



# The Role of *Asatizah* in Addressing Mental Illness Among Generation Y: Case Study from Singapore, Jordan, and the United Kingdom

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**Abstract.** Mental health challenges among Generation Y are rising globally, including within Muslim communities. Despite increased awareness, stigma and a lack of culturally appropriate support often discourage individuals from seeking professional help. In this context, *asatizah*, who are Islamic religious educators and community leaders, can serve as key allies in addressing mental illness, especially in societies where religion plays a central role in daily life. This concept paper explores the potential roles of *asatizah* in identifying early symptoms, providing spiritual counselling, promoting mental health awareness, and connecting affected individuals with mental health professionals. This study employs a qualitative, conceptual design using document analysis and thematic synthesis. Secondary data from journals, reports, and religious guidelines were reviewed to identify themes linking Islamic counselling and mental health. The interpretive approach develops a faith-based framework empowering *asatizah* in Generation Y mental health advocacy. By integrating Islamic teachings with contemporary mental health frameworks, *asatizah* can offer a more holistic, compassionate, and culturally sensitive support system. The paper also outlines proposed strategies for empowering *asatizah* through training and institutional collaboration, intending to foster a more inclusive and supportive approach to mental wellness among Generation Y.

**Keywords:** *Asatizah*, Mental Illness, Generation Y

## 1 Introduction

Mental illness is increasingly recognised as a critical public health concern worldwide. According to the World Health Organisation (2022), approximately one in eight people globally live with a mental disorder, including anxiety, depression, and stress-related conditions. In Malaysia, recent national surveys reveal that mental health issues are

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especially prevalent among youth and young adults, with the highest reported cases found in individuals aged 16 to 35 (Institute for Public Health, 2020). This age group, commonly referred to as Generation Y, faces a unique combination of socio-economic pressures, digital overstimulation, employment instability, and evolving social expectations (Arora & Vyas, 2025). These challenges contribute significantly to psychological strain and emotional vulnerability (Abdullah et al., 2021; Nor Ba'yah & Mohd Khairul, 2019).

Although psychological and psychiatric services are available, many individuals in Muslim communities underutilise these resources. Cultural stigma, fear of judgment, and the belief that mental illness reflects a weakness in faith discourage people from seeking help (Ahad et al., 2023; Yusof & Jalil, 2020). This underscores the need for more culturally relevant and spiritually sensitive approaches to mental health care.

In Muslim societies, religious teachers known as *asatizah* are trusted community leaders. They are often the first point of contact for individuals seeking spiritual guidance during emotional distress. Historically, religious leaders have played a central role in pastoral care, spiritual healing, and ethical leadership within Islamic traditions (Ganzevoort & Roeland, 2014; Al-Krenawi, 2016; Khotimah, 2025). Therefore, *asatizah* holds great potential to contribute meaningfully to the early identification, support, and referral of individuals struggling with mental health issues. Therefore, this conceptual paper is to answer the following research questions:

1. What are the current roles and perceptions of *asatizah* in addressing mental health issues among Generation Y?
2. What knowledge and skills do *asatizah* need to effectively support individuals with mental health challenges?
3. How can collaboration between religious institutions and mental health professionals be strengthened to promote holistic well-being?
4. What framework can be developed to integrate Islamic spiritual care with modern psychological support in a culturally appropriate manner?

## 2 Background and Rationale

Mental health is a growing concern in Malaysia and worldwide. In the 2019 National Health and Morbidity Survey (NHMS), it was reported that 2.3 million Malaysians aged 16 and above were experiencing mental health problems (Institute for Public Health, 2020; Mud Shukri et al., 2023). Young adults, particularly those between the ages of 25 and 34, represented one of the highest-risk groups. This age group aligns closely with Generation Y, who are navigating a rapidly evolving landscape of career uncertainty, digital dependency, and shifting family and societal values (Hamid & Salleh, 2021; Krishna & Agarwal, 2024).

