Dealing with Schizophrenia in Central Java

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Zusammenfassung

In der empirischen Studie wird untersucht, wie psychisch kranke Menschen, ihre Verwandten und Nachbarn mit psychischer Erkrankung in der Familie und im kommunalen Zusammenhang umgehen und wie sie diese innerhalb des kulturellen Kontextes von Zentral-Java / Indonesien verstehen. Dieses impliziert keine Vorstellung davon, psychisch kranke Menschen zu verändern. Stattdessen liegt die Bürde für Veränderung auf den Mitgliedern der Familie und den Nachbarn. Wir fanden, dass die Kombination von vier sich überschneidenden Konzepte (mehrere Wirklichkeiten, keine persönliche Veränderung, *mengemong* und verborgene Entwertung) die unausgesprochenen Richtlinien des Umgangs mit psychischer Erkrankung in Zentral Java kennzeichnet. Diese Richtlinien werden in einer kulturell spezifischen Weise des Verstehens und Erklärens von psychischer Erkrankung eingebettet und beeinflusst durch Veränderung der modernen Einflüsse auf die Gesellschaft in Java.

Schlüsselwörter

Klinische Kulturpsychologie, Umgang mit psychisch Kranken in der Familie und Gemeinde, Alltagstheorien zu psychischer Krankheit, Qualitative Forschung

Summary

This study presents an analysis of how mentally ill people, their relatives and neighbours deal with mental illness and how they describe and explain it within the specific cultural context of Central Java / Indonesia. The combination of a special way of caring and authoritarian guidance found in the concept of *mengemong* does not imply any notion of changing mentally ill persons. We found that the combination of four overlapping concepts (multiple reality, no personal change, *mengemong* and covert devaluation) characterizes the unspoken rules of dealing with mental illness in Central Java. These rules are embedded in a culturally specific way of understanding and explaining mental illness and influenced by changing modern influences on Javanese society. The strengths and limitations of this particular cultural concept are discussed.

Key words

clinical cultural psychology, coping with mental ill persons in family and community, every day life-theories of mental illness, qualitative research

I. Introduction

Kraepelin tried to confirm the universality of his concept of "dementia praecox" in Java in 1904 (Bendick, 1989). He claimed that the basic features and the frequency of dementia praecox are the same in Germany and in Java but he found different symptom patterns. He was the first who observed less severe forms of mental impairment in a not-Western country. Kraepelin hoped that the comparative study of psychopathology would reveal the specific psychological features of a population. So he conceptualized comparative psychiatry as an

ancillary science of anthropological psychology (Kraepelin, 1904 a, p. 435-437).[1] The intercultural studies and especially the International Pilot Study of Schizophrenia (Sartorius, 1986; Sartorius et al. 1987; Sartorius & Jablernsky, 1992) showed apparent intercultural differences in the form, intensity and duration of schizophrenia with a better outcome in developing countries. (s. Lin & Kleinman, 1988; Kleinman, 1988). In particular, the finding that the prognosis for schizophrenia seems to be better in developing countries than in the developed ones has produced much speculation about social and cultural conditions which could contribute to the different course of schizophrenia (s. Kleinman, 1988, p. 47ff; Lefley,1990; Lin & Kleinman, 1988, p. 563ff; Kirmayer, 1989). We intended to learn more about the special way of understanding of and dealing with mental illness in a given cultural setting which may be in fact a contribution of anthropological psychology to a better understanding of the course of the illness.

We tried to follow Rogler in his statement: There is a need for research that departs from the prevailing, almost routinized a priori commitment to standing measures of mental health. Such research, which is more basic and much less often conducted, begins with the assumption that our ignorance is problematical, and it seeks to uncover the indigenous configuration of mental health problems and symptoms in the cultural group. (Rogler, 1989, p. 298)

II. Research Problem

It is our basic assumption that everyday understanding of and dealing with the mentally ill in a given cultural setting is an important contribution to the understanding of chronicity. In our view chronicity or acuteness is an interaction of the biological, social and psychological spheres. In interactions we cannot isolate the influence of one factor without destroying the understanding of the relationship. Chronicity is a phenomenon from which "the cultural" cannot be isolated as a factor in order to reveal the "real" biological core. Such a linear model in fact destroys our very understanding of the phenomenon.
According to Estroff: Chronicity is constructed by: the temporal persistence of self- and other- perceived dysfunction; continual contact with powerful others who diagnose and treat; gradual but forceful redefinition of identity by kin and close associates who observe, are affected by, or share debility; and accompanying loss of roles and identities that are other than illness-related. (Estroff, 1994, p. 259)
Our aim in this study was to uncover the structure and meaning of this interaction in a local culture and to get a better understanding of the web of cultural rules, which govern the understanding of mental illness and the practice of dealing with it. We wanted to know how people describe others perceived as being not normal or mad and what they think about the cause of madness. We were interested in the way how relatives, neighbours, community officials, traditional healers, nurses, psychiatrists, deal with the mentally ill. On the other side we wanted to learn how mentally ill people see themselves and their situation.

III. Some data about Population and mental Illness in Java

Java has been called the most fertile, the most productive and the most densely populated island in the world. There are around 115 million people[2] living in an area as big as England or New York State. The island is traditionally seen as the old cultural heart of Indonesia. 60% of the Indonesian population lives there and nearly 90% of them are Muslim.
Daerah Istimewa Yogyakarta is a small province[3] in central Java with 2,9 million inhabitants. The town *Yogyakarta* (half a million inhabitants) is an old cultural center with many schools and universities, a sultanate court, a rich tradition of art and handicraft production and little heavy industry.
For *mental health care in Indonesia* there are only 7770 beds in 34 mental hospitals (Gardjito, 1992) and nearly no outpatient services. This means there is approximately 1 bed to every 23000 inhabitants. In

Yogyakarta[4] there are more beds in mental hospitals (1 to every 10 000 inhabitants) compared with the Indonesian average.

The worldwide general prevalence of schizophrenia is between 2-10 / 1000 inhabitants. As far as we know in Indonesia there have been two epidemiological studies:
In a slum area in Jakarta Salan (1992) found 1,41 cases per 1000 inhabitants (1,76 for males, 1,04 for females). The rate was much higher in a rural area of *Central Sulawesi* (former Celebes) with 4,6 cases per 1000 inhabitants (Tong & Maryati, 1989). There are no data on the long-term course of schizophrenia in Indonesia.
Only a minority of mentally ill people, then, is treated in mental hospitals. As there is no social insurance system (except for government employees) many families cannot afford the cost of treatment. Most of the people regarded as mad or not normal are brought to traditional healers *(Dukun)* and are left to the support and control provided by their families and neighbourhoods. Others who have escaped or been excluded from the family context live as psychotic tramps on the streets. They can be recognized by their bizarre behaviour and by their dirty and half-clothed appearance.

