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Editorial Correspondence:

Editor, IIUM Journal of Religion and Civilisational Studies (IJRCS)

Research Management Centre, RMC

International Islamic University Malaysia

53100 Gombak Campus

Kuala Lumpur, Malaysia

Tel: (+603) 6421 5002/5010

Fax: (+603) 6421 4862

Website: http://journals.iium.edu.my/irkh/index.php/ijrcs

Comments and suggestions to: alwialatas@iium.edu.my

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Mind, Morality, and Medicine: A Historical Inquiry into Mental Asylums in the Muslim World

Asilatul Hanaa Abdullah[1]

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Abstract: This paper explores the historical development of mental health care in the Muslim world, spanning from the early Islamic period to colonial disruption and the postcolonial era. Drawing on Islamic philosophy, medical ethics, and institutional history, it highlights how mental illness was historically understood and treated through a holistic approach integrating body, mind, and spirit. The study examines the intellectual contributions of scholars such as al-Rāzī, Ibn Sīnā, and al-Ghazālī, and analyses the role of *bīmāristān*—charity-funded hospitals that provided compassionate psychiatric care. Through detailed case studies of key institutions in Baghdad, Cairo, and Damascus, the paper uncovers the ethical, therapeutic, and architectural sophistication of Islamic mental healthcare. It further critiques the colonial marginalisation of these systems and argues for a decolonial framework that revives culturally rooted, integrative mental health models. Ultimately, this research challenges Eurocentric narratives and advocates for a more inclusive history of psychiatry that honours the intellectual and spiritual legacies of the Muslim world.

Keywords: Islamic medicine, mental health, *bīmāristān*, decolonial psychiatry, *waqf*, Sufism, spiritual healing

Introduction

The history of psychiatry has been Eurocentric and has far too often ignored the achievements and intricacies of non-Western societies. Traditional histories privileged the development of psychiatry in Enlightenment Europe and represented non-Western traditions through lack of progress or irrationality. Global hegemony has thus obscured superior systems of treatment in the remainder of the world—most importantly in the Muslim world, where mental illness had already been addressed through multidimensional, ethical, and systematised practices. The Muslim world has a rich and multifaceted history to share on the practice of mental health care, interweaving religious, philosophical, and medical discourses. It is one that undermines assumptions regarding pre-modern societies and opens out to a rich and rewarding path to explore the moralities, spiritualities, and communalities of madness. Accessing this legacy is not an exercise in historiography; it is an ethical imperative to decolonise what we know about psychiatric treatment and to restore dignity to systems of knowledge that are marginalised.

Methodologically, this essay is an interdisciplinary one and depends primarily on intellectual history and the history of institutions. Drawing on reading and examination of classical texts, records from hospitals, records on *waqf* and *madrasah* trusts, and colonial archives, this study relocates the Muslim world not simply as the passive recipient of psychiatric

[1] Dr. Asilatul Hanaa Abdullah is a Malaysian scholar specialising in history, Islamic civilisation, art history, and gender studies. She holds a Doctor of Philosophy degree and has served as a lecturer at the University of Malaya. Currently, she is an independent scholar pursuing a second master's degree in art history and Cultural Management at the College of Creative Arts, Universiti Teknologi MARA (UiTM) Shah Alam. She can be reached at asilatul1983@gmail.com.

knowledge from Europe, but rather as an early leader in humane and systematic treatment of the insane.

The Intellectual Foundations of Mental Health in Islam

Islamic tradition has long recognised the complexity of the human mind with an integrated model of spiritual, mental, and emotional well-being. Anxiety, depression, despair, and inner conflict are repeatedly mentioned in the Qur'an and Hadith—these are feelings that are indicative of the human condition and are responded to in both spiritual and social ways. Qur'anic statements like “Indeed, with hardship comes ease” (Qur'an 94:6) and “So do not despair and do not grieve” (Qur'an 3:139), and prophetic sayings that emphasise patience (*ṣabr*), hope (*rajā’*), and dependence on God (*tawakkul*), are evidence of an early Islamic interest in well-being (Haque, 2004).

Prophet Muhammad (peace be upon him) himself demonstrated high emotional intelligence when his son Ibrahim passed away and he wept and stated, “The eye weeps, and the heart grieves, but we do not say except what pleases our Lord.” It legitimised the expression of feelings in an atmosphere of spiritual trust (Syed et al., 2005). In the Islamic Golden Age, Abu Bakr al-Rāzī, Ibn Sīnā, and Al-Ghazālī were among the thinkers who created systematic models that explored the interaction and synergy among mental health, ethics, and spirituality. Their work continues to influence Islamic psychology and integrated models of care today.

Al-Rāzī rejected explanations based on the supernatural for madness in treatment and causation in psychiatric illness in favour of reason, morals, and practice based on evidence. Ethical conduct, control of one's passion, and the physician as an ethicist were championed by him (Dhanani, 1994). Sorrow, milieu, and bodily disturbances could be the cause of mental disturbance rather than possession by an evil spirit or vice (Gutas, 2001). His practice formed the background in clinical psychology in Islamic medicine.

