CHAPTER V
CONCLUSION

INTRODUCTION

This thesis demonstrates the way in which traditional healing practice among the Malay-speaking Muslims in the Pattani area of Southern Thailand sustains ethnic identity. It has described healing practice as acting both as a monitor and as a facilitator of change through time. Ethnic identity has been observed as displaying a situational and circumstantial 'oscillation' – which Hall (1996), offering a similar paradigm, calls a 'suturing'.

Using the Comaroffs' (1992) analysis, ethnicity has been presented as a concept that demonstrates a relationship of asymmetrical power relations, a relationship most clearly manifested in the assimilationist policies of the modern Thai nation-state that resulted in the attempted coercion of the Malay-speaking ethnic minority of the deep South of Thailand. However, as the century progressed and the dialectic of power relations continued, the paradigm evolved and shifted. By the end of the century, this shift shows both the Thai nation as presenting a greater awareness of the diversity of its population and the Malay-speaking community as acknowledging and adding an identity of Thai citizenship. For the Malay-speaking Muslims of Pattani, this in turn has added a new tangent to their relationship with their Malay neighbours across the border.

Thus within the sphere of power relations over the past century, ethnic identity has been seen as oscillating, ie circumstantial and situationally dependent, yet deriving in the main from core factors of religion, language and culture. We have noted how these core factors, in turn, have not been static in form, but dynamic: for example in the discussion of reform within Islam. The oscillation evident within ethnic identity has been connected to a broader theme of identity as multi-dimensional in time and space – again, as Hall (1996) describes, a process of 'becoming' not of 'being'. The discussion of healing practice through time has illustrated both an external adaptive role and internal plural content.

ANATOMY OF ARGUMENT

Three cumulative stages have been used to prove the argument. Two stages have already been presented and are simply summarized below; the third is clarified in more detail and brings together features of Chapter III and Chapter IV. The first stage has dealt with the historical background and focused on an environment of adaptation and acculturation; the

second has considered events of the last century. This stage has been used as a transition from locating healing practice among external forces to moving into a more detailed analysis of role and thus content, again emphasizing adaptive qualities. Both stages have answered the subsidiary questions outlined in Chapter I

The final stage, examined below, considers the discussion of the role of the healer in more detail, and focuses on the analysis of content. In doing so, the phenomenon of ethnic identity is reviewed and demonstrated as being sustained through traditional healing practice.

FIRST STAGE – HISTORICAL BACKGROUND

The first stage has been set against the broader historical background of the social and cultural development of the Malay Peninsula and continues up to the establishment of Islam. We have seen that healing practice existed within the same realm as beliefs created to deal with the sphere of uncertainty which surrounded man in his interaction with nature. As man's environment broadened and trade developed within the Peninsula, so the belief system became more diverse and sophisticated. Waves of influence were acculturated and accommodated, and with the propagation of Islam, the esoteric form of Sufism played a key role in enabling the acceptance of the religion in the region. Yet this acculturation, adoption and acceptance of other beliefs was not simply the result of man seeking more urbane remedies for his uncertainties, doubts and suspicions; it also involved issues of status and economic gain. Those who dealt with the cosmic forces were considered powerful and masterful, and at the same time, those who professed to be supported by these forces claimed divinity and sought authority and control. As has been noted, the attraction and popularity of Islam for the rulers of the Malay Peninsula during this era rather than at an earlier period was, to a large degree, stimulated not just through the esoteric attraction of Sufism, but also because the religion at that time offered a political attitude that reflected and enhanced their own position. This had not been the case previously.

Thus in this first stage of the argument it has been demonstrated that historically, healing practice has been integrated in an environment of change, openness and absorption of external influence – at points acting as the means or conduit for those changes. This environment encompassed not only spiritual and esoteric needs, but also economic and political necessities.

The relevance and appropriacy of this study is affirmed by recognising that healing practice has been very much interwoven within the fabric of the development of the Malay Peninsula.

SECOND STAGE – REFORM AND SEPARATISM

The second stage of the argument, which is summarized below, acts, in a sense, as a 'liminal' phase; it both continues to demonstrate healing practice within the broader sphere of reform and separatism, but also finally leads into closer discussion of the role of the healer. Therefore, this second stage starts with an overview of the major external forces that shaped the social and cultural development of the Malay-speaking Muslims in the Pattani area during the last century; the position of healing practice is then highlighted within this dynamic.

We have seen that at the turn of the 20th century the subjects of the kingdom of Patani were not only experiencing Islamic reform, but were also contending with the European paradigm of the nation state. As has been described, the dissent and disturbance experienced in the deep South of Thailand during the last century was a manifestation of the machinations of the modern-nation state seeking to assimilate and at times coerce the Malay-speaking Muslim population of the South to become 'citizens'. It has also been observed that reform within Islam to strengthen the unity and orthodoxy of the religion was another factor strongly influencing the peoples of the South. In a sense, the more the state sought to assimilate the Malay-speaking population, the more they reasserted their identity through the strength of Islam.

