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Mental Illness in the Orang Asli (Aborigines) of West Malaysia

by Eng-Kong TAN *and Hubert E. ARMSTRONG, Jr.*

Department of Psychological Medicine,
University of Malaya.

Introduction

THERE ARE about fifty-three thousand Orang Asli in Malaya. They are an exceedingly mixed people with distinct divisions of language, social organisation and physical type. Nevertheless, it is possible to distinguish three major groupings. The most primitive and at the present time the smallest group consists of the Negritos. They are true nomads, moving about hunting small animals and gathering jungle roots mainly in the northern states of Malaya. The second and largest group are the Senois. They are the most advanced and many of their tribes are in contact with towns in the central areas of Malaya. They are traditionally semi-shifting agriculturists and use the blow-pipe in their hunting. The third group are the Proto-Malays who are found mainly in the south of Malaya. They lead a life that is similar to the life of Malay kampong dwellers and those that live along the coasts gain a living from the sea. Each of the three groups of Orang Asli is composed of six tribes (see table 1).

The earliest mention of the extent of mental illness among the aborigines of Malaya seems to have been made by Polunin[1] in 1953. In his comprehensive article covering almost all areas of aborigine health he devoted a small section to "The Mental Characteristics and Diseases of the Nervous System" where he referred to the Malayan aborigines as a "timid, gentle people, little afflicted with aggressive tendencies", "their normal defence is by flight". In his study group of four hundred and fifty aborigines, he found three mentally subnormal persons of whom one was a deaf mute. There was no record of other psychiatric illness.

Many authors have referred to the close social existence, kinship and cooperation of the aborigines especially in major tasks. Sharing of many of their possessions is also part of their normal behaviour. In terms of psychiatric symptomatology, Noone[2] was told by the Senoi (the largest sub-division of the Orang Asli) that "the chief symptom of a certain youth's insanity was the fact that he kept food to himself." Other than these brief references to mental illness in the Orang Asli, reports of members of a tribe with abnormal behaviour have been anecdotal and reported from third persons.

Psychiatric Services. The Medical Service for the Orang Asli provides health care in the villages, at jungle medical posts and at Gombak Orang Asli Hospital (see figure 1). The first line of treatment, however, is the medicineman of the tribe. Among many tribes the "halaq" or magician treats the mentally-disordered with incantations, holy water (ayer jampi) and the imposition of taboos (pantang). This is especially so for neurotic disorders and milder forms of psychosis. When the abnormal behaviour of the mentally ill person disrupts the life of other members of the "saka" (or community) either through direct violent behaviour or deviant behaviour like stealing, members of the tribe decide jointly with their headman what actions should be taken. There is great variation among tribes as to disposition. One extreme case has been cited where the psychotic person is tied to a tree for days without food. He is believed to have angered the god of thunder (Karei), and hence should be left in the hands of this supreme deity who is believed to control thunder and lightning. Another tribe which also believes in evil spirits would typically make an

Table I

Distribution of psychiatric patients by Orang Asli tribes for years 1969-1974

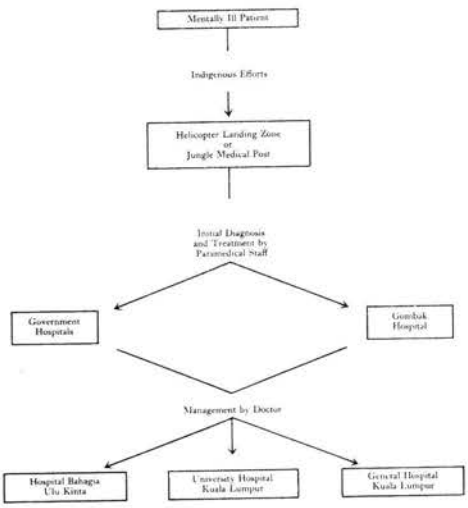
Tribe	Number of patients	Total population*	Number of patients per 10,000 population
Senoi:			
Semai	26	15,506	16.8
Temiar	4	9,929	4.0
Jah Hut	2	2,013	0.9
Semoq Beri	2	1,406	1.4
Mah Meri	22	1,198	183.6
Che Wong	0	272	0.0
Total	56	30,324	18.5
Proto-Malays:			
Jakun	16	8,995	17.8
Temuan	14	8,631	16.2
Semelai	6	2,391	25.1
Orang Kuala	0	1,480	0.0
Orang Seletar	0	277	0.0
Orang Kanaq	0	40	0.0
Total	30	20,814	14.4
Negrito:			
(Kintak, Kensui, Jahai, Mendrig, Bateq, Lanoh)			
Total	0	1,805	0.0

image of the spirit believed to cause the mental illness and would carry out a ritual to appease this spirit. The image would be hanged or burned with the expectation that the person would stop his abnormal behaviour.

