

# Syarah Inaugural

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## PSYCHOTHERAPY FOR RURAL MALAYS- Does It Work?

- ▶ 13 September 2003
- ▶ Dewan Taklimat Tingkat Satu,  
Bangunan Pentadbiran Universiti Putra Malaysia



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173  
S45  
S981  
no.68



U P U T R A M A L A Y S I A

## PSYCHOTHERAPY FOR RURAL MALAYS - DOES IT WORK?

### ABSTRACT

Broadly defined, psychotherapy is a process of interaction between two or more individuals in which skills of one is used in the helping relationship for the emotional support and/or maturation of the other.

The history of formal psychotherapy starts in the mid-19th century. At that time Freud experimented with the use of hypnosis in the treatment of neurotic patients. Initially he used hypnosis to suppress symptoms but later used it to release the emotions associated with repressed ideas. In helping patients to recall suppressed events, he found it effective to get the patients to lie on the couch and talk freely about the past while the therapist kept out of sight. This was the origin of free association. He also built an elaborate theory of mental development and functioning to guide his practice. This eventually gave birth to psychoanalysis on which most modern forms of psychotherapy derived.

Another well-known definition describes psychotherapy as “an interpersonal process designed to bring about modifications of feelings, cognitions, attitudes and behaviour which have proved troublesome to the person seeking help from a trained professional.” This definition draws attention to three characteristics of psychotherapy: the presence of a therapist-patient relationship; the interpersonal context of the psychotherapies; and, implied by the notion of training and professionalism, the sense that therapies are conducted according to a model that guides the therapist’s actions. Psychotherapies are defined in part by their setting and in part by the presence of an explicit model of psychopathology, which in turn generates procedures for relieving distress.

Based on this background, some thirteen years ago we embarked on a journey of experimental research to answer the question whether psychotherapy can work on Malay patients from a rural background. Most therapies insist on strict inclusion criteria for their therapies; the major criteria being well educated and psychologically minded patients. This seems to exclude most of the patients we were treating. To do therapy on these patients would mean to defy the criteria and face poor outcome or to create a new form of therapy with our own model and own criteria. We started with neurotic disorders and gradually worked on depression and finally even on psychosis, which has been said to be resistant to psychotherapy, with remarkable success. The work has been recognized and our model of psychopathology and therapy has been included as a form of therapy within the CBT group. Further work is now being geared towards patients with the more severe and chronic forms of anxiety group of disorders.

## INTRODUCTION

The roots of behavioral and cognitive-behavioral interventions are in classical learning theory (classical and operant learning) and in social learning theory. Wolpe's systematic desensitization method was probably the first rigorous attempt to adapt Pavlovian conditioning to a clinical situation. At the same time, Skinner and colleagues used operant conditioning techniques to modify the behavior of psychotic inpatients. Largely for epistemological reasons, behavioral approaches ignore the importance of cognitive processes. Under the influence of Bandura, Ellis, Michenbaum, and Beck, the balance has been redressed, and cognitions (both conscious and unconscious) have come to occupy an increasingly prominent role in models of psychopathology. Cognitive therapies share with dynamic therapies the assumption of irrational cognitive processes. However, within cognitive therapy, cognitions are seen as having been learned and to be maintained through reinforcement; challenges to these assumptions may therefore be made directly rather than via unconscious determinants as implied by dynamic theory. In addition, the proposed links between symptomatology and specific cognitions are somewhat less complex in cognitive than in dynamic approaches. Nevertheless, there is considerable overlap between modern cognitive therapy and traditional psychoanalytic ideas, and indeed many cognitive propositions derive from analytic formulations. Examples of overlap between these two traditions include the notion of helplessness, the discrepancy between the perceived self and the ideal self, the self-destructiveness of negative cognitions implied in the negative view of the self, the world, and the future; and the tendency defensively to avoid the scrutiny of painful cognitions.

At least traditionally within this orientation, the clinician is less concerned than his or her dynamic counterpart with how maladaptive ideas and behaviors have emerged. Behavioral and cognitive-behavioral clinicians focus on how these maladaptive aspects of functioning are maintained by the individual's environment and through properties inherent to their belief systems. In the early days of cognitive therapy, considerable emphasis was placed on the primacy of cognitions over emotional responses - in other words, the proposition that emotional reactions could be predicted on the basis of beliefs and expectations. More recently there has been a general recognition by both dynamic and cognitive theorists that the separation of these two modes of functioning is an oversimplification of little heuristic value, and one that has no credibility either within philosophical tradition or in modern cognitive science.

Because of the intellectual roots of this orientation in positivist epistemology, the focus of behavioral interventions is on definable behaviors that can be readily monitored and addressed in therapeutic interventions. Cognitive-behavioral treatments represent an integration of this level of analysis with consideration of thoughts and beliefs that may lead to dysfunctional behavior. The goal of such interventions is to change maladaptive beliefs, using a wide range of techniques at the clinician's disposal. These commonly include elements of self-monitoring, identifying, and challenging negative thoughts and

assumptions that maintain problematic behavior and experiences; decatastrophization; and scheduling activities that, in turn, aid further self-monitoring and challenge of dysfunctional beliefs. Although interpretation may at times be a part of the cognitive therapist's armamentarium, finding reasons for particular beliefs is not regarded as an essential or necessarily very effective component of the intervention. The goals of intervention tend to be clear, and the patient's motivation is strongly reinforced by suggestion and support by the therapist.

The distinction between cognitive and behavioral interventions is a controversial one. Clinicians from primarily behavioral tradition consider that interventions such as cognitive restructuring may be effective only through their impact on the patient's behavior, which in turn modifies their subjective state. By contrast, "pure cognitivists" consider directly induced behavioral changes (e.g. through selective reinforcement, or in vivo exposure) to have a long-term effect only in that they force a change in the patient's expectations. In our work we did not concern ourselves with this distinction, which is of limited relevance to technique, although it may have implications for training. We were more concerned about getting our model to follow a cognitive-behavioral approach while modifying ideals/values without imposing ideals and values. This model and the array of techniques at our disposal were more acceptable to our patients and us.

## PSYCHIATRY IN MALAYSIA

The prevailing influence of culture on health is evident in every society. Cultural beliefs determine perceptions of causality, illness behaviour and treatment. Every country in South East Asia has several ethnic groups, religions and languages. Among the Asians the traditional belief that spiritual forces exert immense control over both physical and mental health is still rife. This can also be seen in Malaysia.

Malaysia is made up of three main racial communities. The Malays form 55% of the population while the Chinese 35% and the Indians, the remainder. Because of these racial differences the psychiatric symptoms tend to be slightly different in these groups although the rate of psychiatric disturbance is no different from the rest of the world. However Malaysia is associated with the so-called 'culture bound syndromes'. Amok, Latah and Koro are frequently linked to Malaysia although they have been reported in many other countries.

The Malays are the indigenous people of Malaysia. They are generally soft spoken and shy though that has changed recently. Although most of them have traveled widely and had been educated either overseas or locally most are still holding on to traditions and strong cultural beliefs. The belief that illnesses and especially mental illness can be caused by demons, evil spirits or being charmed by others is still widespread even among the educated. At times even the services of *bomohs* (traditional healers) are called forth before

these people embarked on some important activities like interviews, etc. It is still not uncommon to have psychiatrists having to give way to relatives of patients who request that their mentally ill relatives be discharged or given leave so that they can bring them to see a *bomoh*. Over the last 15 years, the Malays who are mainly Muslims, have become more aware of religion and a religious revival have resulted in many Malays becoming more religious. This has not resulted in new symptomatology of mental illness but it has resulted in new health seeking behaviour among this group. Some now resort to looking for holy water i.e. water that has been given *doa* (invocation) by a holy person or religious teacher. Most now also resort to *sunat hajat* (elective prayers) more frequently as adjunct to treatment of the mentally ill.

The Chinese are mainly involved in the business sector. They were originally migrants who came to work in the tin mines. They worked hard and their numbers gradually grew bigger and finally became established as an important population group in the country. In fact it was one of them, Mr. Yap Ah Loy who founded Kuala Lumpur the present capital city of Malaysia. Like the Malays, they too are now mainly western educated but cultures of the Chinese remain strong. Their belief in the powers of the 'Yin' and 'Yang'; and the balance of these determine mental and physical health is still evident. Some also believe in ghosts and evil spirits as the cause of mental illness. It is not uncommon a few years ago to find Chinese patients presenting to the psychiatrists with lacerations on their backs. This is part of a ritual among some Chinese who believe that the illness is due to evil spirits and the spirits need to be driven away by Chinese monks who would make these lacerations on the patients' back.