Despite the increasing prevalence of mental health challenges, the uptake of formal mental health services among Muslim populations in Malaysia remains critically low. According to Hassan and Azizan (2022), more than 60% of Muslim youth who reported experiencing symptoms of depression or anxiety had never sought professional psychological assistance. This concerning trend reflects a deeper sociocultural and religious disconnect between modern mental health practices and Islamic worldviews. Many

individuals perceive mental illness as a test of faith or a spiritual weakness rather than a legitimate psychological condition requiring clinical attention (Antoniou & Kaloeropoulos, 2024)

Consequently, stigma, shame, and fear of community judgment prevent open discussion or help-seeking behaviour. Furthermore, misconceptions persist that psychiatric treatment, counselling, or medication are incompatible with Islamic teachings, leading to an overreliance on self-help through prayer or spiritual healing alone (Westhead & Georgiages, 2025; Yusof & Jalil, 2020; Abu-Raiya, 2019). These barriers indicate a significant gap in mental health literacy and a lack of culturally sensitive, faith-affirming interventions that resonate with Muslim identities.

The absence of religiously grounded guidance within mainstream mental health services further alienates young Muslims, who often turn first to *asatizah* or other religious figures for comfort and advice. This underscores an urgent need to empower *asatizah* with foundational mental health knowledge and to create collaborative frameworks between religious leaders and healthcare professionals to reduce stigma, enhance early detection, and promote holistic psychological well-being within Islamic communities.

In this setting, religious figures such as *asatizah* are uniquely positioned to help. They are not only spiritual guides but are also trusted confidants, often consulted during personal crises. Studies show that in Muslim communities, individuals frequently turn to religious teachers or imams before approaching clinical services (Zagloul et al., 2025; Leavey et al., 2007; Al-Krenawi, 2016). This presents an opportunity for integrating faith-based support with mental health care.

However, most *asatizah* currently lack formal training in mental health literacy, counselling techniques, or referral pathways. Without proper knowledge, they may unintentionally reinforce stigma or offer advice that contradicts psychological best practices (Ahad et al., 2023; Nordin, 2021). Bridging this knowledge gap is essential to ensure *asatizah* can provide accurate, supportive, and religiously congruent guidance.

To illustrate the gap and opportunity, the following table summarises the current mental health landscape among Generation Y in Malaysia:

**Table 1.** Mental Health Trends and Religious Help-Seeking Among Generation Y in Malaysia

Category	Statistic / Data
Prevalence of mental health issues	1 in 5 Malaysians aged 18 to 35 show signs of depression or anxiety (IPH, 2020; Mohd Tamil et al., 2024)
Professional help-seeking rate	Only 31 per cent of youth with mental health symptoms sought professional support (Hassan & Azizan, 2022; Shidhaye, 2023)
Faith-based help-seeking preference	Over 50 per cent preferred speaking to <i>asatizah</i> or imams before others (Yusof & Jalil, 2020)
Mental health literacy among <i>asatizah</i>	Low to moderate; no standardised training in psychology or counselling (Nordin, 2021; Räuchle et al., 2025)
Public stigma around mental illness	High; especially in religiously conservative communities (Nor Ba'yah & Mohd Khairul, 2019)

The rationale for this concept paper is rooted in the understanding that addressing mental illness requires a holistic and community-based approach. While medical professionals offer clinical support, *asatizah* can serve as frontline spiritual counsellors who guide individuals towards understanding, resilience, and appropriate care. By

empowering *asatizah* with mental health literacy and creating structured collaboration between religious and medical systems, Malaysia can improve early detection, reduce stigma, and promote culturally sensitive care that aligns with Islamic values (Refer to Table 1).

This concept also aligns with international best practices. In Singapore, for example, the Islamic Religious Council of Singapore (MUIS) has initiated training for *asatizah* to support Muslim clients experiencing mental health issues (MUIS, 2020). Similar models in the United Kingdom and Jordan have also demonstrated the benefits of faith-based involvement in psychological support services (Rassool, 2015; Al-Krenawi, 2016; Rahhal & Raman, 2024).

### 3 Objectives

This concept paper proposes to:

1. Explore the potential roles of *asatizah* in addressing mental health issues among Generation Y.
2. Identify current gaps in knowledge, training, and support for *asatizah* regarding mental health awareness.
3. Suggest a framework for integrating Islamic spiritual support with modern psychological practices.
4. Promote inter-agency collaboration between religious institutions and mental health professionals.