IV. Case example

Miss Kidul is 23 years old. She comes from a little village in one of the poorest areas of the rural part of Yogya. It takes 2 - 3 hours to get to the city by bus. She has one younger brother and one sister. All of the children have to go to the city to earn money. Originally, her parents owned one field and some cows. But her father had an accident. He fell from a truck and had to stay in the hospital for half a year. Since that time his leg has been so deformed that he cannot walk or work properly. The family had to sell their cows to pay the hospital fees.
Shortly after this misfortune Kidul got problems. She wanted to marry a man from the town but her parents were ashamed that their future son-in-law would see the poor condition of their house and refused their permission for the marriage. Kidul showed a confused and aggressive behaviour towards neighbours and family. Her parents took her to several *dukun* (traditional healers) nearby who did not charge much because they knew about the family's economic situation. In a ceremony with one of the *dukun* all the clothes Kidul had brought from the town were thrown into a deep cave in the mountains to neutralize the bad influences. But Kidul did not recover.
A respected man in the village who was retired from the army advised Kidul's parents to take her to the mental hospital in Yogya. He and the chief of the village helped to arrange for free treatment. Despite this the family had to pay half the cost of treatment and in addition much money for travel expenses to visit Miss Kidul on a regular basis. The only possibility of getting the money was to sell the field they used for growing maize and maniok. Unfortunately Miss Kidul had a relapse one month after release from the hospital. Her parents and their neighbours report that she became crazed again when she heard that the land was sold for her health. She ran "amok" and attacked her mother and particularly her uncle with a knife because she thought that he had pressed the family to sell the field. We took action together , the neighbours explained later. We caught and held her; then we tried to make her aware *(sadar)*. But after a while she relapsed again. Everybody was afraid of her, so the family held a village meeting with the neighbours and the head of the village. He later explained: The decision of the family and the neighbourhood was that she should be treated with *dibelok* (a traditional form of treatment, which involves tying the individual in wooden stocks) I agreed. Actually we wanted to send her to the hospital again, but the family had no more money and the land was already sold. Kidul remained in the wooden stocks in a cowshed behind her parent s house for 17 months. The neighbours describe how she cried and screamed at night. Her mother gave her something to eat and her brother cut her hair. The wooden stocks were changed once from "randu" to "yati" wood which is harder and is used for chronic cases.
When her brother s boss a doctor visited the village she was thin, dirty and her foot was deformed by the stocks. He decided to take her to the mental hospital in his car. Now she has already been in the hospital for 6

months where she does farm work as rehabilitation. We don t know who took charge of the costs, the doctor or the rudimentary town social welfare system.
In the view of the people in the village, the family and the neighbours cared for Kidul as much as they could. But following the exhaustion of their resources they did not know how to deal with her aggression in any other way than by tying her up. In their opinion *dibelok*[5] is preferable to becoming one of the "orang gila", the dirty and naked homeless crazy men for whom their families do not care.

This case example gives an initial impression of how the shortage of resources is dealt with. This for the area of Yogya rather extreme case illustrates how help and control measures are combined and that severe control measures are applied when resources are lacking. Another interesting aspect of the case is the confrontation between traditional rural and modern influences coming from the town, one which leads to unsolvable problems.

V. Methods

1. Research Conditions

The research was done at the Faculty of Psychology at Gadja Mada University within one year. We learnt the national language (Bahasa Indonesia: BI) which is spoken by many but not all people in the area of Yogyakarta: where content of expression is bounded by specific cultural definitions as is especially the case in the area of interpersonal relations and emotions the Javanese language is necessary. We built up a research group of advanced students and colleagues who spoke the local Javanese language. Here we tried to develop a common understanding of the basic research idea and the competence for carrying out interviews and observation.
It was rather difficult for us to impart the basic ideas and methods of the qualitative research approach to the participants of our group. They found it somewhat strange that emotions and spontaneous expression might be important for research since these aspects of Javanese communication are usually hidden.
For example, we found that the taped interview with one interviewee contained sections, which were disjointed and difficult to understand. When asked why, the interviewers explained that they had switched off the tape when the interviewee showed strong emotional concern because they had wanted to get a good and well-organized interview.
Another problem was that we needed a good deal of time to create an atmosphere of free and spontaneous discussion in the research group so that we could profit from the ideas and cultural knowledge of our colleagues. Because of hierarchy and politeness in the beginning there was no basis for such teamwork. Later we profited very much by the discussion of all major interpretive ideas with our research group and senior colleagues from the faculty.
Often other people were present during the interview, making comments and influencing the presentation of the perspective of the interviewee. Despite the degree of politeness and the tendency to meet expectations, we were astonished at the openness of our informants regarding information, which seemed rather private to us. We were never refused an interview. Our concept of privacy and data protection was rather foreign to Javanese people.
We were also confronted with what we came to call the "Rashomon" problem: hearing quite different versions of the same story. We thus had to deal with the serious problem of the credibility of our informants. Our approach was to reconstruct the different perspectives of our informants in order to understand why each one had a particular version of events and to reveal the case structure by relating the different perspectives and versions to one another. Working in this way we found that the contradictions between the versions of the different interviewees often provided the key-information for the interpretation of the case.
All the texts of the interviews conducted in Javanese were transcribed in three languages (Javanese, BI and English). We conducted the analysis on the basis of the BI and English texts and selectively discussed the

Javanese meanings with the research group. We were aware of the problem of multiple translations and tried to compensate it by this exchange with Javanese speakers. In fact the discussion of the original Javanese meanings and the discussions of why a particular interviewee perspective was presented in the given social context were of paramount importance to our development of the interpretation.
Our interviewers were usually accepted by the interviewees due to the formers association with the hospital. This meant that while the interviewers had no difficulties being accepted by the families and the neighbourhoods, they were regarded as "people from the hospital" with a higher status. Since Indonesian society is structured rather hierarchically there is some social distance between people from the university and ordinary people, e.g. from the village.

