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MALAY PSYCHIATRIC PATIENTS AND TRADITIONAL HEALERS (BOMOHS)

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INTRODUCTION

In Malaysia modern psychiatric concepts and practice coexist with indigenous systems of traditional medicine among the three ethnic groups of Malays, Chinese and Indians. The mentally ill as well as physically ill avail themselves of both these systems of care simultaneously or at different periods. The consultation of traditional healers is at times by necessity because of the unavailability of psychiatrists.

An understanding of the concept and practice of the indigenous systems of medicine as applied to mental illness provides an insight into the behaviour and attitudes of patients who also seek modern psychiatric care. The concepts and causation of mental illness among the Malays have been well documented by Chen (1970) and Hartog and Resner (1972), and among the Chinese in Malaysia by Gwee (1971). This paper presents a profile of Malay psychiatric patients admitted to hospital and the practice of traditional medicine experienced by them and their attitude towards practice.

CULTURAL BACKGROUND

The cultural forces influencing the Malays are derived from Hinduism in the third century and later influences of Islam from the fifteenth century (Chen 1970, Hartog and Resner 1972). These forces interact with more archaic animistic beliefs. Spirits *(jin)* and ghosts *(hantu)* are believed to influence almost all aspects of daily living. These influences could be malevolent or benevolent. One of the causation of mental illness is believed to be supernatural. Spirits *(jin)* can cause illness directly as in spirit possession or indirectly through physical causes. Witchcraft and the wrath of God are other supernatural causes.

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Physical causes are also recognised. "Poisonous blood" is believed to cause puerperal psychosis, "wind" *(angin)* can cause illness either physical or mental. This concept is akin to the Chinese concept of "wind madness" – madness resulting from the entry of evil wind into the Yan system (Gwee 1971). Senility and epilepsy are recognised as forms of mental illness too.

Treatment of mental illness traditionally is centred on the *bomoh.* Diagnosis is arrived at by the history, symptoms and divination by the *bomoh.* Forms of treatment follow as a conorally from the causation and the *bomoh* may prescribe herbs and taboos for physical causes, incantations, spells *(jampi),* exorcism, possession and *main putri* which is a form of psychodrama based on folk-lore and invocation of spirits (Chen 1970, Hartog and Resner 1972, Winstedt 1961) for supernatural causes.

METHODOLOGY

The General Hospital in which this study was conducted is situated in Kota Bharu which is the only large urban centre of the State of Kelantan. The Psychiatric Department of the Hospital was the Regional Mental Health Centre (Hospital) and the effective catchment area was from Kelantan and the neighbouring part of the State of Trengganu. The population of Kelantan was approximately 800,000 comprising 92.7% Malays, 5.4% Chinese, 0.8% Indians and 1.1% Thai and other ethnic groups. The percentage of males in Malays was 49.4% (Vital Statistics 1974). The majority of Malays, Indians and other ethnic groups were rural domiciled and the majority of Chinese were urban domiciled.

The admission policy into the Psychiatric wards was liberal in that relatives, police and patients could seek admission through the Admission and Emergency Department of the hospital at any time. After admission to the Psychiatric wards the patients were managed by any one of the three psychiatrists. All diagnoses were based on the International Classification of Diseases, Edition VIII.

A pilot study was made to ascertain the reasons cited for admissions in order to include as many reasons as possible for this study. From the pilot study the final grouping of reasons was formulated. For this study only Malay patients from the State of Kelantan were included. The study period was from March 1978 to May 1978. A total of 128 patients were admitted and 120 were Malays.

RESULTS

Sex

There were more males admitted than females. Though the male proportion of Malays in the State population was less than half (49.4%) (Vital Statistics 1974), there were74 (61.6%) males as compared to 46 (38.4%) females. The corresponding figures for