As noted in Chapter III, according to Surin Pitsuwan, the Tariqah movement played an active, if somewhat underground role in the separatist action. Although incantations had been replaced with verses from the Qur'an, the Sufi order was diffused with Malay beliefs for healing which naturally linked to notions of sorcery and physical protection. Its practices again continued to deal with empowerment, the overcoming of vulnerability, however, this time the forces to be faced and dealt with were less the forces of nature than the power and authority of the Thai nation-state. Perceived, as Surin suggests, as infiltrating the *pondok* - the centers for Islamic study - the strength of the order was demonstrated through the response of the Thai government during the era of Phibul Songkram: members were persecuted and killed. However, the government could not outlaw the esoteric order without risking an international outcry from other Islamic groups.

Although, during these troubled times, the practices of the Tariqah order may have been more politically covert, Malay Muslim healing practitioners in their dealings with patients were more overt in their proscription of contact with Thai government hospitals and clinics. As noted by Golomb (1985) in Chapter III, seeking treatment for ailments was a political issue; opting for Western medicine was perceived as supporting the state. Thus, in a sense, although healing practice continued to deal with unknown forces, an additional tangent emerged more strongly in the known force of the Thai nation. An assertion against Western style medicine was an assertion of ethnic identity.

THIRD STAGE - HEALING PRACTICE

In this stage reference is made to the key features of Landy's concept (1974), as outlined in the framework of Chapter II, to demonstrate the adaptive features evident within the work of the practitioners and illustrate how ethnic identity is sustained.

1. ROLE RESPONSIBILITY

In the context of Landy's (1974) notion of role responsibility, the local practitioner determines the appropriate treatment for the patient's problem. As we have noted in Chapter III, Golomb (1985) observed how healers were staunchly against the use of Western medicine arguing that ailments were, in a sense, ethnically specific, that they did not translate into the culture of Western-style medicine (considered to be representative of the Thai nation-state). The contemporary situation does not exhibit the same exclusion. As we noted in Chapter IV, all of the healers interviewed accepted and accommodated biomedicine. Fatima (H1) had had no qualms about receiving treatment for cancer at the local hospital as she acknowledged that the treatment and diagnosis bore no relation to her own system of practice. Suda (H6) possessed a government card for old people and was happy to use it to visit the hospital whenever she had a fever.

The healers' position had shifted to one of accommodating biomedical practice, ie in the sense of recognizing that different ailments required different practitioners, and thus biomedicine has become more absorbed within the plural domain of practice. Suda's (H6) attitude in particular demonstrated a very simple, but straightforward approach: whether the patient chose to visit her or the hospital depended on what that person believed in. She would not treat someone who did not believe in her approach, but had no issue if the patient preferred to use the services of the hospital.

However, the local healer was still in a stronger position in that he or she would act as the referral agent where necessary, ie it would often be the healer who would diagnose the problem and decide whether it fell under his or her area of specialty or whether the patient would be better visiting the clinic or hospital – or another healer. As stated previously, both Fatima (H1) and Abdul Allah (H5) stated that the ancestor spirits which possessed them would recommend the individual go to the hospital if the problem was identified by them as being of a physical nature. Thus, the local healer lost no status in referring the patient to a physician.

Furthermore, the traditional practitioner often treated people who had been told by their doctors that they could find no problem. Fatima (H1) talked of treating people for sleeplessness and the inability to rest which was determined as being the result of a curse. The patients would have visited her after having been to the doctor who had found nothing wrong. In the discussion of biomedical practitioners, there was a sense among the healers that the doctors were inadequate and lacking, or arrogant, but ignorant. This attitude was most clearly apparent in the bonesetters who berated doctors for slipshod practices, especially the unnecessary amputation of limbs, which contravenes Islam. Bae Ma (H2) believed it was unnecessary to cut the skin in the treatment of a broken bone, and further considered that the use of plaster on the break would actually traumatize the injury further. As noted in Chapter IV, he mentioned having reset a broken bone that had been badly set by the hospital; an occurrence which both Wae Hama (H4) and Ba-Soh (H8) had also experienced.