### 4 Significance of Study

Both global and national data underscore the urgency of addressing mental health issues among Generation Y. In Malaysia, Generation Y represents a significant portion of the population and workforce. Their mental well-being is therefore not only a public health issue but also a national development concern. According to the Department of Statistics Malaysia (2022), individuals aged between 25 and 40 comprise over 30 per cent of the country's working-age population. High stress levels, emotional burnout, and untreated mental health conditions can lead to reduced productivity, strained family relationships, and a higher risk of self-harm or suicide (Ibrahim et al., 2019; Yaacob et al., 2021).

Despite the availability of psychological services, the help-seeking rate remains critically low. The stigma surrounding mental illness and the perception that emotional suffering is a result of weak faith prevent many from accessing support (Abu-Raiya, 2019; Yusof & Jalil, 2020). In this cultural context, *asatizah*, as spiritual and community leaders, hold significant moral and social influence. Their involvement can transform community perceptions of mental illness and promote a more compassionate, faith-affirming understanding of psychological suffering.

#### 4.1 Promoting Faith-Based Psychological Resilience

This study contributes to efforts aimed at integrating Islamic teachings with evidence-based mental health interventions. Concepts such as *sabr* (patience), *tawakkal* (trust in God), and *istighfar* (seeking forgiveness) can serve as powerful tools in reframing distress within a theological framework that validates suffering without judgment (Keshavarzi & Haque, 2013; Awaad & Ali, 2015).

#### 4.2 Reducing Mental Health Stigma through Religious Leadership

Religious leaders have a track record of influencing public opinion in Muslim societies. Their role in Friday sermons, religious classes, and community events provides a direct channel for addressing misconceptions about mental illness. Past studies show that involving religious leaders in public health campaigns significantly increases community acceptance and behavioural change (Rassool, 2015; Al-Krenawi, 2016).

#### 4.3 Enhancing Community-Based Mental Health Support

The involvement of *asatizah* can enhance existing mental health support systems by filling the gap between the individual and formal clinical services. In a society where trust in religious figures may exceed trust in government or medical institutions, *asatizah* can serve as first responders who listen, validate, and refer individuals in distress. This model aligns with community-based mental health frameworks promoted by the World Health Organisation (2021), which emphasise local and culturally anchored solutions.

#### 4.4 Capacity Building and Interdisciplinary Collaboration

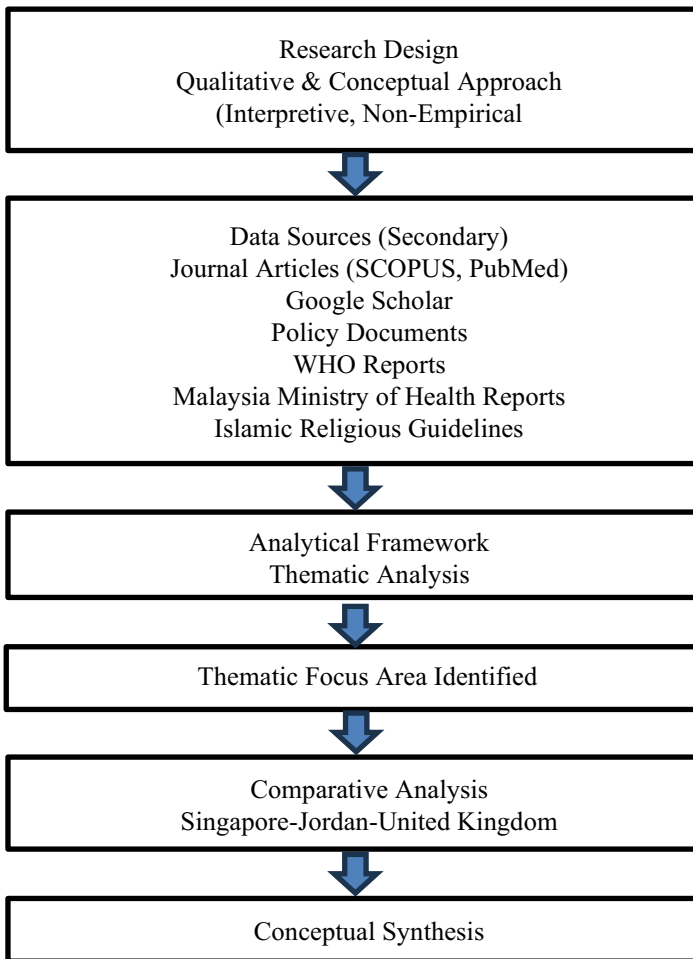
This study also aims to promote capacity building among *asatizah* by proposing mental health literacy training, counselling skills development, and formal partnerships with healthcare professionals. In countries like Singapore and Jordan, similar interdisciplinary collaborations have led to positive outcomes in mental health awareness and support within Muslim communities (MUIS, 2020; Dalky & Gharaibeh, 2019).