Table I

Characteristics of Malay psychiatric in-patients in Kelantan

	Male n = 74	Female n = 46	Total n = 120
Age in years			
Below 10	3	0	3
10 – 19	11	2	13
20 – 29	27	17	44
30 – 39	20	15	35
40 – 49	7	9	16
Above 50	6	3	9
Marital status			
Single	37	7	44
Married	23	20	43
Divorced/separated	13	18	31
Widowed	1	1	2
Domicile			
Urban	17	10	27
Rural	57	36	93
Frequency of hospitalisation			
First	19	21	40
Second – Fourth	37	15	52
Fifth – Seventh	12	5	17
Over seventh	9	5	14
Source of referral			
Self referred	4	2	6
Relative referred	46	29	75
Judiciary	1	0	1
Police	14	11	25
General Practitioner	1	0	1
Traditional healers (bomoh). via relatives	7	5	12
Diagnosis			
Schizophrenia	68	38	106
Depressive psychosis	0	1	1
Manic psychosis	4	1	5
Hysterical neurosis	0	2	2
Epilepsy	2	0	2
Medical and others	4	0	4

First admissions significantly higher in females than males ($\chi^2 = 5.11$, df = 1, $p < 0.025$).

Table II

Comparison of patients who had consulted bomohs with those who had not consulted

	Consultation of bomohs	
	No	Yes
Number of admissions		
First	12	28
Second-Fourth	30	22
Fifth–Seventh	13	4
Over seventh	8	6
Duration of illness before hospitalisation		
Within 1 week	42	16
1 week – 1 month	8	18
1 month – 6 months	5	13
6 months – 2 years	1	5
Over 2 years	4	8
Domicile		
Urban	15	12
Rural	45	48

Consultation of bomohs was significantly higher among first admissions than readmissions ($x^2 = 9.20$, df = 1, $p < 0.005$)
The delay of admission beyond 6 months of those patients who consulted bomohs was significant ($x^2 = 35.05$, df = 3, $p < 0.005$).

Table III

Tabulation (in percentages) of reasons for admission related to different variables of patients

Reasons for admission	All patients	Male	Female	Rural	Urban	Police admission
Insomnia	22.3	22.1	23.0	23.5	16.7	19.5
"Restlessness"	21.5	21.4	21.3	21.0	23.6	24.4
Irrational speech	15.4	14.4	16.7	15.0	16.7	13.4
Wandering from home	10.7	11.1	9.2	11.3	8.3	13.4
Violence	9.5	12.3	5.2	9.7	8.3	9.8
Refusal of food	7.4	6.2	8.6	7.8	5.6	8.5
Social withdrawal	6.2	6.2	7.5	5.9	6.9	4.9
Abnormal emotions	5.1	4.2	6.9	4.4	9.7	3.7
Other reasons	1.9	2.1	1.6	1.4	4.2	2.4
Total	100.0	100.0	100.0	100.0	100.0	100.0

the total hospital admissions for 1978 were 46% males and 54% females. The sex distribution for psychiatric admissions was approximately 8 males to 5 females (Table I). Murphy (1959) found in neighbouring Singapore that the rate of Malay male psychiatric admissions was also higher.

Age

The percentages of adult (above 15 years) Malay population in the State between the ages of 20 to 29 years and 30 to 39 years were 28.4% and 18.6% respectively (Vital Statistics 1974). The corresponding percentages in the patient sample were 38.3% and 29.2% respectively, indicating the relatively higher incidence of admissions of patients in their third or fourth decades (Table I).

The average ages for female, male and total admissions were 39.5 years, 29.7 years and 35.7 years respectively. Murphy (1959) showed that the highest rate of admission for Malay males in Singapore was in the third decade, and for females in the fifth decade.

Marital status

There was a divorce rate of 25.8% among the patients of which there were more females than males. Approximately equal numbers (36.7%) of patients were married or single, but two and a half times as many males than females were single. Among the divorced, 8 out of the 13 males and 11 out of the 18 females were living with parents. Even among the married, 8 males and 6 females were staying with parents. On inquiry the reason given was that the spouse had requested the patient's parents to care for them. In some cases of females, the parents had requested to care for the patient.

Urban-rural distribution

There were relatively more patients from the urban area. The Malay urban population in Kelantan was 5.9% (Vital Statistics 1974). There was negligible sex difference among the urban patients but there were proportionately more males than females among the rural patients.

Education

Thirty-two patients had never attended school. Fifty-eight patients had primary (up to 6 years) education, 29 patients had secondary (up to 13 years) and 1 patient had tertiary (college) education.

