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The naturalization of psychiatry in Indonesia and its interaction with indigenous therapeutics

Psychiatry developed as a modern branch of medical knowledge in Western societies and arrived in Southeast Asia in the late nineteenth century.¹ Dutch colonialism brought psychiatry and psychology to the Dutch East Indies as part of the development of European therapeutics in that part of the empire. During the twentieth century, psychiatry was naturalized in Indonesia (and other Southeast Asian countries) and integrated into the national health care system. In the post-independence period, most Indonesian psychiatrists – there are currently about 450 – received training at Western universities and brought the knowledge of this subject back with them to their home country.

Many studies critically document the development of psychiatry in the West (Foucault 1965; Doerner 1981; Digby 1985) and also in the colonies (Arnold 1988; Ernst 1991, 1997; Pols 2006). All of them show that psychiatry's culture (Littlewood 1996) is itself part of, and has been influenced by, local political cultures. A general outline of the history of psychiatry in Indonesia – though one should speak of a 'national psychiatry' that could be contrasted to the 'national psychiatries' of other Southeast Asian nations – demonstrates how this medical discipline embedded itself in distinctive ways in Indonesian society (Salan and Marezki 1983:377).

During the twentieth century, two main articulations governed the relation between psychiatry and indigenous psychologies. Contrary to the prevailing view that sees psychiatry as embedding itself into third world and developing countries without availing itself of indigenous psychological knowledge, I suggest that the first major articulation aided its naturalization in the local

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Southeast Asian context. Colonial and local psychiatrists had to develop a language for their new medical discipline, which meant not only incorporating foreign words into their native language but also drawing on the language of indigenous psychologies to construct a professional lexicon. Borrowing indigenous psychological terminology, they transformed the local discourse to fit their disciplinary concepts. In the process, psychiatrists contributed to the fashioning of a culturally modern psychology of the nationals they therapeutically served. The Alma Ata conference in 1978 led to a surge in publications by Southeast Asian psychiatrists on indigenous healing and its relevance to Western medicine. This anthropological excursion of academic psychiatry was the second articulation with indigenous knowledge.

Pre-twentieth century beginnings in the archipelago

Although the Dutch colonial government set up the first mental health hospital in the Netherlands East Indies in 1882 (Setyonegoro 1976), hospitalization of the insane occurred much earlier. In the early seventeenth century, the *Verenigde Oost-Indische Compagnie* (VOC, Dutch East India Company) built a hospital just outside Batavia for Europeans (Schoute 1937:27). European medical theory at the time maintained that sickness and health depended on the balance of the bodily humours. The humid climate of Southeast Asia, largely foreign to the constitution of northern Europeans, was believed to have dire effects on their humours, especially when the environmental change had been rapid (Schoute 1937:32). The most common therapeutic treatment practised by European doctors was the restoration of the balance of the humours through blood-letting, cupping, and trepanation, in which a hole was bored into the cranium to let pus and other cranial fluids out. Those suffering from madness were held in chains if they became difficult to manage. Boomgaard (1993:83) suggests that although these surgeons derided indigenous treatments, the two approaches shared some general ideas, including the theory of humoral imbalance. In the early seventeenth century, the Dutch surgeon J. Bontius believed local remedies endogenous to the region should be considered for their efficacy (Schoute 1937:33), but the popularity of this view diminished as European medicine began to carve out its universalistic spatial truth in the archipelago.

One policy of the early hospital in Batavia between 1638 and 1642 was to penalize patients for unruly behaviour, as though they were mutinous ship-mates. These patients were caned, locked up, and forced to do the most repellent tasks. Their only sustenance was water and bread. Those who tried to escape the hospital were secured by their hands to the door with a knife (Schoute 1937:43). We can assume that the hospital would have carried out these severe penalties on those patients showing behavioural and mental

deviance, an approach that reflected the maritime context and the concomitant cultural order of the Dutch presence in the area.

In other parts of the archipelago, ailing Europeans received treatment in military forts. It was only later that hospitals were established in the Spice Islands of Ambon, Banda, and Ternate, among other places. Schoute (1937:40) mentions a report from Banda telling of a Dutch merchant who had gone mad and was being treated in the hospital there. Unable to manage him, the local hospital sent him to the hospital in Batavia, where patients tended to be discharged more rapidly. The transfer of this 'European gone mad' suggests that the hospitals were already working with the health station in Batavia as a hierarchical centre-point, a pattern that became a lasting feature of the Indonesian health care system. The geography of power determined the location of hospitals and defined the relations between them.

The hospital in Batavia was important because the European community in the archipelago consisted mainly of military men and merchants, without extended families to treat them, but only 'people of their own kind and disposition'. Indeed, hospitalization may have provided an identity marker for Europeans in Batavia, who, starting in 1642, were legally required to check themselves in when they were sick (Schoute 1937:35). The VOC took responsibility for the health of Europeans in its service, but the Company did not concern itself with the health of the indigenous population, unless a local king personally applied for the service of Company surgeons (Boomgaard 1993:82).

While economic considerations were responsible for the establishment of VOC hospitals, personal moral compunction seems to have inspired the Board of Deacons at Batavia to establish in 1635 a hospice for the native poor, orphans in particular. This institution, which was headed by a married couple from the Netherlands, was the first European establishment in the archipelago that cared for members of the non-European population. Later a small number of European 'lunatics' were also taken into custodial care here, while the 'native insane' were imprisoned and kept in chains.

A third and highly significant institution in the history of the medical treatment of the insane in Indonesia was the Chinese hospital in Batavia, established in 1640. This hospital, funded by wealthy members of the Chinese community and staffed by Chinese medical specialists, served the Chinese community, including the insane, though eventually Muslims, especially those with significant contacts with the colonial presence, were also taken care of.

During the late eighteenth century, the hospital purchased the building adjacent to it, which was at the time a 'women's house of correction'. The proximity of the correctional facility and the hospital suggests how closely related the rehabilitation of criminal behaviour was with the treatment of mental illness. This association of behavioural and psychological deviance was to come full circle when the Chinese hospital transformed the old house of correction into

the hospital's wing for the insane, with bars on the windows and padlocked doors with grates through which food could be passed. Each room was furnished with a wooden bench and with stocks to lock up the 'turbulent lunatic' (Boomgaard 1993:82), although by 1795 lepers were also held in this part of the hospital (Boomgaard 1993:93), and by the early nineteenth century, growing numbers of indigenous people from both Batavia and the outer islands were being incarcerated in the Chinese hospital in Batavia (Boomgaard 1993:164).

As this brief look at the intended populations of the various medical facilities suggests, the official division of labour for the treatment of madness in Batavia during the early colonial period followed the broad categorical structure of three populations of origin: European, Chinese and 'native'. Whereas the Europeans and Chinese insane were grouped according to their ethnicity, the 'native insane' were lumped together with the poor and the orphans under the category of 'destitute natives', people who were living close to the European presence but who were estranged from their own communities (Schoute 1937:49).