In summary, this study is significant because it bridges a critical gap between mental health care and religious life. It proposes a culturally appropriate, faith-sensitive, and community-integrated approach to mental wellness. By recognising and strengthening the role of *asatizah*, it contributes to national health resilience, social harmony, and the broader mission of destigmatising mental illness within Islamic societies.

## 5 Methodology

This concept paper adopts a qualitative and conceptual research design grounded in document analysis and thematic synthesis. The methodology focuses on analysing secondary sources—such as journal articles, institutional reports, policy documents, and religious guidelines—related to mental health, Islamic counselling, and the role of *asatizah* in community well-being. Guided by the qualitative framework of Braun and Clarke (2006), the study employs thematic analysis to identify recurring patterns,

conceptual gaps, and potential integration points between Islamic spiritual care and psychological support systems. Relevant data were systematically gathered from academic databases including Scopus, PubMed, and Google Scholar, as well as reports from the World Health Organization (WHO) and Malaysia’s Ministry of Health. Literature pertaining to Islamic religious education, counselling ethics, and community mental health initiatives was reviewed to construct a comprehensive understanding of the issue. The analysis proceeded through coding, categorisation, and thematic mapping to generate insights into the potential functions and competencies required of asatizah in mental health advocacy. This conceptual synthesis also draws on comparative case studies from Singapore, Jordan, and the United Kingdom to illustrate best practices in faith-based mental health integration. Based on Fig 1, the overall methodological approach is interpretive rather than empirical, aiming to propose a theoretically grounded and contextually relevant framework for empowering asatizah in addressing mental illness among Generation Y in Malaysia.



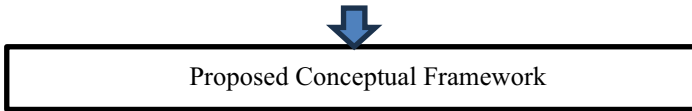


Fig 1 Conceptual Methodological Framework of the Study

## 6 Proposed Scope of Roles for *Asatizah*

In many Muslim communities, *asatizah* are regarded not only as teachers but also as moral guides, problem-solvers, and trusted confidants. Their influence extends beyond the religious sphere into social and psychological domains. Given the increasing mental health needs of Generation Y, particularly in Malaysia, it is both timely and strategic to expand the functional scope of *asatizah* to include roles related to mental health awareness, early intervention, and referral support. This section outlines four key roles that *asatizah* can assume with appropriate training and institutional backing (Refer to Table 2).

### 6.1 Mental Health Literacy Advocates

*Asatizah* can play a critical role in educating the community on the nature, symptoms, and misconceptions surrounding mental illness. By incorporating accurate mental health content into sermons, religious talks, and social media outreach, they can help normalise discussions around psychological well-being. Studies have shown that religious figures trained in mental health concepts are more effective in reducing stigma and encouraging help-seeking behaviour (Koenig, 2012; Dalky, 2012).

For example, an *asatizah* trained to recognise signs of anxiety or depression can advise an individual to seek professional assistance, while also offering spiritual reassurance based on Islamic values such as patience (*sabr*), trust in divine wisdom (*tawakkul*), and remembrance of God (*dhikr*).

### 6.2 Spiritual Support and Ethical Counselling

Islamic spiritual teachings can serve as an effective coping mechanism when framed appropriately. *Asatizah* are ideally positioned to provide counselling grounded in Islamic theology, ethics, and compassion. This includes offering support based on Qur'anic verses, prophetic traditions, and classical Islamic guidance related to emotional distress and resilience (Awaad & Ali, 2015; Haque, 2004).

