensure equitable, accessible care for all; outreach to rural areas
Ethical Practice	Emphasis on compassion (*rahmah*) and ethical responsibility guided by Islamic principles	Mixed: sometimes moral judgment or blame instead of care	Train professionals in Islamic ethics to enhance compassion and reduce stigma
Holistic Approach	Mind–body–spirit integration; psychotherapy, diet, pharmacology	Fragmented services; limited holistic integration	Integrate physical, psychological, and spiritual care through faith-informed frameworks
Stigma	Rare; mental illness seen as medical issue, not moral weakness	High; illness sometimes viewed as failure of faith or moral lapse	Community education on compassionate Islamic perspectives; normalize help-seeking
Gender Considerations	Care for all genders, equitable treatment	Women more likely to seek treatment; men less likely; secrecy due to family honor	Gender-sensitive interventions respecting cultural norms
Religious Role	Treatment aligned with faith; spiritual support included	Religion sometimes misinterpreted; can exacerbate stigma	Clarify authentic religious teachings to support mental health care

Key insights from the synthesis include:

1. **Ethical, compassion-driven care reduces stigma:** Classical Islamic psychiatry emphasized the ethic of *rahmah*, integrating emotional attunement, moral accountability, and patient dignity into treatment.

2. **Holistic mind–body–spirit integration enhances treatment effectiveness:** Bīmāristān physicians combined medical, psychological, and spiritual interventions, reflecting an early biopsychosocial understanding that modern services can emulate through culturally congruent, faith-informed frameworks.
3. **Accessible, community-based services promote equity and support:** Publicly funded care ensured treatment for all, regardless of gender, social status, or financial means. Contemporary Malaysia can adopt similar principles, combining affordability with outreach through religious and community networks.
4. **Professional and policy alignment ensures sustainability and faith congruence:** Training clinicians in both clinical expertise and Islamic ethical principles, along with policies promoting culturally and religiously sensitive care, can reduce stigma, build trust, and enhance mental health outcomes.

CONCLUSION

This study demonstrates that the Islamic Golden Age of mental health care provides a robust framework characterized by ethical, compassionate, and holistic care. In contrast, contemporary Malaysian Muslim perceptions are often shaped by cultural expectations, stigma, and misinterpretations of religious teachings, which limit help-seeking and exacerbate psychological distress. Comparative analysis highlights opportunities to bridge this divergence through culturally congruent education, faith-informed counselling, and system-level integration. Lessons from the classical bīmāristān model offer a blueprint for reform, emphasizing inclusivity, professional competence, and integration of mind–body–spirit principles. Reviving these principles can support more effective, culturally sensitive mental health outcomes in Malaysia.

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