In the past, and still today, the indigenous response to people suffering from madness has depended on how disturbing their behaviour has been to others, and this is no less true today in small Indonesian communities. Broch (2001) observes that villagers care for those who are silently mad, although teasing, especially by children, is common. Aggressive and violent individuals who lash out at people (but do not run amok) might be locked up and held in stocks until they calm down.² The family might also turn to local healers. If the patient does not recover, the family will collect money and send the afflicted to a hospital, invariably far away, for treatment. Similar attitudes prevailed in colonial Indonesia (Schoute 1937:164). Since madness was generally an affair of the family and the village, the increase in the number of indigenous people attending the hospital in Batavia reflected local society's greater involvement with Dutch forms of organization. This hospital, and ones like it that sprang up, provided indigenous society with an alternative outlet for managing behavioural deviance. This also suggests that there were people who were experiencing certain forms of mental and emotional difficulties caused by the rapidly changing environment that were not curable through indigenous means.

A change in Europe and its effect on the treatment of the insane in the Netherlands East Indies

Until the late-eighteenth century in Europe, the insane were separated from society and confined with other social deviants and the poor, without any real attempt at therapeutically alleviating their illness (Shorter 1997:5). Writing

² The general approach to the *amoker* was to shoot him or her.

about the situation in France, Foucault (1965) called this 'the great confinement'. Then some asylum doctors began to consider the therapeutic possibilities of utilizing confinement for therapeutic purposes (Foucault 1965:9). In the 1790s, Philippe Pinel had the chains of patients at the Bicêtre and in Salpêtrière removed, although he did put the unmanageable ones in straitjackets (Foucault 1965:11). In his treatise of 1801 he even wrote of the possibilities of curing the insane in the asylum and returning them to society (Foucault 1965:12). Influenced by the bourgeois work-ethic ideology, he believed that a structured daily workload was therapeutic. His student, Esquirol, also believed that confinement had therapeutic value, inasmuch as isolation from the normal routines of life would divert patients from the disturbances that affected them.

Around the same time, William Tuke opened 'the Quaker retreat' in Yorkshire, England. Although this establishment was for Quakers, it later opened its doors to people from other denominations. Treatment here was based on a 'gentle kindness' that would redirect the patient's own moral desire for recovery (Shorter 1997:21). These new institutions ushered in a new age of 'moral therapy', or in Pinel's words, '*le traitement moral*', which was the main precursor of later forms of psychotherapy. The term 'moral' generally meant 'mental', but here it was undeniably couched in a moral behavioural frame of reference. As Shorter points out, early psychiatrists such as Pinel in France and Tuke in England were probably unaware of each other's work, which meant that humanitarian therapeutic ideas of moral therapy emerged in different countries independently, developing within a political climate of broader democratic moral reform.

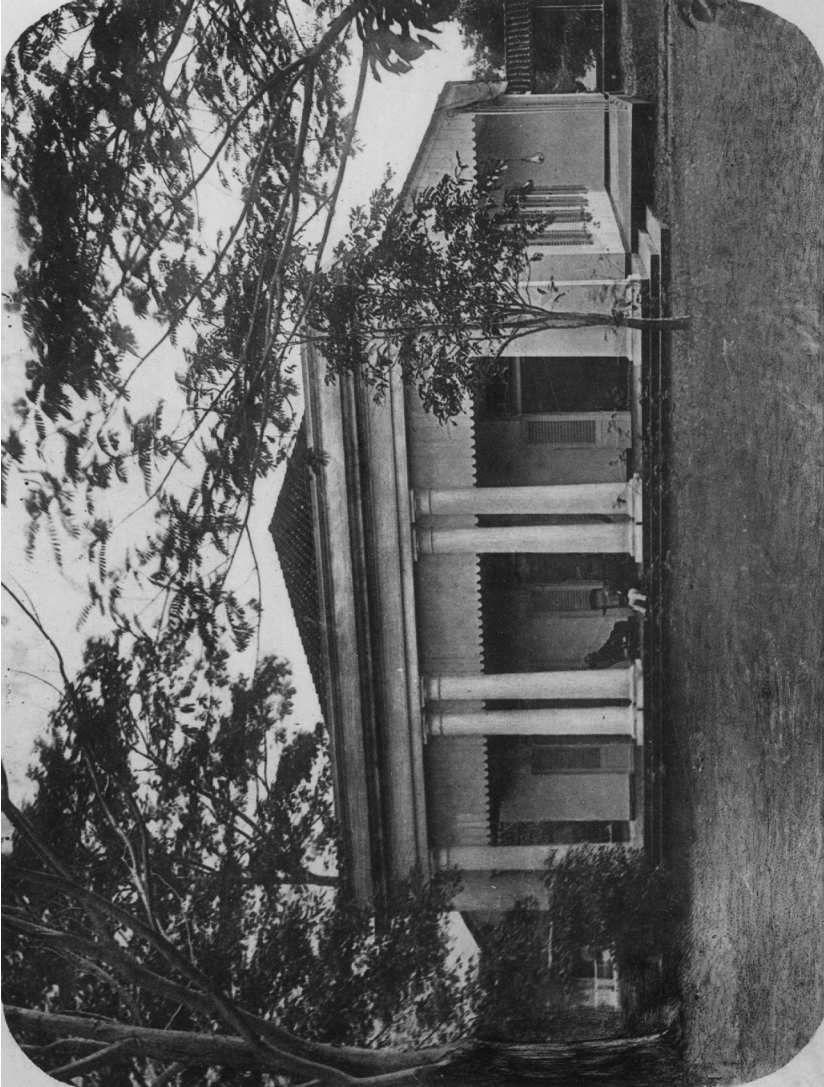
The era of asylum therapy also came to the Lowlands, as part of new medical directions that were to have a major influence in the Indies,³ leading to the building of the archipelago's first mental asylum. In 1795 Professor Brugman from Leiden (1763-1819) directed the military medical service in the Netherlands, introducing reforms that influenced Herman Willem Daendels (1762-1818), who became governor general of the Dutch East Indies. Daendels made the military responsible for medicine in the archipelago; and doctors in the Indies, who now had to pass an exam before practising, were obliged to write reports and send them to the Netherlands. The practice of medicine in the Indies was to be accountable to the mother country. The new system also made use of wards devoted to certain illnesses, and implemented new rules relating to nutrition, hygiene, and medical care (Kerckhoff 1989:11). The new military hospital built in 1832 included a small department for insane soldiers (Schoute 1937:164), who received an unprecedented level of custodial care. Due to the growing number of people suffering from mental afflictions, the colonial government carried out its first mental health census in 1862. In this report, which was sent back to the home country, Dr Wassink estimated that

³ For an early brief account see Bauer and Smit 1868.

there were about 586 'dangerously insane' people on the island of Java, 252 of them under custodial care in the larger cities (Schoute 1937:166). In addition to documenting mental health conditions in the Dutch East Indies, he further made the prescient suggestion that the government should only take responsibility for dangerous lunatics, adding that it would be unnecessarily harsh to remove harmless lunatics from their home environment. On his suggestion the government planned to build an asylum exclusively for Europeans. The aim was to provide a more humane institution, with more beds and straight chairs rather than wooden stocks (Schoute 1937:164).

