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A REVIEW ON IMPULSIVITY AND SUICIDAL BEHAVIOUR AND ITS IMPLICATIONS FOR ISLAMIC-INFORMED MENTAL HEALTH CARE

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Abstract: *Impulsivity is a recognised risk factor for suicidal behaviour, yet most research is grounded in Western contexts, limiting its cultural applicability in Muslim populations. This review examines the link between impulsivity and suicidal behaviour and explores its implications for Islamic-informed mental health care. Following PRISMA guidelines, a systematic search of Scopus, ProQuest, and EBSCO databases was conducted for studies from 2014 to 2024. Thirty peer-reviewed articles were selected and assessed using the Joanna Briggs Institute checklist. Impulsivity consistently predicted suicidal ideation and attempts. Comorbidities such as depression and substance use increased risk. Religious commitment emerged as a protective factor, yet Islamic-based interventions rarely address impulsivity through structured clinical approaches. There is a need for culturally adapted care models integrating Islamic principles with psychological frameworks. Future research should develop validated tools and interventions tailored to Muslim contexts.*

Keywords: *Impulsivity, Suicide, Islamic Mental Health, Review*

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Introduction

Suicide affects individuals, families, and communities worldwide, claiming over 700,000 lives annually (WHO, 2021). Impulsivity is a key risk factor, especially among those with psychiatric disorders, substance use issues, or a family history of suicide (May et al., 2016; Millner et al., 2018). Defined as acting without adequate forethought, impulsivity can manifest through emotional outbursts, poor decision-making, and self-harm (Mai et al., 2021). Research indicates that impulsive individuals tend to attempt suicide repeatedly, suggesting a correlation between impulsivity levels and the likelihood of recurrent suicide attempts (Ramezani & Nourimoghadam, 2024).

Mental health issues in Muslim communities are often obscured by stigma, leading to underreporting and limited access to care (Shoib et al., 2022). The cultural and religious context of Muslim communities calls for a nuanced approach to mental health that respects Islamic values while meeting psychological needs (Majid, 2023). While many countries implement suicide prevention strategies through psychotherapy and pharmacotherapy, these often lack cultural alignment. Islam views suicide as a grave sin but recognises that individuals suffering from severe mental illness may not be fully accountable for their actions (Ramezani & Nourimoghadam, 2024; Sheriff, 2020). Thus, accessible and culturally sensitive mental health services are critical.

The literature on suicide largely emanates from Western paradigms that emphasize individualism and secularism. This body of research has contributed significantly to our understanding of impulsivity as a key risk factor for suicidal behavior. Western literature has provided valuable insights into how impulsivity functions as a suicide risk factor, exploring its neuropsychological underpinnings, comorbidities with mental disorders, and its role in spontaneous suicidal acts (Klonsky & May, 2014; Millner et al., 2018). These studies have developed robust measurement tools—such as the Barratt Impulsiveness Scale (BIS) and UPPS-P Impulsive Behaviour Scale—which remain standard in suicide risk assessments. Importantly, these tools and interventions were designed and validated within Western socio-cultural and secular contexts, where individual autonomy, emotional expression, and psychiatric diagnosis are framed differently than in collectivist, religiously oriented Muslim societies.

A critical synthesis of Western literature is essential to identify conceptual gaps relevant to Muslim populations and to assess whether Western instruments accurately capture culturally significant factors in these communities. For example, while Western research links negative urgency and emotional dysregulation with impulsive suicide (May & Klonsky, 2016), it rarely considers the moral and theological weight suicide carries in Islam, where religious prohibition, fatalism (*qadar*), and communal obligations are central to one's worldview (Sheriff, 2020). Additionally, the stigma surrounding mental illness and suicide in many Muslim communities may interact with impulsivity differently, potentially leading to underreporting, suppression of suicidal ideation, or internalised guilt (Shoib et al., 2022).

Without this preliminary review, efforts to propose Islamic-informed mental health care would risk being disconnected from the established empirical base, potentially replicating biases or omitting key risk mechanisms already identified in global research. Therefore, bridging Western findings with Islamic perspectives demands a well-informed, comparative literature review.