2. Data Sources

All in all, there were 68 interviews done on the theme of mental illness in Central Java.
47 interviews (with: family, community members, professionals from the health care system, mentally ill person him/herself) and additional material (e.g. hospital file) provided the database for 8 in-depth case studies.
21 other interviews were conducted in order to get general context information and to do the theoretical sampling (Psychiatrists, administration, traditional healers, lay persons).
The interviewers (8 advanced students of psychology, 2 anthropologists, and 1 social worker) were all members of our research group. They participated in the project over a long period including the phase of data analysis. All of them spoke Javanese and Indonesian language.
The interviews were tape-recorded and were always conducted by two interviewers out of the research group. They wrote field notes about each interview setting. The interviews were conducted on a half-open basis, lasted between 30-120 minutes and were transcribed word for word. Half-open means that the interviewers followed an interview schedule but that they allowed and encouraged narrative contributions by the interviewees.

3. Data Analysis and theoretical sampling

We used an in-depth case study approach following the grounded-theory approach of Glaser & Strauss (s. Glaser & Strauss, 1967; Strauss, 1987; Strauss & Corbin, 1990; Lofland & Lofland, 1984.)
Progressing case by case we developed both the emerging theory and a growing awareness of the structure of the whole research field. A concrete example of theoretical sampling can be seen in the aspect of our investigation dealing with the devaluation of the mentally ill. In the analysis of our first cases we developed the hypothesis that there is a powerful, shared cultural rule, which allows no blaming, or open devaluation of mentally ill people in Java. However, we then heard about cases of mentally ill individuals who were treated using the traditional method of tying them hand and foot to wooden stocks. Others were obviously excluded from their families and lived partly naked and dirty on the streets. This seemed to contradict our hypothesis. So we interviewed psychiatrists and experts from the local social administration to learn more about this phenomenon and more importantly to gain access to such cases (Case Kidul and Case Hilang) in order to actively challenge our hypothesis by means of new data.
In order to conduct theoretical sampling we had to depart from our initial access structure via the mental hospital. For example, we had to use private rather than professional contacts in order to gain access to cases from the upper class. Furthermore, it was only through interviews with *dukun* (traditional healers) that we were able to gain access to people who would get the diagnosis of schizophrenia if treated by psychiatrists.

VI. Description of the sample

Our sample included 4 men and 4 women ranging in age from 23 to 46. All had been diagnosed as schizophrenic in the mental hospital except for Mr. Kuat who had been treated by a traditional Javanese healer and who had never had any contact with psychiatry. Two of the cases were married, one divorced and one widowed. Five cases came from the village and 3 from the town one coming from upper class. The length of illness ranged from 6 months to 20 years[6] and the signs of illness were mostly rather severe. We chose one patient who had lived on the street for half a year, one case who had been treated exclusively by a dukun and one woman who had been "dipasung" (tied to wooden stocks) in a cowshed for one and a half years.

Description of the sample

	Kaca	Muda	Alane	Kidul	Paheas	Diana	Hilang	Kuat
sex	female				male			
age	41	23	41	23	46	23	30	36
Diagnosis	schizophren.	schizophren.	schizophren.	schizophren.	schizophren.	schizophren.	schizophren.	no psychiatry
children	1 (2 died)	1	-	-	4	-	-	2
school[1]	SHS	SHS	SHS	ES	SHS Lev. 2	SHS lev. 2	ES lev. 3	SHS
home	own house	parents	far relative	parents	moth. in law	parents	parents	parents
rural/ town	town	village	town	village	village	town	village	village
job income	housewife pension	housewife fam./husband	no job family	no job family	no job wife/family	no job parents	no job parents	ojek driver[2] parents/inc.
mental ills. in family	sister	mother	grandmother uncle	no information	father	mother	mother	grandmother uncle
health insur.	yes	no	yes	no	no	yes	no	no
religion	islam	islam	islam	islam	islam	islam	islam	islam
length of illness (years)	16 or 4	half a year	1 or more	3	14 or 4	4	14	20
economic condition	sufficient	sufficient (sold fields)	self / care giver: rich	very poor sold fields	very poor sold fields	very poor	very poor sold fields	sufficient (?) sold fields
Signs	amuk[3], naked break glass	confused run away	paranoid	amuk attack on people hallus.	amuk shouting	autistic, no self care	incoherent talk, withdrawal	amuk naked destroying things
Status of caregiver	small trader	retired clerk farmer	Professor/ nobility	farmer	temple seller on market	low retired clerk	selling on market	village trader/farmer
Pregnancy psychosis	3 prepartal	self postpartal and mother	grandmoth. postpartal	-	-	mother postpartal	mother postpartal	?
Special features	widow	short duration of illness	upper class	2 years in wooden blocks	middle age head of family	autistic retreat	psychotic "tramp"	case of trad. healer

[1]SHS= Senior High School, JHS=Junior High School, ES=Elementary School
[2]ojek= Motorcycle-"taxi"
[3]amuk: indonesian expression for slight or severe degree of aggressiveness

Description of the sample (click to enlarge)

VII. Results

1. Everyday description and criteria for madness / mental illness

a) Self-description

Our interviewees did not offer much description of the experience of mental disturbance. On the contrary, they placed much emphasis on their having already recovered and on their normality. We will come back to this point in the discussion of dealing with mental illness.
But our informants often used an interesting general indicator of distress. They pointed to their head and called themselves *mumet* (Jav.) or *pusing* (BI). The Javanese concept of *mumet* is something between experiencing a whirling sensation, feeling dizzy and having a headache. If interviewees felt able to control their feeling of *mumet* (e.g. by eating no lamb meat as in the case of Mrs. Kaca), they believed that they had recovered.
In this way the mentally ill themselves try to "normalize" their experience. *Mumet* or *pusing* is an unspecific term that is generally used as an expression for all forms of distress.
The only one who described his experience of "craziness" was Mr. Kuat. The story of the beginning of what he himself calls his illness sounds like a passage out of the popular Indian epos Mahabarata. (In fact Mr. Kuat was a lay player of this form of theatre which is extremely popular in this region.)

