

Psychotherapy in Malaysia – An Overview

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Psychotherapy in Malaysia

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Abstract

As a young and developing profession for the last two decades, psychotherapy in Malaysia is not widely known to those outside of the country. Therefore, this paper seeks to provide an overview of the development of psychotherapy in Malaysia. The paper first begins with a review of the Malaysian social-cultural context and mental health scenario, followed by the current practice of psychotherapy and psychotherapists in Malaysia. The title of 'psychotherapist' covers a broad range of professionals in Malaysia. Since the 1970s, the practice of psychotherapy, mostly brought in from the Western world, has evolved from the psychoanalytic tradition to behavioural and cognitive-behavioural traditions. Family systems work is, however, limited. There is growing interest in integrating indigenous cultural beliefs with the Western model of psychotherapy, as well as exploring alternative means to traditional face-to-face counselling mode. This paper therefore discusses several contemporary issues of concern within the field, as well as future directions, in relation to the practice of psychotherapy, research areas as well as training and development of future therapists. With still much room for growth and development, the field presents as a fertile ground for those up for the adventure and challenges of pioneering and revolutionary work.

Keywords: Psychotherapy, Psychotherapists, Malaysia, Southeast Asia

Note: A substantial part of this paper has been submitted (under the same title) to the Argentinian Journal of Clinical Psychology, in which it has been translated and published in Spanish for the May issue (Volume 16). It was an invited paper for their special segment on psychotherapy in different countries. The editor, Lilian Corrado, has allowed that this article be submitted elsewhere to be published in English, but with reference to the Argentinian Journal. For this paper, the author has made some minor amendments and added a section on Mental Health in Malaysia.

Introduction

This article seeks to provide an overview of the development of psychotherapy in Malaysia. The description here is by no means the "ultimate" reality, in light of the continuous growth and development of the field in a rapidly changing society. The article first begins with a brief review of the social-cultural background of Malaysia, in order to provide a contextual framework for the readers in understanding the development of psychotherapy in this country as well as the specific concerns in relation to its current context.

Social-Cultural Background of Malaysia

A developing nation, Malaysia is one of the fastest growing countries in the South East Asian region. Historically, Malaysia (previously known as Malaya) used to serve as a trading post for Chinese, Indian and Arabian traders as early as the fourteenth century, and subsequently came to be colonized by Portuguese, Dutch, British and Japanese between 1854 and 1957. Malaya gained independence in 1957 and subsequently joined with two other states in Borneo to form Malaysia in 1963 (Malaysia 2006).

A multiracial society of about 23 million people⁴ (including 1.3 million of non-citizens), according to the last census in year 2000, Malaysia consists of Malays and other indigenous groups (65.1%), Chinese (26%), Indians (7.7%) and other ethnic minorities (1.2%) (Department of Statistics Malaysia 2005). Each ethnic group in Malaysia has its roots in different civilizations and has undergone long periods of cultural adaptation to the local environment. For instance, the Malays and other indigenous groups (e.g. Iban, Kadazan, Bajau etc.) have long inhabited Malaysia, and therefore considered themselves “bumiputera” (literally means, “prince of the earth”). On the other hand, the Chinese and Indians have their historical roots in Southern China or India, whereby their ancestors were brought in to Malaya during British colonization.

Religion was found to be highly correlated with ethnicity, as revealed in Census 2000 (Department of Statistics, Malaysia 2005). Islam was the mostly widely professed religion (60.4%), typically embraced by the Malays and the indigenous groups. Although Islam is the official religion of the country, freedom of worship is guaranteed by the constitution. Other religions practiced included Buddhism (19.2%), Christianity (9.1%), Hinduism (6.3%) and Confucianism/Taoism/other folk religion (2.6%), according to Census 2000. Traditionally, Chinese and Indians practice Buddhism/Confucianism/Taoism and Hinduism respectively, although some too have converted to Christianity/Catholicism or Islam. In addition, animistic beliefs and practices are still evident, existing across ethnic groups, socioeconomic status and education level. Hence, it is not uncommon that many local people maintain supernatural beliefs in their daily living, particularly in relation to mental health issues.

In Malaysia, each ethnic group makes an effort to retain their own cultural identity through their respective cultural language, clothing, rituals and festivals. Even the political system tends to be race or ethnic-based, in which each ethnic group tries to fend for their group’s welfare. Nevertheless, in many areas, from clothing, food to lingua franca, Malaysian culture has been described as “hybrid” in nature (Smith 2003). All the different ethnic groups to a certain extent have assimilated to each other’s culture and live by a social contract of “tolerance”, which helps the society as a whole to function in harmony for the most part.