Presently most Orang Asli tribes recognise and accept the usefulness of western medicine. This is made easier by the fact that staff at the helicopter landing zones or the jungle medical posts are Orang Asli from local tribes. There are abount seventy such jungle medical posts, each manned by an Orang Asli medical orderly or midwife, assisted by a porter. The medical orderly gives the monthly injections of fluphenazine decanoate, a long-acting phenothiazine, for schizophrenics on maintenance therapy. This is the drug of choice as it obviates the problem of defaulting daily oral medication. For a new case or a relapse of illness in a previously mentally ill person, the orderly consults the doctors from Gombak Hospital during routine helicopter visits or in urgent cases via wireless. Where hospitalization is required, a road vehicle, boat or helicopter will be sent to take the patient to the nearest available government hospital or to Gombak Hospital directly.

Figure 1

Psychiatric Services for the Orang Asli



For the mentally ill Orang Asli, admission into a government hospital that is entirely foreign to him is an added stress. Very often he would feel alienated and problems of communicating with him leave the medical staff exasperated. Other patients tend to stare at the Orang Asli and some, due to a lack of understanding of the way of life of the Orang Asli, will complain to the medical staff about their manner of dressing, eating and voiding in the ward. In larger towns, however, a section of the hospital service is devoted to the care of Orang Asli and here the situation is better, though seldom ideal. The best possible environment for the mentally ill Orang Asli who requires hospitalization is Gombak Hospital, situated twelve miles from Kuala Lumpur along the Selangor-Pahang trunk road. It has a capacity for 450 patients. Mentally ill patients and their accompanying relatives are admitted into the general medical wards.

At Gombak Hospital the mentally ill are well accepted by other patients and receive equal care from the staff. The very fact that they are not isolated or put in separate wards attest to the accepting nature of patients and staff. When difficulties in diagnosis or management arise, medical officers may refer the case to the Psychiatric Unit at University Hospital or General Hospital, Kuala Lumpur either for outpatient consultation or for hospitalization and investigation. Should the illness be one of chronicity coupled with a lack of social support from the tribe, the patient is referred to Hospital Bahagia for long-term hospitalization.

Incidence of Mental Illness among the Orang Asli. At the present it is impossible to keep a record of all cases of mental illness among the Orang Asli. First, the Orang Asli tribes are distributed throughout the country, most of them in difficult and rugged terrain and some in inaccessible areas. Second, many forms of mental illness are not recognized as a state of ill health by various tribes. Among the Orang Asli there is a remarkable attitude of acceptance and non-interference in the affairs of others. Consequently, many forms of non-violent or non-problematic (for others) behaviour which western psychiatrists would view as a minor neurosis or transient situational reaction, are simply not regarded as mental aberrations. Hence only the more severe and problematic cases requiring hospitalization come to our attention. These cases represent the "recorded" incidence of mental illness in contrast to the true incidence.

Method

Records of the main treatment centre for the Orang Asli, Gombak Hospital, were examined to give an idea of the extent and nature of mental illness among these people. The Medical Records Office at Gombak has maintained adequate records of all hospitalised cases for the last six years. A detailed examination of cases admitted for mental illness during this period was conducted.

Results

Between the years 1969-1974 there were eighty-six new cases admitted into Gombak Hospital with a psychiatric diagnosis (see table 1). This is an average of fourteen cases per year (see table 2). The average length of stay for a psychiatric patient at this hospital was 4-6 weeks. This duration of hospitalization is longer than the actual period required for treatment since patients often have to wait for the availability of transport after certified fit for discharge.