Ibn Sīnā's *Canon of Medicine* possessed one of the most sophisticated psychiatric disorder classifications of the medieval period with descriptions of mania, melancholia, and obsessive-compulsive behavior (Nasr, 2006). His balance theory (*mizaj*) among bodily humors and spiritual capacities expanded on the Qur’anic view of human beings as integrated beings consisting of *jism* (body), *nafs* (soul), and *rūḥ* (spirit) (Haque & Keshavarzi, 2013). Ibn Sīnā also suggested music therapy, dietary adaptation, and thought reorientation as treatment—precursors to modern psychosomatic medicine (Haque, 2004).

Al-Ghazālī's *Iḥyā’ ‘ulūm al-dīn* (*Revival of the religious sciences*) presents spiritual psychology based on Qur'anic and Sufi thought traditions. Al-Ghazālī outlined the growth of the self into three phases: *al-nafs al-ammārah* (self-commanding), *al-nafs al-lawwāmah* (self-blaming), and *al-nafs al-muṭma'innah* (tranquil self) (Yusuf, 2012). Al-Ghazālī linked inner pain to heart ailments such as pride and envy and employed spiritual techniques such as *dhikr*, *muḥāsabah*, and companionship on the path to ethics to produce healing (Awaad & Ali, 2016).

Convergence of spiritual healing and science occurred when it was at its peak in the emergence of *bīmāristāns* (hospitals) in Baghdad, Cairo, and Damascus. The hospitals provided wards to treat mental illness and provided music, therapy with light, talking therapy, and ethical treatment with the Islamic value of *raḥmah* (compassion) (Al-Dabbagh, 2012).

Muslim psychologists are going back to these traditions to develop culturally and spiritually suitable models of practice. The emphasis on ethics, community, and the sacred balance of body and soul offers an enduring holistic paradigm (Keshavarzi & Haque, 2013). The intellectual heritage of Islamic mental health rests on a holistic view of the human person.

Scholars like al-Rāzī, Ibn Sīnā, and al-Ghazālī offered an evocative multidisciplinary paradigm that came to terms with psychological distress with compassion, discernment, and ethical responsibility. Their legacy is an inspiration to contemporary attempts to balance faith, science, and the human spirit.

The Role of *bīmāristāns* in the Islamic Golden Age (8–14 centuries)

Bīmāristāns played an important role in the evolution of the concept of healthcare during the Islamic Golden Age (8th–14th centuries), which was an era marked by extensive progress in medicine, philosophy, sciences, and culture in the Islamic world covering the Middle East, North Africa, and Spain (al-Andalus). Their foundation represented an important milestone in the history of medical facilities and represented an amalgamation of scientific discoveries among various cultures like Greek, Roman, Persian, and Indian, and then Islamic achievements (Pormann & Savage-Smith, 2007).

Bīmāristāns pioneered the way in medical treatment and scientific advancement by providing novel treatment and integrated treatment centers. They integrated the practices of ancient Greek physicians, i.e., Hippocrates and Galen, with Islamic physicians like al-Rāzī (Rhazes) and Avicenna (Ibn Sīnā). They had centers that facilitated the evolution and practice in the field of medicine with developments in diagnosis, surgery, ophthalmology, and pharmacology (Pormann & Savage-Smith, 2007). Libraries and the translation movement facilitated the generation and production of extensive literature on medicine so that there could be exchange and distribution of knowledge and innovation (Gutas, 2001).

Among the distinguishing features of *bīmāristāns* was the emphasis on psychiatric well-being. Psychiatric conditions were treated routinely in specialist wards, and methods employed to deal with them were music therapy, dietary regulation, and therapy by talking. It reaffirmed Islamic beliefs in well-being being in equilibrium in the physical, psychic, and spiritual aspects (Bashshur, 2003). Treating psychiatric ailments as genuine health problems was pioneering work, making psychiatric treatment available (Al-Hadidi, 1999).

These Muslim hospitals offered treatment to people from all strata of society and all strata of economy. They were subsidised by trusts called *waqf* so that treatment became free (Mikhail, 2013). It made treatment accessible to the poor and the rich alike and showed the Islamic principle of universal welfare and charity (Mikhail, 2013). Furthermore, the application of public health practices with the use of quarantine in epidemics showed an enlightened approach to controlling the spread of disease (Bashshur, 2003).

Bīmāristāns were also centers of learning in which aspiring doctors could train by apprenticing under the guidance of qualified doctors. They were centers of learning for aspiring practitioners and centers carrying out medical research. Their function in education facilitated the transmission of medical knowledge around the Islamic world and to Europe (Saliba, 2007). Systematic education and curriculum planning in *bīmāristāns* were among the prime motives behind the professionalisation of medicine (Al-Roubaie, 2020).

Bīmāristāns were organised and featured modern-style medical facilities like wards dedicated to the segregation of disease, patient records and history kept separately, and specialised staff (physicians, nurses, and attendants). This level of systematisation made them among the leading healing centers in the world then (Gutas, 2001). Cleanliness and sanitation were given priority in these centers and found their way into better patient outcomes (Pormann & Savage-Smith, 2007). The Islamic Golden Age (8th–14th centuries) witnessed an intense integration of medicine with welfare and philosophy on the public level, most clearly in the emergence of *bīmāristāns* (hospitals). Dedicated to healing and the delivery of medical

treatment to the diseased and afflicted individuals, these centers formed precursors to contemporary hospitals and psychiatric wards, where the mind and body both got equal treatment in the healing and recovery process. Creation of these centers became easy through the Islamic practice of *waqf*—charitable religious trusts—under which guaranteed long-term financing and access by the general public to these centers were ensured.