Category of admission procedures

Voluntary behaviour of seeking admission was infrequent, with only 6 patients doing so. Relatives sought admission through certification for 87 (72.5%) patients. The police brought in 25 (20.8%) patients. One case each was referred from a general practitioner and a magistrate for admission. There was no significant difference in admission procedure between males and females nor between urban and rural patients.

Frequency of hospitalisation

There were significantly more females than males among the 40 first admissions ($p < 0.025$, $x^2 = 5.11$, $df = 1$). Seventy-five percent of first admissions had consulted *bomohs* before hospitalisation as compared to 39% of readmissions. This difference was highly significant ($p < 0.005$, $x^2 = 9.2$, $df = 1$) Table II). Among the readmissions, 14 patients had been admitted more than 7 times over the years.

Reasons for Hospitalisation

The reasons as given by the patient or by the key accompanying person were recorded at the time of admission. More than one reason were recorded where applicable (Table III). There were 390 reasons cited for 120 patients, an average of 3.3 reasons for each patient. Urban patients had an average of 3.5 reasons and rural patients had 3.2 reasons.

Insomnia was the most frequent (22.3%) of all reasons for males, females and rural admissions, but not so for police or urban admissions. Restlessness was the second in rank order for all admissions. This was described as generalised hyperactivity, disturbance and interference with the activities of others including the public. This was invariably complained of by the key informants. This reason was most common in urban and police admissions.

Talking irrationally or irrelevantly was cited as third in rank order of reasons. Wandering away from home was a reason given exclusively by the key informants. This symptom occurred both during the day and night, and some patients did not return home for days. Violence, which included aggressive behaviour physically or verbally and threatening assault, was more common in males than in females. This reason was also more frequently cited among readmissions than first admissions.

The lower rank order of reasons included refusal

of food, withdrawn behaviour (including behaviour of not talking and keeping to himself or being alone in a room) and abnormal emotions. Hallucinations and delusions were not cited as reasons for hospitalisation.

Among police admissions, restlessness was the most common reason. The arrested persons complained of insomnia as the reason for their hospitalisations. Irrational speech and aimless wandering were cited by the police as being more common than violence which was fifth in rank order.

Duration of present illness

Forty-eight percent of patients were hospitalised within a week of the onset of symptoms and another 21.7% from one week to one month. Another 15% were admitted from 1 to 6 months of their illnesses. Ten percent had sought hospitalisation only after a period of 2 years (Table II).

Nine (19.6%) female patients delayed hospitalisation beyond 6 months with 15.2% beyond 2 years whereas corresponding figures for male admissions were 12.2% and 6.8% respectively. For those delaying hospitalisation beyond 1 month, males comprised 25.7% and females 36.9%. In general, females were hospitalised after a longer period of illness than males, but this difference did not reach a significant level. There was also no significant difference between urban and rural patients.

Of the 18 patients who sought admission after 6 months, 13 (72.2%) had sought treatment from *bomohs* before admission. The delay of admission for those who sought treatment from bomohs were highly significant ($p < 0.005, x^2 = 35.05, df = 3$). The diagnoses of the 18 patients delaying admission beyond 6 months were 15 cases of schizophrenia, 2 cases of epilepsy (both cases beyond 2 years) and 1 case of hysterical neurosis.

Diagnosis

One hundred and six patients (88.3%) were suffering from schizophrenia. Manic psychosis was diagnosed in 4 males and 1 female, and depressive psychosis in 1 female. Hysterical neurosis was diagnosed in 2 female patients, but other forms of neurosis were not observed among the patients. Other diagnoses were epileptic psychosis and organic psychosis. One patient was admitted for observation for the judiciary and 3 for underlying medical illnesses (Table 1).

Diagnoses did not differ significantly among rural and urban population in this study. However, there was a higher percentage without reaching significant level of males as compared to females who were schizophrenic.

Table IV

Forms of treatment practised on 60 patients by bomohs

Treatment	No. of patients
Koranic prayers	28
Incantations (jampi)	46
Exorcism	10
Trance	1
"Main putri"	2
Taboos	3
Inhalation of incense	1

More than one form of treatment was practised on some patients.