Of particular interest was the situation of Ba-soh (H8) who had been called to Had Yai hospital to treat a patient. After seeing him 'call the bones back', a physician had offered him a position at the hospital. He had refused because he did not want to leave his village and the people who needed him there. Applying Landy's two notions of role responsibility and the interlinking of status between roles, it can also be seen that if Ba-soh (H8) had accepted a position at the hospital, his status would have been increased in the eyes of the villagers, but only to a degree, and that degree would actually have been from a distant, detached viewpoint. In an environment where healers may label themselves by his or her geographical location rather than the treatment they specialize in, role responsibility is clearly not just denoted by treatment type, but by location, ie within the ethnic group. In a sense, to accept the position at the hospital would suggest the paradigm of upward mobility as described by the Comaroffs (1992). Role strain would be incurred, as the individual would be placed in a contradictory position with and subordinate position to the other members of the 'dominant'

(ie, the hospital) group. If the individual was prepared to compromise his identity, he might acquire a new and different – though it is suggested the chances would be slim. Thus, although he was offering a unique practice within the hospital, a severe loss of status would have been experienced. By remaining in the village and taking care of those who need him most, ie by supporting others, Ba-soh (H8) is actually remaining in the environment that supports him. Thus, to reaffirm Landy's (1974) point regarding cultural preservation as self preservation: it is the culture of his membership group that sanctions his role as a healer, and by sustaining and maintaining its values he is able to legitimize his role.

2. PARTIAL ASSIMILATION

The contemporary acknowledgement and to some degree acceptance of biomedical practice does not suggest that Western medicine is a potent threat to the practice of the local healers or will become the dominant form of treatment. The accommodation of biomedicine demonstrates Landy's (1974) notion of partial assimilation whereby there is local recognition that different systems are complementary. Thus rather than overwhelming and attenuating other treatments and practices, the current position of biomedical practice is more that it has been allocated a position with the greater and stronger pluralist tradition, ie it has been adapted to suit local requirements – a position that was not necessarily available 25 years ago. Analogously, the same could be said for Thai citizenship: to all intents and purposes, the Malay-speaking Muslim population of the South is nowadays more comfortable accommodating a Thai identity; this, of course, occurs within the paradigm of plurality.

As has also been noted in Chapter IV, the range and practice of treatments among healers is not contained within strict labels, unlike the more defined terms that identify and give boundaries to the limit of practice of biomedical practitioners. Local healers rarely delineate or limit themselves in a particular manner to a particular treatment type. As alluded to above, Wae Hama (H4) called himself *bomoh* Gapo, ie by the name of the village he had lived in for most of his life rather than the type of practice that he offered. Certainly, one practice may dominate, but as we have observed, healers cannot be strictly or easily classified. Thus, there is a need to acknowledge that the pluralist tradition does not just signify a wide variety of healers offering specific treatments, but a wide variety of healers who each offer in turn a diversity of practices. The author suggests that this profusion and diffusion of treatments mirrors the plural, fragmented experience of identity. A plural tradition suggests a plural identity.

3. ATTENUATION

To return to the previous discussion of anathema toward biomedicine, two points need to be added. Firstly, the author suggests that if the healers had maintained a determined anti-establishment stance toward biomedicine and continued to refuse to countenance it, the result could have been the attenuation of their own particular role.

In a sense, a parallel might be drawn to the separatist movement – it has dispersed and appears ineffective and inappropriate in the current environment. Christie, citing Ruth McVey's argument, states that, "a separatist movement will be greatly strengthened if the separate identity of the movement can be linked to the memory of a historical state" (Christie 1996). It is here suggested that in the current situation the memory of the past is no longer isolated from or denied within the experience of the present. Accommodating the plurality of difference diffuses its opposition and encourages adaptability.

As mentioned earlier, Landy (1974) observes that when attitudes change through exposure to new beliefs and values, the healer's role can be dissipated through decreasing support. Furthermore, if the healer makes no changes to his or her practice, does not adapt or accommodate, there may follow a decline in the number of clients, especially if the competitors are more powerful.

If local hospitals employed a Malay Muslim physician trained in biomedicine this 'competitor' could potentially be more powerful than a local practitioner because, framed within biomedicine (and, to refer to the Comaroff's, in the process of upward mobility, it is suggested that the physician could experience role strain), the doctor might be seen as more 'attractive', ie in offering newer forms of treatment methods, and more accessible, ie through his ethnic identity. However, although being a Malay Muslim (an identity which according to the Comaroffs would require situational adjustment to remove attributes denoting a prior, 'inferior' social status), the biomedical practitioner has the role of sustaining the culture of biomedical practice not ethnic identity, thus a professional identity would dominate.

Secondly, although biomedical and thus government practices have been accommodated, evidence among the healers of distrust towards government agencies is still observed. It should be added that indications of distrust toward and competitiveness with other healers

has also been noted as existing within the closer, local environment. In a sense, it could be suggested that a reluctance to let another healer treat a patient could be a feature in the development and acquisition of plural healing practices and traditions.

The notion of attenuation needs to be considered carefully, to avoid assuming misplaced perceptions of potential attenuation. As mentioned in Chapter IV with reference to the transfer of knowledge from one generation to another, it was generally observed that the healers' acquisition of the sense or feeling for practice built up over a period of time - like gas filling a bottle (Abdul Allah H5) - until a point was reached where they were 'mature' enough to start practising. This was usually in the individual's 30's or 40's. It was noted that the death of the parent, ie the main practitioner, could act as a trigger for the son or daughter to start their work. Although it may appear to some that traditional healing practice is attenuating and dying out, ie in a misplaced perception of a decreasing number of younger healers, it may just be that people are living longer and the younger generation may not be starting to practice until later, after the older generation has passed on.