However, it is essential that their support remains non-clinical and does not replace psychological or psychiatric treatment. Instead, they can provide complementary counselling that affirms religious identity, reduces spiritual guilt, and restores emotional equilibrium through spiritual narratives.

### 6.3 Early Detection and Referral Agents

*Asatizah* can act as informal gatekeepers in identifying individuals at risk, especially in communities where people are more likely to confide in religious figures than in healthcare professionals. With basic training in mental health first aid and active

listening skills, they can identify red flags such as suicidal ideation, social withdrawal, or sudden behavioural changes.

A Malaysian pilot study by Nordin et al. (2021) demonstrated that religious school teachers who received basic mental health training were better equipped to detect early symptoms of distress among students and refer them appropriately. This shows potential for expansion to broader community roles.

#### 6.4 Community Engagement and Interdisciplinary Collaboration

Beyond individual counselling, *asatizah* can facilitate mental health outreach through partnerships with local clinics, hospitals, and government programmes. They can co-host mental health seminars, organise spiritual wellness workshops, and contribute to resource development such as Islamic mental health brochures, online content, and public health campaigns.

Interdisciplinary models in countries such as Singapore, Jordan, and the United Kingdom have already shown success in including religious leaders in national mental health strategies (MUIS, 2020; Al-Krenawi, 2016; Rassool, 2015). These collaborations not only enhance community trust in mental health services but also ensure that interventions are religiously sensitive and culturally appropriate.

**Table 2.** Summary of Proposed Roles for *Asatizah* in Mental Health Support

Role	Description	Supporting Literature
Mental Health Literacy Advocates	Raise awareness, dispel myths, and promote positive attitudes toward mental illness	Koenig (2012); Dalky (2012)
Spiritual Support and Ethical Guidance	Provide theologically grounded counselling that complements clinical care	Awaad & Ali (2015); Haque (2004)
Early Detection and Referral Agents	Recognise early signs of mental distress and refer individuals to professionals	Nordin et al. (2021); WHO (2021)
Community Engagement and Collaboration	Partner with clinics, schools, and NGOs to promote integrated mental health programmes	MUIS (2020); Rassool (2015); Al-Krenawi (2016)

## 7 Challenges and Considerations

While the involvement of *asatizah* in mental health support presents significant opportunities, it is equally important to acknowledge the structural, institutional, and cultural challenges that may limit the successful implementation of such an initiative. This section outlines several key barriers and practical considerations that must be addressed for effective integration (Refer to Table 3).

### **7.1 Limited Mental Health Training and Knowledge**

One of the most pressing challenges is the lack of formal training in mental health concepts among *asatizah*. Most religious educators are not equipped with foundational knowledge in psychology, counselling, or emotional literacy. As a result, there is a risk that well-meaning advice may unintentionally reinforce stigma, spiritualise psychological disorders, or delay proper clinical intervention (Abu-Raiya & Pargament, 2015; Nordin et al., 2021).

Efforts to address this gap must involve the development of tailored mental health training modules that are religiously and culturally sensitive, combining Islamic principles with basic psychological frameworks.

### **7.2 Role Ambiguity and Professional Boundaries**

The integration of *asatizah* into mental health work raises questions about professional boundaries. Religious leaders are not clinicians, and without clear role definitions, there is a risk of role confusion between spiritual counselling and therapeutic practice. Misunderstandings could also lead to legal or ethical concerns, particularly in cases involving severe mental illness or suicide risk (Koenig, 2012; Awaad et al., 2020).

To mitigate this, it is essential to establish referral protocols and guidelines that clearly distinguish between pastoral care and clinical responsibilities. Training programmes must also include instruction on ethical considerations and referral pathways.

### **7.3 Institutional Resistance and Bureaucratic Inertia**

In some religious institutions, there may be hesitancy to adopt mental health education due to conservative views, fear of change, or perceived incompatibility between religious and psychological sciences. Similarly, collaboration between religious authorities and government health agencies may be hindered by bureaucratic complexity, differing mandates, or lack of trust (Haque, 2004; Al-Krenawi, 2016).