The 1862 report about the conditions and treatment of people suffering from madness in the Dutch East Indies caused a stir in the Netherlands, which already had a number of asylums, where reforms were underway following severe public criticism by Professor Schroeder van der Kolk of the University of Utrecht (Schoute 1937:166). Rather than directly responding to Dr Wassink's request for funding an asylum, more beds, straight chairs, and so on, the Dutch government asked two physicians, Dr F. Bauer and Dr W. Smit, to visit neighbouring European countries to learn about their treatment of the insane before travelling to the Indies to report on conditions there with the intention of seeing what could be done to improve the situation. Bauer and Smit's report, which was published in 1868, opened with a description of the development of the treatment of the insane in a number of countries. Indeed, the project for improving the conditions in the Dutch East Indies was conceived from its very inception to restructure the treatment of the insane according to the international criteria of the day. It is in this report that we see the foundation, at least textually, for the birth of modern psychiatry in Indonesia.

Bauer and Smit asked the Dutch government for permission to open a mental hospital or asylum (*krankzinnigengesticht*) in Buitenzorg (Bogor), a choice determined by its location: Buitenzorg was close to Batavia but otherwise rather secluded, in keeping with the therapeutic principle of custodial care through isolation from the rest of society (Setyonegoro 1976:74). It was not until 1875 that a decree was announced for the construction of the hospital in Buitenzorg (it finally opened in 1882) as well as two auxiliary hospitals in Semarang and Surabaya. Later, a second central institution was built in Malang, and the number of patients grew, until by the turn of the twentieth century doctors complained that there were not enough beds for the patients (Setyonegoro 1976:76). Modern therapeutic methods governed care of the patients in these settings. Rather than being chained up, inmates were to receive moral guidance, and discipline was a matter of gentle but firm control. Whereas general medical care throughout the nineteenth century was under the authority of the military medical service (Kerckhoff 1989:9), the institutionalization of psychiatry made this medical practice the first modern, independent form of medical science to appear in the Netherlands Indies



Krankzinnigengesticht Buitenzorg, first-class ward for European patients, circa 1885
(KITLV, Special Collections, no. 87366)



Krankzinnigengesticht Buitenzorg, ward for peaceful indigenous patients (*inlanders*), circa 1885
(KITLV, Special Collections, no. 87369)

(Schoute 1937:167). These new asylums rejected earlier medical forms of organization, in which different hospitals catered to different groups (Europeans, Chinese, and 'natives'). Instead, the hospitals treated patients regardless of racial, ethnic, or cultural background, though Europeans were separated by class, and wards did show evidence of a 'racialized' approach (Prins 1936:74). It is uncertain how prevailing ideas about race manifested themselves in these asylums (see Ernst 1997; Littlewood and Lipsedge 1982), but we can presume that the late nineteenth-century colonial understanding of natives as childlike and backward (Gouda 1995) was at work, not just in hospital conditions, but also in the rhetoric used to describe these patients (Pols 2007).

Twentieth-century psychiatry in the Dutch East Indies and Indonesia

In the early twentieth century, asylums were built in a number of different cities in the Dutch East Indies, including a hospital in Lawang in 1902 and one in Magelang in 1920 (Kline 1963:183), and since with each new hospital the number of mental health patients increased, demand continued to grow. The hospitals provided an alternative medical system for non-Europeans who were exposed to the colonial regime's modernizing culture, but the way in could be difficult. Admittance to the hospitals was only by court order, an approach that asylum directors criticized. For example, P.K.M. Travaglino (1920:41), who firmly believed in the therapeutic value of the asylum, wrote that if patients were admitted directly, they could be discharged earlier, reducing the patient's anxiety and saving the government money. Such criticisms and suggestions fell on deaf ears until the 1960s.

The fate of psychiatry in the archipelago, soon to be known as Indonesia, was clearly dependent on the development of Dutch medical training on the one hand and on the development of psychiatry in the West on the other. The idea of producing 'native' health care workers in the colonies had started with Willem Bosch (1798-1874), a staff surgeon who held the view that the Netherlands had a moral obligation to the indigenous population (De Moulin 1989:26). In 1851 Bosch became co-founder of the Dokter Jawaschool (Kerckhoff 1989:16), which aimed to train indigenous individuals in the basics of Western medicine. It took more than half a century, by which time the school was called Stovia, for a graduate to be referred to not as 'native doctor' but by the more respectable title 'Indies doctor' (De Moulin 1989:33; Kerckhoff 1989:16), though from the start, graduates could work for the government as vaccinators. A degree also conferred the right to practise medicine privately. This medical school laid the foundation for the first professional medical school in Indonesia, established in 1927 in Batavia, a school that was, at least in terms of educational facilities, on a par with schools in the Netherlands (Kerckhoff

1989), though it wasn't until the 1940s that students were trained in psychiatry, and even then the textbooks were in Dutch. At the same time, a few medical students were beginning to go abroad for their training. Under the Japanese occupation during World War II, the quality of mental health care services in the archipelago declined, as it did in all Southeast Asian countries that were part of the European colonial world (Berne 1950:376). Because Europeans were imprisoned, non-European psychiatrists took charge of the hospitals, which suffered the loss of their imperial source of financial and intellectual support.

Medicine and psychiatry in the Dutch East Indies developed within the colonial political-cultural space. After 1945, Indonesian nationalists stepped into this colonial space and out of it created the Republic of Indonesia. During the years following independence, the Dutch psychiatrists were discharged, causing a reduction of 18 professional doctors for Indonesian psychiatry (Kline 1963:809). By the 1950s, there were fewer than 30 practising psychiatrists in Indonesia (Santoso 1959:798). The national independence of psychiatry did mean that Indonesian psychiatrists could now distinguish themselves on their professional merits, rather than be recognized by their colonizers through a European/native distinction. The independence of psychiatry also allowed for new input and directions from other international sources. Indonesian psychiatry was now freed from its colonial entanglements and seemed to come under the influence of American psychiatry. In 1956, the medical department of the University of Indonesia became affiliated with the medical centre at the University of California through a five-year teaching project funded by the American government (Bowman 1956:921). This resulted in a new psychiatric clinic in Jakarta and the introduction of somatic therapy (ECT) and insulin shock therapy (Kline 1963:809).

In the early 1950s, the new government of Indonesia took over full responsibility for mental health and mental health institutions, part of a larger policy of nationalization and centralization, with the director of mental health of the Ministry of Health in Jakarta functioning as the central agency for planning mental health services (Prasetyo 1979:3). As an expression of their loyalty to the nation (Hunter 1996:22), psychiatrists were legally obliged to work until 2 p.m. each day for the government health care service, which paid them very little. Only after this could they work in their own private clinics (Kline 1963:809).