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Problem statement

Despite extensive Western research establishing impulsivity as a suicide risk factor, there is limited understanding of how these constructs operate within Muslim populations. Existing Islamic-informed mental health literature rarely integrates empirically supported models of impulsivity, resulting in a significant knowledge gap. Without culturally aligned frameworks, clinical interventions may fail to capture culturally shaped emotional regulation processes, religious coping, and theological interpretations of suicide. This gap may limit the effectiveness of suicide prevention strategies in Muslim communities, where stigma and underreporting remain prevalent.

Methods

Search Strategies

The review followed PRISMA guidelines. Keywords used in Scopus, ProQuest, and EBSCO were as follow:

1. "impulsivity" AND ("suicidal ideation" OR "suicidal behavior") AND ("self-harm" OR "self-injury") AND ("mental health") AND ("adults")
2. ("risk-taking" OR "impulsiveness") AND "suicide attempt" AND "Barratt Impulsiveness Scale"
3. "impulsivity" AND "suicidal ideation" AND ("cultural influence" OR "Islamic perspective")
4. ("mental health" AND "adults" AND "suicidal behavior") AND ("risk-taking" OR "impulsivity")

Inclusion criteria were: studies from 2014–2024, peer-reviewed, English language, adult samples, suicide-related outcomes, and quantitative/qualitative/mixed methods. Excluded were reviews, adolescent-only studies, and those focused on non-suicidal self-injury.

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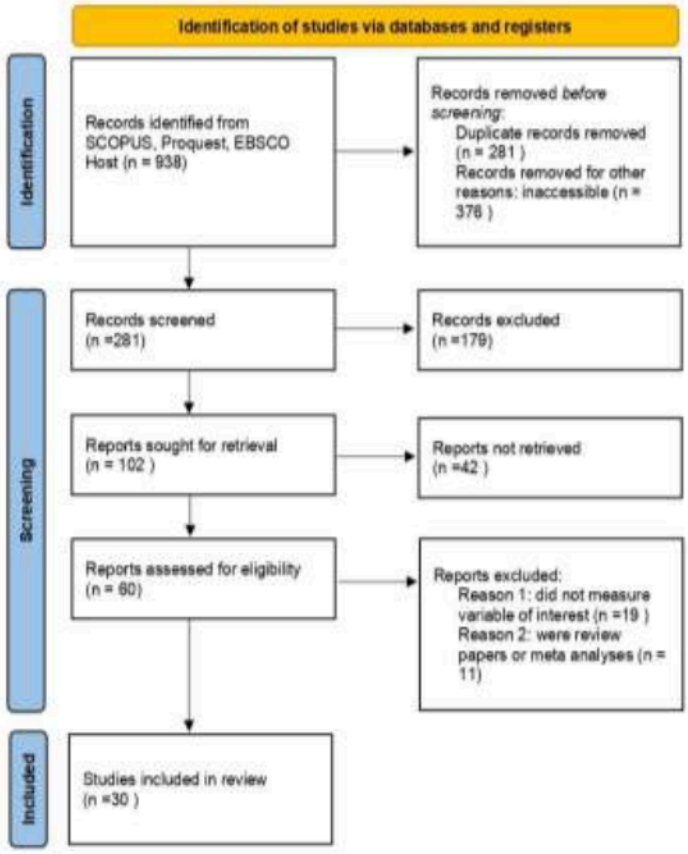

Figure 1: PRISMA chart for the selection process

Data extraction and Analysis

Two reviewers independently screened titles, abstracts, and full texts using the eligibility criteria. Discrepancies were resolved through discussion, and when necessary, a third reviewer adjudicated. Quality was assessed using the Joanna Briggs Institute checklist, requiring a minimum of five "yes" responses for inclusion. Risk of bias was summarised using JBI tools and supplemented with an assessment of sampling limitations, self-report bias, and cross-sectional design dominance across studies."