### History of Malaysian Psychiatry

The earliest recorded evidence of a psychiatric facility in Malaysia, was the existence of a lunatic asylum in Penang, in 1829, with 25 inmates. The next record is the building of the Central Mental Hospital in Tanjong Rambutan, followed by mental hospitals in Tampoi and Sarawak in 1933. In 1961, Malaysia had its first native psychiatrist. The first general hospital psychiatric unit was set up in 1959 in the Penang General Hospital with outpatient and in-patient facility. Later on a number of decentralized psychiatric general hospitals were set up. In 1973, Malaysia started post-graduation program in psychiatry following which psychiatry took off. At present the psychiatrist population ratio in Malaysia is 1: 350,000 and is far below the recommended levels for developing countries. Currently the mental health facilities in Malaysia are basically hospital based. Moreover, even in places where district outpatient services have already been setup, the psychiatric facilities are based in hospitals. Perhaps the most gratifying and the important development in the last 15 years have been the increase in the number of psychiatrists in the country - from 19 in 1988 to around 100 in 1996. The Malaysian government's target is to have around 300 psychiatrists by the year 2000. This has not been achieved. Another important change has been the substantial reduction in the number of beds in the psychiatric hospitals and the increased emphasis on community based mental health services. The motive behind this

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is the policy of deinstitutionalization. Slowly, community psychiatry, child psychiatry, rehabilitation and other specialties came in, placing psychiatry firmly on the road to new horizons.

## MENTAL ILLNESS IN MALAYSIA

The types of mental illnesses are changing in this country. This is probably due to an increased awareness among the general population. In the 1960s western literature described depression as being rare in developing countries. Perhaps depression was not taken seriously as an illness in these countries and most of the patients presented to the physicians with vague somatic complaints. Although this is still generally true i.e. most patients find it hard to accept depression and visit a doctor for the illness, studies have shown that depression is as prevalent in developing countries as in developed countries although the presentation may have a more somatic coloring (Varma, Azhar, 1992a, 1992b; Azhar 1990; Azhar et al, 1991, 1992a) because of the inability of the patient to accept depression per se as a symptom but would project the depression as aches and pains. A study (Varma, Azhar, 1995) looking at the psychiatric symptomatology in patients and their families attending a primary health care facility in Malaysia found that the most common symptoms found were of depression (13.2%), followed by hypochondriacal symptoms (8.2%), anxiety symptoms (6.1%) and psychotic symptoms. It is interesting to note that most of the depressed patients were missed by the doctors because most patients do not complain of depression but of vegetative symptoms such as fatigue, sleep disturbance, back pain, chest pain, nausea, abdominal discomfort or shortness of breath. This is because the culture does not consider depression as an illness. It is an accepted emotion that is short lived. Only weak persons are depressed. It is unmanly to cry and show depression. At times it is shameful to cry. But to have backache or headache is perfectly acceptable. So the main problem of depression in this culture is its late recognition and as such late treatment. However, the outcome even with delayed recognition and treatment is relatively good. The rate of suicide in Malaysia is low and is comparable with other countries. This is probably because; Malaysia is predominantly Muslim and this act as a safety valve against suicide. The rate of suicide is higher in the Chinese than in the Malays primarily because of the religion factor. Even among psychotics, the rate is higher in Chinese compared to Malays (Azhar, 1991).

As mentioned above, hypochondriacal and anxiety symptoms form the highest group. This is probably not much different from other societies but the presentation of the patients is different. Again most of them do not accept these symptoms as psychological problems. They prefer to think of them as physical illness. Most believe that they have the symptoms because of being charmed or because they have lost the soul substance (*semangat*). The loss of the soul substance makes their body weak and patients will suffer from shortness of breath, numbness, tremors, palpitations, abdominal discomfort, etc. Another group of patients will have these symptoms because they believe their ancestors have *Jinns* and

that now after their ancestors have passed away, the *Jinns* have decided to stay in their bodies and the symptoms arise because they are weak or because they refuse to accept the *Jinns*. These *Jinns* are supposed to have special powers to help them or to help others, e.g. a patient of mine with anxiety symptoms believes the symptoms were caused by a *Jinn* that belonged to her mother that have recently passed away. These *Jinn* have chosen to inhabit her. By inhabiting her body she will be an expert *bidan* (maternity nurse) just like her late mother. However she is unable to accept this responsibility because she has her own future plans. The problem with this belief system is that the doctor is not the first person they seek when they develop symptoms but the *bomohs*. They only seek treatment after their illness becomes chronic. These beliefs are also found not only among the rural but also among the urban population. For example, the patient described above is a schoolteacher in an urban area. Hypochondriacal symptoms too are often missed because these symptoms are not necessarily physical or clear. Common worries such as cancer are not often manifested by patients. Most complains are of vague intestinal complaints that do not fit any physical illness. They complain mainly of nausea and *angin* (wind) in the stomach or other parts of the body such as nerves or blood vessels. Their complaints can be easily mistaken for somatic hallucinations or delusions to the unsuspecting doctor. *Angin* or wind is commonly blamed as the source of most illnesses by the *bomohs* and this belief has caught on with most people. Here again the problem is of late treatment as most patients believe the doctors cannot help them since there is no such thing as wind in western medicine and therefore doctors will not be able to detect their illness. Here instead of jumping from doctor to doctor they will jump from one *bomoh* to the other to look for the right *bomoh* who will be able to remove all the wind from their system.

Hysteria is another neurotic illness that occasionally occurs in Malaysia. What is more interesting is the epidemic hysteria that occurs especially in residential schools or hostels. They generally involve young female students. They are also fairly common in factories where the workers are females. It is assumed that these females are being 'disturbed' by spirits who are supposed to inhabit the area where the schools or factories are. The reason why they only affect females is not clear but one explanation is that the females are weaker than the male in their soul substance or *semangat* and thus it is much easier for the ghosts and spirits to disturb them. Usually it starts with one person 'seeing' a spirit or a ghost usually in a deserted place such as the washroom, and becomes hysterical - generally screaming or crying and at times becoming aggressive and violent. Other female colleagues would then join her by screaming and shouting with some becoming violent as well. The screaming and crying goes on until a *bomoh* or a religious person is called to say prayers that will appease the spirits and only then will all the girls settle down. Again because of this belief, the *bomohs* and religious healers are called in such instances. A doctor is very rarely consulted. News of epidemic hysteria usually gets extensive coverage in the media and this results in other schools or factories getting 'infected'. In most cases, only the index person experiences the vision of the spirits. The 'infected' friends mostly do not see the ghosts but experience sensation such as being touched or pushed. The factories and schools involved are usually those that have rather strict rules and regulations. The schools

commonly affected are religious schools where the students are not allowed to openly play games or mix with males. Some schools that send their students to doctors after a hysterical attack have relaxed some of their strict rules with positive results. Unfortunately there are no studies to accurately establish the relationship between mass hysteria and strict rules. However mass hysteria could be considered as a general coping devise, which is accepted by the culture.

Another neurotic illness commonly seen is obsessive-compulsive disorder. This illness' frequency is the same as in the west even though the presentation again is different. Although no systematic study has been done to detect the content of obsessive thoughts in Malaysia, experience of many psychiatrists indicates that very few patients present with the classical obsessive thought of dirt and the compulsion of washing. Among patients in our practice we have only treated two of these patients. Most of the patients that we see present with ruminations of religious content. In our clinic out of about 10 patients being referred, 9 of them have religious ruminations. Examples of these ruminations are 'there is more than one God', 'I have said the *talak* (divorce) to my wife, therefore our continued relationship is sinful', 'the prophet made a mistake'. Treatment would require not just psychological knowledge but religious knowledge. Most patients are given religious psychotherapy, which is described later in this paper. At times religious teachers are called in to aid in treatment but this at times hinders progress as we allow the patient to be reassured. In cognitive therapy, reassurance is regarded as avoidance behaviour. Avoidance is a hindrance in psychotherapy because it prevents disconfirmation of negative thoughts. At times the ruminators use these reassurances as neutralizing thoughts, which, just like avoidance, maintains the symptoms. (Our religious therapy is based on the cognitive therapy model and principles).

Regarding psychotic illness, just like elsewhere, schizophrenia affects 1% of the population. As expected the symptom of schizophrenia is reflected by the patient's culture. The phenomenology of hallucinatory experiences of Chinese patients from a predominantly Chinese area of Malaysia was compared to those of Malay patients from a predominantly Malay area (Azhar, et al, 1992b, 1993). Most Malay patients heard voices that they attribute to God; demons or spirits while Chinese patients attribute them to friends, relatives or neighbors. However, those Chinese that have been brought up in Malay communities had auditory hallucinations like their Malay counterpart, i.e. voices of God, demons or spirits. This clearly indicates how cultural influence can transcend race and religion. Regarding the content of voices; religious issues were significantly more common in the Malay patients. Visual hallucinations were also significantly more common among the Malay patients. 51% of them experienced true visual hallucinations compared with 20% found in most other studies. Although these symptoms do not have any bearing on drug treatment, they have influence on psychosocial management of these patients. Psychological treatment directed at voices will have to be very delicately handled, for example, if they are voices of God, then the doctors cannot challenge the patients to ignore them or to go against them. Some patients who are willing for therapy are told not to challenge the voices but to look for evidence of misinterpreting them as God is infallible but humans are.