Kuat: I couldn't sleep. It was Monday wage night. The light (which had entered my body before) became an old man [...] then the old man told me [...] My boy [...] be patient. You will have a difficult life. At this

moment I had a deep feeling of peace in my heart. Then the old man disappeared. After that came a giant (or something of huge size) who set upon me. It was like a war, but a war with something invisible. So it was then [...] I got confused and I didn't know what to do. [...] Like an enemy came to me. A war, that's the term. But nobody knew the enemy except myself. Then I got angry and ran amok. I felt I wanted to attack that enemy.
He connects his story with the mystical world which is a vivid part of Javanese culture: I had a relapse when I faced the supernatural, which does not exist in this world, but in another mystical world, and whether I felt happy or sad, whether I laughed or sang, was dependent on this mystical world [...] It looked as if I talked to myself but really I was invited to talk by an invisible creature or an evil spirit.
Mr. Kuat also described experiences that still persist: Until now, it is like that. Still like that. But now I am strong, aren t I? I mean [...] it is really something supernatural which enters my body. Now I am strong enough [...]. Even now when I feel sad, they come to me and entertain me (laughs) [...] the friends who are invisible [...]. It is usual for me. It feels like somebody is giving me a massage. Once, when I was having this sensation of massage, I could only see hands. There was nothing else, only hands. That's usual [ ].
Mr. Kuat was the only one who had no contact with the mental health care system. We can suppose that he had learned to talk about his past and present psychotic experience within the framework of the cultural knowledge of the traditional healer by whom he was treated for twenty years. He was thus supplied with concepts and a language to express his psychotic experiences in a way, which could be shared by the members of his culture. Rogler and Hollingshead (1985) have made similar observations in Puerto Rican families.
In describing his present state Mr. Kuat uses the popular Javanese concept of inner power. He has become strong (Indon. kuat) and is consequently able to handle the supernatural power which enters his body, an experience which obviously occurs in the form of acoustic, tactile and visual hallucinations. In a similar way he gives a dramatic account of his past acute psychotic experiences and his running amok in the form of a description of a fight with a giant supernatural being.

b) Description by "others" (all interviewed family members / neighbours)

Description by "others" was all statements in our interviews, which were made by people not diagnosed as mentally ill. The main indicator for identifying people who are not normal ("orang kurang waras") or mad people ("orang gila") in our sample was deviant social behaviour.
Shouting on the street, breaking glass, destroying things, and attacking people with a knife are all described as *mengamuk* in 4 of our cases. Being aggressive seems to be a highly deviant form of behaviour in Java.
"Running amok" (indon. *mengamuk*) has a different meaning in the Indonesian and the English language. Not only severe forms of life-threatening behaviour but also being slightly aggressive are called *mengamuk* in Indonesia. In our sample the word was applied in this way.
In two of our cases the exposure of nakedness was seen as sign of being *gila*, something, which is considered very provocative in Java.
In two of our cases our informants described a rather extreme form of social retreat entailing a lack of care for oneself, a lack of socially appropriate behaviour and something often mentioned a neglect of religious duties.
In one case people also described incoherent talking or talking nonsense. Being confused, running away and talking strangely were the main signs in the acute case. Two women were said to have had an irrational belief in being loved.
It appears, then, that special forms of behaviour which violate social rules and the failure to fulfil one s social role are the main everyday criteria of mental illness.
Aggressive behaviour and exposure of nakedness tend to be quickly classified as deviant. This aspect can be directly related to the broader cultural context of Java where emotional control seems to be a high ideal. The exposure of nakedness and being dirty seem to play a special role in the attribution of deviance because both are considered extremely provocative and disgusting by Javanese people. Mr. Kuat, who refers to his formerly having exposed himself,[7] is extremely ashamed about this fact and the Javanese interviewers show a high degree of irritation with him. He claims to only know about the episode from the reports of others, was not conscious at the time and therefore cannot remember it. It is not uncommon for one of the numerous homeless

psychotic tramps to cross a busy street dirty and naked. Everybody else on the street actively ignores him as if he does not exist and no action is taken. We got the impression that being naked and dirty have a communicative function and are important in constituting a special relationship between mad and normal people. However, we have no data on this topic.

Observations of inner experiences or psychological functioning are less commonly used as criteria for madness by family members or neighbours.
Being confused *(bingung)* was used in three cases. Mrs. Muda was additionally described as not being aware of what she was doing and her family also referred to her inability to remember things as a criterion for being "crazy".
We found a lack of concern with inner states similar to that observed by Westermeyer & Wintrob in Laos (1979). Relatives do not seem very interested in the observation or exploration of inner processes of the psychotic members of their families. For example despite the higher frequency of acoustic hallucinations in Indonesia compared with London (s. Salan, 1992b) we never heard something about this phenomenon by relatives.

2. How do people explain the causes of mental illness and relapses?

Our interview partners used different causes to which they attributed mental illness. Most popular were different psychological causes followed by hereditary and magic explanations. We found no idea of a personal responsibility of the mentally ill himself. We are aware of the fact that the following categories seem to be rather ethnocentristic. We will show that the meaning of stress is different in Java. If we talk about "magic" or "supernatural" concepts we must keep in mind that these concepts reveal real (albeit largely invisible) social forces in many traditional cultures. Our "Western" view is different. In Java or Sri Lanka (s. Argenti-Pillen, 2000) what we call magic are very ordinary, everyday concepts, a commonsense way of talking about social relationships.

case	Heredity/Con	Stress	Stress	Stress	Supernatural
Kaca	2	1		2	1
Pakem	2			4	
Muda	1	1		2	
Diam		4	3	1	

Causes of mental illness (Number of persons who used a concept in a given case)

a.) Stress

As is the case in Western countries (s. Weber, 1987), the term "stress" is very popular in modern Java (even in Javanese texts). However, the ideas associated with stress seem to be quite different to those in Western countries:
The belief in a special sensitivity to disappointment and aggression is very common: For example, in the case of Mr. Diam all informants share the idea of a damaging effect of disappointment. We were rather surprised at the idea that not getting the right motorbike should lead to mental illness in a young man. But in fact this disappointment and the refusal of an adequate education are regarded as causes of mental illness in Diam. These new demands of young men seem to exert a high pressure on the older generation if they exceed the