This essay examines the emergence of *bīmāristāns* in relation to psychiatric treatment. Based on an investigation into the intersection of the principles of *waqf*, practice in the healing arts, and spatial gendering, this project aims to shed illumination on the history and heritage surrounding *bīmāristāns* and the treatment of mental illness. It will examine the contributions made by major institutions such as the ʻAḍudī Hospital in Baghdad, the Manṣūrī Hospital in Cairo, and the Nūrī Hospital in Damascus.

The Role of *Waqf* in Funding Hospitals

Waqf stands in the centre and foundation of continuity and historical growth of the Islamic world in institutions such as *bīmāristāns* (hospitals). As stated in Islamic law, *waqf* is an act through which an individual donates some portion of his/her property or assets to some noble cause pertaining to society or religion on an everlasting basis (El-Azhary, 2007). *Waqf* is not just a religious obligation but an obligation by society and an instrument of welfare as well. The use of *waqf* to sustain *bīmāristāns* is an indication that its use is not just to sustain some noble cause or society on an everlasting basis but its uninterrupted continuity without state confiscation or *waqf* can be defined as the everlasting dedication of some assets or property to benefit society with the aim to generate lasting benefit to society (Hassan, 2013). Whether in the form of property, assets, or land, this property is left to some cause on trust and its income is applied to sustain the discussed cause.

The *bīmāristāns,* being precursors to modern hospitals, required significant and uninterrupted financial support to continue operations. Without organisation of modern-day health systems and the welfare state, *waqf* provided the financial support that allowed these institutions to continue operations for centuries.

The initial establishment of *bīmāristāns* with extensive wards to provide medical services, libraries, gardens, and administrative complexes was financed by the *waqf* endowments. The financial support from the endowment on a long-term basis allowed the maintenance and repair work on complexes of hospitals at regular intervals so that hospitals had the ability to function and be healing-friendly (Hassan, 2013).

One of the significant operational aspects of *bīmāristāns* was the provision of qualified and experienced medical staff in the form of physicians, nurses, pharmacists, and attendants who required payment of salaries at regular intervals that were guaranteed by provision through the *waqf* endowments. The payment of salaries was specified in the agreement on the provision of *waqf*, and proceeds from the endowment were put to use to fulfil these financial commitments so that there would be no delay and qualified professionals would continue to be on duty (Siddiqi, 1986).

The costs of drugs, surgical tools and equipment, and other necessities were financed through the revenue generated by the income from the *waqf* properties. This allowed *bīmāristāns* to treat huge quantities of patients without any costs being incurred to them, one of the absolute essentials of these hospitals (Pormann & Savage-Smith, 2007).

The hospitals were not only treatment facilities but welfare nets of societies as well. The patients arrived with no resources to maintain themselves, mostly those who were too sick to

work. *Waqf* offered an opportunity to offer the patients food, shelter, and treatment at no cost to themselves. Some hospitals, such as al-Manṣūrī Hospital in Cairo, could offer thousands of daily treatments to the patients due to the immense revenue from the *waqf* to fund the high costs of providing this mass-level treatment (Al-Azmeh, 2001). As the operation grew and demand for the facility increased, the revenue from the *waqf* could then be used to expand the facility and construct new wards or use any new treatments. Special psychiatric wards, for example, were added to some *bīmāristāns*, such as the ʻAḍudī Hospital in Baghdad, to make it an establishment to treat individuals with psychiatric illness. The nature of the *waqf* allowed hospitals to grow and adapt to needs evolving in the practice (Gutas, 2001).

Case Studies of Major *Bīmāristāns*

ʻAḍudī Hospital in Baghdad

The ʻAḍudī Hospital, founded in the year 978 CE, is one of the greatest hospitals in medieval Islamic society. The Buyid leader Aḍud al-Dawlah commissioned the hospital with an immediate reputation that gave it an image of medicoscientific progress in healing physical and psychological diseases (Khalil, 2011). As an intellectual city and successful city-state, Baghdad provided fertile soil to build advanced centers like the ʻAḍudī Hospital. The Buyid regime, with its passion for intellectual and cultural advancement, commissioned the ʻAḍudī Hospital. The site of the hospital constituted an urban area in Baghdad so that individuals could access it conveniently. The setup of the hospital was not political in nature but by the interest of the Buyid leaders to promote knowledge and medicoscientific innovations on its soil (Al-Mahdawi, 2003). The hospital set itself above others in the region with its state-of-the-art facility. The facility had specialised wards by the category of disease or by disease, with the treatment of diseases of the mind being among its specialised treatment areas. The wards were well organised in boosting healing through systematic treatment (Nicolai, 2015). Spacious spaces with ample natural light and fresh air and access to garden spaces were among the healing spaces designed in the facility. The facility also had wards for infectious diseases, surgical operations, and treatment of diseases of the mind with specialised treatment given priority (Sabra, 2007).