The three themes were developed through an inductive synthesis guided directly by the patterns observed in the summary table of the 30 included studies. After data extraction, all findings in the table were reviewed repeatedly to identify clusters of studies reporting similar issues. Studies that examined impulsivity as a direct predictor of suicidal ideation or attempts formed a large and consistent cluster across multiple settings, which naturally led to the first theme. A second cluster emerged from studies showing that impulsivity interacted with psychiatric conditions—such as depression, PTSD, bipolar disorder, and substance use—indicating that impulsivity rarely occurred in isolation. A third cluster became evident from studies that explicitly differentiated impulsive versus planned suicide attempts or described differences in lethality, intent, or contextual triggers.

These three clusters represented the most recurrent and conceptually coherent patterns across the table. Through comparison of similarities, differences, and overlaps within each cluster, the reviewers consolidated the patterns into the following analytical themes: (1) impulsivity as a core suicide risk factor, (2) interaction of impulsivity with psychiatric comorbidities, and (3)

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distinctions between impulsive and planned suicide attempts. This thematic structure therefore reflects the dominant patterns consistently supported by the distribution of findings across the 30 studies.

Ethical Considerations

No ethical approval was required as this review does not involve human participants.

Results

This review of 30 studies reveals three key themes in understanding the role of impulsivity in suicidal behaviour: (1) impulsivity as a core suicide risk factor, (2) its interaction with psychiatric comorbidities, and (3) distinctions between impulsive and planned suicide attempts.

Table 1: Summary of included article

No.	Authors/ Country	Population & Study Design	Independent Variables	Measurement of Impulsive Suicide	Outcome Summary	Limitations	JBI Total "Yes"
1.	Salami, Brooks & Lamis [13]/U.S	African Americans, N=97, Cross-sectional	The UPSS Impulsive Behavior Scale, Reasons for Living Inventory	Modified Scale for Suicide Ideation (MSSI)	Impulsivity may, in part, manifest through emotional responses to distress, which can trigger suicidal thoughts, but the researchers highlight a critical relationship where protective factors such as having reasons to live may mitigate this risk.	Cross-sectional limits causal inference	6
2.	May & Klonsky [2]/U.S	Adults suicide attempters, N=205, Cross-sectional	UPSS	Suicide Intent Scale	Highlights impulsivity as a crucial predictor of suicidal behavior. It invites further exploration into defining impulsivity more clearly and developing targeted interventions that effectively measure and manage impulsivity in at-risk populations.	Variability in definitions of attempt impulsivity	5
3.	Millner, et al. [3]/U.S	Lifetime suicide attempters and controls, N=297, Cross-sectional	Medical records, UPPS-P, Barratt impulsiveness scale (BIS)	Pathway to suicidal action interview (PSAI) Beck Hopelessnes s Scale, Beck Depression inventoty, Beck Suicide Scale for Ideation	Suicide attempters may not have significant elevated impulsive trait, compared to suicidal ideators. However, when in negative urgency, suicidal attempter may have higher impulsiveness.	Low statistical power; sample bias due to lengthy survey	5
4.	Kim et al.,, [14]/South Korea	N=1003, Cross-sectional study	Demographic, psychiatric factors	Planned suicide attempters, impulsive suicide attempters,	Profiles of planned vs. impulsive attempters identified	Selection bias due to underrepresenta tion of severe cases	6
5.	Lin et al.,[15]/China	Rural youth, N=162, Case-control	Social support, coping strategies	Psychologica l autopsy	High-impulsivity suicides younger with less support	Proxy data may lack reliability; small sample	6