Table II

Mental illness among the Orang Aslis by Diagnostic Category*

Diagnoses	Number of Patients	Percentage
Schizophrenia	65	75.4
Mental retardation	6	7.0
Epileptic	4	4.6
Organic psychosis	3	3.5
Drug dependence	2	2.3
Pathological grief reaction	1	1.2
Psychotic depression	1	1.2
Reactive depression	1	1.2
Puerperal psychosis	1	1.2
Personality disorder	1	1.2
Total	86	100.0

*For years 1969-1974

About a third (32%) of the psychiatric cases seen at Gombak were referred to another hospital. Ten percent of these cases are referred to the University Hospital in Petaling Jaya for further investigations and management, four percent to the General Hospital, Kuala Lumpur and eighteen percent to the large psychiatric institution, Hospital Bahagia for long-term management. These are average figures for the last six years. There is a downward trend in the number of cases referred to other hospitals over the years. This is mainly due to the fact that younger medical officers at the hospital have received more psychiatric training as medical

students and feel more confident in managing the mentally ill at Gombak. Currently cases are often referred to other hospitals only for a second opinion while the general management of the patient is carried out at Gombak.

Table III
Psychiatric cases admitted to Gombak Hospital by year

Year	Number of cases
1969	16
1970	8
1971	20
1972	19
1973	12
1974	11
Total	86

Schizophrenia. There is a fairly wide range of mental illness among the Orang Asli as Table II illustrates. The relative proportion of schizophrenics to the entire patient population with psychiatric diagnosis is 75.4%, a figure comparable to the statistics from psychiatric units in hospitals elsewhere in the country. Among schizophrenic cases, the average age on admission is 31 years. This is at best a rough figure because many Orang Asli do not know their age and the figure recorded in the case files is often an estimate. The proportion of male to female schizophrenics is 4:3. There are about equal numbers of acute and chronic schizophrenic cases seen on admission. It is difficult to classify the type of schizophrenia, except in those few obvious cases with florid symptomatology. The usual descriptions of abnormal behaviour include "running around aimlessly", "cutting down trees indiscriminately", "shouting nonsense and singing to himself" and "threatening to harm others." In the mental status examination there are two extremes noted:- "agitated and aggressive behaviour", and "withdrawn and non-communicative." In about half of the cases there is mention of delusions (usually of a paranoid nature) and hallucinations (mainly auditory). During their initial psychosis the great majority of schizophrenics respond to oral phenothiazines alone. Five percent of the schizophrenic cases required electro-convulsive therapy. A third of the cases are placed on fluphenazine decanoate (an intramuscular long-acting phenothiazine) before discharge. Slightly more than one third of the cases (38%) had relapses of their psychotic behaviour requiring readmissions during the six-year period studied.

Other psychiatric diagnoses. There were six cases of mental retardation. These were children ranging from one to five years of age. In one case the mental retardation was due to birth injury and in two cases it was associated with microcephaly and epilepsy. Among the four cases of epileptic psychosis, the psychotic behaviour occurred at an average age of eighteen years. The age of onset of the epilepsy in these cases was recorded. Three of these cases had temporal lobe epilepsy and the fourth was a case of petit mal epilepsy. Of the three cases of organic psychosis, one was of traumatic etiology (bullet wound in left temporal region) and the other two were due to a severe underlying medical illness associated with malnutrition. One case of drug dependence involved the smoking of opium for two years and the other case was iatrogenic in origin, being a dependence on pethidine following fracture of the shaft of the femur.

The case of pathological grief reaction involved the death of the parents and wife of an adult male. The deaths occurred one after another within a period of one month and the patient was noticed to be wandering about in the jungle looking for his lost ones. He subsequently talked to the deceased as if they were in his company. He was transferred to the University Hospital where he was treated with high doses of chloropromazine and required four electroconvulsive therapies before he was well enough for discharge. Another two cases of mental illness occurred after the death of spouses as well – a man became psychotically depressed after the death of his wife and a woman suffered from a mild depression following her husband's death. There was one case of puerperal psychosis. A thirty-five year old housewife became psychotic soon after delivering a dead foetus at five months gestation. She was noted to be incoherent in speech and harboured paranoid delusions as well. However, she responded rapidly to oral phenothiazines. Finally, there was one case considered as a hysterical personality disorder – a middle-aged lady who was hyperventilating and demonstrative after a quarrel with husband over some domestic issues.

In addition to these psychiatric diagnoses, about ten percent of the mentally ill patients had other accompanying medical illnesses, such as bronchitis, gastroenteritis, anaemia and urinary-tract infection.