Interestingly though, language tends to be “territorial” in Malaysia, whereby the national language (Malay) holds its power in government agencies and public educational systems, whereas the English language predominates in corporate

⁴ Estimated at 27 million people in 2007, according to the Department of Statistics Malaysia (http://www.statistics.gov.my/english/frameset_keystats.php)

firms or private colleges. Other ethnic languages (e.g., Mandarin, Tamil) are usually used in ethnic schools. Additionally, ethnic dialects, commonly used in informal settings with family and friends, are also dispersed across the country according to geographical locations. Not to mention, there are about 18 aboriginal language groups in Peninsula Malaysia and at least 54 indigenous languages (including dialects) in East Malaysia (Smith 2003). Quite commonly, Malaysians tend to use a combination of language and dialect, often interchangeably in a conversation, depending on the social contexts. Although Malaysians are generally multilinguistic, their level of language proficiency may vary depending on their exposure to different languages and motivations to learn a second language.

Although on one hand, the various ethnic cultures are assimilated with one another in many ways, racial tension continues to exist subtly and surfaces from time to time (Abdullah 1999). Since the largest racial riots on May 13, 1969, maintaining communal trust has been a nationwide agenda. Nonetheless, it has been a challenge because ethnocentric sentiments are entrenched within each ethnic group. Meanwhile, the proposed ideology to create an inclusive national identity (*Bangsa Malaysia* or Malaysian race), remains a heated debate among different ethnic groups ('Bangsa Malaysia' 2006).

In general, the Malaysian society is hierarchical in nature. Although there is no clear specification of social classes in Malaysia, social functions and interactions are marked by differential treatment according to one's status (both ascribed and acquired) in the society. This inequality is considered normal, as manifested in the way homage is paid to those who are senior in age and position (Merriam & Mohamad 2000). The hierarchical structure is also defined by gender, in which men are usually the head of the household or community (Schermerhorn 1994; Scorzelli 1987). Nonetheless, over the last two decades, women in Malaysia have strived to improve their legal status and their rights in family and financial matters (Siraj 1994).

Mental Health in Malaysia

In general, mental health issues remain a stigma in the Malaysian society (Crabtree & Chong 2000), although this is slowly changing. The understanding of mental health in Malaysia varies from people to people, depending on their ethnic and religious beliefs (Edman & Koon 2000; Haque 2005), as well as the influence of Western psychiatry. These cultural mental health beliefs then shape the help-seeking pathways of the Malaysian people (Razali & Najib 2000; Rhi, Ha & Kim 1995).

For example, Malays attribute mental illness to multiple causes, including the loss of *semangat*, understood as the "soul substance" (Haque 2005) or "spirit of life" (Laderman 2001). Excessive or unexpressed *angin* (wind) in the body is also believed to induce pathology (Haque 2005; Ng K.S. 1998, 2003). In addition, some believe in supernatural causes, such as the possession of *Jinn* (Genie) or the result of *Santau* (black magic), typically sent by enemies (Haque 2005). Therefore, Malays traditionally seek help from traditional healers known as *bomoh* or *pawang*, who are believed to have the knowledge and ability to get rid

of any spiritual possession as well as physical or psychological illnesses. While some *bomoh* may use the Qur'an in treating the illness, others may use herbs and Malay Magic, based on early animistic and Hindu traditions (Haque 2005). Some indigenous shamanic healing may involve communal presence, which is thought to have healing effect on the patient (Harris 2001; Laderman 2001).

Likewise, Chinese mental health beliefs are also pluralistic, influenced by ancient Chinese philosophy (Haque 2005) as well as animistic and folk religious beliefs (Ng K.S. 1998, 2003). Based on ancient Chinese philosophy, good health is related to a balanced physical, mental and spiritual functioning, which is regulated by the circulation of *ch'i* (air or breath) (Haque, 2005). Accordingly, Chinese may seek help from Chinese physician (*sin-se*) who may use herbs, acupuncture or *ch'i-gong* (a form of martial art) to re-balance *ch'i* in one's body. In addition, conforming to one's family and social expectations is also considered pertinent for the well-being of the individual (Haque 2005). In cases whereby the patient is believed to be spiritually harassed by unwelcome spirits, families may turn to mediums in temples and folk religious rituals to get rid of or appease the spirits (Ng, K.S. 1998, 2003).

Traditionally, Indians' mental health beliefs are influenced by Hindu beliefs, as recorded in the *Vedas* (Books of Knowledge). According to the *Ayurveda*, health is considered an integrated whole and balance among three entities: the body, mind and soul (Haque 2005). In line with that, mental health is attributed to diet, relationship with the gods, teachers and the Brahmins (Haque 2005). Like the Chinese, Indian families typically turn to their "holy men" in the Hindu temples for help (Ng, K.S. 1998, 2003).