Delusions among Malaysian patients have also been studied. Azhar, et al (1995), found that there is a higher prevalence of religious and other sub culturally related delusions in Malay patients. Persecutory delusions were more common in Malay patients while grandiose delusions were more common in the Chinese. Nihilistic and delusions of guilt were also more common in the Malays. Analysis of grandiose delusions indicates that more of the Malay patients were deluded about being in authority or having power given by God. On the other hand the Chinese patients were deluded about their wealth and social status. Most of the content of delusions in Malay patients were centered on interpretation of the Quran, being sinful, being specially chosen by God, being given powers by God, being descendants of God or prophet. Analysis of persecutory delusions indicate that the Chinese believed members of their families or close friends wanted to harm them while the Malays believe the general public wants to harm them. Reasons for harm given by the Chinese include their wealth, knowledge and skills. The Malays on the other hand cited jealousy of their God-given power as the main reason.

Another aspect of psychosis that has received widespread attention in the West is the role of expressed emotions in relatives in the maintenance of psychosis. Very little information exists about relatives expressed emotion in non-Western countries and its relationship to maintenance of schizophrenia. Only one study exists so far in Malaysia and it indicates a trend in the opposite direction (Azhar, et al, 1996b). The families of 83 schizophrenic patients who had more than two episodes of schizophrenia were studied. The most salient feature discovered was the virtual absence of high level of expressed emotion as the cause of relapse. The majority of the families had low expressed emotion (72.3%) while only 25.3% had high expressed emotion. The most likely explanation for this disagreement is the cultural differences between Malaysian families and Western families. Obviously this has significant bearing on the family therapy of patients. As most families already have positive emotions, there is no sense in further developing this aspect of interaction with the patient. In the first place expressed emotion may not have any role in our patients or perhaps the utilization of expressed emotion as proposed in the West in order to prevent relapse might not apply to our patients.

## **CULTURE BOUND SYNDROMES IN MALAYSIA**

Some disorders are found only in certain cultures and it often has a sudden onset, short duration and good prognosis. Culture is a mixture in which all biological, psychological functioning operate in the manifestation of psychopathology and it may not be wrong to state that all psychiatric syndromes may be bound culturally in some way or another. This term has generally been used by Western professionals to identify a few syndromes reported in different other cultures. However, it should be understood that if a traditional healer from Asia or Africa, for example is exposed to a Western patient, he might find certain behaviors of those patients to be odd and surprising. The term culture-bound syndrome denotes recurrent, locality-specific patterns of aberrant behaviour and troubling experience

that may or may not be linked to a particular diagnostic category. These syndromes are generally limited to specific societies or culture areas and have a troubling set of experiences and observations. The importance of culture-bound syndromes lie in the fact that these have been identified as important diagnostic categories, deserving mention in the DSM-IV (Diagnostic and statistical manual of the American Psychiatric Association, 4<sup>th</sup> edition).

Almost each country in Southeast Asia has several ethnic groups, religions and languages. Among the Asians the traditional belief that spiritual forces exert immense control over both physical and mental health is still rife, and many of the culture specific syndromes are attributed to those beliefs. We would mention some of the commonly described, "culture-bound syndromes" from this part of the world, although they may have been also reported somewhere else.

### **Trance States**

Possession trance states are not peculiar only to Southeast Asia but occur in other parts of the world as well. There are however, certain characteristic features of possession-trance that are common to the different ethnic groups in Malaysia. These are: the alteration in the level of consciousness, amnesia for the period of the trance, duration of less than an hour, fatigue at the termination of the trance, normal behaviour in the interval between the trances, onset before 25 years, occurrence in low social class people with poor educational level and in those who witnessed a trance previously. Possession-trance is akin to a hysterical episode (Kua, Sim, Chee, 1986). It begins in an individual under stress but is unable to cope with it and thus resolves the conflict by possession-trance. During the trance the stereotyped behaviour allows the release of repressed feelings. This socially sanctioned behaviour is recognized as a sign of distress, which would evoke an appropriate response from the community. Moreover, the individual is treated with respect because he is perceived to be favored by a deity. This condition is likened to a defense mechanism for the preservation of self-dignity and self-worth. These people are almost never referred to any psychiatric facility. Treatment is mostly sought from the traditional healers where fewer stigmas are attached to the patient.

### **Koro**

Koro is an acute anxiety reaction characterized by an intense fear that the person's genitalia (commonly penis or female breast or genitalia) is shrinking and may disappear into the abdomen, leading to death. It is an acute anxiety state with panic attack (Gwee, 1968). The person may attempt to secure a hold on his penis by tying a ribbon around it or grasping it with whatever is available. This generally occurs in cultures where belief about Koro is prevalent and thus family members get disturbed about the attack. The panic over impending disappearance of the penis leads family members to helping the patient in tying his genitalia with strings. Although Koro affects individuals, occasionally there is an epidemic. Some time back, an epidemic of koro-like syndrome occurred in Thailand, where

it is called rok-ioo, which was later on blamed on poisoned food. Most cases are reported in Southeast Asia and southern China, where it is described as suk-yeong. Occasional reports of Koro from Western cultures are also seen. A few cases of Koro have also been reported in cases of organic brain syndromes. Koro individuals are described as those with low educational background and who are dependent or have immature personalities. Koro has usually been thought of as a psychogenic disorder resulting from the interaction of cultural, social and psychodynamic factors in especially predisposed persons. Cultural fears about nocturnal emission, masturbation, and sexual overindulgence leading to fears about virility seem to give rise to the condition. The precipitating factors may include coitus, a sudden exposure of the penis to cold water or hearing stories of people dying of Koro. However, the disorder is short-lived and the person usually recovers after explanation and reassurance. The patients may be treated with psychotherapy or antipsychotic drugs. Sometimes sedation may be necessary. In a few cases modified insulin and electroplexy may be needed. Most of the patients in long term follow up show improvement and do not have further attacks, although they may be prone to develop anxiety. However, the prognosis is related to the premorbid personality and any adjustment problems. A case of sporadic Koro has been described where there is a complication of marital disharmony and sexual rejection (Adityanjee, Azhar, Subramaniam, 1991). There is suggestion that there is a distinction between sporadic Koro and epidemic Koro. The sporadic form can present with Koro as a symptom or with Koro syndrome, which in turn consists of classical Koro and Koro grafted upon underlying psychiatric illness. Classical Koro as described by Devan and Ong (1987) is more likely to be seen epidemically whereas the Koro symptom (Sachdev, 1985) is unlikely to occur in epidemic proportions.

## Amok

First described in Southeast Asia, this word is derived from the Malay word '*mengamok*' meaning to engage furiously in battle. Amok describes the sudden onset of wild rage. It is a rare illness, which has been described in Malaysia, Singapore, Philippines, Papua New Guinea, Puerto Rico (*mal de pelea*) and Java. Examples of persons with a syndrome similar to amok in the United States have also been reported. Those people turned out to be suffering from schizophrenia, bipolar disorder or depressive disorder. It was fairly common in Malaysia many decades back but of late has become rare. It is a form of dissociative disorder characterized by a period of brooding followed by an outburst of violent, aggressive, or homicidal behaviour directed at people and objects. The person runs about armed with a weapon, such as a knife and attacks everybody indiscriminately in his path before he is eventually overpowered, or sometimes, commits suicide. Prior to the outbreak he appears to be withdrawn and depressed and he has complete amnesia of the attack. The episode tends to be precipitated by a perceived slight or insult and is common among males. The Malaysian native also refers to the attack as *mata gelap* (dark eye). The attack is often accompanied by persecutory ideas, exhaustion and return to premorbid level later on. Some of the cases have been reported to be having schizophrenia, paranoid psychosis, epilepsy or brain lesion. The reasons for occurrence of this syndrome in Malaysian people

are not very clear. One of the reasons for this condition may be a cultural expression of aggression in society where restrictions are imposed on adolescents and adults. The belief in magical possession by demons and evil spirits may be another factor. The easy availability of knife as a lethal weapon has also been referred to as contributory factor. Social stresses, role crisis and separation from family may also be a contributory factor. The attack lasts for a few hours. The treatment consists of restraint and sedation or treatment with antipsychotic medication, if psychosis is diagnosed.

## **Latah**

This is an uncommon disorder seen among Malays and Indonesian women. It is known in the Philippines as mali-mali and in Thailand as bah-tschi. This disorder was found predominantly in Malaysian and Javanese women but also found in males. However, in recent times this disease is becoming rare and nowadays hardly any case of latah is seen. The cause of latah has been considered to be an intense fear reaction to a stimulus leading to disorganization of ego boundaries. The personality is stable when the person is out of attack, which may occur to intelligent people. The Malaysian people's belief in possession states may be a factor contributing to the Latah reactions. Latah has also been suggested to be a hereditary disease running in families having a startle reaction to stimuli, which would otherwise not cause that reaction in normal individuals.