Perhaps the clearest demonstration of attenuation is apparent in the case of the traditional midwife, although this should be investigated further. The case of the midwives as discussed in Chapter IIII, although not a focus of interest for this particular study, amply suggests an attenuated role that is unable to adapt sufficiently in practice and as a result has been, in a sense, dominated and thus placed at the mercy of the more powerful 'aegis' of the state. To draw a link to the Comaroffs' theory (1992), it is suggested that attenuation is hastened by ascription. The state labeling the midwives negatively has a strong impact on the already vulnerable practice. Nowadays, using Landy's (1974) terms of reference, it would seem there are no sanctioning agents within the community that can support or protect the practice of the traditional midwives. Government health officials by keeping a register of pregnancies are also able to monitor the midwives. Although three of the bonesetters mentioned had links to government agencies (Bae Lo H9 – Chief Sub District Officer; Yussuf H7, and Abdul Allah H5, both former government health volunteers) the other healers interviewed showed little interest and more reluctance to have any contact with them.

In part, it can be suggested that the vulnerability of the midwives' role was exacerbated by a lack of adaptability within their œuvre.

To illustrate this point with reference to the data collected, the situation of Bae Lo (H9), the snakebite curer who also dealt with spirit possession is examined. Out of all the healers interviewed, he displayed the most 'role strain'. As mentioned in Chapter IV, his role as healer appears to conflict with his position as Chief Sub District Officer, illustrating the Comaroffs' point that the pursuit of upward mobility by an individual in a subordinate group necessitates that he or she negate or remove cultural attributes that would denote prior 'inferior' social status. Also, in Chapter II we note how Landy (1974) refers to status being interlinked between the different roles occupied. In this particular case, neither role supports or enhances the other, thus the resultant role strain. The treatment for snakebite lacks adaptive qualities (which is also true for the midwives), ie there are prescribed set remedies. Although some aspects may have changed over time – such as the use of verses from the Qur'an, on the whole the treatment, by definition, cannot change. This lack of adaptability creates a 'distance', ie between old and new, and thus further, a tension between the two major roles the individual possesses.

4. ROLE STRAIN AND ADAPTABILITY

Briefly, to draw a comparison between Bae Lo (H9) with Fatima (H1) who also at the final interview appeared to shift in her attitude by stating there was no 'supernatural thing', we can conclude that for Fatima (H1) this is not a case of role strain caused by conflicting external role demands, but a clear demonstration of ambiguity and adaptability within the realm of practice. It is quite possible that her comments may have been spoken for the benefit of my research assistant who is devout and of the new generation in her practice of her religion.

5. ACCOMMODATING COUNSEL

We have already observed how, during the 1980's at the height of the separatist movement, healers were influential in maintaining a division between continued support for local practice and rejection of government sponsored biomedical services. Thus the healer's role, unlike the biomedical practitioner, accommodates more than just the treatment of problems and ailments; the counsel the healer gives illustrates the issues of the time. In order to meet the needs of the people who come to see them, healers need to demonstrate an empathy and understanding of the concerns of the day as they relate to their patients.

As we have seen, the spirit healers noted that nowadays there is a greater and growing demand for treatment for more emotional problems such as 'heartache' and stress, which,

especially, points to problems within marriages and relationships. We have observed how Fatima's (H1) ancestral spirit although acknowledging a contemporary climate of economic interdependence recommended a female client obey and submit to her husband.

It has also been noted that, in a sense, the healers have a role in conflict resolution within their communities: individuals with a grudge or suspicion of others will employ the services of a healer rather than confront the antagonist directly. Abdul Allah (H5) said jealousy was the most common problem he dealt with, either of material things or regarding love interests. Fatima (H1) talked of the popularity of love potions and other practices aimed at winning over the object of one's love. On the receiving end, Al Karim talked of more traditional treatments for innocent individuals wrongly accused of malpractice or black magic.

On a more subtle level, the treatment of spirit possession, which has been analysed as an internalization of issues between senior and junior members of a family, mothers and daughters, fathers and sons has seen the spirit medium in a role of facilitator, and in a sense, negotiator. As we have observed, the treatments for these contemporary concerns are steeped in established and traditional practice. The use of strong breaths, the action of 'sweeping' or 'brushing' the possessed individual, as described by both Abdul Allah (H5) and Bae Loh (H9) demonstrate a connection to the older practices described in Chapter III.