economic resources of poor families.
This leads to another event believed to be a cause of mental illness in the Case of Diam: Faced with the demands of the son there is an explosive mixture of shame, helplessness, and anger in the father which leads to scolding and even beating the son. The expression of aggressive feelings is normally suppressed in Java and this may be connected with the notion that they are harmful to others.
The relatives of Diam see frustration and scolding as directly are affecting body and soul. There is no conceptual separation between feelings (inner pressure, loss of the desire to live) and becoming physically weak or developing nervous problems.
We found these ideas present in other cases too: The father of Mr. Kuat is very eager to assure us that he did not disappoint his son. In the case of Mrs. Kaca, Mrs. Muda and Kidul the disappointment in love concerns is regarded as a cause of mental illness.
We find, then, a culturally specific concept of psychological *vulnerability* in our informants, which is connected with the term "stress". The ideas connected with stress had undergone a specific Javanese transformation in the way it was used by our informants to explain mental illness. In their usage, the concept of "stress" encompassed range of old Javanese ideas about the influences, which are harmful to the development of little children.
The Javanese way of raising children has been described by Hildred Geertz (1961). According to her it is believed that emotional upset, disappointment, frustration and anger may cause a "startled state" (kaget) in children who, in turn, may cause illness. She makes the observation that *the conception of mentally ill people is connected with that of the Javanese child:* The child before he is five or six is said to be *durung djawa*, which literally means *not yet Javanese*. The same phrase is applied to mentally unbalanced persons and to adults who are not properly respectful to their elders for instance, a daughter-in-law who is rude to her parents-in-law. It implies a person who is not yet civilized, not yet able to control emotions in an adult manner, not yet able to speak with the respectful circumlocutions appropriate to different occasions. He is also said to be *durung ngerti* (does not yet understand) and therefore it is thought that there is no point in forcing him to be what he is not or punishing him for incomprehensible faults. (Geertz, H., 1961, p. 105)
There seems to be, then, a special Javanese way of conceptualizing psychological causes of mental illness as an experience of the damage, which should be prevented in child education. Such a concept reflects the general attitude towards human relations. There is a constant feeling of concern (s. Mulder, 1990; Magnis-Suseno, 1981) regarding possible threats to human relations. "Thinking too hard or too much" is another cause of mental illness used in connection to stress and basically has to do with worrying (e.g. experiencing responsibility as a burden). Our own impression was that the changes presently occurring in Javanese society increase this problem. Modernization is creating new needs and, at the same time, there is a growing gap between rich and poor people with the later experiencing "stress" and shame because they cannot meet the needs of their children.

b.) Hereditary

The influential causal concept of heredity is included in the traditional Javanese rules of marriage. The criteria for choosing a partner are "Bibit, bebet, bobot" (heredity, worldly health and moral character).[8] These rules appear to be strictly applied especially to the upper class and to women.
For example Alone s grandmother was sent back to her family and replaced by a second wife after she had been diagnosed as having pregnancy psychosis. The old lady who cares for Alone predicts that she will not find a man because of bad "bibit". The whole branch of the family descending from the "mad" grandmother is regarded as highly strange.
The concept also appears in our other case studies and is often mixed with a weak constitution.

c.) Supernatural

Supernatural causes of mental illness mentioned were the following: breaking traditional Javanese rules (e.g. marriage rules), neglecting to care for the family kris (sword) and being possessed by magical forces or influences.
There seems to be a rich diversity of ideas how mental illness can be seen as effect of supernatural influences, which still carry a great deal of importance in everyday life. Nearly everybody (including our colleagues at the university) believes in supernatural influences. As everybody wants to be modern and a good Muslim we mostly heard about these theories and practices only indirectly. Another reason for this was that our interviewers were associated with the university mental hospital. Our informants were consequently ashamed to talk about this subject because the interviewers had a medical and an academic background.
Apart from the upper class case, all families consulted a *dukun* (traditional healer) or a kyai (Islamic healer). In the case of Mr. Kuat we witnessed a fairly successful, long-term treatment conducted by a *dukun*.
The belief in supernatural causes seems to be influential but is in a defensive position in relation to modern ideas about causes. From the point of view of the person concerned, supernatural causes are external influences. There may be a disturbance in the cosmic order due to incorrect behaviour but, in the cases we studied, this was never attributed to a deliberate act of the mentally ill person. In the case of Hilang the parents had violated the traditional marriage rules; in the family of Kaca there was a neglect of the family sword; and in the cases of Kuat and Kidul the origin of the magical influence remained unclear. However, in all the cases the mentally ill person always appeared as a victim. The logic used here is thus similar to that found in the notion of heredity and to the way in which psychological causes are conceptualized. The traditional healers always claimed to treat *(mengobati)* "diseases". The logic employed here is quite similar to the medical one. To treat *(mengobati)* means using *oba*". *Obat* is a means or substance with magical or medical power to heal. For this reason the parallel system of health care does not appear contradictory to everyday understanding. Following one informant (in the case of Kaca): you just test out what helps best and leave coexistent causes in your head.

d.) Personal responsibility or personal failure

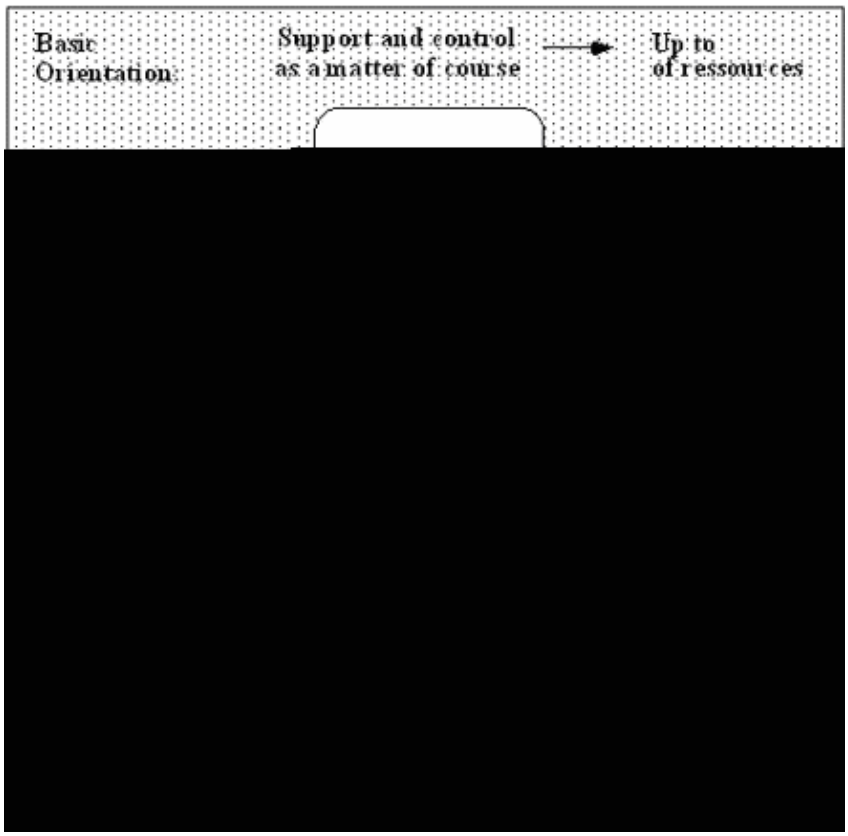
We found no idea of personal responsibility for mental illness e.g. that moral failure leads to schizophrenia. Mental illness and negative moral attitudes were described more as a combination than directly in terms of cause and effect. The informants described gambling, being spoiled or more subtle negative forms of behaviour, which preceded or went together with mental illness, but left the possibility of a causal relationship open. Interestingly these forms of behaviour were not seen as an object of change.
The inability to cope with life events, which is most often suspected to be the cause of mental illness in Germany (s. Angermeyer, 1992), plays a minor role in Java. The psychological cause is seen more in the misbehaviour of others, which is seen as directly damaging the nervous system and not in internal problems or conflicts or in competences.