Latah occurs in two forms. The first one is the startle reaction, in which the person suspends all normal activities and starts a behaviour characterized by compulsive imitation of words, gestures or acts and automatic obedience may be present. The person may also utter obscenities. The other one consists of a chain of unusual and inappropriate motor and verbal manifestations, which are generally out of the voluntary control of the person. The behaviour is precipitated by any frightening incident. However, persons are fully aware of the situation inspite of not having control over their actions and any attempt to control the persons leads to resistance. They may feel shy after the episode, as usually they are the center of jokes later on by the people. It can go on to become chronic disease, if uncontrolled for several years, leading to permanent automatic obedience and echo reactions. This may also lead to personality deterioration. The person may hide away from the society.

Those with this condition do not seek medical help and they are viewed by family members or friends as just 'odd personalities'. However, once treatment is sought, it should consist basically of psychotherapy. If latah reaction is found to be associated with some psychiatric disorder, benzodiazepines and major tranquilizers may also be used.

## PSYCHOTHERAPY IN MALAYSIA

### *Background*

Psychiatry in its infancy in Malaysia was mainly for the treatment of psychotics who were put in asylums; psychotherapy was never meant for them. It developed much later in the seventies. It was, as in the Western countries, mainly used for neurotic patients and first came to be practiced by local psychiatrists in the capital cities. Since these psychiatrists received their training overseas, the most common form of psychotherapy in the seventies and eighties was of the psychoanalytic type. The patients were mainly those who are themselves Western educated and spoke English. This, of course, means that the majority of patients who were not sophisticated enough were left out.

The culture of most Malaysians who are Muslims too could not readily accept the psychoanalytic model of Freud (Freud, 1949). As such most neurotic patients tend to visit indigenous religious faith healers with very little prospects for improvement. Most of the symptoms were attributed to lost of '*semangat*' (soul substance), being charmed by enemies or being disturbed or haunted by evil spirits. Various verses and incantations are recited to free the patient of all these spirits. At times verses of the Quran or Sunnah are used. Many other forms of pseudoreligious practices are used by these healers to convince the patients that they are religious and their trade is being acknowledged by God. An example of such a practice is when a so-called religious person recites verses of the Quran to catch spirits. One of these healers literally puts these unseen spirits in bottles and throws them in the river. Others would start by reciting the Quran but ends by summoning some spirits that is aligned to him to fight the bad spirits inhabiting the sick person. Yet others would recite the Quran and start to see messages and future events from a basin of water. Any Muslim knows that predicting the future or fortune telling is against the teaching of the Quran and the Prophet. These practices have been going on for years and are still being practiced in most parts of the country today. Subsequently as more Muslims became educated and could differentiate proper religious substance from pseudoreligious techniques, they tend to look for more scientific form of treatment. Freud's psychoanalysis does not fit into either being religious or scientific. As such the younger Muslim psychiatrists started to practice more of supportive psychotherapy rather than psychoanalysis.

Supportive psychotherapy places more emphasis on supporting or maintaining a patient's existing personality structure and defense mechanisms (Tian, 1995). The key feature is the provision of an ongoing, consistent relationship in which the therapist aims to maximize the patient's strengths, minimize his dependence on the therapist and help him to live as independently as possible. Family therapy and group therapy also started to become popular as the patients become more sophisticated and understand that their illness was at times caused by or has effects on other family members.

However a scientific approach to psychotherapy with religious input only started in the early nineties in Malaysia (Sharma, Azhar, Varma, 1995). Controlled studies involving patients with anxiety disorder (Azhar, et al, 1993b, Azhar, 1993b, 1994a, 1994c), depressive disorder (Azhar et al, 1995a, 1995b), and bereavement (Azhar et al, 1994b, 1995d) indicate that religious psychotherapy brings about more rapid improvement compared to supportive psychotherapy. The tables below show some of the results from those studies.

#### Hamilton Anxiety score of study and control groups

	Day		13 months		6 months	
	Study	Control	Study	Control	Study	Control
Mean	21.90	21.03	3.77	6.97	1.10	1.48
s.d.	6.26	3.54	3.06	2.90	1.40	1.46
	NS		P<0.001		NS	

#### Psychotherapy for depressed clients

Psychotherapy	Total patients	HDS Mean 2 weeks	HDS Mean 2 months	HDS Mean 6 months
Supportive	32	20.04	6.75	1.81
R-CBT	32	19.06	4.84	1.34
		NS	P=0.001	NS

#### HDS for patients with bereavement

	Day 1		Day 30		Day 90		Day 180	
	Study	Control	Study	Control	Study	Control	Study	Control
Mean	22.47	21.93	9.93	13.26	3.33	4.20	3.06	3.60
SD	1.19	1.34	1.34	2.43	0.82	1.27	0.88	0.51
	NS		P=0.001		P=0.01		NS	

### *Religious psychotherapy in Malaysia.*

#### *Introduction.*

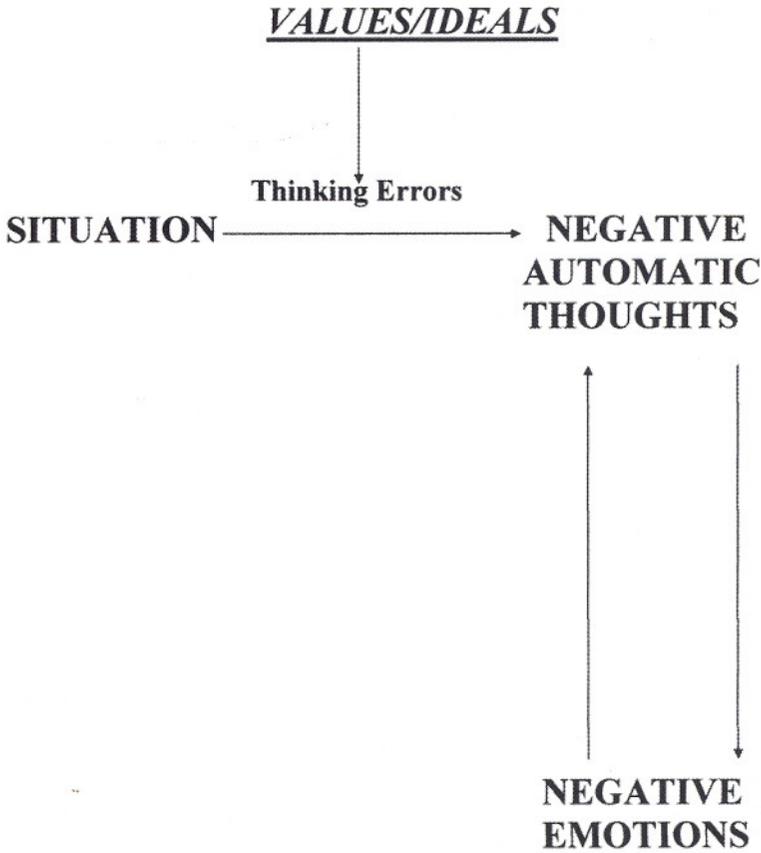
Psychotherapy is important and effective if carried out properly and patient selection is done carefully and correctly. In Rural Malaysia, the field of psychotherapy is limited if we follow the Western concept since most patients are very culturally tuned to culture-based medication. Simple psychotherapy or counseling by faith healers seem to be fairly effective anecdotally though improvement do not last.

Psychotherapy is a sociocultural institution and their issues will play a major role in the mode and outcome of psychotherapy. Ideally psychotherapy should be able to take into account the impact on therapy of religious beliefs and practices, especially those that play powerful roles in patient's lives (Koltko, 1990).

Koltko (1990) illustrates how religious beliefs are relevant to many issues in psychotherapy, such as receptivity to psychotherapy in general and relative accessibility to different specific approaches. He emphasizes that a therapist should keep in mind that religious beliefs and values held by a community have existed for much longer than the therapist's particular therapeutic orientation, because they have had adaptive functions. Hence the therapist should not lightly challenge or attempt to change them. He should be sensitive to differences in issues affecting different subgroups of believers. Thus, when taken into account in psychotherapy, religious beliefs will inevitably affect its receptivity by patients and its ultimate outcome.

#### *Our model and conceptualization*

This bring us directly to our conceptualization of religious psychotherapy (Azhar, 1995g, 1996a, 1996c; Azhar et al, 1996a). We hypothesize that the main problem in human emotional disorders is not in the conflicts, especially of the sexual nature, but in the value system and the ideals. Each one of us has ideals or values that we have acquired over the years through learning experience and modeling. These ideals and values will determine our actions and emotions and if one tend to show negative emotions then the fault could be traced back to wrong ideals or values and a modification of these ideals or values could help to eliminate or control negative emotions. This is an oversimplification of the problem. There are of course many factors that contribute to negative emotions, but our values and ideals is the central etiological factor. We base this on Quranic psychology. Different values on morality produce two different individuals with different emotional makeup. We attempt to present clinical evidence in support of this hypothesis.

