The consultation of traditional healers by Malay patients

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Summary

Sixty four percent (104 patients) of Malay patients attending the Psychiatric Clinic for the first time were interviewed. A similar number from the general Out-patients Department (O.P.D.) randomly chosen, served as the control group. Seventy six (73.1%) psychiatric patients had consulted a bomoh prior to their visit to the clinic as compared to 26 (25%) O.P.D. patients. The number of bomohs consulted was significantly higher among the psychiatric patients than the O.P.D. patients. The strength of social support, the availability of a bomoh and the belief of the patients, friends and/or relatives in the bomoh have been suggested as the main factors that influenced the Malay patients in seeking bomoh treatment. The belief that mental illness is due to supernatural causes is firmly held by bomohs who reinforce this notion in those who seek their advice. The importance of understanding the patient's cultural background in treating psychiatric patients is highlighted.

Key words: Traditional healers, bomoh, Malay psychiatric patient, supernatural causes, mental illness.

Introduction

Traditional (indigenous) medicine is a rather vague term used to distinguish ancient and culture-bound health care practice which existed before modern scientific medicine. Traditional medicine has been practised to some degree in all cultures. Traditional medicine caters for the health needs of at least 80% of the African population.[1] In Malaysia, a diversity of traditional medicine exists among the three major races; Malay, Chinese and Indian. The indigenous Malay medicine-man (traditional healer) who knows the folklore of disease causation, treatment and prevention is called a "Bomoh".

The importance of traditional healers as a first line of contact with the psychiatric patient has been recognised. In order to meet the goal of "health for all" by the year 2000, the W.H.O. is directing efforts to orientate traditional healers to meet the needs of primary health care. The thirteenth World Health Assembly adopted a resolution to promote and develop training and research in traditional medicine as an activity in the overall programme of the organization.[1]

The culture of rural Malays was influenced by Hinduism, Islam and western civilisation. However, their original animistic belief in certain aspects of life has not changed much. Their traditional medical systems and common customs are to an extent animistic. Indigenous Malay medicine ascribes illness to two classes of causative factors; physical causes and supernatural causes. Physical causes include certain foods, heat and cold, "kuman" (tiny particles), physical trauma, brain impairment and "angin" (wind). Physical causes can arise directly or they may rise from the working of supernatural agents. The supernatural causes include the activities of a wide variety of spirits, witchcraft and the wrath of God.

It is also considered that certain conditions predispose to illness. These include the loss of "semangat" (vital force of soul substance), severe mental stress and incorrect behaviour. Details of the Malay concept of mental illness have been elaborated by Chen,[2] Rosner and Hartog.[3]

The only recent study on the consultation of Malay traditional healers did not attempt to identify the factor(s) which influenced these individuals to seek bomoh treatment.[4] The author's interest in this subject was aroused when he observed that a high percentage of patients attending the psychiatric clinic had consulted a bomoh prior to their seeking hospital treatment. The aim of this study was firstly to identify the factor(s) which motivated patients to consult the bomoh and secondly to compare the rate of bomoh consultation between the psychiatric patient population and patients attending the out-patient department (O.P.D.). This study includes a variety of cases and more than half of these were cases of neuroses whereas 88.3% of Yeoh's cases were schizophrenics.[4]

Methodology

The study was conducted at the Psychiatric Clinic of the University Hospital (USM) Kubang Kerian over a one year period (between May 1985 to April 1986). The Clinic had been started in April 1984. Since there were no in-patient facilities at the University Hospital then, the cases needing admission were referred to the Psychiatric Unit, General Hospital Kota Bharu 6 km. away from the University Hospital.

One hundred and eighty two patients (first visit) were registered during the study period of whom, 162 (89%) were Malays, 17 (9.3%) Chinese, 2 (1.1%) Indians and 1 (0.5%) Thai. These figures do not include 101 referrals from various wards. Only Malay patients were selected for this study and 104 (64.2%) patients participated in the study. The rest were not chosen because they were uncooperative or could not give reliable information. If the patient was below 18 years of age the interview was conducted in the presence of the guardian or relative. Information was collected through a semi-structured interview based on a proforma designed for the study. The proforma contained biodata, socio-economic variables, details of presenting illness, attitudes, assessment of the belief in bomoh and patient-bomoh interaction if they had sought bomoh treatment prior to the hospital visit. All the diagnoses were based on the Diagnostic and Statistical Manual of Mental Disorder (DSM–III).[5]