During the 1960s and 1970s, medicine in general and psychiatry in particular took new directions, especially when it came to outreach, with legislation laying the foundation for new, open-style hospitals. In the old, Dutch-style system, patients could be admitted only through court order or through certification by a physician, after which the patient's name would be placed at the bottom of a waiting list. The Mental Health Act of 1966 allowed patients to be admitted voluntarily through non-legal procedures.

Primary health care was first introduced as an idea during the second half of the first Five-Year Development Plan (REPELITA I, 1969-1974) and fully implemented during the second Five-Year Development Plan (REPELITA II, 1974-1979). The Indonesian government established several general hospitals, and built smaller health care centres and mobile clinics in each district of the country (*puskesmas/pos keliling*) (Hunter 1996:27), with the aim of providing universal access to modern health care services and increasing the general level of health care (Salan and Maretzki 1983:380). The government also introduced services for outpatients. By the 1970s there were 22 psychiatric hospitals in Indonesia, and mental health workers – nurses, clinical psychologists, social workers, and even anthropologists – were also integrated into local health clinics (*puskesmas*) (Prasetyo 1979:3). In this national health movement, primary health care was not only a matter of international medical standards and practices, but was also the rhetoric of socio-economic development (Prasetyo 1979:23). National health care and its sub-branch of psychiatry were now linked to the political rationale of national development in general (*pembangunan*). During the Soeharto period, health care was, in ideological terms, not a right but a national gift from the state to its peoples. Such gifts could be unreliable: following the independence of East Timor (Timor Leste), much of the health care infrastructure set up by the national government was destroyed as part of the Indonesian pull-out.⁴

Trends in treatment

Psychiatric treatment during the early to middle twentieth century was changing fast, and for many later commentators, especially those from the anti-psychiatry school, it was taking an inhumane direction, one that shared much with a trend that in Europe ultimately led to the Nazi regime's biological experiments on humans. In Berlin, Manfred Sakel pioneered the practice of insulin-induced coma as a treatment for schizophrenia. He found that a large dose of the newly discovered hormone insulin caused muscles to absorb glucose from the blood, putting the patient into a brief hypoglycemic (low blood sugar) coma; on coming out of the coma, the schizophrenic patient would be calm, a change that Sakel attributed to a broader personality change. Sakel went so far as to claim in 1933 that putting a psychotic patient into coma could provide a cure for psychiatric illness (Shorter 1997:208). The therapeutic regime was a complicated one. For full effect, coma had to be induced dozens of times (Alexander and Selesnick 1995:280) and physicians had to be highly skilled in the procedure in order to avoid irreversible coma. Nonetheless, entire wards were devoted to insulin shock therapy.

⁴ Almost 80% of the East Timorese health care infrastructure was destroyed (Minas 2002).

This period saw the introduction of a variety of such somatic shock treatments, all of which involved therapeutically induced, epileptic-type convulsive seizures in schizophrenic patients. Ladislaus Joseph von Meduna induced convulsion with the drug metrazol, but this was later abandoned after the introduction of electroshock therapy (ECT). Ugo Cerletti began to experiment in Genoa in 1938 with electroshock therapy to alleviate severe depression, by passing 70 to 130 volts of electricity through the brain for several seconds in order to produce convulsions (Alexander and Selesnick 1995:281); this eliminated the physical disturbance and vomiting of metrazol treatment. The patient would simply lose consciousness, causing memory loss of recent and upsetting events. But the limits of ECT soon became apparent, since it relieved symptoms of severe depression, but not the psychological disturbance itself.

Another practice that came on the psychiatric scene in the 1930s was psychosurgery. In Lisbon, Egas Moniz pioneered leucotomy, in which the connection between the frontal lobes and the rest of the brain was severed. This was taken up in the United States, where its main champion, Dr Walter Freeman, a neurologist by training, perfected a procedure in which he inserted a cocktail-cabinet ice pick into the eye-socket and accomplished the operation with a few taps of a hammer. Like ECT, leucotomy had its shortcomings. Although it seemed to relieve psychiatric disorders, it left the patient in a 'soulless' condition (Shorter 1997:208).

In the 1950s, neuroleptics and anti-psychotic drugs became popular in psychiatric circles. In 1931, Dr S. Sidique and R. Sidique had isolated the active properties of *rauwolfia serpentina*, a plant used in India for treating snake-bites; this drug reduced blood pressure and calmed excited patients (Alexander and Selesnick 1995:287). Another important drug was chlorpromazine (largactil). However, these drugs had little effect on depression. It wasn't until the 1980s that the 'wonder drug' Prozac was found to raise serotonin levels and thereby relieve depression. Use of such drugs made it possible for patients to be discharged sooner, but it also meant a medication-dependent life that in low-income, developing countries was not always affordable.

These somatic and drug treatments usually came quickly to Southeast Asia, but their wide-scale implementation was hampered by financial considerations. Up until the 1950s, the primary site of psychiatric management and treatment of the mentally ill remained the asylum. In the Dutch East Indies, the first asylum at Buitenzorg (Bogor) used isolation therapy, though patients' movements were generally unrestricted. An important standard rehabilitation method was occupational therapy (*arbeidstherapie*) (Setyonegoro 1976:77). Rooted in the bourgeois work ethic of late eighteenth-century Europe, the original idea was to occupy patients with work and thus distract their minds. Work therapy involved the formation of work colonies (*kolonies*), in which the more rehabilitated patients spent time at individual tasks such as weaving and

batik painting, as well as in group settings. In some situations, these tasks were not all that different from tasks given to penal inmates, such as clearing scrub land. In the 1950s in Bangli (Bali),⁵ a colony of patients who had difficulty working in society were under psychiatric supervision and undergoing work therapy. This colony of patients was self-supporting, bringing its own agricultural products to the market (Kline 1963:809). The asylum at Bogor retained these therapeutic procedures well into the post-independence period. Kline, visiting the asylum in the early 1960s when the hospital still performed occupational, electroshock, and insulin shock therapy (doctors would prescribe the costly drug chlorpromazine to patients only if the family could afford it), stressed that patients were free to come and go as they pleased.

During the early 1960s, the hospital in Grogol, near Jakarta, was already practising ECT, though because proper equipment was costly, convulsions were induced by placing the electrodes on the patient's head and plugging the wiring in the wall socket (Kline 1963). Whereas the Dutch hospitals would pay families to assume responsibility for the medication of discharged patients, during the immediate post-colonial period the hospital stopped providing medication to patients because it was too expensive. Again, the type of treatment used at other hospitals was determined by financial considerations. In the asylum at Magelang, which specialized in (treating) schizophrenia, doctors used ECT and occupational therapy, but also administered morphine, which was an outdated nineteenth-century treatment. It was only in the hospital in Jakarta, with its connection with the University of California, that both electroshock therapy and insulin treatment were used and chlorpromazine and reserpine could be fully experimented with. Lobotomy was carried out there infrequently (Bowman 1956:921).