Addressing this requires sustained dialogue, policy advocacy, and involvement of respected religious scholars who support mental health integration from an Islamic jurisprudential perspective.

### **7.4 Stigma and Community Misconceptions**

Despite increased public awareness, mental illness continues to be heavily stigmatised in many Muslim communities. Mental health conditions are sometimes attributed to spiritual weakness, lack of faith, or supernatural causes such as *jinn* possession. This cultural narrative deters individuals from acknowledging their struggles or seeking professional help (Yusof & Jalil, 2020; Rassool, 2015).

For *asatizah* to become effective mental health advocates, they must be equipped to address these misconceptions with compassion and theological clarity. This includes framing mental illness as part of human vulnerability rather than moral failure.

### 7.5 Resource and Capacity Limitations

Implementing mental health literacy training for *asatizah* on a national scale requires significant financial and logistical resources. Many institutions face limitations in terms of budget, manpower, or infrastructure. Additionally, rural and underserved communities may have fewer opportunities for formal training or access to mental health professionals (WHO, 2021; Ibrahim et al., 2019).

A phased, pilot-based approach that prioritises high-need areas may be necessary, along with cross-sector collaboration with NGOs, universities, and ministries of health and religion.

**Table 3.** Summary of Challenges and Mitigation Strategies

Challenge	Explanation	Recommended Mitigation
Limited mental health training	Lack of psychological knowledge among <i>asatizah</i>	Develop culturally adapted training modules
Role ambiguity	Blurring of lines between spiritual and clinical care	Establish referral protocols and ethical guidelines
Institutional resistance	Reluctance from religious authorities or agencies	Engage influential scholars and policy advocates
Cultural stigma and misconceptions	Negative views on mental illness are rooted in religious misunderstandings	Promote theologically sound, destigmatising narratives
Resource limitations	Limited funding and infrastructure in rural or under-resourced areas	Begin with scalable pilot programmes and multi-agency partnerships

## 8 Conclusion and Way Forward

This concept paper has underscored the critical importance of leveraging the unique position of *asatizah* to address mental health challenges among Generation Y in Malaysia. Generation Y faces a convergence of socio-economic stressors, digital pressures and evolving social expectations that have contributed to rising rates of depression, anxiety and burnout. Conventional mental health services, while essential, remain under-utilised in many Muslim communities because of stigma, misconceptions and a perceived incompatibility with religious beliefs.

*Asatizah* are trusted figures who already fulfil roles in spiritual guidance, ethical leadership and community support. By equipping them with foundational mental health literacy and clear referral pathways, they can act as frontline advocates for early symptom recognition, empathetic spiritual counselling and destigmatisation. Collaborative models from Singapore, Jordan and the United Kingdom demonstrate that training religious leaders in basic psychological skills and forging partnerships with mental health professionals yield improved help-seeking rates and community acceptance (MUIS, 2020; Al-Krenawi, 2016; Rassool, 2015).

Moving forward, a phased implementation strategy is recommended. The first phase involves the co-development of culturally adapted training curricula in mental health first aid, ethical counselling boundaries and referral protocols. This curriculum should be created through an interdisciplinary working group comprising *asatizah*, clinical

psychologists, psychiatrists and policymakers. The second phase entails piloting the training with a representative cohort of *asatizah* in urban and semi-urban districts, accompanied by process evaluation to refine content and delivery methods. The third phase expands the programme nationally, embedding ongoing supervision, peer support networks and formal collaborations with health agencies.

Policy advocacy is essential to institutionalise these efforts. This includes securing endorsements from key religious councils, integrating mental health modules into *asatizah* certification requirements and establishing memoranda of understanding between religious bodies and health ministries. Finally, continuous monitoring and evaluation using both quantitative metrics (for example, referral rates to mental health services, changes in community attitudes) and qualitative feedback (for example, participant interviews, case studies) will ensure the initiative remains responsive to emerging needs and upholds both clinical efficacy and religious authenticity.

In conclusion, empowering *asatizah* with mental health competencies offers a culturally resonant, community-centred approach to improving psychological well-being among Generation Y. By bridging religious and clinical realms, this model holds promise for reducing stigma, enhancing early intervention and fostering holistic resilience in faith communities.

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