The ʻAḍudī Hospital employed some of the most distinguished doctors during this time period, the most notable being al-Rāzī (Rhazes), one of the leading intellectuals during his generation. His psychiatric work, pharmacology, and ethics are greatly valued (Mikhail, 2013). Al-Rāzī's psychiatric practice and contribution to the classification system of psychiatric illness and humoral imbalance served as the foundation for treatments in the hospital. Al-Rāzī, one of the leading practitioners in ʻAḍudī, is responsible for establishing the humoral theory on psychiatry, whereby psychiatric illness resulted from imbalance in the humors in the human body (Gutas, 2001). The theory served as the foundation on which psychiatric illness in the hospital received treatment through medical intervention to correct this imbalance. Al-Rāzī's work on psychosomatic illness and his insistence on psychiatrically ill patients being treated humanely were revolutionary during this period (Nahas, 2004).

One of the most advanced aspects of ʻAḍudī Hospital was its systematic patient treatment. The hospital utilised its system of maintaining patient records to enable doctors to monitor the patient's progress and history and providing them with ongoing and individualised treatment (Nicolai, 2015). Diagnosis and treatment of and patient response to every patient were all noted in an open-ended patient record that would inform subsequent treatments. The system of keeping these patient records preceded modern-day medical records. The hospital represented an exemplary model of specialised treatment, particularly in treating psychiatric illness. The hospital had specialised wards to deal with psychiatric illness and used a

combination of psychiatric and physical treatments on its patients. In addition to pharmacological treatment methods like the use of herbal drugs and the administration of tranquillising tonics, the hospital employed environmental therapy and the application of music to calm the patient down. They had dietary prescriptions as part of the overall system of care in which food seemed to impact the physical and mental condition (Pormann & Savage-Smith, 2007).

Al-Manṣūrī Hospital in Cairo

The 1284 CE al-Manṣūrī Hospital, founded by the Mamluk Sultan Qalāwūn in Cairo, is another focal point in medieval Islamic healing history. The hospital was acclaimed in that it introduced an unprecedented method to provide holistic treatment to all strata of society regardless of financial standing (Saliba, 2007). Al-Manṣūrī Hospital was founded to be an extension of the broader vision by Sultan Qalāwūn to promote public welfare and advance the practice of healing. It later grew to become one of the largest and most well-known hospitals in the Islamic world. Its founding was facilitated through *waqf* (charitable contributions), which kept it going (Al-Mahdawi, 2003). Al-Manṣūrī Hospital was an important organisation not only in Cairo but also one that served to set an exemplary model for hospitals throughout the Islamic world.

Al-Manṣūrī Hospital's capacity to cater to more than 4,000 people on a daily basis was an accomplishment, an indication of its effectiveness and size. What made this particular hospital unique was its commitment to universal access to health care. In contrast to medieval hospitals in most parts of the world, where treatment was accessible only to the affluent, al-Manṣūrī catered to all irrespective of class and catered to the poor in society (Bashshur, 2003). The wards in the hospital were separated from one another by specialised medical needs, like mental health, surgery, and ophthalmology. The wards of psychiatric patients had therapy facilities to aid in psychiatric patient healing. The wards were usually found in quiet and serene parts within the hospital with garden views and sunlight and thus an environment conducive to healing (Mikhail, 2013).

Al-Manṣūrī psychiatric wards were carefully designed to provide psychiatric patients with physical treatment and counseling support through guidance. Patients were mostly diagnosed using humoral theory and were given treatment with herbal drugs supplemented by dietary changes and counseling (Sabra, 2007). Environmental factors, from the structure of the hospital to healing gardens and nature trails by the seaside surrounding the city, were significant in the treatment practices (Khan, 2012). Al-Manṣūrī Hospital was the one to introduce treatment practices for psychiatric disorders. Not just through the application of the therapy provided by sound through its healing effect on the mind, doctors in the hospital employed herbal drugs, dietary changes, and exercise routines to prescribe to psychiatric patients. Such treatments were supplemented to an integrated psychosomatic treatment to address the aspects of mental illness, with the patient's physical and mental state being considered to be interrelated (Pormann & Savage-Smith, 2007). The hospital acted as an education school too. Physicians, students, and trainee practitioners could be given education regarding modern practices in the practice of medicine that were founded on both Greek theory and Islamic medicine. The library in the hospital operated as an important education center with an extensive collection of books on medicine to study, many being authored by doctors such as Ibn Sīnā (Avicenna) and al-Rāzī (Mikhail, 2013).

Damascus Nūrī Hospital

The Nūrī Hospital, which Nūr al-Dīn Zangi established in the 12th century in the city of Damascus, is another exemplary facility in Islamic healthcare progress. It is best remembered for its provision of inpatient and outpatient care and its emphasis on the use of medical instruments and books in clinical practice (Al-Mahdawi, 2003). The Nūrī Hospital formed part of Nūr al-Dīn's larger effort to promote public health and education within his territories. The provision by the hospital of inpatient and outpatient care made it open to people from diverse backgrounds. The hospital had plenty of resources in the form of medical instruments and books and financial support in the form of *waqf* endowments that ensured the continuance of operations (Bashshur, 2003).

The Nūrī Hospital has been reported to have the capability to offer treatment to both inpatients and outpatients. Outpatient treatment created an opportunity through which individuals with minor conditions could receive treatment without being admitted to it, whereas major conditions were handled on an inpatient basis (Sabra, 2007). The complex gave the hospital the ability to admit scores of patients and perform numerous cases with ease. Another one among the most glaring features of Nūrī Hospital was the donation of medical appliances and books that made the hospital like an education and innovation hub for medicine. The hospital's library boasted an extremely extensive array of medical texts, and most of them were compulsory reading materials for learning physicians to practice and refine skills (Khan, 2012). Surgical equipment and diagnostic equipment allowed the doctors to perform and conduct numerous procedures with very high precision.