Kreapelin's 1904 visit to the Buitenzorg asylum and Travaglinio's critique

Let us revisit the year 1904, when Emile Kreapelin, the father of biological psychiatry, made a short visit to the asylum in Buitenzorg. This offers an opportunity to reconsider the medical and cultural foundations of psychiatric diagnosis and treatment as they developed in Indonesia in the twentieth century.

Kreapelin had already devised his biological classification of mental diseases, which was to be the foundation of later psychiatric classification and etiology, and which he first published as a textbook in 1893. He travelled to Southeast Asia to see whether other 'races' living in different climates were also afflicted by *dementia praecox* (schizophrenia). In order to determine whether the manifestations of the disease were the same in different countries, Kreapelin (2000:38) believed that observations must be made by the

⁵ The hospital in Bangli was opened in 1930.

same person, in this case himself. No less important was his goal of proving that this disease was not merely an illness of civilization or a product of environmental factors (Kreapelin 2000:38; Lucas and Barret 1995:296).

Kreapelin first visited the asylum in Singapore and concluded that the 'clinical picture' was similar to the one in Europe (Lucas and Barret 1995:296). In Buitenzorg, which was then under the directorship of Dr Hoffman, he found that the 'clinical picture' there confirmed his position. Following his 'glimpse' of the situation – to use a term from Foucault – he published a paper concluding that European patients in Southeast Asia showed the same clinical picture that he had observed in Europe (Kreapelin 2000). Among the 'native' patients he found *dementia praecox* to be common, although manic-depressive insanity was less common than among Europeans, while what he called 'psychic epilepsy' was more frequent. He wrote: 'Of the numerous forms of *dementia praecox* encountered by Javanese not one of the symptoms common among Europeans was missing, but they were all less florid, less distinctively marked' (Kreapelin 2000:40). He further claimed that auditory hallucinations were minor among the Javanese compared to Europeans, while systematic delusional states were either absent or less severe. The illness rarely developed into states characteristically found among European patients, and violent excitement was rare. Further, 'the end state was usually one of vague silly confusion with no striking accompaniment' (Kreapelin 2000:40). With regards to manic-depressive illness, 'when it did occur, [it] was usually mild and fleeting, and feelings of guilt were never experienced', while 'manic excitement too was a great deal less marked and more uniform than we are accustomed to see here' (Kreapelin 2000:40). Notwithstanding the differences in content, he concluded this 'glimpse' of the 'native' patients of Buitenzorg by asserting: 'on a comparison between the phenomena of disease which I found there and those with which I was familiar at home, the overall similarities far outweigh the deviant features' (Kreapelin 2000:40). The differences Kreapelin saw were cultural in nature, relating to content, so it was the form of the disease that he claimed was similar. His biological paradigm led him to think that 'the differences might be explained as a shift in the frequency of occurrence of individual species of generic illness'. He continued: 'The relative absence of delusions among Javanese might be related to the lower stage of intellectual development attained, and the rarity of auditory hallucinations might reflect the fact that speech counts far less than it does with us and thoughts tend to be governed by sensory images' (Kreapelin 2000:40).

The distinction that Kreapelin drew between the European and the 'native' was one of 'race', though from our perspective today, we might focus on what we view as cultural differences (Littlewood and Dein 2000:38). In European thinking at the time, there was a tendency to view the patient's behaviour as a regression or degeneration to a lower intellectual development similar to

that of children and 'natives' of the empire, a view Kreapelin shared (Lucas and Barrett 1995:297). However, in order to maintain the universal similarity of the form of the disease so that it would fall in line with his biological classification, Kreapelin reduced the content of 'native psychoses' to a lower intellectual development in which speech, the fundamental form of human communication, was less important. In other words, the 'natives' were so intellectually dull, and their way of thinking was close to the psychotic's delusion anyway, that in their madness they were less prone to having delusions. What Kreapelin did not consider was that he might not have been looking at the same thing, and that the patients he saw were afflicted with something else.

In 1920 Dr P.K.M. Travaglinio, a Dutch director of the asylum near Lawang, published a critique of Kreapelin's work in a Dutch Indies journal. In his paper, Travaglinio noted that between 1918 and 1919, 786 patients, mainly Javanese and Madurese, were admitted to his asylum. Only 111, or 14%, showed symptoms such as sudden shouting, singing, talking fussy, tearing clothes, walking about nude, showing an inclination to swear, or occasional violent outbursts, symptoms common in European asylums (Travaglinio 1920:39). Just under one-quarter of the patients experienced hallucinations, and all experienced anomalies of mood. Travaglinio (1920:39) noted a cure rate of at least 95%, and 90% of the patients stayed in the asylum only briefly (from a few days to six months), while only 2% stayed for longer than a year. Travaglinio did agree with Kreapelin that patients did not manifest feelings of guilt, which was understandable for people brought up in shame cultures rather than guilt cultures: 'At first they look like *dementia praecox*' but 'the quickly occurring cure speaks against the psychosis' (Travaglinio 1920:41). Instead, Travaglinio referred to their illnesses as 'emotional psychosis' and attributed the cause to what we would today call dispositions of emotional disorder emerging out of the culturally constructed emotionality of Javanese and Madurese social life.

Travaglinio (1920:39) further described the mental condition of his patients in the asylum:

An old proverb has it that 'children, fools and drunkards speak the truth'. Some checking considerations are always busy in normal persons, which prevent them to express themselves as they mean to. These checks do not yet exist in children, they are poisoned in the intoxicated, and in the mad they are either destroyed or temporarily suppressed [...] The lunatic native is not timid, he does not stand in awe of us. When I am passing through the native ward, they pat me jovially on the shoulder, hands are offered to me from all sides, and they treat me to lengthy narration.

Travaglinio spoke Malay and he would have been familiar with the concept of *malu*, which is probably what he means by 'checking considerations'. What he seems to be suggesting is that in the asylum the Javanese and Madurese inmates did not exhibit the emotional cultural complex that in Malay is called

malu (shame, stage-fright, embarrassment, shyness), and which is responsible for creating behavioural checks. In fact, in Indonesia, not being *malu* in certain interactions is a sign of behavioural and mental deviance (*gila*). The fact that being *malu* is a culturally ideal emotional behaviour does not mean that people may not emotionally suffer from it – indeed, some disturbances might be related to the more negative mental effects of this emotional complex.

The Dutch East Indies asylum, which rejected the policy of restraint, was a trans-cultural therapeutic space in which Europeans would have given ‘natives’ some behavioural leeway because of their lunacy. In general, a mad person was not punished for lack of *malu* behaviour but was put through a moral rehabilitation procedure which would have been culturally alien to indigenous morality. In the therapeutic space of the asylum, laying hands on a European was not viewed as a sign of equality or subversion but rather as the act of a patient who was foolish at best and mad at worst. In the asylum context, this act actually revealed the reality of unequal social relations because it could not be performed outside of the hospital. Travaglini (1920:39) equates the patient’s behaviour with that of a child or a drunkard who is not socially restrained and blurts out expressions of truth. In the Dutch East Indies, these wards may have been therapeutic in relation to the cultural restraints of *malu* and other social and cultural emotional pressures precisely because they were trans-cultural spaces.