Consultation of Traditional healers (bomohs)

Sixty patients had consulted traditional healers during their present illness before admission. A higher percentage of rural patients than urban patients consulted *bomohs,* but this difference did not reach a significant level. Similarly there was no significant difference in the variables of sex, age and level of education. The causation of the patient's illness was inquired of the key informant. In 12 of the cases, the explanation was that the patient had been charmed *(gila kena buat),* in 46 cases they were mad *(gila)* and 2 cases were medically ill.

Seventy percent of all first admissions had consulted *bomohs* compared to 40% of readmissions. This was highly significant ($x2 = 9.20$, $df = 1$, $p < 0.005$) (Table IV). For those who had consulted *bomohs*, the period from onset of symptoms to hospitalisation was significantly delayed ($x2 = 35.05$, $df = 3$, $p < 0.005$) (Table 2). Seventy percent and 80% were hospitalised after one week and after one month respectively when the *bomohs* were consulted as compared to 26.6% and 56.6% respectively when they were not consulted.

The *bomohs* consulted were from the local community in half of the 60 cases and in another 28 cases, they were from nearly communities. In only 2 cases were *bomohs* from outside the State sought.

The decision to seek help from *bomohs* was arrived at by the patient's primary group in 45 out of the 60 cases. This group comprised the immediate family members as well as relatives who lived in the same village. Individual decision was recorded in 5 patients and decision by others in 10 cases.

During their current illnesses the number of *bomohs* consulted ranged from 1 to 8. Nineteen patients sought only 1 *bomoh* each and 11 patients sought more than 6 *bomohs* each. The average was 3. The reasons expressed for the change of *bomohs* were "no improvement" in 38 cases, the *bomohs* were too expensive in 2 cases and the *bomoh* refused further treatment in one case. This *bomoh* had advised admission to hospital.

The number of consultations with each *bomoh* ranged from 1 visit to 5 visits. The average number of visits was 2.1. The total period of treatment by *bomohs* ranged from 1 day to 2 years. Thirty five patients were treated for a period of up to 2 weeks. Eleven patients were treated for over 3 months. Not all **bomohs** undertook to treat the patients exclusively. Twelve of them had advised hospitalisation for their patients.

Among the 60 patients who consulted *bomohs* for their present psychiatric complaints, 27 had consulted them in the past too for similar complaints. Twenty-three had never consulted them and 3 had consulted for physical illnesses in the past. The remaining 17 had consulted *bomohs* for supernatural reasons.

Thrity-two of the 60 patients who had consulted *bomohs* during their current illnesses had previous hospitalisations. After the latest discharge from hospital, 20 of the 32 cases had, on returning home, consulted them again. However, among the 48 readmissions out of the 60 patients who had not consulted *bomohs* during the current illnesses, only 2 had consulted them after their latest discharge.

Their attitudes towards consultation of *bomohs* after discharge for the current illnesses differed. Among those who had consulted **bomohs** for their current illnesses, 7 stated categorically they would consult them again, 36 would not, and 17 were uncertain. Corresponding figures for those who had not consulted *bomohs* currently were 4, 51 and 5 respectively.

The decision whether to consult *bomohs* remained fairly constant for both groups of patients though for those who had consulted them in the past, their future intentions were less certain. As the patients treated by *bomohs* had been ill for a longer duration, this uncertainty to consult them in the future suggested a change in attitude perhaps related to the failure of treatment, at least in this hospital sample.

The cost of each *bomoh* treatment varied from below 5 dollars to over 20 dollars per visit with 35 patients paying the former and 2 patients the latter. This compared with the current charge by a general practitioner of 5 to 15 dollars per visit with medication included. Four patients also presented gifts in the form of cloth and chickens. The total cost of treatment by *bomohs* ranged from less than 10 dollars to over 400 dollars. Twenty-one patients paid less than 10 dollars, 14 patients paid from 11 to 50 dollars, 5 patients paid over 400 dollars.

The forms of treatment carried out on the patients by the *bomohs* were many and combinations of these were often encountered. As an example, prayers from the Koran were also used in conjunction with incantations. The most frequent procedure was incantation *(jampi)* practised on 46 patients. This procedure was often accompanied by the intake of water or food over which the incantations *(jampi)* had been said. Prayers from the Koran were recorded in 28 cases and exorcism in 10 cases. In 1 case of exorcism the patient was symbolically beaten to drive out the evil spirit. One patient was made to inhale incense and another was put into a trance. For 3 patients the *bomohs* also prescribed a set of taboos *(pantang)* and the avoidance of certain foods.