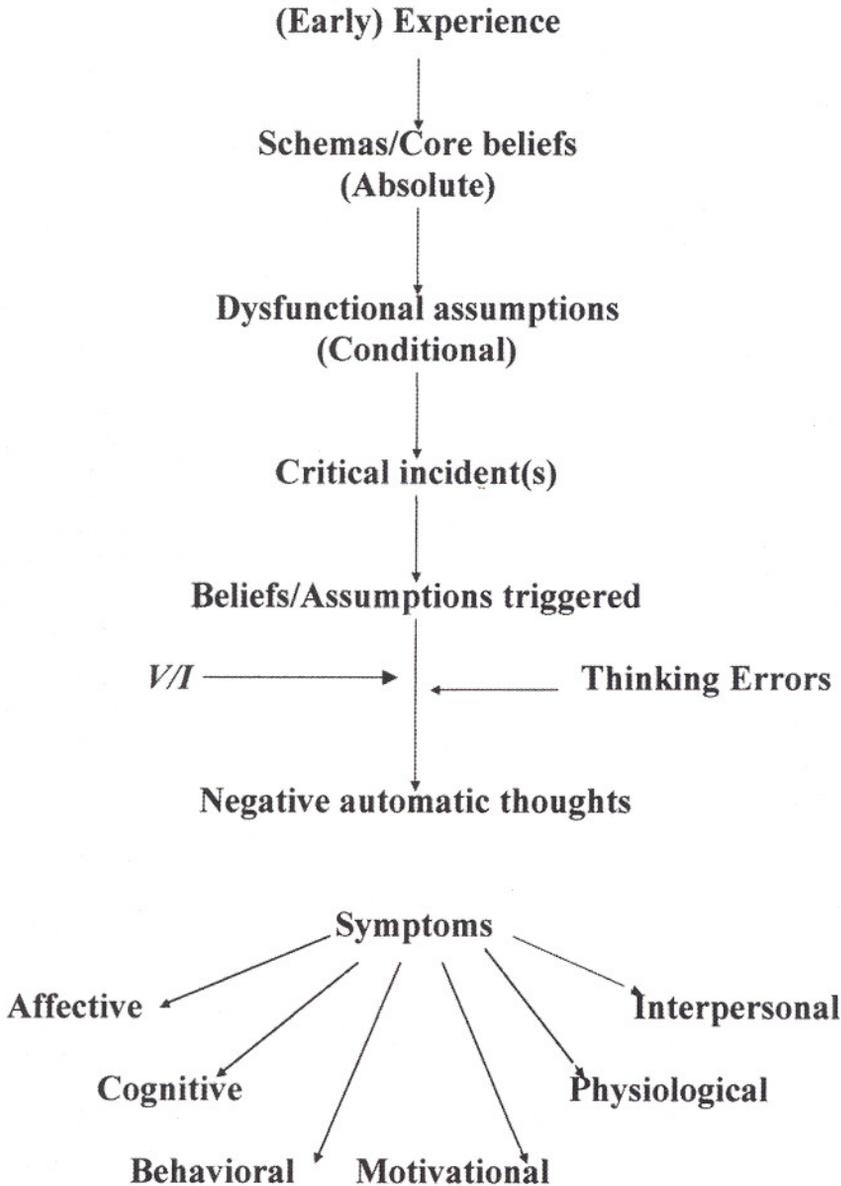


**Model: Effect of Values/Ideals on psychopathology**

*Our experience with religious psychotherapy*

In our experience since 1990 with anxiety patients, we have found that there was a significant improvement in the study group as compared with the control group (Azhar et al, 1994c). Similar results were seen in depressed patients (Azhar et al, 1995b) and bereaved patients (Azhar et al, 1995d). Overall, religious psychotherapy was found more acceptable to patients and produces faster recovery than supportive psychotherapy (Azhar et al, 1994a). However more work needs to be done to look at its actual long-term outcome and whether it is useful in relapse prevention in comparison to drugs. At this stage, we have ample evidence to suggest that there is a significant change in the "values" of the patients treated with religious psychotherapy compared with those treated with supportive psychotherapy. Based on these findings, the religious psychotherapy model seems to be supported, i.e. what is needed is a "value search" and "value change" not "conflict search" and "conflict resolution".

The basic technique of religious psychotherapy is borrowed heavily from the techniques used by Beck (Beck, 1967, 1979) to treat depression. We first identify negative thoughts in the patients and attempt to modify them using cognitive techniques. Once the patient learns this we go deeper and using the downward arrow techniques (Beck, 1979) or the prejudice model of Christine Padesky, we try to identify dysfunctional assumptions in the patient and later on the "ideal" and "values" of the patient. Once we attain this level, we use religious techniques in a scientific way to modify the values.



The mainstay of our techniques is that it has to be through collaboration and Socratic questioning at all levels. By collaboration, we mean we work with the patient to find a solution. We do not preach or teach him what he should or should not do. Socratic questioning means we ask questions to the patient so that he will find the answers rather than the answers are given to him. For example if he believes people are laughing at him, we ask him how he knows that for a fact, why would people want to do that, would he do the same to people, what evidence has he got to show, etc. It must be data driven and scientific and at no time is the therapist allowed to start preaching, or force his values on the patient. He has to work together with the patient to find the patients' "values" using the Quran and Sunnah as guidance but never through lectures or preaching or imposition of values. A therapist who has a tendency to do this is not suitable to carry out this form of psychotherapy no matter how religious he may be.

Once patients can learn this technique, they can be discharged, as they should be able to treat themselves the next time a problem should arise. So basically this technique helps a patient to know the Islamic coping skills in a scientific manner, and logically the outcome should be excellent and relapses are not expected. Work is presently being directed towards these aspects.

Religious psychotherapy has become very popular in our practice, as most of the patients are religious. Almost 70% of the patients referred to the psychotherapy clinic end up with this form of therapy. The relatives of the patients are also keen for the patient to follow this therapy (Azhar et al, 1994a). At that moment it was only being used for neurotic patients and as such the selection criteria included only this type of patients. Besides, they must have a minimal amount of educational background as it involves cognitive behaviour techniques that require a lot of input from the patients themselves. All of them will need to carry out a lot of behaviour experiments during sessions and at home. As such the other important criteria is that they have to be motivated to improve themselves. However, the most important criteria is that they have to be religious for all discussions will fall back on religion as the source of guidance and evidence. In our work for the purpose of being objective and scientific, all patients must fill up a religious scale questionnaire before undergoing therapy. This is a scale that we developed initially for our study but have now been used on a regular basis. It consists of 20 questions on prayers, fasting, *zakat* (alms), performing the haj, sunat prayers, other social obligations as good Muslims and belief in Quran and Hadith. This will help to establish if the patients are really religiously motivated to undergo the therapy. All patients who score 70% and above on the scale have been known to show improvement after therapy (Azhar et al, 1994a).

As with other therapies, this therapy is also being tried on other disorders besides neurosis. Work has started on patients with chronic pain and other somatoform disorders. Small samples of patients with psychosis, i.e. patients with bipolar disorders are also being tried with this therapy. At the moment there is confidence among the therapists that this therapy

would be able to at least maintain improvement in these groups of patients although they may not offer a permanent cure. The quality of life of patients who have undergone this treatment will be better. Research is also being directed in this area of the relationship between quality of life and religious psychotherapy.

Apart from this, a small group of other disorders have been tried with positive results namely, sexual addiction (Azhar, 1993a; Azhar et al, 1995c), akathisia-induced suicidal behaviour (Azhar et al, 1992c). The bravest attempt however has been applying this technique on psychotic patients with remarkable success. The patients' response to all modalities of thought together with anxiety and depressive symptoms show expected outcome (Azhar, 1996b; Azhar et al, 1997c, 2000a). The graphs below summarize the results.

