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Medical phychology in Malaysia: A developing profession in a developing nation

by John E. Carr
University of Washington

IN ESTABLISHING training programs for health care professionals, developing nations inevitably must determine which professions will be given the country's finite educational resources over a limited period of time. Instead of a uniform evolution of an integrated system of health care delivery, this assignment of priorities results in idiosyncratic interrelations among professions and a unique health care system which may appear to be quite confusing, especially when viewed from the "outside".

Malaysia is a rapidly developing nation of 10 million people in Southeast Asia. It is blessed by an abundance of natural resources and, through sound economic planning, has gained recognition as one of the most progressive nations in Asia. Considerable effort has been devoted to the development of its educational system and the training of much needed professionals in the various health care specialties. Government scholarships are made available to train students at home and abroad and through various granting agencies and collaborative arrangements with institutions overseas, Malaysian universities enjoy a constant stream of visiting lecturers and professors.

The training of psychiatrists has been assigned a high priority by the Ministry of Health. Whereas only a handful of psychiatrists could be found throughout the country less than a decade ago, at the present time approximately 20 specialists in this field are on assignment with universities or government clinics and hospitals. Almost half of this number are located in the Department of Psychological Medicine at the University of Malaya Faculty of Medicine in Kuala Lumpur. It is one of the larger departments and has responsibility for two wards of 28 beds each, a large outpatient clinic and a day care unit. In addition, it plays a major role in medical student training and offers a post-graduate training program in Psychological Medicine leading to a masters degree. This program is one of three postgraduate programs offered by the Faculty of Medicine.

In contrast, medical psychology does not enjoy a priority status in Malaysia's development plans. There are no clinical training programs in any of the higher institutions of learning in the country, although there are educational psychologists and a few counselling psychologists located in individual posts in various schools.

Since the vast majority of medical and educational specialists in Malaysia have been trained in foreign settings, these individuals are not only familiar with the role of medical psychologists but have been trained to utilize psychological services and skills in the exercise of their own clinical specialties. Thus, foreign training establishes certain expectations which are incompatible with the Malaysian scene as it actually exists.

The impact of these expectations and their incompatibility with reality is revealed in the clinical activities of the country's only medical psychologist for the calendar year 1973. The psychologist was an Indian woman holding an MA in Medical Psychology received in the United Kingdom. In addition to her clinical activities, she carried teaching responsibilities for 1st, 2nd, 3rd and 4th year medical students, 1st year nurses, and postgraduate psy-

chiatrists. She also served as a consultant to several schools and local agencies for children, and did behavioral therapeutic consultations for the departments of Pediatrics and Psychological Medicine. The clinical activities were carried out on two clinic half-days per week. An exact number of total cases seen was difficult to determine since a high proportion of scheduled cases failed to appear (about 20%) and many of those that did appear were follow-up consultations (about half). Of the more than 200 patient contacts for the year, 54 were "new" cases in which an initial comprehensive psychological evaluation was conducted and a formal psychological report prepared.

Age and ethnic group. The majority of cases seen were children, 80% being 15 years or younger and over half being under the age of 10. While Malays constitute 53% of the population of Malaysia and Chinese and Indians 35% and 11% respectively, cases referred for psychological evaluation included a greater number of Chinese (35%) and Indians (31%) than Malays (24%). This not only reflects the urban location of the hospital where the majority of the country's Chinese and Indians are located, but also reflects the health care practices of the various ethnic groups. Being distant from medical centers, the urban Malays tend to rely more upon traditional indigenous practitioners. Thus, the kinds of problems generally referred to psychologists in more developed countries are seldom identified as "medical" or "psychological" among rural Malays but instead may be viewed as the result of external influences, e.g. spirits. Those Malay patients who were referred tended to be either in higher socioeconomic levels, more highly educated and familiar with western medical practices, or referred in from rural area by district health officials.

Education. Because of the age and socioeconomic bias, it is not surprising that the majority of cases seen were in the primary (30%) and secondary (43%) levels. The small proportion of illiterate patients seen reflects both the higher socioeconomic and urban locale of the hospital and the higher literacy rate of Malaysia in comparison with other Asian nations. The age/education parameters also reflect the fact that many of the cases referred are in response to parental or school concern with educational failure.