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6.	Fanning, Lee & Coccaro [16]/U.S	Community sample, N=1460, Clinical study	PTSD, Intermittent explosive disorder Clinical assessments	Lifetime suicide attempt and characteristics of suicidal behavior.	Impulsive aggression linked to suicidal behavior	Focus on comorbid conditions may obscure individual effects	6
7.	Moukaddam et al., [17]/U.S	Mood disorders, N=32, Multimodal study	UPPS-P, BIS-11	MINI-based suicidality assessment	Higher impulsivity correlates with suicidal thoughts.	Limited to specific mental health disorders	5
8.	Colborn et al., [18]/U.S	Military members, N=152, Randomized trial	Barratt Impulsiveness Scale Motor impulsivity using 30-item	Lifetime suicide attempts	The study found that higher levels of impulsivity are significantly associated with individuals who reported multiple lifetime suicide attempts. This suggests that impulsivity may serve as a critical risk factor for not just accounting for suicidal intent but also the prevalence of actual attempts.	Focus on inpatients limits generalizability	6
9.	Zhang et al.,[19]/China	Mentally healthy individuals, N=480, Cross-sectional	Depression using Self-rating depression scale (SDS), Barratt Impulsiveness Scale	Self-rating Idea of Suicide Scale (SIOSS)	Impulsiveness predicts depression and suicidal ideation.	Cross-sectional limits causal interpretation	5
10.	Kang et al., [20]/Korea	Patients with major depressive disorder, N=87, Cross-sectional	Demographics, clinical scales were assessed at the time of the MRI scanning.	Beck Scale for Suicide Ideation, BIS	Links between impulsivity traits and brain volume observed.	Small sample size; lack of healthy controls	5
11.	Abdullah, et al. [7]/Pakistan	N=747, Cross-sectional study	Socio-demographic, Barratt's impulsiveness scale Depression Anxiety Stress Scale (DASS) Religious commitment inventory	Beck Scale for Suicide Ideation	The study establishes a significant relationship between psychological distress and suicidal ideation. Participants exhibiting higher levels of psychological distress, as measured by the DASS, demonstrated increased rates of suicidal thoughts.	Limited to male Sunni participants; generalizability issues	6
12.	Ramezani & Nourimoghadam [21]/Iran	Adults aged 20+, N=422, Descriptive study	BIS, the Cohesive self-knowledge scale.	Beck Scale for Suicide Ideation	Impulsivity directly linked to suicidal tendency while integrative self-knowledge were inverse and significant protective factors against suicide.	Relies on self-reported data	5
13.	Brokke, Landrø & Haaland [22]/Norway	Psychiatric patients, N=98, Cross-sectional	Barratt Impulsiveness Scale Aggression questionnaire	Columbia-suicide severity scale	Impulsive behavior more prominent in female low-lethality attempts.	Small sample size; difficult to include large groups	6

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			Montgomery-Asberg depression rating scale				
14.	Chen & Li [23]/China	Patients with depression, N=258, Cross-sectional	Beck Hopelessness Scale, Hamilton Depression Scale, BIS-Chinese	Chinese version of suicidal ideation	Positive correlation between impulsivity and suicidal ideation.	Convenience sampling may introduce bias	6
15.	Daneshmend et al., [24]/Canada	University students, N=539, Cross-sectional	Cannabis use, Barratt Impulsiveness Scale Childhood trauma questionnaire	Suicidal thoughts and behavior within the past 12 months	Links cannabis use to suicide outcomes, mediated by impulsivity.	Cross-sectional limits causal inference	5
16.	Melhem et al., [25]/U.S	Offspring of mood disorder patients, N=663, Longitudinal cohort	Beck Depression Inventory (BDI-39) for adults (18+), and Children's Depression Inventory for minors (<18). Beck Hopelessness Scale for adults, and Hopelessness Scale for Children. Brief Symptom Inventory (BSI) for adults, and the Emotionality, Activity, Sociability, Impulsivity (EASI) subscales for minors. Buss-Durkee Hostility Inventory for adults, and Children's Hostility Inventory for minors. Brown-Goodwin Aggression Scale at baseline and follow-ups. Childhood Trauma Questionnaire and an adapted version of the Abuse Dimensions Inventory.	Columbia Suicide History Form Medical Lethality Rating Scale	Depression trajectory predicts suicide attempt.	Participation protocols may have reduced suicidal events	6
17.	Coryell et al.,[26]/U.S	History of multiple suicide attempts, N=202, Cross-sectional	CSSRS-BL, Barratt's Impulsiveness Scale Overt Aggression Scale	History of suicide attempts	Those with multiple suicide attempts found those with a history of suicide attempts to have higher ratings for aggression and for impulsivity. Both of these tendencies were independent predictors and therefore additive as risk factors for suicide behavior	Does not establish temporal relationships	5
18.	Johnson et al., [27]/U.S	Adults with suicide attempt	Emotion-related Impulsivity	Columbia-Suicide	Impulsivity and rumination linked to suicidal ideation.	Relies on self-report measures	5