For the non-Muslims, two other religious world views that may influence one's mental health beliefs are Christianity and Buddhism. For the former, there is much emphasis on spiritual factors on top of the other biopsychosocial factors that form one's mental health (Faw, as cited in Haque 2005). In Buddhist philosophy, however, mental health is linked with *Karma* (fruit of the past) and practicing the right mind and action (Haque 2005). In addition, with globalisation and through the dissemination of Western knowledge, more Malaysians are now open to Western medical and psychological treatment approaches (Razali & Najib 2000; Rhi, Ha & Kim 1995).

Clearly, there is no one single "Malaysian" mental health belief and practice. Rather, the Malaysian people are generally pluralistic in their mental health beliefs and help-seeking pathways (Edman & Koon 2000; Razali & Najib 2000). Relating to that, Rhi, Ha & Kim (1995) found that more than 60% psychiatric patients in Malaysia first sought magicoreligious therapy, followed by psychiatric care; most other help-seeking pathways involved or combined magicoreligious therapy. Even some local treatment approaches were integrative in nature (Razali, Hasanah, Khan & Subramaniam 2000; Varma & Azhar 1996), typically combining both traditional and Western treatment methods. For many, pragmatism is the goal, which is very much reflective of the Eastern worldview (Sinha & Sinha 1997).

Although the stigma associated with mental illness may have prevented some from seeking help, mental disorders has been identified to be among the

country's top ten diseases (Syed Yusof 2006). According to a national health and morbidity survey in 2001 (as cited in Syed Yusof 2006), adults who suffered psychological problems had increased from 11% to 19% in the last decade alone. Parallel to that, a study in urban schools in 2000 suggested that up to one in five teenagers in Malaysia were having mental health problems at any given time. This study also revealed that the top three mental health problems among children and adolescents were mood disorders, somatic complaints and disruptive behaviour disorders (Kaur 2003).

Like many developing countries, mental health services in Malaysia are often "neglected" in the process of meeting more urgent needs, such as economics and physical healthcare (Deva 1990; Haque 2005). The expenditure on mental health in relation to the total health budget is 1.9% and 1.7% respectively for the year 2002 and 2003 (Malaysian Mental Health Association, 2003). Availability of mental health services is significantly lower than the mental health needs in the community. Across the nation, there are only 240 psychiatrists (Syed Yusof 2006) and less than 50 clinical psychologists (Ng, L.O., Teoh & Haque 2003; Ng, W.S., Ford, N., Shore, K. & Bae, S. 2005). Although there is greater improvement in mental health care through the recent establishment of the Mental Health Act 2001, much emphasis is placed on psychiatric care, whereas other forms of psychosocial care (e.g. psychotherapy and case management) are not adequately addressed in the Act (Crabtree & Chong 2001).

Psychotherapy and Psychotherapists in Malaysia

In Malaysia, the title of "psychotherapist" covers a broad range of professionals, including psychologists, counsellors, social workers, psychiatric nurses, psychiatrists, religious leaders, teachers, physicians and so forth (Bond et al. 2001). According to a recent study on psychotherapists in Malaysia (Ng, W.S. 2006), a nationwide search of individuals who do "psychotherapy" -- broadly defined as any form of talk therapy within a professional relationship to promote healing of the distressed person(s) -- yielded a result of more than 300 people in major cities alone. This number is likely to be an underestimation, given that the search was concentrated in major cities and primarily dependent on professional networking. In other words, we are likely to have missed out those who quietly provide services to their community outside of big cities and urban areas, with or without professional qualification, but usually recognized by their local community (e.g. religious leaders, traditional healers, teachers and physicians etc.). Up until August 2006, a total of 119 individuals (48.6% response rate) participated in the study; all of them fulfil the selection criteria of having practiced psychotherapy with the Malaysian population in Malaysia. The majority of the participants reported their professional identity as "counsellor" or "psychologist." Other professionals, not typically associated with psychotherapy, but who reported having practiced psychotherapy include psychiatrist, nurse, occupational therapist, social worker and minister (Ng, W.S. 2006)⁵.

According to Azhar and Varma (2000), psychotherapy did not develop until the 1970s. It was mainly used for non-psychotic (e.g. depressed, anxious etc.)