In 2 patients a form of psychodrama with spirit possession *(main putri)* was enacted. This usually took place at night and only a few *bomohs* professed to be able to conduct a *main putri.* The patient and the family gathered in a house and amidst the beating of gongs, drums and chanting, the *bomoh* (and sometimes the patient and relatives) went into a trance. The *bomoh* during the trance was possessed and was in communication with the spiritual world. Through an assistant and interpreter *(mindok),* the causation and explanation of the illness were elicited

and directions were received to neutralise the causation or to appease the malevolent spirits.

DISCUSSION

There were more males hospitalised than females in the ratio of 8 to 5 though the male-female distribution of population was almost equal and slightly more females were admitted into the other wards of the hospital. Females were older on admission and among first admissions, there were significantly more females ($p < 0.025$).

Murphy (1959) found that Malay females were older than males on admission, and attributed this to social strains of middle age and unadaptability to seek independent employment in the event of widowhood. The lower incidence of female admissions taken in conjunction with the older age at admission and the lower incidence of readmissions in this present study suggested the influence of other factors as well.

The female child in a Malay family has close emotional ties to the mother and these ties prevail even after marriage (Djamour 1965). During adolescence the son has greater freedom of movement and is expected to work whereas the daughter has a role closer to home. This different attitude and emotional tie towards the son and daughter possibly influenced the decision of parents towards delay in hospitalisation (hence separation) of their daughters.

In the reasons for hospitalisation among female patients, violence was only half as frequent as in males. This socially disruptive behaviour was a pressing reason for hospitalisation. The social withdrawal, lack of initiative and emotional bluntness associated with early stages of some forms of mental illness could be misinterpreted or even accepted as female passiveness and adolescent acquiescence within the family. This acceptance would delay early recognition of mental illness until other more disorganised symptoms arose or until chronicity led to doubts on the mental health of the patient.

There was no significant difference in diagnoses between the sexes or between the rural and urban patients. Schizophrenia was most common (88.3%). Manic depressive psychosis was noted in 5% of patients. It was noted that psychotic disorders occurred in 93.3% of all admissions. That psychoses formed the vast majority of admissions was also noted in a Malaysian mental institution by Tan (1964) and in another institution by McGregor (1972). Catatonic schizophrenia was observed in only 1 patient in this present study and toxic confusional states were uncommonly encountered.

Neurotic disorders (including neurotic depression) were seldom causes for hospitalisation and in this study, none was hospitalised except for 2 cases of hysterical neurosis. However, neurotic disorders formed a higher percentage of outpatient cases. In the similar period of this study, the percentage of neurotic disorders among new outpatients was 37.8% and the percentage of psychoses was 29.7%.

The consultation of *bomohs* was significantly more among first admissions ($p < 0.005$). Even after discharge from the hospital from previous admissions, the consultations continued, but this practice became less frequent with repeated admissions and chronicity of the illness, probably attributable to failure in finding a cure with the *bomohs*. There was frequent changing of bomohs too, and the average number consulted before a decision was made for hospitalisation was 3.

The delay in hospitalisation after the onset of illness beyond 6 months was significantly more frequent in those who had consulted *bomohs* (p 0.005). This delay adversely affected the opportunity of early treatment and in some cases also resulted in the deterioration of the physical state of the patients. Some were dehydrated or in exhaustion, some had passed on to chronicity and an epileptic was treated for 2 years without control of fits. It was perhaps encouraging that not all *bomohs* persisted in treating all cases. Twelve of the 60 patients consulting them had been advised hospitalisation.

Seven patients stated categorically they would consult *bomohs* again on discharge after the current admission and 17 patients were uncertain. With an understanding of the deep-seated cultural beliefs and mores, no discouragement was given to the patients if they decided to consult *bomohs*. However, the patients were encouraged to report at the hospital or at the nearest psychiatric clinic for review and to continue medication where necessary. This had resulted in a number of patients availing himself of both forms of management. The possibility of the extension of mental health care by the establishment of contact and the encouragement for cooperation from traditional healers needs further exploration. This

possibility merits careful consideration in view of the scarcity of mental health professionals and the remoteness of sections of the population from health facilities.