Just like in the case with other Islamic hospitals, Nūrī Hospital employed a holistic approach to patient care that integrated medical, spiritual, and psychological therapies. Mentally ill patients received specialised therapy in special wards where doctors employed an array of therapies, including herbal remedies, music therapy, and environmental therapy (Pormann & Savage-Smith, 2007). Psychological therapy and talking therapy were also among the psychiatric treatmens offered by the hospital, with doctors taking extra care to ensure the emotional and moral welfare of the patients (Mikhail, 2013). Nūrī Hospital left more than just its influences on patient therapy; it left an impact on the practice of education in the medical world. The hospital was the center point in the education and practice of physicians, with physicians having to excel both in the practical practice of medicine and in the study aspects found in the classical texts. The integration of practical learning by doing and academic study singled out the hospital from many contemporary medical establishments (Bashshur, 2003).

The ʻAḍudī, al-Manṣūrī, and Nūrī hospitals were pioneering hospitals that made up an important part of the establishment of the practice of medicine, particularly in psychiatry and holistic healing. They integrated medical therapy, psychology, and spiritual healing into one form and manifested the Islamic ideal of health in a state of balance of the body, mind, and spirit. The use of the *waqf* endowments made these hospitals economically independent so that high-quality treatments could be provided to people regardless of station in society.

The hospitals were revolutionary in being devoted to specialised treatment, to the use of music and environmental therapy, and to making gendered spaces that were adaptive and adjusted to cultural needs and were still efficient in treatment. The focus on patient dignity, on the advancement of science and human treatment, gave these hospitals the foundation on which were built the medical institutions of today and following models for healthcare today worldwide.

Treatments for Mental Illness: A Holistic Approach

The Islamic bīmāristāns deployed an array of treatments to deal with mental illness that harmonised medicines and philosophical therapy and gave prime importance to the individual's general well-being—soul, body, and mind. Such an approach reflects an Islamic general concept of being healthy, encompassing physical, emotional, and spiritual equilibrium. Music served perfectly well in medieval Islamic therapy and particularly in curing illness of the mind. Both Ibn Sīnā and al-Rāzī realised its therapeutic power and thought that it could counterbalance the humors and pacify the soul. Music served to pacify restless patients with melancholic or maniacal depression according to the condition of the patient (Siddiqi, 1986). Al-Rāzī thought that some melodies or instruments would release diversified emotional reactions. Soft and euphonious melodies placated nervous patients and lively melodies energised depressed ones (Hassan, 2013). Music therapy allowed people to balance on an emotional level. Melodies and rhythms acted on the humors in the human system and allowed people to balance on an emotional level. Some thinkers suggested specific pieces to specific illnesses with attention to the power to mend through emotion and mind (Mikhail, 2013). *Naṣīḥah* or *mushāwarah* (advice or counseling) served to treat the mind in Islamic bīmāristāns. The therapy comprised conversation between the patient and the physician whereby the physician listened to issues and problems of an individual on an emotional level. The emphasis lay on enlightening individuals on illness and attuning to awareness on how to cope with it (Gutas, 2001). The emphasis with *naṣīḥah* lay on reason and moral advice. Physicians like Ibn Sīnā and al-Rāzī also provided philosophical and ethical counseling and encouraged the patient to rethink his/her problems and aided with practical solutions through Islamic ethical theory (Khalil, 2011). Rudimentary forms of cognitive-behavioral therapy were employed by some theorists in which the patient was encouraged to identify negative thought patterns and replace them with positive ones and this worked very effectively when treating depression and anxiety (Nahas, 2004).

Regimen through nutrition was the interest of Islamic practices and humoral balance was the focus. Physicians adapted regimens to the condition and physical state and temperament of the patient (Pormann & Savage-Smith, 2007). Foods were considered to impact the humors and the mood of the body. Irritable patients were administered cucumbers and other foods that cool and warm foods like meat and spices to melancholic temperaments (Siddiqi, 1986). Periodic fasting was used to eliminate excess humors and maintain balance. Mentally ill patients are recommended to fast in moderation and calm the mind and the body (Hassan, 2013). Water treatments like hydrotherapy and medicated baths were used routinely in Islamic bīmāristāns owing to their healing qualities. Physical and psychiatric ailments were eased with hot and cold baths and perfumed herbs (Bashshur, 2003). Physical and psychosomatic calming qualities were given to herbal or oil-scented water. Hydrotherapy in particular was used to treat restless patients (Mikhail, 2013). Bathing played an important spiritual role and came in sympathy with purificatory rituals to wash the body with the aim of cleansing the soul in an effort to provide general healing (Nicolai, 2015).

The architectural design and physical environment of bīmāristāns were planned to promote a therapeutic atmosphere. The hospitals were typically constructed around calm gardens, fountains, and courtyards, which brought tranquility to the patients (Khan, 2012). The gardens enabled a chance to connect with nature, which was thought to have healing effects. Taking a walk around gardens or enjoying the quietness and peacefulness in the environment would soothe anxiety and calm mental exhaustion (Sabra, 2007). Psychiatric wards commonly featured isolated areas to think and recover from causes of distraction. The availability of quiet and pleasing environments manifested the strong influence of the environment on emotional and mental states (Al-Azmeh, 2001).