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		history, N=total (2 samples), Cross-sectional	Three- Factor Impulsivity Index and Rumination using Suicide Rumination Scale	Severity Rating Scale Deliberate Self- Harm Inventory			
19.	Cáceda et al., [28]/U.S	Acutely suicidal patients, N=82, Observational	Beck Anxiety Inventory (BAI), Beck Hopelessness Scale (BHS), Barratt Impulsiveness Scale, Childhood Trauma Questionnaire, and the Psychache Scale	C-SSRS and Beck Depression Inventory	Links impulsive choice to suicidal ideation	Small sample size may limit generalizability	5
20.	Beckman et al., [29]/Sweden	Young adults, N=666, Prospective cohort	Demographics, impulsivity	Prevalence of impulsive suicide attempts	Substance use disorder linked to impulsive attempts.	Study limits generalizability	5
21.	Palagini et al., [30]/Italy	Bipolar disorder patients, N=77, Cross-sectional	Insomnia, emotion dysregulation (DERS) The Beck Depression Inventory- II (BDI-II) and the Young Mania Rating Scale (YMRS)	Scale for Suicide Ideation (SSI)	Emotional impulsivity linked to suicidality	Lack of physiological measures; cross-sectional limits interpretation	5
22.	Jiménez et al., [31]/Spain	Euthymic bipolar outpatients, N=215, Cross-sectional	Sociodemographic and clinical differences	C-SRSS criteria	Increased impulsivity raises suicide risk.	Cross-sectional limits causality	5
23.	McMahon et al., [32]/U.S	Civilian adults, N=43,093, Cross-sectional	Childhood maltreatment, impulsivity	Interpersonal violence, self-injury	Maltreatment and impulsivity predict self-harm and suicide	Self-reported data may introduce bias	5
24.	Hadzic et al., [33]/Germany	Psychiatric inpatients, N=84, Cross-sectional	Barratt Impulsiveness Scale (BIS) Interpersonal Needs Questionnaire (INQ)	Suicide Behaviors Questionnaire Revised (SBQ-R) German Capability for Suicide Questionnaire (GCSQ) Beck Scale for Suicide Ideation (BSS)	Impulsivity linked to passive suicidal ideation.	Small sample may limit findings	6
25.	Chaudhury et al., [34]/U.S	Major depressive episode seekers, N=110, Cross-sectional	BIS, history of abuse , Buss-Durkee Hostility Scale	Diagnostic and suicide attempt classifications	Planned attempts linked to greater lethality.	Potential recall bias among participants	5
26.	Guillou-Landreat et al., [35]/France	Mental disorder participants,	Clinical characteristics UPPS	Risk of suicide	Pathological gamblers show higher suicide risk.	Selection bias due to gender imbalance	6