Although Fatima (H1) declared in interview that the use of black magic, the employment of curses and the manipulation of spirits were declining, it was interesting to note the importance of verses from the Qur'an in resolving and dissolving the antagonistic spirits. Bae Loh (H9) emphasized the potency of one particular verse from the Qur'an, suggesting that the verse had usurped the power of any other previous incantations and sacred words formerly used indicating an adaptive shift.

A demonstration of the lateral aspects of both established practice with contemporary issues was apparent in the discussion with Al Karim (H3) describing the similarity between the symptoms of drug addiction from amphetamines and a curse from black magic: only careful examination of the patient's eyes could distinguish one from the other. Drug addiction was a familiar problem for the healers to be asked to deal with, and the spirit mediums, in particular, discussed their frequent treatment of the condition.

As was noted in Chapter III, *bisa* is a known facet of Malay medical practice – referring to food avoidance - and Laderman has suggested a tentative link could be drawn allergies. A demonstration of *bisa* is apparent in the foods that bonesetters forbid a patient from eating. Consumption of these items inhibits the repair of the break. However, an extension of *bisa*, demonstrating an acknowledgement of contemporary issues regarding problems associated with food, was clear in comments made by Al Karim (H3) and Wae Hama (H4). They both considered that the processing of and the chemicals added in the mass production of food was a major cause of sickness today. Again, the contemporary relevance of the healer is demonstrated in their adjustment to the handling of existing issues and the adaptation of established beliefs.

6. RESYNTHESIS

In Chapter II, Landy's (1974) notion of resynthesis was discussed. He argues that it has not been uncommon for civilizations, although steeped in more cosmic beliefs to adopt technological advances, and he observes that it is not unusual for healers to adopt the paraphernalia of modern medicine. This is clearly the case with Al Karim (H3), who has adopted and absorbed the use of the blood pressure monitor into his practice, interpreting it in his own terms. Although this emphasizes a contemporary approach to his practice, it is offset by the more conservative aspects of his œuvre, for example, his description of how he became a healer. Although strongly contemporary, in a sense, 'western' in some of his attitudes and approaches, Al Karim (H3) also demonstrated deep-seated religious beliefs.

The use or disuse of paraphernalia and accessories demonstrates the change and adaptation of practice over the past century. A comparison of accessories observed and noted by Skeat and Winstedt, as mentioned in Chapter III, with those in a contemporary setting suggests that it is only betel that continues to play a key role in treatment practices. Other accessories included, although to a lesser extent, the continued use of rice, benzoin incense, the use of thread and tobacco. More in-depth research is required to confirm this, however, I would suggest that the use of betel for offerings, as medication (Al Karim H3), as a barrier (Bae Lo H9; Yussuf H7), and as a means of diagnosis (Abdul Allah H5) could be considered a pertinent factor in monitoring the role of the healer in future. Bae Ma (H2), for example, a devout Muslim of the new generation, rejected the use of betel in his practice, considering it a distraction from his work and his connection with God. Abdul Allah (H5) on the other hand made reference to mention of it in the Qur'an as justification for its application.

7. CULTURAL CONSERVATIVE

The fundamental feature of Landy's (1974) approach to healing roles rests on his premise that the healer is adaptive and manages change from an essentially conservative position. Given the nature of the socio-cultural and political changes the Malay-speaking Thai Muslims have experienced during the past century, it would be expected that these incoming influences would be accommodated in order to maintain the prior beliefs. It is this process that creates a lateral, ambiguous quality to the content of practice. And this is, indeed, what has been observed.

Based on the data presented in Chapter III, the prior beliefs displayed were essentially those of Malay culture and pre-reform Islam. Naturally, as has been demonstrated, Malay culture is an amalgamation over time of a diverse range of beliefs and influences. This study has identified aspects which accommodate the scope of practice as it is demonstrated today, however, it needs to be restated that they are not to be considered a finite and limited 'list'. These aspects are framed within the contemporary environment. A century ago different aspects would have been dominant; in a century's time, again, other aspects will rise to the fore. The aim throughout this section has been not to separate and discriminate the different strands of practice, but to illustrate those particular facets and, using Landy's terms, to demonstrate how the culturally conservative healer maintains his position and sustains ethnic identity.

For example, the comparison between becoming a healer in the current era and in the past displays a common link of inheritance. This appears to suggest inheritance of the skill although an older, established aspect of the tradition gives the healer a preferred authenticity in the contemporary world.

However, the degree and intensity of this almost innate inheritance varied among the healers from a 'sense' of the ability in Wae Hama (H4) to the repeated visions of Al Karim (H3) and from Abdul Allah's (H5) accumulative gas in a bottle analogy to Ba-Soh's (H8) experience of severe illness. Again, not occurring in isolation, but as a demonstration of the lateral fusing of religion with the notion of inheritance, the range of incidents included Ba-Soh's (H8) and Abdul Allah's (H5) experience during Ramadan as well as Abdul Allah's (H5) frequent reference to the Qur'an to explain the accessories used in healing practice. At the other end of this particular scale rests Bae Ma (H2) whose religious practice is more of the new generation, and this is reflected in his approach to the acquisition and study of his skill, ie he

makes no reference to visions or dreams, and his only reference to inheritance is that he was taught by his grandparents.