Theories of Care: The Humoral System and Spiritual Healing

Islamic medicine borrowed inspiration from Hippocrates and Galen and incorporated the four humors: blood, phlegm, yellow bile, and black bile. Physical and mental well-being depended on this theory, with illness being attributed to imbalances, including an upset mind (Mikhail, 2013). An imbalance in one of the humors would produce many physical diseases. Having too much blood would lead to mania and having too much yellow bile would make one irritable (Pormann & Savage-Smith, 2007). Mental illness would be imagined to be a disturbance to the rational powers of the soul with imbalances in humour being demonstrated by symptoms like melancholy or worry. Treatments to rectify this imbalance were through dietary action, exercise, medication, and psychotherapy (Hassan, 2013).

Islamic tradition added a spiritual dimension to treating illness in the mind. Physicians like Ibn Sīnā and al-Rāzī considered the soul to be supreme in healing the mind, with emphasis on morality and reason. In addition to being just a physiological illness, mental illness could also be a spiritual illness and could be cured through moral advice, prayer, and contemplation (Nahas, 2004). Ibn Sīnā conceived reason to be supreme in resolving mental agitation. Intellectual work and intellectual contemplation were considered techniques by which the patient could be assisted to discontinue despair (Khalil, 2011). Islamic scholars gave significant importance to maintaining spiritual well-being through worshiping God and through praying to God. Psychological disarray could be an excess overflow of spiritual crisis and thus compelled the patient to practice activities like praying, fasting, and contemplation to be restored to sanity (Al-Mahdawi, 2003).

The Süleymaniye Complex: A Nexus of Medicine, Spirituality, and Ottoman Architecture

The Süleymaniye complex, erected in the 16th century under the rule of Sultan Suleiman the Magnificent, is an architectural representation of Ottoman prosperity and success in culture and architecture. The complex designed by renowned architect Mimar Sinan includes a great mosque, darüşşifa (hospital), school of medicine, and Sufi ritual spaces. Such an advanced integration of religious, school-like, and wellness facilities is an articulation of the Islamic Age's holistic concept of well-being and, more so, the provision of mental health care in those eras. The darüşşifa played an important role in the Ottoman Empire in the provision of holistic physical and mental illness treatment in keeping with its ethos. It is in these complexes that pioneering doctors like Şerafeddin Sabuncuoğlu made important contributions to the practice of procedures in medicine. As an early 15th-century surgery practitioner, Sabuncuoğlu is noted because his surgical handbook, *Kitab al-Masā'il* (Book of Questions), outlined several surgical procedures and provided the importance of an individual's knowledge regarding the anatomy of humans (Güven, 2008).

The practice by Sabuncuoğlu mirrored the model of holism in which the interconnection between the mind and the body was understood. His focus on observation and learning through experience guided generations to come (Güven, 2008). Although he did not directly associate with the Süleymaniye Complex, his innovations in surgical procedures and in knowledge of the practice of medicine were the foundation on which subsequent practices in Ottoman medical complexes operated. The combination of spiritual and medical therapy in the Süleymaniye Complex mirrors the concept on which provision of mental health rested during the Islamic Golden Age. Sufi masters and doctors worked together to administer treatment to the patient on an integrated level by acknowledging that mental illness could be the byproduct and product of physical and spiritual imbalance (Al-Suwaidan, 2009). Individuals presenting with concerns about the condition of the mind were treated with an array of interventions in

the darüşşifa consisting of pharmacological remedies. Herbs were used in correspondence with the patient's presenting symptoms with added support by humoral theory to connect physical health to emotional states (Al-Suwaidan, 2009). Dietary Therapy: Cues on food to correct the imbalance and to engage and clear the mind comprised the focal point in treatment (Nasr, 1996). Psychological Interventions: Talk therapy and empathic listening were central to intervention. Physicians and Sufi masters would engage the patient in conversations whereby emotions and concerns could be released (Nasr, 1996).

Furthermore, Sufi traditions played an important role in ensuring mental well-being. Having a Sufi lodge (*tekkesi*) on site ensured that group sessions of spiritual healing techniques, i.e., *dhikr* (practices of remembrance) and *samāʿ* (musical devotion), could be organised. They were designed to calm fears and provide an atmosphere of calm and belonging to the patients (Nasr, 1996). The model set by the Süleymaniye Complex in bringing together the healing traditions in the treatment of mental illness found an echo outside Istanbul with the establishment and spread of similar centers throughout the Islamic world. The principles that evolved in the complex—standards of compassion, sympathy, and group support—continue to be an important part of contemporary thought in the treatment of mental illness.

The architectural vision of Koca Sinan Pasha and the work of doctors like Sabuncuoğlu serve to highlight the advanced level of health comprehension characteristic of the Ottoman Empire. The integrated model of wellness—tackling the interconnectedness of the body, mind, and spirit—attests to wise considerations in treating mental illness and the need for an integrated model that balances both the paradigms of the spiritual and the medical. The Süleymaniye Complex attests to the intellectual richness and heritage of the Ottoman Empire. Its union of architectural innovation and advancement with medicine and spiritual healing attests to an advanced comprehension of the complexities of human health issues. Integrated efforts on the part of physicians, Sufi leaders, and architects on the complex provide an exemplary model of holistic treatment with ongoing applicability to practice in the area of mental illness in the current day. As we progress into the future, the Süleymaniye Complex reminds us of the ever-present value of holistic treatment methods and practices in achieving health and wellness.