Travaglini’s ‘insider’ descriptions raise doubts about the clinical picture of ‘native’ patients Krapelin saw and his ability to reduce their symptoms to his Occam’s-razor-style system of disease classification. Before taking up his post in the Dutch East Indies, Travaglini visited Krapelin to ask about his experiences. Krapelin seems to have been convinced that amok was a form of ‘psychic epilepsy’ (Travaglini 1920:41). Travaglini (1920:43) wrote that among the 80 epileptics in his asylum, not one had run amok. He added that whereas he believed Krapelin at the time, following his experiences in the asylum, it dawned upon him that Krapelin did not prove his assertion: ‘At that time I accepted it on the authority of his personality’. Travaglini (1920:41) emphasized using caution in accepting ‘statements of eminent persons on the authority of their personality’.

Krapelin and Travaglini expressed the same authoritative convictions about their ability to recognize madness in Europeans. They knew the European madman when they saw him because his behaviour resembled those ‘who fill the asylums back home’. Their authority when it came to the European lunatic was complete, so it was only the different symptoms of madness in ‘natives’ that for both authors raised questions of diagnostic recognition.

A digression into the history of anthropology and the materialist view of indigenous healing

When psychiatry as a branch of Western medicine with claims to universal knowledge came to Southeast Asia, it did not come alone. Another imported branch of modern Western knowledge that was to influence these countries was the science of the particular: anthropology. Peter Boomgaard (1993:85) makes an important observation about the relationship between biomedicine, anthropology, and indigenous healing in the Dutch East Indies, claiming that with the microbial revolution in the nineteenth century, indigenous healing knowledge was left to anthropologists. If the aim of psychiatry was and is to understand and heal people's mental ailments, anthropology's aims were to study people as they culturally and socially are. This meant that people's ethno-psychologies and healing practices, which are also rooted in universal knowledge frames about what it means to be human, were particularized as cultures and interpreted through the category of religion.

In the late nineteenth century, the most important work to influence how moderns were to view indigenous psychologies and healing practices was that of E.B. Tylor (1871). Tylor universalized indigenous psychologies and healing methods in which 'spirits' and 'souls' play an interpretative and phenomenal role under the discipline of the scientific study of religion and within a civilizational framework. Although Tylor recognized a psychological component to what he called animism, he nevertheless defined it as a false science. Tylor, a secularized monotheist,⁶ came close to understanding such ethno-psychologies, but the view from his armchair missed the psychological mark, framing the subject within the study of religion, using religious terminology that was inappropriate to the ethnographic descriptions he was addressing. He concluded his first volume by summing up a vision of materialist Western knowledge: 'The divisions which have separated the great religions of the world into intolerant and hostile sects are for the most part superficial, in comparison with the deepest of all religious schisms, that which divides Animism from Materialism' (Tylor 1871:453).

Tylor exerted a defining influence on colonial scholars and administrators, both British and Dutch, in the Malay-speaking world, who now had a theoretical frame for understanding the diverse experiences of their subjects through the concept of 'primitive religious animistic belief'. Indigenous ideas of consciousness and psychological experience, as well as indigenous therapy, were now largely labelled religious superstition.

⁶ By secularized monotheist I mean that he was born and brought up in a monotheistic faith and then became an atheist. Nevertheless, his monotheistic religious upbringing still influenced his secular vision. Most major nineteenth-century social scientists were secularized monotheists, and their monotheistic upbringing influenced their understanding of other people's radically different non-monotheistic ways of thinking.

Psychiatry's first articulation with indigenous psychologies: semantic shifts

If psychiatry shunned indigenous healing, which did not yet have a spokesperson within anthropology, how did it articulate itself with regard to indigenous ethno-psychologies in Asian countries? When psychiatric knowledge was brought to these countries, local terminology needed to be developed for its concepts. Words like 'schizophrenia', 'unconscious', 'biology', and even 'mind' did not have exact equivalents in the indigenous psychological lexicon, which had its own terms for the internal constitution of the person and the psychic experience, and which has generally provided much subject matter for late twentieth-century anthropology. In order to develop a lexicon within the modern national language, elite practitioners had to draw on their native language for terms – in some cases the very terms that referred to people's 'superstitious experiences'.

The first major articulation of psychiatry with indigenous psychological knowledge started the moment psychiatry was brought to these countries. However, the construction of a national psychiatric language was never completed, and the same practitioners incorporated many terms from English. Before independence, Indonesian psychiatry was laden with Dutch terms. As with so many colonial things, after independence these Dutch terms were abandoned and erased from the textbooks, a development that left Indonesian psychiatry linguistically impoverished. In the 1950s, English psychiatric textbooks replaced those written in Dutch (Bowman 1956:921), and psychiatry now had to find a national sub-language for its concepts. The language of Indonesian psychiatry appropriated words from Malay (Indonesian) and replaced Dutch terms with 'Indonesianized' English ones. Whereas the Indonesian word for psychiatrist is *psikiater* (*psikiatri*/psychiatry) and the word for psychology is *psikologi*, the word for psychiatric hospital became *rumah sakit jiwa*, which means 'house/sick/soul', hence 'hospital for the sick soul'. The word *jiwa* was borrowed from one of the Malay words for 'soul', a word that means something very different to the western psychiatrist. Whereas in Malay the word for madness is *gila*, which connotes behavioural deviance as much as mental deviance, it is not used in psychiatry, as that would be the equivalent of English-speaking psychiatry using the word 'crazy' or 'mad'. The term for mental illness is *sakit jiwa*, or 'illness of the soul', while the term for mental health is *kesehatan jiwa*, or 'health of the soul'. The average Indonesian uses the words *sakit jiwa* or *masalah batin/dalam* ('a problem of the inner') to refer to the experience of *sakit jiwa*. The English word 'mental' was adopted and used, as in *gangguan mental* ('mental disturbance'). More recently the English-derived word *minda* is used for 'mind', a term for a concept that seems to be alien to the cultures of the archipelago.⁷ Both 'schizophrenia' and 'depression' as terms for

⁷ *Budi akal* does not translate as 'mind' but moral or conscious reason.

clinical disease remain *skizofrenia* and *depresi*, although for the latter there are other terms as well, such as *kesedihan* and *kemurungan*.

Translating psychiatric terms into Indonesian was not the only problem. Indonesian psychiatry originally developed within a colonial framework that harboured many cultures. Although Malay was the lingua franca of the area, it was not the native language of most of the peoples of the archipelago. Even if certain terms were translated into Malay, these terms would not have personal, experiential meanings to non-Malay-speaking groups, unless they first became culturally modern Indonesians.