Language. Fifty percent of the evaluations completed were conducted in English, while 11% were conducted in Malay, 4% in Hokkien (a Chinese dialect), and 7% in Tamil. The high proportion of English medium evaluations is attributable to the fact that in the majority of cases English may be the one language the psychologist and patient had in common, regardless of cultural background. Twenty-two percent of the cases referred had no language indicating that the second largest number of cases were referred for various forms of communications disability or for a primary disorder where communication disability was a secondary characteristic (e.g., mental retardation).

Sex. Seventy-two percent of the cases seen were males while only 28% were female. This remarkable discrepancy in utilization of psychological services by sex reflects an important characteristic of Asian culture, namely that males are more important than females. Therefore, when sons are ill or experience school disabilities, parents are more likely to be concerned and seek consultation with specialists than if the same difficulties are experienced with their daughters. Throughout Asia and especially in Malaysia success and achievement are very much education related and education is highly competitive. If parents are to look forward to a comfortable old age where they shall be supported by their sons, they must insure their son's ultimate success early on.

Sources of referral and referral questions. The majority of referrals for psychological evaluation came from three departments: Psychological Medicine; Pediatrics; or Ear, Nose and Throat. The patients from ENT tended to be young children with sensory disabilities while those from Peds tended to manifest developmental delays or neurological impairment.

The predominant referral question had to do with the patients' intellectual capabilities or, more precisely, "Is this patient retarded?" In many instances the retardation was of suspected genetic or pathological origin. In other cases, language disability was the presenting problem with selective intellectual impairment the suspected cause (e.g., dyslexia). In only a small minority of cases was personality disorder the basis for referral. Not surprisingly, the test findings confirmed a high incidence of mental retardation and related sensory deficit or language disability. Even among those cases referred for "personality disorder" a high proportion were found to be retarded.

Recommendations, follow-up, and outcome. Based upon her test findings, the psychologist had made several categories of recommendations. In 35% of the cases tested no specific recommendations were made, primarily because no recommendations were sought. In the remainder of the cases seen, recommendations had to do with special education (24%), communication therapy (15%), behaviour therapy (9%), or treatment programs that could be carried

out at home (4%). The remainder of the recommendations had to do with administrative changes, i.e. school changes, different teachers, alterations in program, etc.

The recommendations made by the psychologist were followed in only 22% of the cases. Follow-up on the psychologist's recommendations was reported in only 26% of the records reviewed and progress reported in only 17% of those cases.

Expectancy. Obviously, the medical psychologist was perceived as a professional whose expertise was most closely associated with the evaluation of intelligence and learning disabilities in children. The nature of the referrals further suggests that the psychologist was seen as being able to provide reliable and valid test findings, and that her professional role was viewed as somewhat similar to that of other specialists who provide important "laboratory data", such as EEG, Radiology, etc., regardless of the age, education, ethnic background or language of the patient. Thus, expectancies concerning professional role reflected a certain degree of naivete with regard to what the psychologist could be expected to do given the limitations and sources of error inherent in behavioral measurement in a multi-ethnic, multi-lingual culture.

Another set of expectations had to do with the implications of the psychologist's findings and recommendations as well as the implications of the original referrals. The primary presumption behind most of the referrals for psychological evaluation was that they had some meaning with regard to clarifying current diagnostic vaguery or future prognostic plans. The reality of the situation was that in the majority of cases they did neither. Not because the psychologist was inept or incompetent, but rather because (a) the referral had been an "academic exercise", well learned during the referring doctor's training, but minimally relevant in the present setting, and (b) the outcome and recommendations were moot since back-up resources in the community were severely limited. A frequent example of (a) was the referral of school age children with a history of gross developmental delay, lack of speech, poor motor coordination, and established mental retardation, to "determine the IQ". An example of (b) was the referral of the same child for "evaluation to assist in special school placement" when there were limited or no special schools or institutions available to the child or family.

While it has achieved a high standard of academic excellence in medical training, Malaysia, like other developing nations, faces the task of making its highly regarded training programs increasingly responsive to the special needs of the country. While Medical Psychology is deserving of attention as a new priority in many developing nations it must evolve as a uniquely indigenous phenomenon. The application of behavioral principles and clinical skills evolved in western settings must be made relevant to the realities of local life.