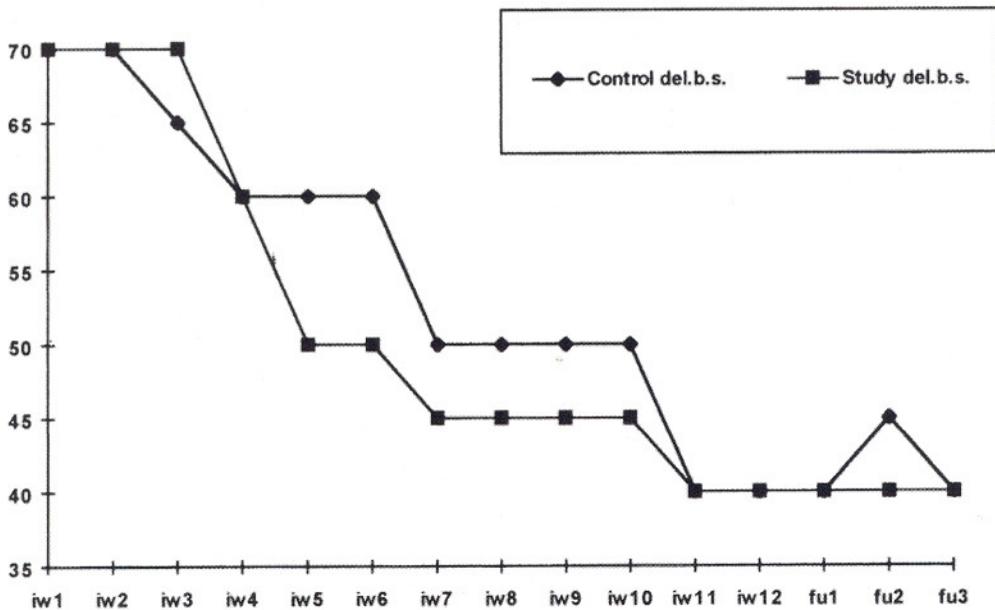


Figure 1: Patients' belief conviction while receiving Cognitive Therapy

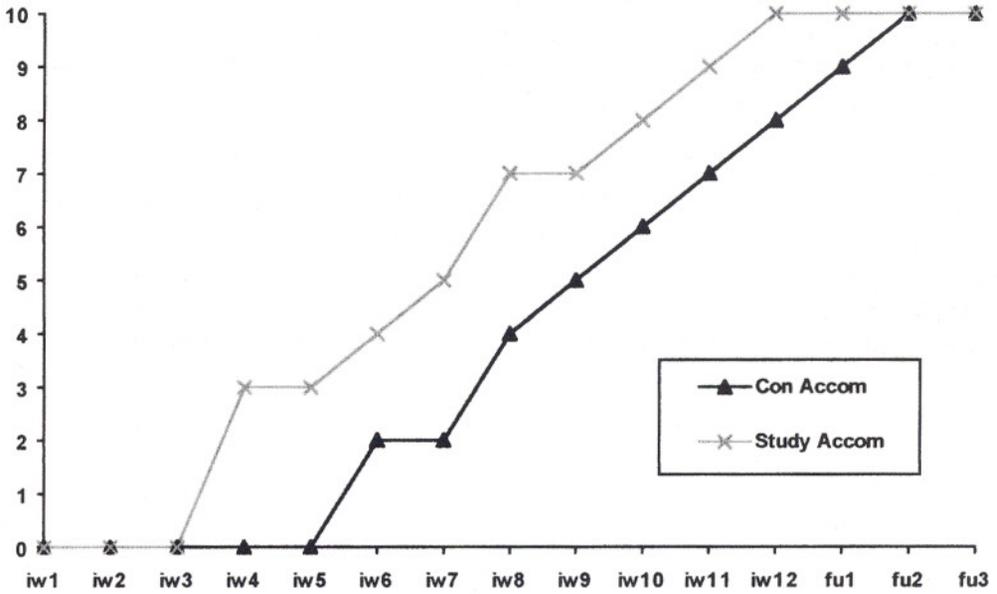


Figure 2: Patients' accommodation while receiving Cognitive Therapy

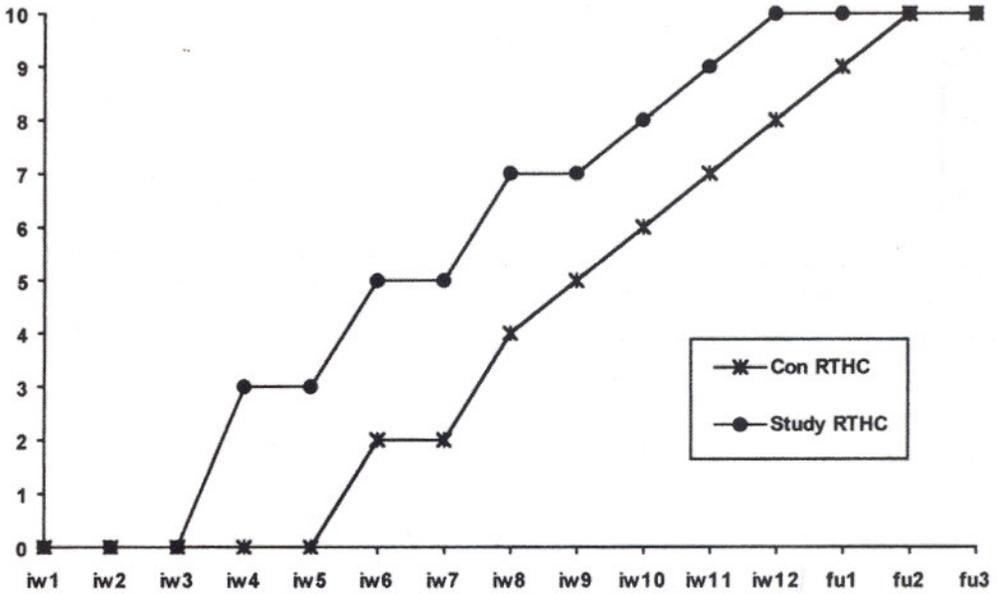


Figure 3: Patients RTHC while receiving Cognitive Therapy

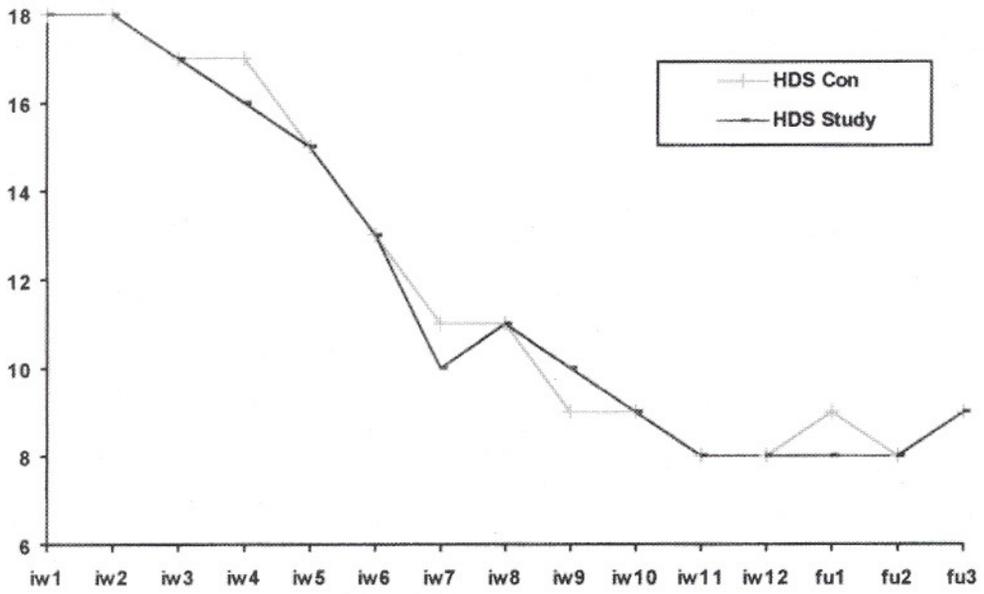


Figure 4: Patients HDS while receiving Cognitive Therapy

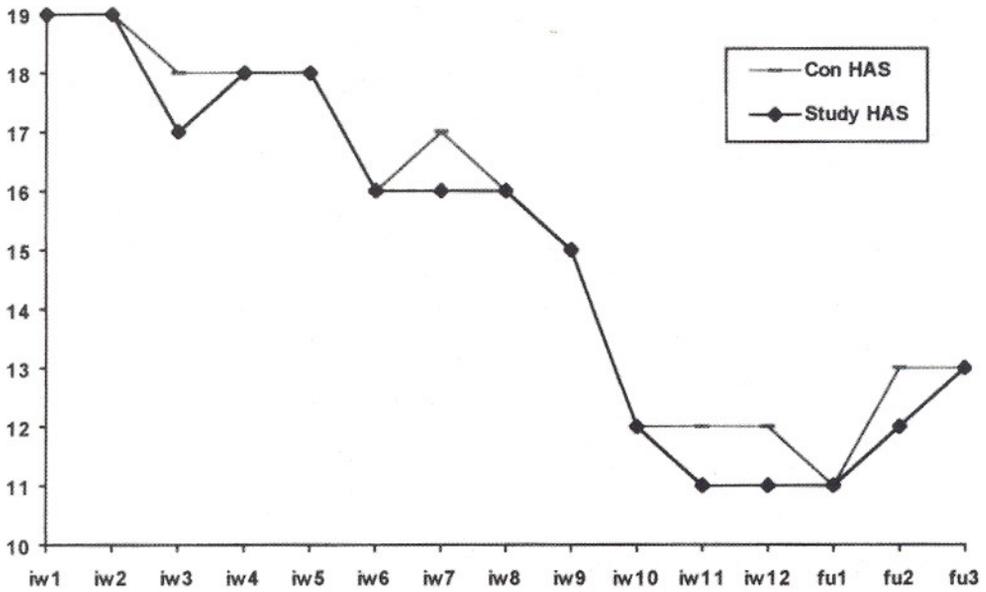


Figure 5: Patients HAS while receiving Cognitive Therapy

Looking further into the therapy of patients with neurotic disorders, it became obvious that cognitive-behaviorally the formulations can be generally divided into coping and avoidance and using 3 different models, our R-CBT model can be incorporated into the treatment (Azhar et al, 1997a, 1997b) as shown in the table below.