Fifty one (49%) of the psychiatric cases included in the study were referred from the out-patient clinic. Thirteen (12.5%) patients came from the neurology clinic. General practitioners referred 10 patients (9.6%). The rest were cases referred by other specialists in the hospital, self referrals, cases re-referred for follow up and cases referred by medical students involved in community and family case studies. Seventeen patients had been on psychiatric treatment elsewhere prior to the visit. However only four of them were officially referred for psychiatric consultation. Of the 104 patients selected, two were admitted to the medical ward (as psychiatric cases) and one was referred for admission to the psychiatric ward, General Hospital, Kota Bharu. The rest were followed up at the psychiatric clinic.

Results

Number of bomoh consulted: A total of 76 (73.1%) psychiatric patients had consulted bomohs prior to the hospital visit. About one-third (32.9%) had consulted three to five bomohs. Only 26 patients from the O.P.D. had consulted a bomoh and the majority (65.4%) had visited one or two bomohs. On average each psychiatric patient made two to three visits to a bomoh.

Details of the number of bomohs consulted is shown in Table I. The number of bomohs consulted was significantly higher among the psychiatric patients than the O.P.D. patients. ($X^2 = 46.2$, $df = 1, p < 0.01$).

Table I

Number of bomohs consulted by psychiatric patients and O.P.D. patients

No. of Bomohs consulted	Psychiatric patients n = 76	O.P.D. patients n = 26
1 – 2	19 (25%)	17 (65.4%)
3 – 5	25 (32.9%)	7 (26.9%)
6 – 9	11 (14.5%)	2 (7.7%)
> 10	21 (27.6%)	–

Two patients from the O.P.D. who had consulted six to nine bomohs were cases of chronic asthma since childhood and blurring of vision (of unknown cause). Seven patients who had consulted three to five bomohs were cases of ununited fracture of the right femur, chronic bronchitis, bronchial asthma, hypertension, chronic renal failure, neurotic depression and congenital heart disease respectively.

Diagnoses: Table II is a breakdown of the psychiatric diagnoses in the 104 selected patients, expressed as a percentage of the total pool of 162 registered patients. It shows that among the five commonest diagnoses, anxiety disorder was slightly under-represented (59.4%). The other four main diagnoses, viz schizophreniform disorder and schizophrenia, major depression and a typical depression, dysthymic disorder and somatoform disorder were generally over-represented (more than 64.2%). The number of the rest of the cases were small. This indicates that the sample interviewed was representative of the Malay patient population presenting during the study period.

The percentage of cases seeking bomoh consultation prior to the hospital visit is shown in Table III. Chronic cases with a high morbidity rate like shizophrenia, anxiety disorder and depression had the highest bomoh consultation rate. More than 80% of these patients had consulted bomohs. Somatoform disorders also had a higher bomoh consultation rate (75%). Among the four commonest diagnoses in the study, only dysthymic disorder had a consultation rate below 50%.

Age and sex: 55 male and 49 female psychiatric patients were included in the study. Among the O.P.D. patients, 49 were males and 55 were females (Table IV). There was no significant difference in the male: female ratio in either the psychiatric or the O.P.D. groups. The average ages of the psychiatric and the O.P.D. patients were 28.9 years and 32.3 years respectively. The difference in the average age between the two groups was due to the presence of 14 patients below 18 years in the psychiatric group. There were only four patients from the O.P.D. under 18 years of age.

Educational status: The educational status of patients in both the psychiatric group and the O.P.D. groups in relation to bomoh consultation is shown in Table IV. Nearly half of the psychiatric patients (49%) and the O.P.D. patients (48%) had received upper secondary school education (up to age of 18 years). The percentage of those who never attended school was small