The causation and concept of mental illness in the Malays derive from beliefs in spiritual interference or from physical causes. From these concepts various forms of mental illness are recognised (Chen 1970, Hartog and Resner 1972). However, the symptomatology leading to hospitalisation could be classified into three groups: acute disorganised behaviour directed towards the community as manifested by violence, "restlessness", and "wandering from home", behaviour of a less acute nature but causing distress to the family with insomnia, irrational speech and abnormal emotions; and life-threatening states of a withdrawn retarded state (and inability to care for himself) and refusal of food.

When the patient's illness reaches any one of these three states, a decision is arrived at by the patient's in-group for hospitalisation. Though the reasons for the patients in this study to consult *bomohs* might be different, there was no significant difference in the reasons requiring hospitalisation between those who had or had not consulted *bomohs*. There was however more admissions from rural areas who manifested behaviour causing distress to the family rather than the community as opposed to urban admissions where disorganised behaviour directed towards the community was more common. The most frequent reason for urban admissions was behaviour directed towards interference with the activities of others including the public and generalised hyperactivity, classified under restlessness.

It was noted that the most frequent reason for hospitalisation from the rural areas was insomnia. This symptom distressed not only the patient but his family as well. It was commonly complained of by his family that his nocturnal movements at home disturbed their sleep or they manifested anxiety when the patient left the house to wander about in the neighbourhood.

Life-threatening symptoms of withdrawn behaviour with psychomotor retardation resulting in neglect of personal needs and refusal of food were also reasons for hospitalisation. Some cases of severe mania or catatonic excitement were also admitted for these reasons.

When the symptoms and behaviour of the patients became so disorganised as to pose a threat or danger to others, social action was directed towards hospitalisation of the patients. It was observed that this was particularly so in urban areas where there was greater social distance and isolation among individuals.

Provencher (1972) in comparing the social interaction life styles of urban and rural Malays, commented on the mutual recognition of every member of a rural community in contrast with less widespread recognition in urban areas. He also observed that interaction routines on a familiar basis were confined to the kitchen in urban homes, but these were broadened to include the inside and even beyond the confines of the rural home compound. It is possible that mutual recognition and the familiar mode of social interaction allowed for greater tolerance of idiosyncracies in the rural community. Another aspect is the close kinship either by marriage or birth among the village *(kampong)* community and the tolerance of injuries if committed by a kinsman (Djamour 1965). Only in acute disorganised behaviour is admission sought. Patients who were discharged with residual symptoms were recognised as such and their behaviour viewed as cranky or eccentric but tolerated (Chen 1970, Hartog and Resner 1972). Similar behaviour was less acceptable in an urban setting, and stricter social control by enforcement agencies contributed to a higher rate of hospitalisation. Police admissions from urban areas at 29.6% of all urban admissions were 9.2% higher than rural admissions though this difference did not reach a level of significance.

The higher rate of urban admissions over rural admissions was unlikely to be solely attributable to differences in social interaction styles. There are limitations of accepting hospital statistics as epidemiological foundations. However, in this study the percentage of urban admissions was high, approximately 4 times the percentage of urban population. Industrialisation and urbanisation in Malaysia had increased the urban population of Malays in comparison with the other ethnic groups (Vital Statistics 1974). The sociological influences on urban living and mental health are complex and changing. Further studies on the consequences of urbanisation on mental health would be enlightening.

SUMMARY

This paper describes the characteristics of

Malay psychiatric in-patients, their attitudes towards hospitalisation and their practice of consulting traditional healers *(bomohs).* The behaviour patterns which prompted hospitalisation were: acute disorganised behaviour directed at the community, behaviour of a less acute nature distressing the family and life-threatening crises. The social interaction life styles of urban and rural Malays are discussed in relation to the differences observed between urban and rural hospitalised patients. When the traditional healers were consulted there was a delay before hospitalisation, but there was an awareness of the need for hospitalisation shown by a small number of the traditional healers. Some patients who had consulted the traditional healers had the tendency to continue the consultations after leaving the hospital, but this practice became less frequent after each discharge from hospital.

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