	<u>ANXIETY DIS</u>	RESIST- AGAINST CHANGE	MULTI- SYMPT
<b>ACTIVE COPING</b>	Simple Pho Agora Pho Social Pho	<b>LOW</b>	↓
<u>BEHAV XS D</u>			
<b>ACTIVE AVOIDANCE</b>	OCD/PD Gambling	<b>MED</b>	
<u>RESIGNATION D</u>			
<b>PASSIVE AVOIDANCE</b>	Depression PTSD	<b>HIGH</b>	

**3 MODELS**

1. Skills deficit model
2. Conditioned anxiety model
3. Cognitive inhibition model

First analyze which area deficit  
 if skills - Behav. th.  
 if cog - CBT  
 R-CBT – for MED and HIGH

Further experiments were then attempted using the acute disorders such as panic (Azhar et al, 1997c) with encouraging results as shown below.

Patient	Sex	Age	Panic Frequency per week		Catastrophic belief Score		HAS	
			Pre-treatment	After 3 sessions	Pre-treatment	After 3 sessions	Pre-treatment	After 3 sessions
1	F	45	20	9	100	50	32	20
2	M	32	24	5	100	60	41	30
3	M	17	10	0	100	10	35	21
4	F	30	19	10	100	50	36	30
5	F	31	15	0	100	10	40	20
6	M	43	16	9	100	30	38	30
7	F	38	11	3	100	40	37	28
8	M	28	15	0	100	15	41	21
9	F	40	19	5	100	60	40	20
10	F	32	12	0	100	10	30	10
11	M	30	16	9	100	50	35	21
12	M	19	12	3	100	30	38	30
13	F	29	16	0	100	10	40	18
14	M	28	20	4	100	30	37	21

Work with identifying eating disorder beliefs among teenagers were also attempted (Azhar et al, 1997d, 2001b; Normah, Azhar, et al, 2000; Noorjan, Azhar, et al, 2002) as prelude to treating the disorder using R-CBT and the following were discovered: -

1. It seems that B and BN are closer to substance dependence in their cognitive processing while AN is closer to OCD. As such if the CBT approach is to be used in treatment then the two groups of patients need to be approached differently. The B/BN patients would require us to work on their *deserving* for food and need for control while the AN requires the *responsibility* approach.
2. B/BN/AN all have different personality profiles based on their DAs and CBs. This again means that we need to approach them differently and this could account for their presentation in (1) above.
3. AN/BN has more negative beliefs about self and the world but not of others. This could be used to advantage in psychotherapy as their positive beliefs about others including the therapist helps in rapport development and therapy process.

4. It is important to build positive beliefs as well as challenge and change negative beliefs in these patients.

Another group of patients being looked at were the victims of violence (Azhar, 1998b). Cognitive patterns that emerged were: -

- (1) Thoughts that occur *during* the traumatic event. A bipolar construct of mental planning verses mental defeat, relating to thoughts during the assault. It was found to have good outcome following imaginal exposure therapy was associated with mental planning during trauma, and inferior outcome was associated with lack of mental planning during the trauma.
- (2) The victim's subsequent appraisal of the way they behaved and felt during the assault may be important. Some indirect evidence that negative appraisals of actions are associated with poorer outcome comes from studies looking at internal attributions for negative outcomes and studies addressing self-blame. In two studies of survivors of shipping disasters internal attributions for negative events involving the individual (assessed within 6 months of the disaster), were significantly correlated with depression and intrusions up to 19 months post disaster. With respect to self-blame it has been found that post-rape psychopathology was positively associated with blaming one's actions, and with blaming aspects of one's personality.
- (3) The victim's appraisals of the way in which other people responded to them in the aftermath. Several investigators have reported data suggesting that those who perceive that other people have failed to react in a positive or supportive manner, report greater post-traumatic psychopathology.
- (4) The victim's interpretation of the PTSD symptoms. It has been postulated that appraisals of symptoms and signs of incompetence or inadequacy may act to intensify PTSD. It is proposed, with respect to the maintenance of symptoms of intrusion, that the 'negative idiosyncratic meaning of intrusions' acts to increase distress and to make it more likely that the individual will engage in strategies to control the intrusions. These strategies may then act to maintain or even to exacerbate intrusive symptoms. Negative interpretations of symptoms also play a central, maintaining role in panic disorder and it is of interest to note that individuals with PTSD have Anxiety Sensitivity Index scores that approach those of panic patients.
- (5) The global negative beliefs that the individual may hold about themselves, their world, and their future following the assault. There has been considerable discussion of the role of shattering and confirmation of pre-existing beliefs in the development of PTSD. The former refers to the proposal that a traumatic event presents the individual with information that is inconsistent with pre-existing beliefs. This is said to shatter core assumptions: such as 'the world is benevolent', 'the world is meaningful', and 'the

self is worthy'. In some cases, a traumatic event presents the individual with information that acts to confirm and reinforce pre-existing *negative* beliefs about the safety of the world and the worthiness of the self.

A pilot study has indicated that the five cognitive factors mentioned above are associated with persistence of PTSD symptoms. However some of the factors may be a consequence rather than a cause of persistence. The results however have helped us to understand PTSD better and have made psychological treatment of the victims more focused. The above issues must be taken into consideration when treating victims. For example victims with mental defeat during assault should not be treated with imaginal exposure as this could make them worst. Each case needs to be analyzed in detail and a suitable treatment model planned based on the current evidence of research knowledge for each individual victim. Much more information are needed and a more extensive research to provide this information is underway but in the meantime, we have currently ample experimental and scientific knowledge to treat victims of torture or PTSD patients with more accuracy and hopefully with good results. This however can only happen if there is a strong support and effort by everyone concerned with the treatment of these victims as the management is a team approach although, the psychotherapy may be on an individual basis initially

As we progressed to more difficult patients, we attempted to find out if the use of combination therapy would in any way help to reduce pathology or length of treatment. What we found was very encouraging. The combination of R-CBT with medication has faster response and reduces the use of medication in terms of dosage and therefore side effects and costs (Azhar et al, 2000a, 2002b; Azhar, 2002d). The disorders tested were panic disorder and health anxiety disorders and the drugs used were fluvoxamine and nefazodone respectively. The tables below indicate the positive responses.

Treatment types	Age Mean (sd) Range	Panic Freq pre Rx	Panic Freq 9 sess	Catas Belief Pre Rx	Catas Belief 9 sess	HAS Pre Rx	HAS 9 sess
CBT +FVX	31.57 8.00 17-45	16.07 4.01	4.07 3.87	100	31.79 18.36	37.14 3.32	22.86 5.93
		chi sq 40.29 df 35 p<0.0001				chi sq 45.31 df 35 p<0.0001	
CBT.	31.66 8.09 18-44	16.36 3.08	3.64 2.21	100	30.71 9.97	37.0 3.44	21.50 5.17
		chisq 58.33 df 56 p<0.0001				chisq 69.22 df 60.0 p<0.0001	
FVX.	31.36 7.54 18-44	16.07 3.95	9.07 1.98	100	80.71	36.50 3.23	28.71 4.18
		chisq 42.39 df 42 p<0.0001				chisq 64.56 df 63 p<0.0001	

Treatment types	Age Mean (sd)	BDI pre Rx	BDI 9 sess	BAI Pre Rx	BAI 9 sess	QOL Pre Rx	QOL 9 sess
CBT + NFD	33.11 (6.88) 17-45	30.50 (2.12)	21.16 (2.77)	33.66 (2.3)	21.22 (3.81)	63.83 (3.73)	80.16 (2.72)
		p<0.0001		p<0.0001		p<0.0001	
CBT.	30.94 (6.12)	31.72 (3.21)	22.44 (3.97)	34.83 (2.38)	21.50 (4.21)	65.33 (4.64)	78.77 (4.53)
		p<0.0001		p<0.0001		p<0.0001	
NFD.	31.00 (7.93)	30.75 (1.86)	26.75 (2.24)	32.95 (2.32)	29.05 (1.93)	63.05 (4.66)	68.80 (3.54)
		p<0.0001		p<0.0001		p<0.0001	

Treatment types received by patients and the results of BDI, BAI, and QOL at baseline and at end of 9 weeks.