Table II

Psychiatric diagnosis, number and percentage of cases selected in the study

Diagnosis	No. of registered Malay patients	No. of cases selected	%
Schizophreniform disorder and schizophrenia	34	23	67.6
Anxiety disorder	32	19	59.4
Major depression and a typical depression	27	19	70.4
Dysthymic disorder	23	17	73.9
Somatoform disorder	17	12	70.6
Adjustment disorder with depressed mood	8	3	37.5
Psychological factors affecting physical condition	5	3	60
Organic mental disorder and epilepsy	6	2	33.3
Inhibited sexual desire	2	1	50
Psychiatric disorder in childhood	4	4	100
Adjustment/identify disorder of adolescence	1	1	100
Mania	1	–	–
Atypical psychosis	1	–	–
Non-psychiatric case	1	–	–
Total	162	104	

in both groups. In general, consultation of bomoh is not confined only to groups who had not attained higher education, as even university graduates consulted a bomoh. Consultation of bomoh in the psychiatric group was uniformly spread across all levels of education, whereas it was more prominent among those who had lower levels of education in the O.P.D. group.

Degree of belief in bomoh: For simplification, the degree of belief was divided into three main groups; strong belief, mixed belief and no belief in bomoh expertise in treating mental illness (Table IV). A belief is considered strong when a patient believed in bomoh expertise for the treatment of all type of mental illness. Mixed belief is a belief that bomoh had expertise in treating certain types of mental illness only. The third category includes patients who did not believe that the bomoh's treatment had any influence in the outcome of their illness and also patients who made no comment on the effectiveness of the bomoh's intervention.

Table III

Psychiatric diagnosis and percentage of the cases seeking bomoh consultation among Malay patients

Diagnosis	Bomoh Consultation		Total cases
	Yes	No	
Schizophreniform disorder and schizophrenia	20 (87%)	3	23
Anxiety disorders	16 (84.2%)	3	19
Major depression	13 (86.7%)	2	15
Atypical depression	3 (75%)	1	4
Dysthymic disorder	7 (41.2%)	10	17
Somatoform disorder	9 (75%)	3	12
Adjustment disorder with depressed mood	1	2	3
Psychological factors affecting physical condition	1	2	3
Organic mental disorder and epilepsy	2	–	2
Inhibited sexual desire	1	–	1
Psychiatric disorder in childhood	2	2	4
Adjustment/Identity disorder of adolescence	1	–	1
Total	76	28	104

The majority of the patients in both groups had a mixed belief. 27.6% of the psychiatric patients and 34.6% of the O.P.D. patients who had consulted bomohs did not believe or were ignorant of their expertise. A high percentage of the psychiatric patients (42.1%) and the O.P.D. patients (38.5%) who had consulted bomohs for their present illness would not consult them in future because they had lost confidence in them.

Duration of illness and spending: Generally, duration of the illness was longer in those who had consulted the bomoh compared with those who had not consulted the bomoh in both groups. Consulting a bomoh generally resulted in a delay in visiting the hospital. The number of bomohs consulted in both groups correlated well with the duration of the illness (Table V). In general the longer the duration of the illness, the more the number of bomohs consulted. The amount of money spent on the treatment also correlated with the number of bomohs they had consulted (Table V).

The charge per visit varied from $10.00 to $100.00 compared to $5.00 to $20.00 as reported by Yeoh.[4] However, there were a few bomohs who did not ask for a specific amount. The

Table IV

Educational attainment, beliefs and duration of illness of patients who had consulted bomoh with those who had not consulted in the psychiatric and the O.P.D. group

	Bomoh Consultation			
	Psychiatric patients		O.P.D. patients	
	YES (N=76)	NO (N=28)	YES (N=26)	NO (N=78)
Sex				
Male	39	16	12	37
Female	37	12	14	41
Educational status				
None	4	2	2	11
Primary school	21	1	5	12
Lower secondary school	8	6	7	13
Upper secondary school	35	16	12	38
Undergraduate	5	–	–	3
Graduate	3	3	–	1
Degree of belief in bomoh				
Strong belief	15	5	5	8
Mixed belief	40	11	12	32
No belief	21	12	9	38
Duration of illness				
Within 1 month	2	4	2	41
1 month to < 6 months	20	8	7	16
6 months to < 2 years	27	10	3	10
2 years to < 5 years	15	6	7	10
More than 5 years	12	–	7	1

total expense incurred by the patient included transport charges which was sometimes higher than the consultation charges. However a few bomohs were willing to make home visits when requested. They usually charged high consultation fees.