In a paper published in 1959 in the *American Journal of Psychiatry*, the Indonesian psychiatrist Dr Iman Santoso somewhat apologetically explained why psychotherapy was slow to develop in Indonesia. He wrote that 'Indonesia' is comprised of many languages, and not only does the Indonesian language not have words for these forms of therapy, but most people would not understand them if it did, unless they had been educated abroad. He further pointed out that because he was Javanese he treated certain Javanese, but not people from other linguistic groups, whose emotional lives formed another barrier of understanding (Santoso 1959:800). He thus concluded that for psychotherapy to work, every language group would need a psychotherapist from that group. Santoso's fascinating paper touched on a complicated problem in mental health management: the problem of the relationship between Western-originated therapy, mental health, and cultural difference, especially language.

The problem goes even deeper. Taking his example from the Iban, Robert Barrett (2004) raised the question of whether Kurt Schneider's first-rank symptoms can be applied at all to the indigenous context. Barrett (2004:99), an Australian psychiatrist who speaks Malay, was 'unable to arrive at a satisfactory translation of the questions relating to the first-rank symptoms of subjective thought disorder for his Iban patients'. He elaborated:

These questions presuppose a Western cultural concept of personhood, which gives a privileged place to internal mental life as a defining feature of the person. It is a mental life that is recognised as located in the brain, and that is experienced as disembodied. And it is a mental life that is experienced as being quite separate from that of others (Barrett 2004:99).

In short, the questions relating to Schneider's first-rank symptoms presuppose a very particular universalized concept of the person and psychological experience that is culturally alien to indigenous concepts.

The second articulation: the medical practitioner and the 'traditional healer'

Since the 1950s, the World Health Organization (WHO) has been actively involved in the promotion and development of Southeast Asian health care

systems, including psychiatry. At the 1978 conference held in Alma Ata in the USSR with the goal of providing universal primary health care by the year 2000, the WHO issued a radical resolution. Since modern health care personnel and resources were limited and health care services could not reach everyone, health care delivery could enlist the ranks of 'traditional healers', especially since they played such an important role. Moreover, these traditional healers were not necessarily village healers but could also be modern professionals working creatively within local religious traditions. Nor were the activities of these practitioners limited to villagers in the countryside or to the urban poor. Educated members of the middle and upper-middle classes also made use of non-biomedical forms of healing.

The WHO's 1978 resolution suggested to medical professionals in developing nations, who in their materialist medical training were tacitly taught to look down on traditional healers as archaic, superstitious quacks, to integrate them into their health care systems. This meant a radical, perhaps even shocking change in policy. In his closing speech to a conference held in Jakarta, the director general of the Indonesian medical health care system maintained: 'it is not easy for a Western-trained Doctor to make the mental-switch [...] sometimes we wish to think it is not necessary but it should be done' (Soebekti 1979:439). But approaching and incorporating these healers was not to be accomplished on terms free of the manifestation of post-colonial power relations. Soebekti (1979) gives us an idea of how traditional healers could be incorporated:

- identification and classification of healers;
- research into the effectiveness of healing;
- recognition of traditional healers by officials;
- training of traditional healers in order to raise the quality of their services;
- education of the public about the importance and benefits of traditional healers;
- development of legal aspects of healing;
- involvement of traditional healers in primary health care.

Before traditional healers could be involved in primary health care they would have to undergo these stages of acceptance. However, Soebekti seems to have forgotten that the healers were accepted by the population as they were, so that they did not need to be 'upgraded'. The oddest stage of the above procedure was the fifth step, in which the public, which already approached such healers without needing to be told to, had to be educated as to the benefits of such healers; indeed, this requirement should have been aimed at members of the medical profession. Furthermore, 'raising the quality of their services', or 'upgrading', was suggestive of a certain degree of 'meddling'. As the director general also asserted, in true Orde Baru spirit, 'it would be necessary to identify what is worth preserving in the practices', thus selecting what seemed ra-

tional and discarding what did not appeal to the medical gaze (Soebekti 1979). Although it was well intended, the WHO resolution could have been damaging to healers who worked with knowledge that could not be divorced from their cultural context, as the general medical term 'traditional healer' would suggestively allow (Klienman 1979; Maretzki 1979:86; Connor 1982:792). Fortunately, health ministries rejected this meddling in the healing knowledge and practices in their countries by not incorporating most healers – specifically, those who practise altered states of consciousness – into their health care systems. The national health policies that did try to focus on the incorporation of indigenous healers mainly focused on those working within traditions that seemed more rational to the bio-medical gaze. In Indonesia, healers working within Chinese and Unani traditions were registered, and village midwives were incorporated into the primary health care system.

The relationship with those healers working within the traditions of *animisme* – the Tyloresque term itself is subject to critique – is more complicated. Within modern Indonesian discourse, *animisme* is a widely held set of beliefs relating to souls and spirits. However, contrary to Tylor's reasoning, in which 'primitive animism' is the foundation of all religions, and which survived into the modern age as Religion, in official Indonesian discourse *animisme* is not a religion but a catch-all term for belief (*kepercayaan*) in souls and spirits. Such people practise *mystica* and *magi*. However, the term *animisme* also covers another discursive reality in Indonesia. In certain Muslim-influenced parts of the archipelago, ideas and practices associated with *animisme* are referred to as *ilmu kebatinan* (inner knowledge). It is no secret that a culturally modern Indonesian official who derides village practices as *animisme* might turn to a healer working within such a knowledge system for help when he or a member of his family is ill. In this context, *animisme* is reconfigured as *ilmu batin*. Sciortino (1995) describes a similarly ambivalent attitude among health workers in Central Java. Within the medical frame of reference and within its space of practice, health workers oppose traditional medicine as archaic, though they turn to it in their private lives. Sciortino rightly attributes this to the distinction between *ilmu batin* and *ilmu lahir* or *ilmu akal* (outer knowledge, or knowledge based on reason). Anderson (1977) points out that the various *kebatinan* traditions (and, we might add, other so-called 'animistic' traditions) have tried through their own universalism to encompass the plurality of the world. He compares this to the secular perspective that looks at Islam, animism, and *kebatinan* and comparatively treats them within a larger humanist/anthropological historical framework under the category of religion: 'This means the strange and the plural can be incorporated under universal rubrics' (Anderson 1977:19). It seems that for many Indonesian health workers, but not necessarily elites such as psychiatrists, the distinction between *ilmu akal* and *ilmu batin* underlies this pluralist attitude (Sciortino 1995). In certain contexts,

biomedicine becomes culturally incorporated through indigenous categories, rather than the other way around. The hospital and the health clinic are *akal* (reason) spaces, with no room for *batin* phenomena, not because they are incompatible with the indigenous perspective – it could even be argued that the psychodynamic principles of Freud, Jung, and Adler are foundationally similar to *kebatinan* (Anderson 1977:19) – but because the rational-materialist's perspective does not allow for such complementarities. The indigenous perspective categorizes modern medicine as *ilmu akal*, even as it retains *kebatinan* knowledge and experience within another context of practice. The indigenous vision can rationally retain the plurality of different types of medical knowledge in a way that materialist, biomedical knowledge cannot.