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		N=194, Cross-sectional	Wender-Utah Rating Scale-Child (WURS-C) Shorter 125-item version of the Temperament and Character Inventory (TCI-125) Defense style questionnaire (QSD). Questionnaire of Life Events Gambling characteristics Gambling related cognitions scale				
27.	El-Sayed et al., [36]/Egypt	Bipolar disorder patients, N=60, RCT	Acceptance and Action Questionnaire II, the Short Arabic Version (ACT), Impulsivity Behavior Scale	Beck Scale for Suicide Ideation	ACT significantly reduces suicidal thoughts.	Short follow-up limits evaluation of long-term effects	5
28.	Bi et al., [37]/China	Emergency department patients, N=363, Cross-sectional	Hamilton Rating Scale, BIS, Eysenck Personality Questionnaire	Beck Scale for Suicidal Ideation	High-lethality linked to impulsivity and conflicts.	Self-reported measures may limit reliability	5
29.	Murphy et al., [38]/U.S	Medically severe suicide attempt patients, N=15, RCT	Intervention group on lithium therapy and control group on matching pill placebo	Impulsivity and arousal using Immediate Memory Task, Internal State Scale and the Time Perception Task .	Lithium may increase response latency in decision-making.	Small sample size limits conclusions	5
30.	Costanza et al., [39]/Switzerland	Substance use disorder patients, N=48, Cross-sectional	BIS, State and Trait Anger Expression Inventory, version 2 (STAXI-2) Life History of Aggression, Presence of risk-taking behavor (gambling, binge drinking, risky sexual behavior, danger- ous driving behavior, and extreme sport activities)	History of lifetime suicide attempts	Higher impulsivity linked to more risk-taking behaviors.	Small sample size; cross-sectional limits information	6

Impulsivity as a Core Suicide Risk Factor

Impulsivity consistently emerged as a strong predictor of suicidal ideation and behaviour. Studies using established measures such as the UPPS-P and Barratt Impulsiveness Scale (BIS) reported that individuals with higher impulsivity scores were more likely to report suicide attempts (May & Klonsky, 2016; Colborn et al., 2017). Salami et al. (2015) noted that impulsivity, when combined with emotional distress, significantly increased suicidal thoughts,

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although protective factors such as having reasons for living buffered this effect. Millner et al. (2018) distinguished impulsive suicide attempters from ideators by noting a rise in negative urgency—impulsivity driven by acute emotional distress.

Religiosity and self-awareness emerged as key protective factors. Abdullah et al. (2023) showed that higher religious commitment correlated with reduced suicidal ideation among Pakistani males, while Ramezani and Nourimoghadam (2024) found that integrative self-knowledge inversely predicted suicide risk, despite elevated impulsivity.

Interaction with Psychiatric Comorbidities

The second theme addresses how impulsivity interacts with co-occurring mental health conditions. Depression, PTSD, anxiety, substance use disorders, and histories of trauma were consistently shown to compound the risk of suicide when combined with impulsive traits. Fanning et al. (2016) found that impulsive aggression among individuals with PTSD was linked to increased lifetime suicide attempts. Zhang et al. (2018) and Chen & Li (2022) reported that impulsivity amplified the effects of depression on suicidal ideation in Chinese samples. In neuroimaging research, Kang et al. (2020) found correlations between impulsivity traits and altered brain volumes in patients with major depressive disorder.

Daneshmend et al. (2022) demonstrated that among university students, cannabis use mediated the relationship between impulsivity and suicidal behaviour, particularly in those with childhood trauma. Similarly, Johnson et al. (2021) and Cáceda et al. (2021) found that emotion-related impulsivity and psychological pain predicted suicidal ideation. Studies on bipolar disorder (Palagini et al., 2019; El-Sayed et al., 2021) identified insomnia and emotional dysregulation as pathways linking impulsivity with suicidality. Across the board, impulsivity intensified emotional dysregulation and impaired judgment, elevating suicide risk.

Distinctions Between Impulsive and Planned Suicide Attempts

Several studies distinguished between impulsive and planned suicidal behaviour. Impulsive attempts were more common among younger individuals, less lethal, and often triggered by acute interpersonal conflict or distress. Lin et al. (2016) found that high-impulsivity suicides occurred among rural youth with limited social support, while Kim et al. (2015) highlighted different psychiatric profiles between impulsive and planned attempters. Brokke et al. (2017) and Beckman et al. (2019) observed that female psychiatric patients and young adults, respectively, exhibited more impulsive and lower-lethality attempts.

Conversely, planned suicide attempts were associated with more premeditation, higher lethality, and chronic mental health issues such as major depressive disorder (Chaudhury et al., 2020; Bi et al., 2022). Coryell et al. (2018) found that aggression and impulsivity were independent and additive predictors among individuals with a history of multiple attempts.