Sufism, Spiritual Healing, and the Social Perception of Madness

The concept of madness has developed and shifted through the ages and has been reflective of cultural beliefs, religious comprehension, and shared responses to madness. In Sufi mysticism within Islam, the intersection of spiritual and mental states is complicated and offers a specific framework through which to study the meanings of healing and madness. Sufi rituals in khanaqahs and shrine complexes to saints offer significant insight into the ways in which Islamic cultures explain and respond to madness and include beliefs in godly madness, communal support networks, and religious blessings (*barakah*).

Historically, madness has been culturally and temporally defined in diverse ways. Ancient cultures spiritually accounted for mental illness either through demonic possession or godly vengeance (Kleinman, 1988). Such explanations made way for an array of treatments ranging from exorcisms to communal care. Cultures vary when classifying madness and some Islamic societies embrace some behaviors as madness if connected with spiritual consciousness or with being divinely inspired (Coyle, 2005). Madness has been stigmatised and pathologised in Western societies (Foucault, 2006).

Khānqāhs are significant institutions in Sufi orders and serve to act as healing centers, learning centers, and centers for contemplation. The members are given shelter and belonging by the lodges and are intended to offer shelter to psychologically afflicted or socially

dispossessed persons (Schimmel, 1975). Khānqāhs' therapy is through ritual, chant (*dhikr*), and music (*samāʿ*), believed to induce intellectual illumination and liberation from negative emotions and spirituality (Hoffman, 2010). Saint shrines associated with the lives of Sufi saints are places to which pilgrims travel to obtain blessings and consolation. The shrine that contains the saint is believed to operate in ways such that intervention by the deity is provoked by the proximity of the saint and pilgrims are offered consolation by the psychologically afflicted and the socially dispossessed (Ernst, 2011). Pilgrimage to the shrine is one among several sources of consolation and solace and places the experiences of the individuals with issues into an overarching spiritual context.

The concepts of *junūn* (madness), *barakah* (spiritual blessing), and divine madness are related to Islamic culture and reflect a ubiquitous approach to describing states of mind. *Junūn* is traditionally accounted for spiritually and suggests that mad individuals are in an elevated spiritual awareness (Shah, 1972). The concept is on par with that of divine madness, whereby states of ecstasy are expressions of the presence or inspiration of God. Such states are sometimes allowed in Sufi cults because they make individuals closer to God (Knysh, 2012). *Barakah* or spiritual blessing could be transmitted in several ways, ranging from physical touch by the saint or among members who pray together. *Barakah* is reported to be therapeutic and comforts and changes distressed individuals (Lazarev, 1996). The convergence of *barakah* and mental health reveals that spiritual experiences are sources rich in emotional and psychological sustenance.

The lines separating sainthood and madness will probably be drawn so ambiguously in popular thought to provide alternative perceptions. In some contexts, the same set of characteristics that make one a saint—such behavior being unusual, extreme emotion, and ecstatic states—can be perceived to be evidence of madness (Bashir, 2009). That will provide an alternative type of insight into madness and insanity whereby some behaviors are sanctified instead of stigmatised. Popular discourses on Sufism in culture will idealise one who personifies these characteristics. Saints, mystics, and poets are depicted to be enlightened and mad simultaneously and the separation made and so finely tuned is that of spiritual ecstasy and psychosomatic pain (Safran, 2004). Such dualities are to blame for constructing madness in society to the extent that sympathy and dignity instead of fear and rejection could be negative consequences. The majority of the time, one who presented madness-type conditions would be able to secure refuge and acceptance in Sufi societies, through which episodes could be regarded as part of spiritual seeking.

Decline of Traditional Institutions

One of the significant consequences of colonialism was the collapse of traditional institutions, among them *bīmāristāns* and communal healing practices. Their institutions were dissolved by colonial powers and substituted with Western-type asylums with the main focus on medicalisation and containment. The transformation did not totally replace the holistic treatment given by traditional systems with spiritual and communal-related aspects and social intervention (Ahmed, 2019). As it is, most individuals with mental illness were left with inadequate treatment and thus left with treatment discontinuity that has persisted up to the postcolonial era. After colonialism, the newly formed psychiatric facilities were oftentimes not given the organisational structure, staff, and budgets to meet the needs of their populations. In most cases, the facilities were not well-equipped to deal with the complex interaction of the cultural, social, and psychosocial forces of psychiatric disease. The inability to maintain traditional facilities has resulted in ongoing levels of mental health care issues, adding to issues of treatment quality and access (Khan, 2021). Stigma is an ongoing hindrance to quality treatment in most societies that had colonial intervention. Historical associations among

psychiatric illness, colonisation, and institutions have continued to promote negative attitudes and beliefs, leading to discrimination and exclusion from society for those seeking to access treatment (White, 2020). The stigma commonly deters people from accessing psychiatric treatment, with a resultant unmet demand and increased marginalisation.