3. Dealing with mental illness

So far we presented the way of perceiving and explaining mental illness.
The conceptions presented so far are integrated in an everyday practice of dealing with mental illness, which we want to introduce in the case of Mrs. Kaca:
Mrs. Kaca is a 41-year-old widow living with her 12-year-old son in a densely populated area of the city Yogya(karta). Like many Javanese towns Yogya has a village ("Kampung") organized in neighbourhoods which close bonds within and between families. The siblings of Mrs. Kaca with their spouses and children live in a complex of 5 small houses where they operate little shops, a food stall and sell bottled gasoline. Her father had a small batik stamp factory and her mother sold vegetables on the market. Mrs. Kaca was the seventh of nine children, four of which died. Bu Barut, her elder sister by 12 years, is now her "wali" (a form

of guard).
Mrs. Kaca graduated from senior high school (SMA). All informants (except Mrs. Kaca) agree that she was spoiled by her mother who gave her a special princess-like position among the siblings. The informants suppose that the reason for this was a slight retardation in the development of the child and frequent bouts of illness. However, this situation changed when she was forced by her father to marry her cousin for economic reasons. The marriage was against the traditional Javanese rules due to the fact that Mrs. Kaca s husband was the son of her father s younger sister.
The young couple went to Jakarta where the husband got a job as a security guard at the army supply directorate. They lived in the house of the husband s brother (Pak Abri) who himself lived in Yogya. In Jakarta they began to have difficulties. According to Pak[9] Abri, Mrs. Kaca was too extravagant with money and consequently accumulated large debts. During the early period of each of her three pregnancies she was treated in a mental hospital for pregnancy psychosis. The first and second child died very young; a son born in 1980 is still living. According to Bu Barut, Mrs. Kaca s elder sister, the husband started to drink and to gamble. He subsequently developed a serious heart disease. Pak Abri took care of him, paid the debts and took the family back to Yogya where the husband died 3 months later. By this time Mrs. Kaca s father had also died. Since then (1980) Mrs. Kaca has been living with her son in her own inherited house. As the widow of a Public servant she gets a pension of Rp. 50000 ($25) per month. She claims she is also the owner of a boarding house for 4 students. Her elder sister keeps the profit from this house. The mother who cared so much for her died in 1984. Since 1988 Mrs. Kaca has undergone six treatments in two different mental hospitals. The hospital file records the following symptomatic behaviour: She approached strange men, exposed herself naked in the food stall and in the family's boarding house. She was singing, dancing and laughing without reason and she was aggressive or "running amok" *(mengamuk)*, breaking mirrors, smashing plates and glasses in the house and shouting insulting and vulgar words on the street. She felt threatened, imagining different people were going to shoot her. In the hospital (connected to the university) where her family took her in 1990 she was diagnosed as schizophrenic, residual type, and was treated with ECT and neuroleptic medication. Now (Feb. / March 1992) her behaviour seems to have stabilized.
In her interview, Mrs. Kaca, who is back home from hospital for four months, tries to convince the interviewers that her condition is "already good", that she has "already recovered". She has taken no more medicine for three months and tries to prove that she can handle her life: she fulfils her religious duties, offers help to those in her family and neighbourhood, she cares for her son and is independent in financial affairs. There seem to be no problems. She does not express any fears, hopes or other emotions.
The main symptom she connects with her illness is being *mumet* (Jav.) (Indon. *pusing*).[10] This has nearly been cured now, she claims, because of ECT, because she is eating no goat meat and because she is taking a nap at noon.
The neighbour, Bu Hadi, states that the neighbours care for Mrs. Kaca in the way of *mengemong*, a practice similar to caring for children with special regard for the present emotional state. They do so because everybody knows that she is not normal. They do not give her full responsibility and ignore her deviant and strange behaviour. For Mrs. Kaca s future she sees only a change if the "affairs of the heart" turn out positively. Otherwise she will have relapses and be able to work only on a limited basis.
Pak Abri, Mrs. Kaca s brother-in-law, is retired from the army and therefore has a respected local position. His wife is the cousin of Mrs. Kaca and the sister of her deceased husband. Pak Abri seems to be critical of Mrs. Kaca s behaviour, especially of her wasting of money and her "princess-like" behaviour. But at the same time she is accepted the way she is and there is *no demand to change* and no blaming for any failure or for not fulfilling developmental tasks. Deviant behavior, in Pak Abri s view, is an object of practical help and strict control by others. He thinks that biology and predisposition to mental (nerve) illness *(sakit saraf)* play a large part in Mrs. Kaca s problems. Approaching men is explained by a "second puberty". He rules out the possibility of Mrs. Kaca being possessed on the basis of the failure of different traditional healers *(dukuns)* who had been consulted. He thinks such "magic" models are applicable to other cases (e.g. his sister), but that this case is one of biological disturbance. For Pak Abri helping and controlling a family member who is in trouble goes without saying. This obligation to help and control is strictly regulated by family bonds. He accuses the family of origin of not fulfilling this obligation properly. In his view the most important criteria