The appearance of the tiger spirit as a guide was also connected with the inheritance of skill. Although still pertinent and relevant to the practice of Yussuf (H7) and Abdul Allah (H5) Neither professed to display the licking, rubbing and nuzzling behaviour during treatment as was observed in Chapter III; this aspect, it appears has dissipated over time, yet is retained, again, in a sense both as a conservative demonstration of tradition and, at times, a marker of ethnic identity. We witness how the tiger spirit had forbidden Yussuf (H7) to continue treating a Buddhist patient for polio.

The mention of spirits infusing the environment hearkens back to pre-reformist attitudes. Reform has sought to detach the local Malay *hantu* from the *jiin* of Islam; however, in the data of Chapter IV, the Malay spirits were still much in evidence. Fatima (H1) talked of dealing with the appeasement of spirits disturbed by the unwitting violations of new people moving into the area. Thus a contemporary and pertinent issue of change within the community through the influx of people from outside the area is presented through an ancient belief of spirits infusing the environment.

With regard to the spirit healers, especially in their role as offering accommodating counsel, their adaptive practices appear to thrive in circumstances where issues of contemporary and social relevance cannot be dealt with directly; thus elements of past established traditions are brought into the present domain in order to act as a means to offer or create some sense of closure – whether it be a love potion to attract a potential suitor, or a protective spell to repel the perceived jealousy of acquaintances or rivals. The healer, in seeking to maintain the stability of his or her position within the community needs to adapt and blend the old and the new, and in a sense 'frame' the issue presented to them within a lateral and ambiguous paradigm that resonates with the plurality of ethnic identity. Bearing this in mind, it is thus quite logical that biomedicine be included within the realm as a 'filtering' option. The discernment and separation of problems with a physical cause from problems stirred in the cosmos, acts to reaffirm the position of the spirits. Nowadays biomedicine is established and understood within the local community, thus the spirit healer has responded to this and adapted his or her practice to recognise biomedical practice, and allocate or redirect problems as appropriate.

However, it is in the core practice of the bonesetters where dissonance is found with biomedicine. Unlike spirit healers, where biomedicine can be accommodated as another aspect of practice, with the practice of bonesetting, there is more direct competition in the nature of treatment. As noted in the presentation of Landy's concept of adaptability in Chapter II, healers are in danger of becoming attenuated where the indigenous culture begins to approximate more closely external influences or where the influences of the outer, 'dominant' group gain in popularity. In this respect, it could be suggested that local medical facilities might encroach on the popularity of bonesetters. However, as has been demonstrated, as the current situation stands, the proclivity for amputation and the apparent mediocrity of treatment does not suggest the bonesetters are under any threat. Most importantly though is that at the heart of the bonesetters' practice are issues of ethnic identity, namely in the proscription of amputation in Islam, and its infusion through practice. It is this which maintains the cultural conservatism of the bonesetter.

In order to maintain his or her adaptive role and sustain ethnic identity, the healer does not reject the 'old' to accommodate the 'new'. Instead he or she retains prior aspects of belief and also accommodates newer influences. This is by no means as calculating and conscious as is described here. As has been identified, these newer influences are predominantly those of Islamic reform and more recently, aspects of biomedical practices, which are seen as representing the 'modernised' world. It was noted in Chapter III that prior to reform, Islam was interwoven in the healer's practice along with references to previous Hindu customs.

The ethnographic data of traditional healing described and identified four key aspects of practice. These aspects demonstrate a link to core features of Malay ethnic identity, most dominantly, religion and Malay culture. The healer, in the role of cultural conservative, seeks to accommodate change and absorb new attitudes or beliefs (such as Islamic reform) in order to maintain established attitudes and values (such as the belief in ancestral spirits). Thus, a healer demonstrating this process of cultural conservation, which is of course dependent on the treatment situation, is also demonstrating the oscillation and plurality of his or her ethnic identity. In demonstrating this form of cultural preservation, the healer also acts to preserve and sustain his or her own role and thus his or her own ethnic identity.

The major shifts in practice that have been observed nowadays are firstly the lack of any overt Hindu reference, and, in its place a predominance of reference to the Qur'an. This suggests that the adaptive process is continuing on its dynamic path, in a sense, 'shifting',

leaving behind aspects that no longer serve a purpose or bear relevance (at this time), and acculturating and absorbing those that do; all of the healers referred to Islam in the affirmation of their practice.