The relationship of Indonesian medical doctors with traditional healers and their knowledge is clearly complex, to the point where generalizations are dubious. Some dismiss certain traditions but accept others specifically related to their own religions. Other physicians may see the utility of local healers and try to work with them (Thong 1992), while others might justify it through personal belief. Whereas in Indonesia it was considered unethical for a biomedical practitioner to work together with a traditional healer, or even be one, some non-governmental public measures were nonetheless undertaken to provide a more holistic service. In Jakarta the Yayasan Pengembangan Swadaya Indonesia (YPSI) ran clinics that provided a complementary service incorporating biomedical doctors with acupuncturists and herbalists (*sinshe*), although no spirit mediums were involved (Boedhihartono 1982:30). One psychiatrist in Yogyakarta accused some of his local colleagues who practised traditional forms of healing of being unscientific and taking advantage of people's superstition (Boedhihartono 1982:29). As Boedhihartono was writing in the years just after the Alma Ata conference, his brief account reveals conflicts among Indonesian health professionals as to the role that traditional healing practices might play in their services.

One consequence of this new move following the Alma Ata conference was a proliferation of writings in books and journals by psychiatrists on what they called 'traditional healing'. Much of this literature, although descriptively informative, was highly reductive from an anthropological point of view, and somewhat resembled anthropological descriptions common in nineteenth-century writings. The word 'traditional healer' reflected the binary power relation between biomedicine as a product of the culture of modernity and the healing knowledge of the cultures of a particular nation. The term simply lumped all these diverse therapeutic practices, some cultural and others part of universal medical traditions, into one category. The category was then broken down into sub-categories, and the result failed to place biomedicine in a complementary relationship with other systems, but always in dichotomous contrast with 'traditional healing' as a unitary other. The tone in these descrip-

tions was generally one of elite distance, and although the medical authors in their 'ethnographic excursions' did not deny a sense of coevalness in traditional healers, they did describe their practices as outdated. In comparison, Indonesian writers described these practices as part of the Indonesian national heritage, not as the heritage of any particular culture or ethnic group.

Some of the literature did try to explore the differences between biomedicine and traditional healing, but the founding dichotomy undermined the effort, which ended up restructuring and strengthening the boundaries it sought to question. The dichotomies – the biomedicine of the rational-scientific us versus the traditional healing of the religious-spiritual-pre-rational-archaic them – resembled Tylor's materialist/us and spiritualist/other dichotomy. Such accounts, written by psychiatrists from Indonesia and other Southeast Asian countries, allowed members of the medical profession to look on the 'traditional-healer' in their societies as an inverted mirror reflecting their own modern image represented through their own elite profession.

Concluding remarks

The process by which psychiatry and its culture became part of the developing national modernity of Indonesia was inevitable. The arrival of psychiatry as a branch of Western medicine with universal claims to knowledge was closely followed by anthropology and other socio-cultural disciplines. We cannot divorce the history of psychiatry from the study of culture in Indonesia, since during the critical period of psychiatry's establishment, the two disciplines reinforced each other's visions of indigenous therapeutics and psychological knowledge. The 'native' was in the view of psychiatry at worst not that far off from the psychotic, and in the view of the early anthropologists at best nothing more than a believer in 'false science' based on superstition. It was this utter denial of the validity of indigenous knowledge that allowed modernity's knowledge systems to prepare the fields of epistemological order in the archipelago for the planting of their disciplines there.

When psychiatric knowledge was brought to Southeast Asia, it had to develop a language for its concepts in each country – it had to be naturalized. To do so its practitioners had to draw on the language of indigenous cultural and religious healing traditions that had given their everyday language the words for psychological experiences. This could be considered to be the first incorporation of indigenous healing knowledge into psychiatry. The problem with Indonesian psychiatry was that it had to develop in an overarching political-cultural framework that harboured a diversity of cultures and languages. In this modern political-cultural framework, psychiatric concepts of self, mental disorder, and therapy were difficult to translate into the Malay lingua franca,

which reflected the cultural awkwardness of Indonesian psychiatry's relationship with the society it served. Moreover, until the 1950s, Indonesians were not in control of this creative process of 'indigenizing'. Indonesians had first to embody a concept of a modern Indonesian 'self' through which a national psychiatry could work with and culturally influence the national community it was supposed to treat. To accomplish this, Indonesians had to rid themselves of their then colonized or native identity. Culturally, psychiatry in Indonesia can only speak, fashion, and respond to and through the modern Indonesian self, which is fully developed among the elite and the middle classes.

One issue that was bound to emerge in the post-colonial era was the relationship that psychiatry should have towards 'traditional healing'. During the pre-psychiatry colonial period there were moments when Dutch medical officials tried to utilize indigenous therapeutics and suggested health policies that were conceptually closer to developments occurring during the late-twentieth century that forced psychiatry to make some accommodation towards indigenous therapy. J. Bontius (with his focus on the use of indigenous therapeutics) and Dr Wassink (with his concept of community care) were two such officials. But their voices were swamped by the triumph of biomedical developments in Europe during the second half of the nineteenth century.

Psychiatry's second articulation with indigenous forms of healing occurred in the late twentieth century. Here again the universalist 'rational' traditions were officially accepted, but not the spirit-medium-based ones – the relationship with spirit and shamanic healers is more personal and idiosyncratic, depending on the openness of the biomedical doctor towards the psychology of medical plurality and on personal religious belief. In many respects these doctors, who may have personal religious convictions themselves, approach the therapeutic world in terms of a 'placebo' type of true/false dichotomy.

Since the 1960s, a growing number of anthropological studies of shamanic and spirit-medium traditions have tried to go beyond the modern, Tylor-style approach that sees religion as false knowledge, trying to understand the efficacy of techniques through the models of psychotherapeutic healing.⁸ Such anthropological studies suggest that these spirit-focused healers who seem so bizarre to the medical modernist gaze may actually be the primary health care psychotherapists that are so badly needed. It is these healers who can speak the same psychological language as the patients who seek them: they share the same fundamental phenomenological concepts of consciousness and self. It is these healers who should be respected and aligned with national psychiatry, rather than with medicine in general.

⁸ See Lévi-Strauss 1963; Moerman 1979; Kapferer 1979, 1991; Desjarlais 1989; Dow 1986; Frank and Frank 1991; Laderman 1991; Laderman and Roseman 1997; Csordas 2002; Porath 2003.

The scholarship dealing with the history of psychiatry in Southeast Asian countries has failed to represent the actual naturalization and indigenization process of this discipline. For this reason, it has not captured how established indigenous concepts for psychological experience and the internal constituents of the person, which have fashioned a population's psychic identity and emotional experience for centuries, become semantically transformed into psychiatric and psychological labels resonating with so much power that those who apply them could side-step the knowledge systems from which these terms were originally drawn. Thorough historical, linguistic, and anthropological research should be carried out into psychiatry's first naturalization process in Indonesia and other Southeast Asian countries, an approach that would go beyond the now commonplace 'psychiatry as a tool of imperial control' approach. Such research should be carried out within a comparative framework, as only then can we see how 'indigenous' these psychiatries really are.

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