

THE CONCEPT OF “BADI” AS A PATHOGENIC STRESS: 2 CASE REPORTS

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INTRODUCTION

Cultural beliefs have a pathogenic as well as a pathoplastic effect on psychiatric illness. Most psychiatric disorders can be seen as the result of an environmental stress acting on pre-disposed individuals. What is experienced and perceived as stressful, however, is to a some extent determined by socio-cultural beliefs. (1).

The belief in “badi” is a potential source of stress to pre-disposed individuals. Although the concept of badi seems unclear, belief in it is widespread among rural Malays and aboriginals. According to K M Endicott, (2) in the Malay world-view, the “badi” is an independent entity that remains in place of ‘nyawa’ and ‘semangat’ in cases of violent and unusual death. It is free to leave the corpse and, like a spirit, to enter other bodies at will, “devouring the semangat” or “to possess anyone who accidentally comes in contact with it and cause him to become sick”.

This paper reports 2 cases in which belief in “badi” is crucial in the precipitation of the patient’s psychiatric disorder.

CASE REPORTS

One midnight in 1984, in the campus of a local University, 2 students were fatally injured when the motorcycle they were riding knocked down a lamp post. Four students on 2 separate motorcycles came to their rescue within minutes of the accident. They helped to carry the victims to the nearby District Hospital. One victim died on the spot, the other soon after arrival at hospital. Of the 4 students who went to the rescue, 2 developed psychiatric disorders soon after the accident.

CASE 1

The patient was a 23-year old Malay male from Pasir Mas, Kelantan who was in his third year at the University.

He was on a motorcycle with a friend when he came upon the accident that midnight. One victim had apparently died of head injuries, while the other was still alive. He dragged the second victim to the side of the road and allegedly had to wait half an hour before Security Guards came to bring the victims to hospital. The patient was angry at this delay on the part of the Security Guards in bringing the victims to hospital and said "they should be more efficient".

One week after the accident, the patient started to become restless, with poor concentration and recurring thoughts regarding the accident. He felt sad and guilty because he felt he should have done more to help the accident victims. He claimed to have several episodes of hearing voices at midnight calling him to visit the accident site. At the site, he would crawl and cry for help, behaving as if he was the accident victim of that night. He would become aggressive if he was restrained from going to the accident site. Subsequently, he would have amnesia for the episodes.

No abnormality was elicited from his family or personal history. His developmental history was normal and his academic performance, both in school and University, had been satisfactory. There was no history of drug abuse.

On clinical examination, he was found to be mildly anxious. His talk was coherent and relevant and he was able to relate well. There were no features of psychosis. He believed that the "badi" has entered his body because he had touched a person who had died a violent death. He said that the "badi" must be removed. Otherwise, his mind would be disturbed and he would become mad. Physical examination revealed no abnormality.

He was treated with an antianxiety drug and was asked to see a "bomoh" in Kelantan in order to remove the "badi" from his body. He returned a week later, saying that the "badi" had been removed by the "bomoh" and he had no more symptoms. There had been no recurrence of his symptoms since then.

CASE 2

The patient was 21-year old Malay male from Salor, Kelantan who was in his second year in the University.

He was also on a motorcycle with a friend when he came upon the accident that midnight. He helped to carry the victims to the side of the road, and subsequently to the hospital. He also expressed anger that the Security Guards were allegedly slow in coming to help the victims.

The next day, he went to the Security Guard office, saying that the accident site had become haunted and that he himself had become possessed by "orang halus" as the "badi" of the dead victims had entered him. He asked to be given some gold with which he could fence off the haunted accident site magically. Subsequently, he was noticed to become more sen-

sitive and aggressive. He got into fights with strangers because he felt that they were staring and talking about him.

His family history and personal history were unremarkable. Premorbidly, he was sociable, friendly and caring. There was no history of drug abuse.

On clinical examination, he appeared quizzical and was pre-occupied with astronomy, interstellar travel and electronics. He also had grandiose projects planned including inventing a new calendar system, a new method of calculating Muslim prayer times and a project to create wierd sound effects. He also had ideas of reference but denied any hallucinatory experience. He had no insight into his illness. There was no formal thought disorder nor any Schneider's symptoms.

Physical examination was unremarkable.

He was treated with antipsychotic drugs resulting in the remission of his symptoms. He stopped taking his medication, however, and did not continue with his follow-up. There was a relapse of his illness 7 months later. The psychosis this time was more schizophreniform. He was noted to be perplexed, preoccupied with philosophy, auditory hallucinations with delusion of control. However, these psychotic symptoms remitted rapidly with resumption of his antipsychotic medication. He has had another mild relapse in July 1986. His delusion of reference had recurred and he had become anxious and depressed with insomnia since then. Again these symptoms remitted rapidly with resumption of his antipsychotic medication. Both these relapses occurred in the context of an approaching stressful examination.

DISCUSSION

These two patients shared a common belief regarding "badi" and its evil effects on anyone contaminated by it. Both were exposed to a traumatic and stressful event, but the pathogenic effect of the stressor was greatly increased by their belief in "badi" resulting in the development of acute psychological reactions to the stress, even though both appear normal psychologically before the exposure to the stressor.

The psychological reaction of the first patient can be considered an Acute Post-traumatic Stress Disorder (DSM-III). In this disorder the patient may experience a dissociative-like state during which they may re-experience and relive the traumatic event. In addition, the patient also experiences recurrent, intrusive recollections and dreams or nightmares regarding the event, psychic numbness, increased autonomic arousal and associated depression or anxiety (3). Although this disorder often remits spontaneously, the exorcism by the bomoh with whom the patients shares a common belief regarding "badi" obviously facilitates the process.

The psychological reaction of the second patient is best seen as a Reactive Psychosis. The two mild relapses he has had too occurred in the context of stressful examinations that he was preparing for.

It is uncertain why the psychological reaction of the second patient is more severe than the first. There is no evidence from his developmental history that he has more psychopathology compared to the first patient.

These two cases clearly illustrate the pathogenic effect cultural beliefs may have on individuals who subscribe to them, though these beliefs may appear irrational to the Western-trained observer.

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