As has been observed, a fundamental tenet of practice was that all illness comes from God. All the healers qualified this statement adding, for example, that the manifestation of illness in a day-to-day form comes from food or a humoral imbalance or spirit disturbances. Within practice it was particularly interesting to note that all healers apart from one, Wae Hama (H4) stated that all the incantations they used in treatment were verses from the Qur'an (whether this is always the case is impossible to say, the point is that the healers wished to appear to be doing so - which then demonstrates what they would deem as appropriate behaviour).

All healers appropriated verses from the Qur'an for other functions. This also included the bonesetters who would utter phrases and blow the words across the oil they prepared for massaging bone breaks, and this also included Bae Ma (H2) a devout Muslim of the new generation. This suggests that, in order to accommodate reform – which objects to the inclusion of non-orthodox practices – the healers had abandoned former words and incantations of possibly Hindu and Malay origin, and sought to accommodate reform by referring only to the Qur'an and, in a sense, authenticating their practice in only acknowledging Qur'anic references. This 'upgrading' , ie the employ of verses from the Qur'an over other powerful words, and incantations such as those described in Chapter III, not only demonstrates healing practice as adaptive, but also draws parallels to the original adoption of the religion – as discussed in Chapter III (see The Coming of Islam, pp. 37-39).

During interviews, attempts were made to determine which verses were being used, but this generally caused confusion and unease; it was difficult to ask the question without disturbing the flow of the interview. Thus, the author suggests that the healers' use of verses from the Qur'an in incantations acts as a means of firstly, 'validating' their practice and secondly, retaining prior beliefs in other aspects of practice. The use of the Qur'an in this way suggests a further point made in Chapter III whereby responses to reform are understood through local conditions (pp 47). Although it may appear that the healers, by referring to the Qur'an within their practice, are seeking to authenticate their œuvre, it could also be suggested that a shifting dislocation and appropriation of the Qur'an from its more usual application is also occurring. However, the broad view is that Islam frames practice, gives it boundaries and infuses practice throughout.

With regard to the sway of secular influences, it was Al Karim (H3) who demonstrated the most contemporary views of those interviewed. Not only had he resynthesised biomedical equipment, ie the blood pressure monitor, into his practice, but he also demonstrated knowledge and attitudes of contemporary psychology of both patient-doctor relationships and the mind-body connection. However, these 'modern' beliefs were interwoven with Islam, discussion of spirits and black magic.

A further demonstration of the infiltration of contemporary biomedicine was the reference made by several of the healers to the diagnosis and treatment of cancer. Again, the term was 'resynthesised', ie adapted and accommodated to blend into the etiology of the healer's practice and potentially removed from its biomedical definition. The reference, however, to a lack of calcium and vitamins slowing the healing process of broken bones was a standard response.

The strength of the bonesetters' practice has been increased as a result of the inadequacy and the reported incompetence of the local medical services. Furthermore, as has also been noted, the work of the bonesetters, especially with regard to dire injuries, is most strongly sanctioned through the proscription of amputation within Islam. The issue of religious practice and contemporary biomedicine comes together most pertinently in the statements of healers such as Wae Hama (H4) and Yussuf (H7) who questioned the role, and from their perspective, the veracity of physicians and doctors. Although the doctors had knowledge, they had not been given the ability to heal by God. Thus their view presented a different perspective where the secular notions of professionalism and expression of accomplishment were questioned by the healers whose faith places the power of God to the fore. According to all of the healers, God alone grants the ability to heal, it cannot be 'acquired', and only God can decide who can be cured. In line with the tenets of Islam, none of the healers believed they possessed any special talent or ability; everything they were able to do was a demonstration of the power of God. Their belief lay in God, not in themselves.

In highlighting Islam in this manner, the aim is not to slot the religion as a single facet within the shaping of identity. To quote Christie: Islam " . . . cannot merely be pigeon-holed within the overall identity of a particular people, but ... it can act as an important autonomous force" (Christie 1996: 193). He adds that "For the Malay Muslims of Patani, the relationship between Islam and 'Malayness' has been, and to a great degree still is, inextricable" (Christie 1996: 187)

Chaiwat considers "The process of identity negotiation involves the uses of elusive resources such as myths, a curse and religious beliefs" (Chaiwat 1993: 214). This analysis of healing practice, both in its external position and its internal content, has demonstrated the arena it creates for these elements in the negotiation and affirmation of all aspects of identity. In 'Islam and the Quest of Social Science' (1993), Chaiwat's further asks how to cope with the paradox of identity – focusing in his analysis on the case of Muslim social scientists. He rejects the assumption that "the configuration of a person's identities can be compartmentalized" (Chaiwat 1989: 60) adding that, "If the meaning of a person should be appreciated holistically, any attempt at compartmentalization would sadly delimit the realization of his or her full potentiality (Chaiwat 1989: 60).

"The process of identity negotiation is dynamic. It involves negotiations and renegotiations by different groups of ethnic actors across time in their attempts to chart or expand their cultural space . . ." (Chaiwat 1993: 215). Healing practice demonstrates and acts as an accommodating safe space for this negotiation, especially given that the practitioners operate in an environment where the patient is at his or her most physically and often emotionally vulnerable.