for Mrs. Kaca s recovery are the fulfilment of social obligations (caring for the son).
If we look at the material as a whole, we find striking contradictions in the different perspectives of our informants. For example, we hear that there was a mismarriage (with her cousin) and that there was no mismarriage, that the marriage was based on love (Bu Hadi, Bu Barut) and that it was not (Pak Abri), that Mrs. Kaca is happy and that she is not. There is a coexistence of the expectation of a good and a bad prognosis, of adopting and not adopting magical concepts and of having and not having consulted *dukuns* (traditional healers). Mrs. Kaca and partly Bu Barut give a picture of well being and normality while the other informants see her as dependent and severely reduced in her capabilities. There are reports of proper and no proper caring by the family of origin and of Mrs. Kaca owning and not owning a boarding house for students. Our impression was that all those concerned "co-operated" in creating such *multiple realities*, which seemed to serve problem management. Nobody challenges the coexistence of these mostly contradictory realities one version of which represents the more official and socially acceptable view. They simply coexist; nobody insists that one version is "really" true even if they are present[11] when somebody states the contrary to what another interviewee has previously stated.
This may be related to the observation that we did not find any conflicts, which might have proved the moving force for demands for personal change. Nobody expected that Mrs. Kaca should change and nobody blamed her for not achieving or for being weak and dependent. The responsibilities of help and control did not at all entail the aim of changing inner states and we were astonished to find that help was not suspended as a punishment for failure and negatively valued social behaviour.
In the following diagram we see four overlapping concepts which form one strategy of dealing with mental illness on the background of a basic orientation:



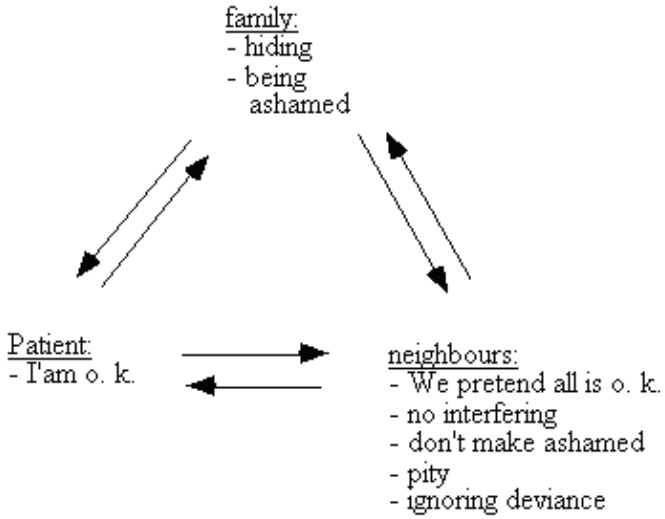
Dealing with mental illnes

As a background for the four overlapping concepts of dealing with mental illness, a basic orientation towards

taking on responsibility for help and control is represented in the diagram. In each case there was no question that this orientation was a matter of course. On the other hand, there were three cases in which we could study the limits of this orientation. The most extreme case was that of Kidul. In each of these cases the families had sold the land they lived from. In the case of Mr. Pakem, the chief of the neighbourhood reports that they hold several neighbourhood meetings because of the disturbing behaviour of Mr. Pakem over the last years. The patience of the neighbours had come to an end and their willingness to provide support as well because Mr. Pakem is demanding cigarettes or money from everybody he meets on the street, he is forcing people with words, he disturbs celebrations by his unrespectful and impertinent behaviour, his clothes don t look properly and he is taking away things from the small food stalls. Perhaps here the limit of the *mengemong* caring attitude is reached and if there are no more means to bring him to hospital he is at the threshold of being excluded and becoming a psychotic tramp.

a.) Multiple Realities Dealing with shame

We have seen in the example of the Kaca case that constructing multiple realities seems to be a way of coping with mental illness.
Constructing multiple realities means acting as if everything is normal while knowing that the reality is different. Through this way of acting a certain form of reality is practically constituted which is more favourable for the patient or his/her family. The aspects of reality regarded as negative are denied, hidden, or glossed over. People act towards the patient as if he/she is healthy and towards the family as if there is no disgrace in having this person as a family member. The mentally ill person acts as if he/she is normal or already recovered. These interactions are interrelated in the following way:



There is then, no blaming and no confrontation, only a harmonious reality. This form of reality seems to provide shelter and security. All participate in creating this multiple reality and all patients who are not completely confused try hard to convince everybody that they are healthy. Nobody contradicts these "as if" realities and we found a peaceful coexistence of different versions.
An important force in constituting multiple realities is the Javanese form of shame.
If we take the case example of Diam we see that the subject of shame in regard to the mentally ill son is a difficult one. The father does not talk about his own feeling of shame but about the avoidance of the feeling of shame in others. What makes the matter more complicated is that the Javanese concept of *Lingsem* and *Isin* is different from the Western concept of shame (s. Keeler, 1983; Geertz, C. 1973; Geertz, H., 1961;

Koentjaraningrat, 1985). Pak Duriman provides the following account of taking his son home from the mental hospital: Yesterday, when we went back from the north, I tried to find a way which avoided meeting many friends (relatives); we avoided meeting them till we arrived at home. [...] There were still some who did not know.

Another problem was represented by the mental hospital itself, which is a department of a big general hospital where some relatives of Pak Duriman are working:

I have many relatives who work there as medical aides. I ensured that they did not know in order not to make them *lingsem*. [...] I covered things up so that they didn t find out about my son. [...] If I went to the hospital I always hid myself and entered from the south entrance [...]. The other people around here got accustomed to it (while pointing to the surrounding area). It is important that they do not let other people know in order not to make the patient feel *isin*.

There seems to be a problem of protecting the relatives from feeling *lingsem* and his son from feeling *isin*. Of course, he himself will probably also want to avoid these feelings himself. According to Koentjaraningrat (1985, p. 248) *isin* refers to a feeling in which an individual ego considers himself extremely inferior towards another person because he, Ego, thinks that the other person despises him very much and thinks that he (Ego) is a very inferior and worthless person. In terms of behaviour and action Ego will constantly try to avoid the other person, and keep away from him. *Lingsem*, the krami version[12] of *isin* is more similar to the English meaning of shame.

Diam s father expects that Diam will feel despised, inferior and worthless and avoid contact with others if they know about his mental illness. On the other hand, he expects that his relatives who work in the hospital will feel *lingsem* because it is obvious that they have a family member as a patient in the psychiatric department.