Distribution of mental illness. The tribal distribution of psychiatric patients at Gombak Hospital is shown in Table 1. The Senoi is the group most exposed to and influenced by urban areas in the country. It has the highest number of patients per ten thousand population in the last six years (18.5/10,000). The prevalence rate for Proto-Malays is

14.4/10,000 population for the same period of time. There is only a very small number of Negrito patients admitted each year into Gombak Hospital. As mentioned earlier, they are the most primitive of the Orang Asli and they remain very much an isolated miniority group. Although there is not a single case fo a mentally ill Negrito admitted into the hospital over the last six years, one cannot conclude that the Negritos are entirely free of mental disorders.

Among the Senoi, the Mah Meri tribe appears to be over-represented in the total psychiatric patient population (183.6/10,000 population). This can be explained by the fact that almost all the Mah Meris live on Carrey Island which is only thirty-five miles from Gombak Hospital. The Mah Meris are renowned for their intricate woodcarvings and as a group they are very much assimilated into general island culture. They earn their livelihood as rubber-tappers, fishermen and oil palm estate workers. They are responsive to the medical care offered through Gombak Hospital and hence a high proportion of psychiatric cases are detected and treated at Gombak Hospital. Follow-up management of chronic achizophrenics is carried out on the island by a medical officer who visits the medical post there at least once a month.

On the whole, it would appear that the "prevalence" of mental illness is related to the degree of assimilation of the tribes with the general population. Among the Senoi, the Semai and Mah Meri tribes are most integrated with the urban population and they have relatively high prevalence rates. Among the Proto-Malay, the Semelai, Jakun and Temuan tribes are the more "civilized" group and it is also these tribes that have relatively high prevalence rates of mental illness compared to the other three tribes (Orang Kuala, Orang Seletar and Orang Kanaf) who live in the remote jungles and coasts of the state of Johore.

In contrast to being influenced by "assimilation" processes, prevalence rates may simply reflect the accessibility of medical care to these tribes. Since medical care is more readily available to tribes which are more integrated with the general population, it is expected that the detection and treatment of these patients would be more comprehensive than in other more primitive groups. Thus it is not possible to consider the integration of the Orang Asli with the rest of the population as having a direct causal effect in their increased prevalence rates of mental illness. In a separate paper by the present authors, however, it has been shown that assimilation of the Orang Asli into a broader cultural milieu has effects on their self-concept. The "body-image barrier" index is lowered among the Orang Asli with greater proximity to outside influence. The Orang Asli are in a process of transition and it could be expected that this process would impact on mental health statistics of the population.

Discussion

It may not be altogether appropriate to study mental illness in a culture like that of the Malaysian aborigines using western-orientated diagnostic categories. Very often the symptomatology of the mentally ill fails to fit neatly into categories. Furthermore, the limits of "normality" and the definitions of "deviant behaviour" utilized by western psychiatry deviated from those employed by the Orang Asli. These norms and definitions even differ from tribe to tribe among the Orang Asli themselves. At this time, however, there is no other frame of reference to use in a study of this nature. Using the diagnostic categories enunciated in the International Classification of Diseases has the advantage of making transcultural comparisons possible and perhaps more meaningful. In search of an alternative, Dentan[4] has presented data of a particular tribe's (Semai) response to mental aberrations. In his interesting socio-anthropological approach to the study of mental illness in this group he has accepted a simplistic classification of behaviour into two dichotomous dimensions: individual problem/not problem and social problem/not problem.

Whatever approach may be used in the study of problematic behaviour among the Orang Asli, the urgency of the issues at hand needs to be emphasized. As pointed out by Baharon the Orang Asli can no longer be regarded as an isolated and insignificant people who have little to offer for the future of the nation. Furthermore, the process of integration of the Orang Asli with the rest of the peoples of the country is no easy matter for "apart from having to overcome the many odds in their quest for a better life, they have had to face a kind of social barrier of illusions, misconceptions and prejudices about them."[5] Further studies into the psychological problems of the Orang Asli could help them to break this barrier and at the same time retain their identity as a people rich in culture and strong in group cohesiveness.

Summary

A brief survey of the psychiatric services available for the Orang Asli is outlined. A study of the psychiatric cases admitted into Gombak Hospital between 1969-1974 according to diagnostic categories and distribution among tribes is presented. Comments are made with reference to the nature of mental illness among the Orang Asli, a culture in transition.

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