This thesis has focused on the healer. It has examined his or her practice and then sought to locate the œuvre within history and socio-culturally in order to ascertain how healers sustain ethnic identity.

The demonstration of the adaptability of healing practice and ethnic identity has wide-ranging implications. In the broad sphere, promoting the plurality of identity softens the stark notion of difference and suggests a fresh paradigm of 'connectedness'. This approach is already evidenced in contemporary Thai society where the mulitculturalism of the Thai population has been promoted more strongly over recent years and the former clumsy assimilationist approach has been put to rest. Furthermore, another lesson to be learned is that change can be introduced if established values are preserved, ie maintained and respected. In a sense, this simple point expresses the unique development and growth of the Malay Peninsula.

The implications for healing practice and biomedicine per se, derive from this point. Policies emanating from Public Health Departments need to be created and implemented by combining the expertise of these Departments with the understanding and perspective of the

people to be affected. Greater mediation and communication can enhance the success of projects. By acting as agents of change and being respected as such, and not simply as conduits for top-down policies, healers can play an important role in the successful implementation of projects.

In order to achieve this I would recommend that a more in-depth study be conducted on the practice of healers. In this study, all the healers have demonstrated adaptive qualities in the sustaining of ethnic identity. Only one, Bae Lo (H9) displays any role strain and possible attenuation. Al Karim (H3) has been seen to be the most progressive and far reaching in his practice in both his resynthesis of the blood pressure monitor and his knowledge of the dynamic of patient-healer relationships. Bae Ma (H2) has demonstrated the most progressive attitudes framed within Islamic reform and Fatima (H1) the most adept at presenting the most contrastive mix of aspects within her practice of spirit healing.

However, a further study should be carried out to consolidate the, in a sense, simply introductory material presented in this thesis. This should not involve a taxonomic analysis of content, but should aim to work with communities, using a team of people, to identify more closely and more accurately with the aid of computer assisted analysis the commonally held understanding of illness problems and their treatment in the Malay-speaking Thai Muslim community.

As outlined by Anderson in Chapter 5 of 'Medicine, Science, and Health. The Aims and Achievements of Medical Anthropology' (1996: 120-125), adopting a postpositivist applied anthropological approach would be of great use in this environment, and would require the involvement of a section of the community, not just the healer. Triangulation, using multiple techniques, would enable researchers to achieve a comprehensive result from both quantitative and qualitative methods. Approaches employing a free-listing technique, whereby a group of informants could, for example, describe every illness known to them, would establish what is termed the 'cultural domain'. This could be then be 'assessed' into 'contrast sets' by asking informants to sort the given terms (written or drawn on cards) in particular ways, (these 'classifications' would depend on the exact nature and terms of the study), such as grouping together problems that seemed similar.

The results of this pile-sort technique could be computer processed and statistically analysed into a cluster model. This would present a conceptual model of the previously described

cultural domain. In order to triangulate the variability between informants a further pile-sort task to rank order the illnesses – again, in terms specific to the objectives of the particular study could be implemented. The results, illustrative of and relevant to the population of the group as a whole, would allow researchers by measuring the 'fit between rankings' to determine a high level of cultural consistency.

A study such as this would enable a greater understanding of the cultural meaning, relevance and treatment of ailments and illness problems in the Malay Muslim communities. The healers demonstrate great adaptability to and absorption of contemporary influences and their role should be promoted within their communities. A more detailed study of the healers' œuvre could potentially offer a route by which the ethnic minority could be more effectively inducted into an understanding of biomedicine, based on their cultural understanding, and thus avoid an increasing misappropriation of drugs (see Luechai Sringernyuang 2000).

Healing practice in the South absorbs and reflects socio-cultural and historical influences over time. It has been a major feature of man's greater discourse with his environment. Of course, the term environment accommodates not just the natural world - and the cosmic forces perceived to infuse it, but also the material relationships man has created with others, whether they be from a different region or a different country. In the broad background to healing, it is observed as a means, not just to cure, but also to empower. Interaction with and manipulation of the forces that 'charge' healing practice have also stimulated the 'force' of trade, propagated the 'authority' of religion, and 'disrupted' the initiating power of the nation-state.

However, in the past century the world has changed – and so have the terms within which healing traditions have existed. Sandwiched between changes in religious practice as a result of reform and 'modernization', and a diaspora of soul as a result of the creation of the Thai nation-state, healers and their practices have continued to absorb and adapt to their environment. Adaptive thus means still playing a meaningful role, which means still relating to the patient, offering a meaningful environment in which the patient, vulnerable through the problem ailing them, can feel safe, ie thus healing practice reflects and sustains ethnic identity offering the patient a ubiquitously, multi-faceted environment which appeals to the versatility and plurality of ethnic identity.