Location of bomoh: A majority of bomohs consulted by the psychiatric patients were within the local community and 36% were from a nearby community. A few patients visited bomohs outside the State of Kelantan and Peninsular Malaysia. A total of nine patients had consulted bomohs outside the states. Six patients consulted bomohs in the neighbouring state of Trengganu, of whom three were residents of that state. Another three patients visited bomohs in other states in Malaysia. Two patients had gone to South Thailand to consult the bomoh. The popularity of a bomoh is the main factor which attracts patients to him.

Methods of treatment by bomohs: Various methods of treatment were employed by the bomohs. These included various types of incantation (jampi), exorcism, trance, the giving of holy water

Table V

The number of bomohs consulted by the psychiatric and the O.P.D. patients in relation to duration of illness and cost

	Number of bomohs consulted							
	< 2		3–5		6–9		> 10	
	Psy. pt.	OPD pt.	Psy. pt.	OPD pt.	Psy. pt.	OPD pt.	Pys. pt.	OPD pt.
Duration of illness								
Within 1 month	1	2	1	–	–	–	–	–
1 month to < 6 months	7	7	6	–	4	–	2	–
6 months to < 2 years	5	2	9	1	6	–	7	–
2 years to < 5 years	2	4	7	3	1	–	6	–
More than 5 years	4	2	2	3	–	2	6	–
Spending								
Less than $100.00	18	15	7	4	–	–	–	–
$100.00 to < $500.00	1	2	15	2	6	–	–	–
$500.00 to < $1,000.001	–	–	3	1	5	1	4	–
More than $1,000.00	–	–	–	–	–	1	17	–

(air tawar), taking a special bath (bath with a mixture of flowers or lemon) prescribing herbs and many other methods. Combinations of these procedures were common. Various types of Malay magic and folklore have been well discussed by Winstedt.[6] No single case of the "main puteri" (a form of psychodrama) was reported in this study compared to Yeoh's[4] study where two patients were treated by the "main puteri". It seems that the "main puteri" is not as popular as before. A detailed account of the "main puteri" has been given by Gimlette.[7]

The process of treatment starts with a diagnostic procedure followed by detection of the cause of illness. The next step is the removal or neutralisation of the causative agent (if it has been found) by the prescription of a specific treatment. The diagnostic procedures and types of treatment given by each bomoh may be different depending on their expertise and training. Bomohs attributed the improvement in their patients to the success of removing or neutralizing the causative agents. Some of the patients had no improvement despite the bomohs' claims that they had successfully removed the causative agents.

A few bomohs harboured spirits as a medium in treating their patients, apart from helping them chase away the evil spirits who intruded their territory. These familiar spirits sometimes turn malevolent or run away from careless owners: "Hantu Raya" (mighty spirit) is an example. Laderman[8] claimed that "Hantu Raya" is the most feared evil spirit on the East Coast of Peninsular Malaysia.

Social support and marital status: In the psychiatric group, 45 patients (43.3%) were married, 52 (50%) were still single and seven (6.7%) were divorced. The details of the social status were as

follows: Head of the family 25, earning dependent 22, dependent 43 and underage (below 18 years old) 14. Nearly half of the patients were dependent (41.3%) and the highest bomoh consultation was also within this group (43.4%); the head of the family was the second highest (25.0%) in the consultation rate.

Decision of seeking bomoh treatment: A majority of psychiatric patients (55.3%) went to see a bomoh at the behest of relatives and guardians. Ten patients (13.2%) followed the advice or suggestion of friends. Nineteen (25%) patients were persuaded or forced by relatives and/or friends. Only five (6.6%) patients, went to consult the bomoh of their own accord.

There were three main groups of psychiatric patients who did not consult the bomoh. The first group of seven were outsiders (non Kelantanese). Five stayed here because of their work and the other two had followed their family. They did not consult a bomoh because they did not know of any. Only one out of the eight outsiders had sought bomoh treatment and this patient had been staying in Kelantan for more than two years.

The second group of patients were seven women who had poor social support. Five of them had marital problems and had been neglected, another two were divorcees and had been rejected by their families. All of them did not seek bomoh treatment because nobody sympathised with them or gave them support. Fear of being molested and difficulty in locating a bomoh's residence were the other reasons for not consulting a bomoh. A few of the husbands of this group forbade their wives from going for treatment. The rest (14 patients) who did not consult a bomoh were a mixed group of people. The majority of them had a "wait and see" attitude. They indicated that they would probably see a bomoh later if psychiatric treatment failed.