Critical analysis and its Implications for Islamic-Informed Mental Health Care

Islamic traditions underscore virtues such as sabr (patience), tawakkul (reliance on God), and nahi ‘anil fasha’ (restraint from destructive acts) as internal mechanisms for self-regulation (Majid, 2023; Abdullah et al., 2023). Classical Muslim scholars emphasise that the balance between nafs (desire), aql (intellect), and qalb (spiritual heart) shapes a person’s capacity to control impulsive behaviour. From this perspective, the empirical finding that impulsivity is a core predictor of suicidal behaviour aligns with longstanding Islamic teachings that view impulsive actions as arising from a weakened nafs or a distressed qalb. Yet, while these spiritual

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constructs resonate with psychological models of emotion-driven impulsivity, they are seldom translated into structured clinical interventions for individuals at risk.

Although affect regulation is frequently discussed within Islamic psychology, it remains insufficiently integrated with contemporary psychometric assessments and therapeutic models such as CBT or DBT (Elzamzamy et al., 2023). Muslim scholars highlight that impulsive behaviour often reflects temporary emotional overwhelm rather than deliberate intent, which aligns with empirical distinctions between impulsive and planned suicide attempts. Islamic jurisprudence recognises differences in niyyah (intention) and mental capacity, noting that severe psychological distress may diminish personal culpability. This insight is particularly important in clinical settings because it validates a compassionate, non-punitive response to individuals exhibiting impulsive suicidal behaviour.

Similarly, the interaction between impulsivity and psychiatric comorbidities—such as depression, PTSD, trauma, and substance use—echoes Islamic teachings that emotional disorder can impair judgment (aql) and reduce self-control. Muslim scholars argue that such states weaken both psychological and spiritual resilience. Thus, while contemporary studies demonstrate how comorbidities intensify impulsivity and suicide risk, Islamic scholarship frames these experiences as conditions in which individuals require enhanced support, mercy, and structured interventions rather than moral condemnation. This provides a culturally grounded rationale for integrating mental health treatment with pastoral counselling, spiritual education, and community-based support systems.

In recent years, faith-sensitive mental health services in Malaysia, Indonesia, Pakistan, and parts of the Middle East have begun incorporating practices such as dhikr (remembrance of God), ruqyah (spiritual healing), supplication, and Qur'anic reflection into therapeutic contexts (Khattak et al., 2023; Hajiyousouf & Bulut, 2022). While these practices offer spiritual comfort, most remain general in nature and are not explicitly designed to address clinical manifestations of impulsivity, emotional dysregulation, or suicidality. The findings from this review suggest that without deliberate integration of psychological models—such as the role of negative urgency or the impact of comorbid conditions—faith-based interventions may overlook key mechanisms driving impulsive suicidal acts.

This reflects a broader need to align Islamic ethical principles with evidence-based psychological frameworks that account for the complexity of human behaviour under distress. Islamic jurisprudence's recognition of reduced culpability during intense psychological suffering (Sheriff, 2020; Uyun et al., 2019) supports the development of clinical pathways that prioritise empathy, non-judgment, and collaborative care. However, many Muslim-majority contexts continue to face systemic challenges, including stigma, underreporting, limited mental health literacy, and insufficient suicide prevention infrastructure (Shoib et al., 2022).

Given these conceptual and clinical challenges, Islamic-informed mental health care cannot rely solely on religious guidance or conventional therapy in isolation. Instead, it requires clinicians who are able to translate Islamic moral–spiritual insights into therapeutic relevance and integrate them with evidence-based psychological approaches. This positions mental health professionals as key intermediaries who bridge the gap between scholarly Islamic perspectives on impulsivity, emotional distress, and intention, and the practical needs of individuals experiencing suicidality.