Additionally, there remains inadequate psychiatric infrastructure in the majority of countries. Most postcolonial countries inherited fragmented health structures and physically- rather than psychologically-focused health systems, with the effect being little resource allocation, training, and funding to provide mental health services (Miller, 2018). Lack of this structure has hindered the delivery of complete services in psychiatry and deprived numerous individuals of the services required to address needs in terms of mental well-being. Despite these limitations, efforts in some countries like Turkey, Malaysia, and Iran have attempted to merge Islamic principles with contemporary psychiatric practice. In Iran, to give an illustration, there has been an organised effort to incorporate traditional Islamic healing methods into contemporary psychiatric practice. The effort attests to the importance of spiritual and cultural dimensions in psychiatry and attempts to provide holistic treatment that resonates with the values and beliefs of the patient (Rahman, 2019).

Similarly, in Malaysia, there has been an effort to marry traditional Islamic healing with modern psychiatry by sensitising practitioners to culturally appropriate practice that recognises and respects Islamic values and provides an acceptable forum in which the patient is comfortable seeking services (Ali, 2020). In doing this, efforts are made to reduce stigmatisation and move towards greater access to psychiatric services. There has similarly been more momentum towards integrating Islamic knowledge into modern psychiatric practice in Turkey as well. More and more mental health practitioners are referring to the role spirituality plays in healing and the need to address the spiritual needs of the patient alongside the psychological needs (Omar, 2022). It is an integration of traditional and contemporary approaches to healing that reflects greater recognition of culturally appropriate treatment in an increasingly plural and diverse society.

The postcolonial psychiatric practice is defined by traditions and breaks. The disintegration of traditional institutions and the persistent stigma associated with illness presented tremendous problems to the delivery of adequate care. Yet efforts towards integrating Islamic thought and contemporary psychiatric practice in Iran, Malaysia, and Turkey offer promising prospects to surmount these difficulties. In bringing cultural and religious aspects into provision to complement that delivered by contemporary psychiatric practice, these efforts not only make provision more relevant to the lives of people but also offer a culture under which people feel accompanied through the healing process. Continued evolution of psychiatric practice in the postcolonial context reaffirms the importance of noting and valuing alternative cultural insights into seeking integrated and effective psychiatric provision.

The colonialist historical context engenders grave ethical concerns in contemporary mental health systems. Indigenous practice displacement and imposition of psychiatric models from the West far too frequently resulted in culturally callous and irresponsible treatment insensitive to the needs of culturally diverse clientele. Such disconnection threatens alienation and distrust on the part of consumers and among Muslim populations, whose beliefs regarding mental health are informed by cultural and religious concerns. On an ethical level, contemporary mental health systems need to be attuned to and correct the injustices perpetrated by colonialism. Not only should there be recognition of value regarding traditional healing systems but integration of these models into contemporary systems of treatment. Mental health professionals ought to work to provide treatment respectful to patient cultural and spiritual affirmation and produce therapeutic relationships leading to healing and empowerment.

Call for a Decolonial Approach to Psychiatry in Muslim Contexts

Against this backdrop of continuities and transformation processes, there is an imperative to develop a decolonial psychiatry within Muslim societies. A decolonial psychiatry would try to reverse the colonial legacies in contemporary mental health practice by bringing local knowledge, ethical praxis, and healing traditions to the fore. Such an intervention would demand the participation of traditional healers and mental health practitioners in the construction of an integrated model of mental health that includes spiritual, emotional, and communal spheres. Such an intervention would demand policy initiatives that would make it possible to create mental health systems able to engage with the specific needs of Muslim populations with the appropriate type of access to care that is both effective and culturally attuned.

Briefly, the future of Muslim mental health will demand an investment in the rich cultural and spiritual landscape on the terrain of mental health. In adopting the concept of the decolonial, the systems of mental health can begin to repair the wounds of colonialism and move directionally to an integrated and empathic system of mental health care mindful of the rich traditions and ideals on which these societies are founded.

Conclusion

The earlier history of provision in the Muslim world attests to the rich tradition of convergence on ethical, spiritual, and medical horizons that precedes and refutes dominant Euro-centric paradigms in psychiatry. From intellectual labors by thinkers like al-Rāzī, Ibn Sīnā, and al-Ghazālī to humanitarian practice by bīmāristāns under the auspices of *waqf* endowments, Muslim societies nurtured solutions to mental illness built on dignity and balance and communal treatment. Not only were these traditions treating the pain of the mind with kindness, but the soul and spirit were paramount in the healing model. colonial psychiatry centres replaced them with organisational schemes usually bereft of cultural relevance and ethical sensibility. The legacy of underfinancing, stigmatising, and detached systems of mental health continues to inform the provision of care in much of the Islamic world. Nevertheless, with resumed activity in Iran, Malaysia, and Turkey comes an impalpable renaissance—a desire to reconnect with Islamic mental health care's spiritual, communitarian, and philosophical foundations.

A Muslim decolonial psychiatry does not reject modern medicine but rather calls for its refiguration by local ethics, histories, and belief systems. In recognising and revivifying Islamic history's pluralistic and holistic healing traditions, the systems of mental health are presently able to promote more humane, more inclusive, and more culturally attuned models. In this way, we not only recover an oppressed intellectual heritage but also open the way to more just and spiritually more resonant futures in global provision of mental health.

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