⁵ More findings of the study are currently being analysed and written up to be submitted for publication at a later date.

patients and first came to be practiced by local psychiatrists in the major cities. Since these psychiatrists received their training overseas, the most common form of therapy in the 1970s to 1980s was of the psychoanalytic type. In line with that, some practice hypnosis and formed the National Association of Hypnosis in Malaysia (Singh & Khan, 1998). The patients were limited to those who were Western educated and spoke English. Many found this form of psychotherapy incompatible with their culture and religion. Meanwhile, supportive psychotherapy was also used, in which the therapist aimed to maximize the patient's strength, minimize his dependence on the therapist and help him to live as independently as possible (Azhar & Varma 2000).

Counselling in Malaysia developed in line with the development of drug rehabilitation and school systems in the 1980s (Scorzelli 1987). During that time, the roles of counsellors usually were confined to either drug rehabilitation or school/university settings (Scorzelli 1987). Most do not have the job title of a "counsellor" but are referred to as "officers" of the various governmental ministries. Short-term in-service training programmes, ranging from 8 weeks to a year, was the only training that these counsellors received for their counselling work. Training consultants were usually employed from overseas, such as the United States. Furthermore, counselling was considered a secondary responsibility on top of their teaching responsibilities. On the other hand, those employed as drug counsellors lack formal training in counselling and are often recovered addicts themselves (Scorzelli 1987).

Meanwhile, the advance training of numerous mental health professionals, primarily from abroad, has brought new waves of therapeutic approaches into Malaysia. For instance, as early as 1986, Ratnam Singh, a clinical psychologist trained in Australia, had been conducting behaviour therapy clinics at the psychiatric department of a local university for adults and children with a variety of diagnostic presentations. The few practitioners of behavioural therapy at that time were all foreign-trained (Singh & Khan 1998). Although interest in behavioural therapy was emerging in Malaysia in early 1990s, the conditions of the mental health system at the time (e.g. psychiatrist-oriented referral system and the mismatch with the local cultural beliefs) seemed to have constrained the development of behavioural therapy in Malaysia (Singh & Khan 1998).

In 1994, a psychiatrist named Dr. Azhar Md. Zain who underwent training in cognitive and behavioural therapy in the U.K. returned to Malaysia, and since then has promoted the use of cognitive and behavioural therapy in Malaysia. Furthermore, Azhar and several other practitioners have begun incorporating religious (i.e. Islamic) and sociocultural elements in cognitive therapy, which produced positive results in their patients (Azhar & Varma 1995a, 1995b; Azhar, Varma & Dharap 1994; Razali, Hasanah, Aminah & Subramaniam 1998). Varma & Azhar (1996) postulated that religious patients and their families responded positively to religious-oriented psychotherapy because it is consistent with their values and identities. In line with that, religious psychology, specifically Islamic psychology and therapy, has grown significantly in Malaysia, as seen in the development of institutes, seminars and conferences on Islamic counselling and psychotherapy (Haque & Masuan 2002).

On the other hand, there is little training and practice of systemic family therapy in Malaysia (Ng, K.S. 1998, 2003). Some family work is being done at drug rehabilitation programs and hospital-based crisis one-stop centres, which serve to educate immediate family members in better supporting the identified patients. Religious leaders often get involved in family work to facilitate mutual adjustments in difficult relationships. Sometimes, the family court system also may refer a couple or family to the *Kadi* (court registrar) or to social workers for family counselling. More recently, family therapy has emerged as a potential alternative to the traditional use of caning to deal with students with chronic behavioural problems at school (Ng, K.S. 1998, 2003). Yet, one of the main challenges of school-based family counselling is the severe lacking of counsellors with expertise in family counselling (Chiam 2003).

In spite of the fact that all ethnic groups consider families as an important resource, most of the counselling and psychology training in different universities in the last few decades have been very individual-based, with minimal emphasis on the family systems. It was only recently that a new family counselling track was incorporated into the education department at a local university (Ng, K.S. 1998, 2003). This could be related to the cultural norm that emphasises keeping family problems within the family. Additionally, there were concerns that the use of certain interventions, such as confrontations, role clarification and boundary setting, might result in shaming and questioning the authority of the family head, which might be considered culturally inappropriate for Malaysian families (Scorzelli 1987).

Nevertheless, there was also evidence of positive results when a family's culture was taken into account in therapy. For instance, when the concept of schizophrenia was explained to the family from a cultural perspective and not in a way that disputed their beliefs about supernatural causes, researchers found that such Culturally-Modified Family Therapy was superior in increasing medication compliance and reducing family burden, compared with pure Behaviour Family Therapy (Razali, Hasanah, Khan & Subramaniam 2000).