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Reframing the Role of Mental Health Professionals in Collaborative Islamic Care

To address this gap, mental health professionals must adopt a more collaborative and interdisciplinary approach that goes beyond spiritual reinforcement and integrates Islamic principles with psychological theory and practice. The role of clinicians should be reframed not simply as therapists, but as cultural translators and facilitators of integrated care. Their responsibilities include:

1. Translating psychological constructs into culturally meaningful terms: For example, mapping the concept of "negative urgency" onto Islamic teachings about emotional control and *ghadab* (anger).
2. Developing culturally attuned interventions: Employing therapeutic approaches—such as cognitive-behavioural therapy (CBT)—in ways that reflect Islamic epistemology, such as linking cognitive reframing to concepts of divine wisdom (*hikmah*) and accountability (*hisab*) (Sabki et al., 2019).
3. Collaborating with religious authorities: Partnering with imams, chaplains, and Islamic scholars to co-develop faith-sensitive care pathways, particularly in suicide prevention and crisis response (Elzamzamy et al., 2023).
4. Reducing stigma within religious contexts: Through community education, clinicians can help reframe mental illness not as a spiritual failure but as part of the human test, thus enabling earlier help-seeking (Haque et al., 2016).
5. Bridging moral language with psychological safety: While scholars may advocate mercy for those with impaired judgment, clinicians can operationalise this principle by offering trauma-informed care that respects both spiritual and psychological needs.

This collaborative care model aligns with the bio-psycho-social-spiritual framework, allowing both religious leaders and mental health professionals to contribute from their areas of expertise. Imams can offer religious reassurance and theological framing, while clinicians address cognitive, emotional, and behavioural concerns using structured methods. Together, they provide holistic, accessible care that is both spiritually authentic and psychologically sound.

Conclusion

This review highlights the significant role of impulsivity as a predictor of suicidal behaviour, particularly in individuals with comorbid psychiatric disorders such as depression and substance use. The findings emphasize that impulsivity consistently contributes to suicidal ideation and attempts, with religiosity identified as a protective factor. Despite these insights, existing mental health interventions, particularly within Islamic contexts, lack structured approaches to addressing impulsivity. This gap underscores the need for the development of culturally sensitive mental health care models that integrate Islamic principles with established psychological frameworks. Collaborative efforts between mental health professionals and religious authorities are essential to create a more comprehensive approach to mental health care that aligns with both spiritual and psychological needs. Future research should focus on the development of culturally validated tools and interventions to address impulsivity and suicide risk within Muslim populations, ensuring that Islamic-informed mental health care is both clinically effective and spiritually relevant.

This review has several limitations related to the quality and characteristics of the included studies. First, the majority of studies were cross-sectional, restricting the ability to infer causal relationships between impulsivity and suicidal behaviour. Many relied on self-reported measures, which are susceptible to recall and social desirability biases, particularly in cultural contexts where suicide is highly stigmatized. Second, there was considerable heterogeneity in

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sample populations, ranging from psychiatric inpatients to university students, which may limit comparability and the generalisability of findings. Third, important confounding variables—such as depression severity, trauma history, emotion dysregulation, and substance use—were inconsistently controlled across studies, potentially influencing estimates of the association between impulsivity and suicidality.

Several studies also used small sample sizes or lacked follow-up data, reducing statistical power and limiting insight into the temporal dynamics of impulsive suicidal behaviour. Additionally, most measurement tools were developed in Western contexts, with limited validation in Muslim-majority populations, raising concerns about cultural applicability. These sources of bias were considered in interpreting the review findings and underscore the need for more rigorous, culturally grounded research designs in future studies.

Conflict of Interest

The authors have no conflicts of interest to disclose, whether financial, professional, or personal, related to this manuscript.

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Author contributions

Nurasikin (Corresponding Author) led the conceptualization of the review, developed the research questions, and designed the systematic search strategy. She analyzed the findings and interpreted their implications for Islamic-informed mental health care. As the corresponding author, she was responsible for drafting and revising the manuscript, ensuring adherence to PRISMA guidelines, and securing final approval for the manuscript. Other authors contributed to various stages of the review, including identifying relevant studies, assisting with data extraction, and providing critical feedback on the manuscript. Their input was essential in refining the methodology and enhancing the integration of cultural and religious perspectives into the analysis.

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