Causes of illnesses: Table VI lists the causes of the illness as told by the bomoh to the respectives psychiatric patients. The causes recorded in the table are based on the commonest cause given by the bomoh or the professionalism of the most influential bomoh. If a consensus could not be reached the two most commonly expressed causes from the bomoh were considered.

The cause of the illness in 26 (34.2%) patients were various types of charms (witchcraft). However, in nearly half of them (42.3%) the bomoh did not specify the method of charms. The bomoh did not convey the cause of the illness in six (7.9%) patients. Seventeen (22.4%) patients were ill due to two causative factors. The cause of illness given by the bomoh in eight patients varied (more than two), but with the combination of the causes as listed in Table VI. The patients' opinion on the causation of the illness as attributed by the various bomohs was assessed separately. Five (6.6%) patients fully agreed, 19 (25%) patients expressed a strong possibility, 18 (23.7%) patients said it was possible but less likely, 17 (22.4%) did not believe at all and 11 (14.5%) patients were unsure.

The two commonest methods of charming were putting a charm in food or drink and charm by physical instruments. The instruments commonly used included needles, string, photographs and clothes of the enemy. These materials are wrapped in a yellow cloth and placed in a small bottle which contains a special oil called 'minyak mati dibunuh' (oil of murdered people). The bottle is buried under the house or in the compound. If the enemy passed by and stepped across the buried instruments, he would suffer a specific illness.

The bomohs usually told the patients the reason for being charmed and even the name of the person who had charmed them. Charming is done by some bomohs who are engaged by certain people to place a curse on their enemy. The most common reasons cited by the bomoh were

Table VI

Causes of illnesses as told by the bomoh to patients

Causes of illnesses		Number of patients
1.	Charm (Non specific)	11
2.	Charm in food or drink	5
3.	Charm by various instruments	6
4.	Indirectly charmed	4
5.	Act of evil spirits	5
6.	Physical causes	3
7.	"Keturunan" (Genetic factor)	2
8.	Wrath of God	4
9.	Stress (thinking too much)	2
10.	"Lemah semangat" (Low self-esteem)	3
11.	No comment	6
12.	Charm and physical causes	4
13.	Evil spirits and low self-esteem	4
14.	Charm and wrath of God	3
15.	Stress and genetic factor	2
16.	Charm and stress	4
17.	More than two causes (combination of the above)	8
	Total	76

jealousy, anger and revenge. Charms cast by frustrated men or their families because of rejected marriage proposals were common. Jealousy of someone's success and revenge on the old enemy were among the popular reasons expressed by the bomoh. Some of the patients were surprised by the bomoh's remarks because as far as they were aware, they did not have any enemy. However, a few of them had already anticipated the reason.

Discussion

Bomoh consultation by psychiatric patients was significantly higher than the O.P.D. patients ($p < 0.01$). Yeoh[4] found that 70% of all first admissions had consulted the bomoh compared to 40% of readmissions. His percentage of bomoh consultation of first admissions is similar to the consultation rate found in this study (73.1%). The majority of patients who did not participate in the study were more ill than the rest and were unable to give reliable information and/or were uncooperative. If they were included in the study sample, the percentage of bomoh consultations would have been higher than that observed in the present study.

Although this study did not identify a single overriding factor which influenced the seeking of bomoh treatment, there is no doubt that multiple factors are involved. There are several clues regarding the degree of belief and social support that needs further exploration. Half of the

psychiatric patients who had not consulted the bomoh were non-Kelantanese or had poor social support. Another 14 patients were a mixed group of people, with different social backgrounds, educational status and degree of belief in bomoh expertise. Little can be commented on these patients because they are a heterogenous group. It would have been more information if a larger number of patients were included.

One important factor that motivates people to seek bomoh treatment is the deep-seated cultural beliefs. The cultural belief also corresponded to the strength of belief in a bomoh. None of the seven non-Kelantanese patients who did not consult bomoh and their families had a strong belief in bomoh. The poor beliefs in the bomoh together with lack of information on the availability of the bomoh made them less motivated to seek bomoh treatment.