BDI ; Beck Depression Inventory

BAI ; Beck Anxiety Inventory

QOL; WHO Quality of life – Brief Version Scale

Treatment type	BDI	BAI	QOL
CBT + NFD	128.77	140.57	224.88
CBT	59.31	136.34	87.36
NFD	37.64	33.23	33.22

Values of F scores from ANOVA for BDI, BAI, and QOL following 9 weeks of treatment using the various treatment types.

BDI ; Beck Depression Inventory

BAI ; Beck Anxiety Inventory

QOL; WHO Quality of life – Brief Version Scale

Treatment Types	PR Pre	PR 9s	SYS Pre	SYS 9s
CBT + NFD	93.1 3.02	83.4 2.99	123.5 3.82	115.0 4.08
	p = 0.0016		p = 0.004715	
CBT	95.4 2.76	82.0 2.00	126.0 4.47	115.7 4.49
	p = 0.0015		p = 0.004619	
NFD	96.0 1.63	89.4 1.51	125.7 4.49	118.6 2.44
	p= 0.00147		n.s.	

Values of systolic blood pressure and pulse rate at baseline and following 9 weeks of treatment using the various treatment types.

Treatment Type	Mean	S.D.
CBT + NFD	186.11	65.98
NFD	335.00	81.27
p < 0.00001		

Dosage of NFD required in the two different groups of patients

At this point we were able to be confident to propose our model to others in the field and analysis of our work with various disorders were reported in several journals and meetings (Azhar et al, 1995f, 1996a, 1996d, 1997a, 1997b, 1997d). At this stage too all our patients who were still on follow-up had completed a two-year therapy and we were able to measure the actual change in ideals/values to further consolidate our model (Azhar et al, 1999a; Azhar, 1998a, 1999, 2000c, 2001). The tables below indicate the change.

#### Depression 2 year follow-up

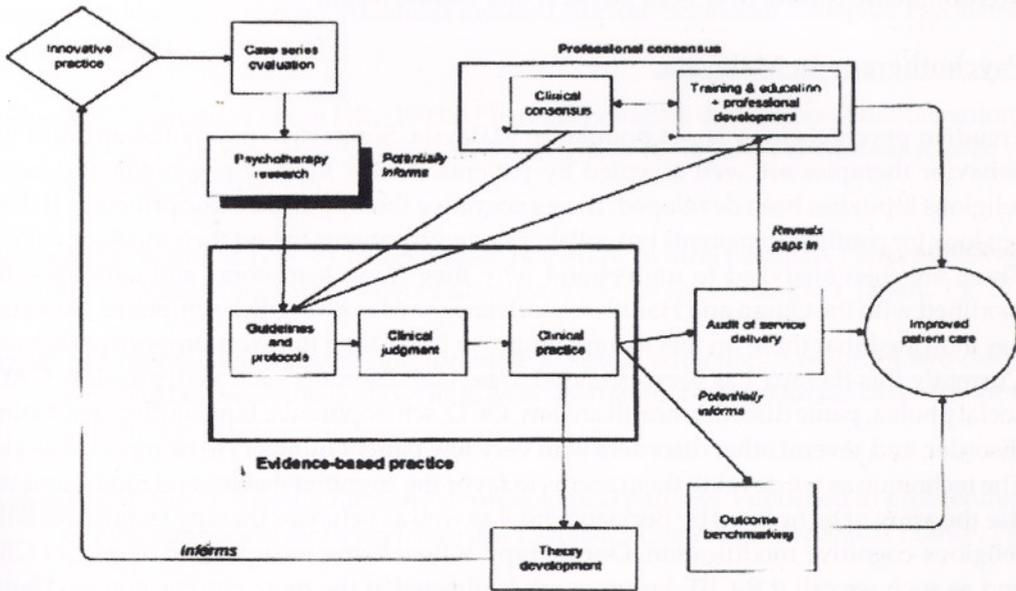
Study Group	HDS mean	s.d	VMS mean	s.d
9 m	5.40	2.41	84.00	7.38
24 m	3.00	0.82	93.00	4.83
	$\chi^2 = 4.47, df=2, p = 0.10$		$\chi^2=3.52,df=2,p=0.17$	
<b>Control Group</b>				
9 m	14.50	1.71	35.63	7.27
24 m	11.13	1.20	45.31	6.18
	$\chi^2 = 7.95, df=3, p = 0.04$		$\chi^2=9.31,df=3,p=0.02$	
<b>Control Group + 6/52 RPT</b>				
1 w	12.38	2.09	44.38	6.55
6 w	6.81	4.76	78.13	24.82
	$\chi^2 = 8.88, df=8, p = 0.35$		$\chi^2=5.09,df=5,p=0.4$	

#### Anxiety Group two year follow-up

Study Group	HAS mean	s.d	VMS mean	s.d
9 m	2.53	0.94	86.76	6.83
24 m	1.47	0.51	93.82	2.19
	$\chi^2 = 1.99, df=1, p = 0.15$		$\chi^2=1.17,df=1,p=0.27$	
<b>Control Group</b>				
9 m	19.85	5.89	28.50	18.99
24 m	15.55	5.11	37.01	15.34
	$\chi^2 = 14.70 df=8, p = 0.06$		$\chi^2=15.96, df=7,p=0.02$	
<b>Control Group + 6/52 RPT</b>				
1 w	18.05	5.74	34.00	16.67
6 w	11.40	7.25	63.25	31.72
	$\chi^2 = 16.71 df=15, p = 0.33$		$\chi^2=14.99,df=7,p=0.03$	

As the model seems to have positive effect when used in combination with drugs, we were keen to see if patients with mild symptoms could have similar effect if combined with non-drug modalities but using healthy lifestyle strategies as adjunct to therapy. Positive response was seen using regimented exercise training for anxious patients (Azhar et al, 1999b) and food i.e. chicken essence also for anxious patients and highly stressed normal individuals (Azhar et al, 2001a, 2002; Azhar, 2002b).

As we progressed, we begin to see an emerging pattern of different cognitive impairment among different patient groups. In simplistic terms, depressed patients tend to show memory bias while anxious patients tend to have attention bias. This when added to the model will definitely enhance therapy and help to determine specific techniques for specific disorders (Azhar, 2003a). For the future we are looking at more complex chronic non-psychotic cases such as generalized anxiety disorder, obsessive compulsive disorder and social phobia. Already we are identifying the pattern of Type 2 worry in generalized anxiety disorder, responsibility and attention bias in OCD and immediate and delayed memory bias in social phobia (Azhar, 2003b). What we have achieved is essentially incorporating our innovative practice into clinical practice for improved patient care following the evidence-based flow chart below.



Achieving evidence-based practice in the psychological therapies.

Alas, our hope is to incorporate these findings into the teaching of undergraduate and postgraduate medical students as knowledge in these basic techniques can help any patient in any field of medicine (Azhar, 2002c, 2002e).

## CONCLUSION

Influence of culture on mental health is evident in Malaysia. The types of mental illness seen in this country are changing. Depressive, hypochondriacal, and anxiety symptoms are more commonly seen and the presentation seems to favor a somatic picture. Most patients prefer to talk in terms of physical problems rather than mental problems and explain their problems in terms of loss of soul substance. Epidemic hysteria is another episodic phenomena seen. Obsessive-compulsive patients present mainly as ruminators with commonly religious content. The cultural influence is also seen in psychotic patients. The contents of delusions and hallucinations of patients are mainly regarding religious and sociocultural issues. An interesting aspect of relapsed schizophrenia in Malaysians is that they are not related to high expressed emotions in patients' relatives.

Culture-bound syndromes in Malaysia include trance states, koro, amok, and latah. Many of the culture specific syndromes are attributed to the traditional belief that spiritual forces exert immense control over both physical and mental health.

### Psychotherapy in Malaysia.

Freudian psychotherapy is not popular in Malaysia. Supportive psychotherapy and the behavior therapies are well accepted by patients. A new form of psychotherapy using religious input has been developed. It uses cognitive therapy as the basic principle. It does not look for conflicts in patients but collaborates with patients to find their ideals or values. These are then analyzed to understand why they cause symptoms and subsequently modified with the Quran and Hadith as guidelines so as to extinguish symptoms. Research has indicated that those on this therapy improve faster than those on supportive therapy. Currently this therapy has been extended to several disorders such as depression, GAD, social phobia, panic disorder, health anxiety, OCD, schizophrenia, Bipolar disorder, Eating disorder, and several other disorders with very few patient numbers to be reported as yet. The technique as we develop them seems to favor the cognitive-behavioral model and we use the array of techniques by Beckian school as well as behavior therapy techniques with religious-cognitive modification. Our therapy is now being incorporated as part of CBT and as such we call it R-CBT. Future work is directed at the more chronic non-psychotic disorders as well as mild disorders with more emphasis on understanding psychopathology and in turn developing better models and techniques for use on our patients. From the results achieved so far, it is very clear that psychotherapy does work on rural Malay patients just as well, if not better, than other patients as long as modifications are made to techniques and strictly adhered to and influence of culture is taken into consideration while preparing the psychopathological formulation.

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