Recently, the potential of electronic-counselling (or e-counselling) has been explored in Malaysia. Harun, Zainudin & Hamzah (2001) conducted a study among Malaysians to examine their willingness to participate in e-counselling. Findings were rather mixed: while about half of the participants expressed a willingness to participate in e-counselling, more than half of the respondents also expressed some reservation to the lack of physical presence of the counsellor in e-counselling. Relatively speaking, this study found that female and young people between the ages of 25 to 35 were more inclined to try e-counselling.

Although there are no current legal rules or ethical codes in Malaysia to regulate the conduct and activities of a 'psychotherapist' per se, there is a more stringent demand for professionalism, as evident by the establishment of the Counsellors Act (Act 580) in 1998. Under this Act, those who want to practice professionally as a 'counsellor' need to be registered under the Act. The Act also delineates the Code of Ethics of a counsellor, specifically in relation to issues of qualifications, confidentiality, privileged communication, professional negligence and informed consent, similar to those of the American Counselling Association (ACA 2006).

The Act, however, does not apply to professional titles such as “psychotherapist” or “psychologist”.

Specific Concerns and Future Direction

Practice of Psychotherapy - The availability of psychotherapy has definitely increased over the years, in response to greater awareness of mental health issues at different levels in the Malaysian society. However, the issue of quality control has also emerged, due to increased attention given to professionalism. One such example would be the establishment of the Counsellors Act 1998. Although it makes sense to have greater accountability in any professional work to safeguard the integrity of the profession and to protect the consumer’s welfare, current professional regulations have also resulted in a loss of valuable human resources who have been providing good psychotherapy services to their community. The loss is certainly felt by the local community who has been receiving services at nil to minimal cost. As the field develops, it is likely that the field will move towards more regulation (e.g. laws that govern the use of professional titles including psychotherapist and psychologist) as well as standardisation of service provision, similar to the development of managed care in the developed countries.

In line with the ethical practice of psychotherapy, there is also a pressing need to heighten the therapists’ awareness and sensitivity to the cultural dimension embedded within the therapy system (Sue, Arredondo & McDavis 1992). Clearly, much of the current psychotherapy practice in Malaysia is directly plucked out from the Western model of psychotherapy. While this may have appeared to work for some indigenous clients thus far, there needs to be more conscious effort to contextualise therapy work to the cultural beliefs and needs of the clients.

Research of Psychotherapy - It is apparent that indigenous research and publication on the local psychotherapy condition is relatively little, compared to the body of psychotherapy research done in the United States, United Kingdom or Australia. In general, Malaysian researchers rely substantially on references and literature from Western countries. The pitfall is that many end up using standards and paradigm of Western societies on non-Western people in a non-Western setting. There is still much to be discovered and revealed about the nuances in cultural differences and thus, more work still needs to be done to explore and develop the benchmark of psychotherapy, as according to Malaysian culture and norms.

Development of Psychotherapist - Unlike other professions, psychotherapist as a profession suffers a longstanding misunderstanding and stigma, typically associated with mental illness, or “crazy people”. In a developing nation where many are still striving economically, the stereotype that “you can’t earn a living” by doing psychotherapy has traditionally discouraged many parents and youngsters from pursuing psychology or psychotherapy as a career. Limited personnel in psychotherapy work essentially leads to a bad chain of effect, whereby there is a shortage of clinical supervisors and practice placements, thus resulting in less than ideal training experience, which means the quality of

therapists produced will suffer. Hence, more education is needed to create public awareness to demystify psychology and psychotherapy, as well as to encourage more potential students to consider psychotherapy as a career option.

Another area of concern has to do with language. Because most graduate-level training materials are in English, this, by default, shortlists a small pool of people who are somewhat proficient in the English language to be in the field. Anecdotal information is showing much difficulty in finding therapy referral for non-English or non-Malay speaking clients. Hence, psychotherapists who speak ethnic languages are currently in great demand. As the market demands, it is likely that more emphasis will be placed on multilingual abilities, especially ethnic language and dialects. This certainly will have implication on the selection criteria in graduate school as well as in the curriculum of psychotherapy training.

Last but not least, a contextualised training of multicultural competency presents as a huge challenge in a country where there is a lack of empirical and clinical documentation in this area. The implication of this might mean producing therapists who are “culture-blind” -- a potential threat to a multicultural nation like Malaysia (Laungani 2004). Hence, training programmes bear great responsibility to ensure the teaching and learning of relevant cultural knowledge, skills and attitude applicable to the context of Malaysia.

Conclusion

This article provides an overview of the development of psychotherapy in Malaysia, including some contemporary issues of concern and anticipated future direction. As a relatively young field in a developing country, psychotherapy has fared well slowly but certainly. With still much room for growth and development, it presents as a fertile field for those up for the adventure and challenges of pioneering and revolutionary work.

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