The reason why another seven psychiatric patients did not consult the bomoh could be explained purely because of lack of social support and encouragement from others. This point is firstly supported by the fact that the majority of the patients (93.4%) consulted the bomoh because of the influence, suggestion or persuasion of relatives and/or friends. Secondaly, a significant percentage of patients (27.6% of the psychiatric cases and 34.6% of the O.P.D. cases) who had consulted bomohs were ignorant of or did not believe in their expertise to treat mental illness. The author would consider that the strength of social support, the availability of bomoh and the beliefs of the patients or relatives in the bomoh, were the main factors that influenced people in seeking bomoh treatment. Thus the decision to seek medical assistance is typically a family affair and it is part of the cultural context of healing-seeking treatment.

The author in his interview with three leading bomohs from "Pertubuhan Bomoh-Bomoh Melayu Kelantan" (Kelantan Malay Bomohs Association) confirmed most of the earlier findings. The majority of bomohs are not full time. One of the bomohs interviewed is a teacher and the other two are farmers. Each of them have different training backgrounds and expertise. All of them expressed the same view regarding the practice of witchcraft and charming. They condemned the practice as it is contrary to Islamic principles. They claimed that such practices were done by non-muslim bomohs. However, they did not rule out the possibility of some black bomohs practicing it for financial purposes. They agreed that the mysterious oil, "Minyak mati dibunuh" existed. This is again the practice of black bomohs and it is claimed that the oil possesses extra-ordinary powers.

Some people who initially did not believe in bomohs later changed their views when they noticed a mild improvement after the visit. The bomoh had reinforced the cultural belief among this group of patients. A mild temporary improvement is expected with neurotic cases but the results on the psychotic illness is still discouraging. Murphy[9] believed that folk healers can be as effective as medical practitioners with certain types of disorder and in certain cultural settings. He stressed the importance of knowing cultural beliefs to avoid emotional conflict. Henderson and Primeaux[10] also stressed the importance of understanding patients' cultural background and added that little good can be accomplished if the practitioner tries to be little religious beliefs and folk cultures.

Conclusion

The author would like to advise his colleagues to have a better understanding of the culture of the patients. The author in his practice does not specifically dissuade patients from seeking bomoh treatment as long as the bomoh does not interfere with his treatment. There is no doubt that the bomoh is a good psychotherapist who can communicate with patients more effectively

than the medical practitioner. The patients at certain stages of treatment will be able to make their own decisions about whether they need to see a bomoh any more.

Acknowledgements

I wish to thank the Director of Hospital University Sains Malaysia, Kubang Kerian for permission to publish this paper; Dr. Zulkifli Ahmad, Department of Community Medicine for statistical advice; Dr. Mahendra Raj of the Department of Medicine for assistance with the preparation of this manuscript; Puan Roseni Ahmad and Puan Nik Meriam Nik Taib for secretarial assistance.

References

1. Bannerman, R.H., Burton, J. and Wen-Chieh, C. Traditional medicine and health care coverage. Chapter 22. W.H.O., Geneva, 1983.
2. Chen, P.C.Y. Indigenous Malay Psychotherapy. Trop Geogr Med 1970; 22 : 409–415.
3. Resner, G. and Hartog, J. Concept and terminology of mental disorder among Malays. J of Cross-cultural psychology 1970; 1 : 369–382.
4. Yeoh, O.H. Malay psychiatric patients and traditional healers (bomoh). Med. J Malaysia 1980; 34 : 349–357.
5. American Psychiatric Association. The diagnostic and statistical manual of mental disorder, Third Edition (DSM–III), Washington, U.S.A., 1980.
6. Winstedt, R. The Malay magician. Revised edition. Oxford University Press, Kuala Lumpur, 1961.
7. Gimlette, J.N. Malay poisons and charm cures. Oxford University Press, Kuala Lumpur, 1971.
8. Laderman, C. Wives and midwives. Childbirth and nutrition in rural Malaysia. University of California Press, 1983.
9. Murphy, H.B.M. Current trends in transcultural psychiatry. Proc Roy Soc Med 1973; 66 : 711–716.
10. Henderson, G. and Primeaux, M. Transcultural Health Care. Introduction. Addison-Wesley Publishing Company, California, 1981.