There is a complicated web of feeling *isin* and different precautions to prevent the feeling of *isin* in different people, a factor that contributes to the construction of multiple realities.

b. "Mengemong" (Caring as for a child) instead of personal change

The concept of *mengemong* is closely related to the absence of any idea of change in the individual concerned. In the case of 23 years old Mrs. Muda we could study the advice given to the family at the initial onset of mental illness:

Al interviewees and even the Javanese interviewers agree to the necessity of a special way of caring which they call *mengemong*. This message is most explicitly given by Pak Dirjo (the uncle of Mrs. Muda s husband) and eagerly accepted by the husband: Yes, I often said such a child has to be handled with patience and treated in a gentle manner, not roughly. [...] Yes, I often warned them first her husband and then both her parents that they must be careful. Her father is able to be patient, cares *(mengemong)* for her, but her mother was rather [...] Once, when Mrs. Muda had been healthy again for some time, her mother spoke rather roughly, which made her daughter feel unpleasant, as if under pressure. She must be taken care of in a way such that she is not spoken too roughly. I have already told her father.

Both Pak Dirjo and the husband hold the view that a further relapse depends on the behaviour of the family members. The main principle is to avoid all emotional upset or disturbance in the "child"-patient; all family members should be patient and there should be no rough words, no disappointment and her husband should be attentive and caring, not asking too much of her in regard to housework. When her husband cannot take care of her the parents should do it. In fact, taken as a whole, the interviewees almost seem to be explaining the principles of relapse-prevention following the British Expressed Emotion[13] concept to the interviewers. The village nurse is convinced that the family must be calm and should not exert stress on Mrs. Muda: The whole family should accept her in the heart, be peaceful and I think she soon will recover. The neighbour advises Mrs. Muda: Yes, you should take a rest first, make your mind calm, don't think about anything. The uncle stresses especially the necessity of a change in the husband s behaviour and gives strict advice: If you love her more and more she will be much better and happier. If you used to go out to play volleyball in the afternoon, use this time now to stay at home and just be with her. Don't go anywhere!

One does not find, then, the idea that mentally ill people should be changed or cured by influencing their personality or inner states. As mentally ill patients are not seen as having failed in developmental tasks the burden of change is placed on other people. There is no idea of individual psychotherapy but rather a *static model of compensation*. As mentally ill people are believed to be not complete others must therefore compensate for this incompleteness through *mengemong*.

A popular Western idea of change and development is the concept of having to be confronted with reality and becoming an individual personality by passing through critical stages. In Java we find a different model of development[14] due to the fact that confrontation is avoided by creating multiple realities.

The main point in not expecting any change in the mentally ill person is that there is no idea of self-responsibility and no demand or expectation of self-directed control in relation to people regarded as not normal. Consequently we found no disparagement, no blame and no hostility directed towards the mentally ill.

The concept of *(me)ngemong* derives from regarding mental patients as similar to Javanese children before the age of 5 - 6 (s. Page 12). So a child as well as a mental patient cannot understand, is not civilized and has no shame and proper respect. As such a person cannot control emotions he should not confronted with demands. In the West we tend to regard children as responsible for their actions very early on in life: we blame them for misbehaviour, confront them with demands and explore their motives. All this is not included in the Javanese way of dealing with little children of mental patients. They should be handled in a relaxed, supportive, gentle and unemotional way. Through this usually gentle form of caring guidance a direct confrontation or application of force is avoided as far as possible.

However, where deemed necessary in the case of mentally ill persons, force will be used. We had seen in the case of Kidul how the control of aggressive behaviour could be very drastic. In the case of Kuat he was tied to a pillar in the yard of the house.

But it is important that the ultimate measures of physical control used as an answer to highly irritating acts of aggression be employed unemotionally without feelings of revenge or punishment in a situation deemed legatee (i.e. in the case of Ms Kidul, the chief of the village had to give his approval).

It would seem that caring and guidance are regarded as closely connected and do not exclude the strong paternalistic-authoritarian orientation we find in Javanese society (s. Kerstan & Berninghausen, 1991). It seems that this paternalistic-authoritarian aspect of the culture is pronounced in both controlling and caring aspects of the mengemong concept. This seems to fit the strictly hierarchical organization of Indonesian society in regard to politics, administration and family.

c.) Covert Devaluation

Covert devaluation is a form of devaluation, which does not entail any blaming of the victim. In most of the cases there was a form of unspoken rule to act towards the mentally ill person as if everything was in order, as if he or she was normal or had already recovered. As a general rule, then, there is a tendency to hide the reduction of social status and objective social value of a person regarded as not normal. This devaluation is not seen as disparagement but as a reduction of the rights and duties of the social role. Indeed, it can be argued that perhaps there is nothing behind this social role (e.g. the self-directing individual see: Geertz, C., 1974) which could be devalued in the "Western" way where the experience of devaluation seems to be connected to self esteem. We encountered some difficulties with this subject because we did not find an empirically based indigenous personality psychology in Java.[15] Mulder (1990) has collected some data which point to a different concept of *inner self (kebatinan)* in Java. It seems to be important that people do not confront the patient with their real opinion in regard to his or her inferiority. Based on the principle of multiple realities, people treat the patient in a *mengemong way* without talking about the reasons for doing this. Through *mengemong* any burden on the patient is avoided. On the other hand, this devaluates the patient indirectly by excluding him or her from any demanding activities.

Although covert devaluation and the resulting stigma obviously do exist and exert considerable influence on the lives of mentally ill people and their families. What is more difficult to show in the empirical material is

the absence of an openly disparaging aspect in the concept of "covert devaluation".
We developed the hypothesis that while devaluation clearly takes place, the fact that the mentally ill in Java are not openly confronted with this devaluation means that they do not develop the forms of *self-devaluation* found in the West. It would certainly be interesting to undertake more research on this topic. Perhaps the Western concept of self in which a self-directing and self-responsible ego is expected to develop creates a particular vulnerability to being blamed and consequently leads to self-blaming.
To get more data about the concept of covert devaluation we looked in particular for a case of *dipasung* (being tied in wooden stocks) and chose the case of Miss Kidul because we had the impression that in this particular case there was a strong likelihood of rather open devaluation and a clear attribution of blame given that the individual concerned had been subjected to such humiliating conditions. Even if we concede that our informants from the village tried to defend and excuse themselves and give a rather favourable picture of the shocking reality, they nevertheless confirmed the social rules, which we had come across in the other cases. There was no blaming of the patient and no open devaluation. The responsibility for help and control was a matter of course and it seemed to us that, despite external appearances, even this situation confirmed the special concept of caring, which was called *mengemong*.
The hiding of being submitted to an extreme and humiliating procedure could not function in this case and had to be legitimated: being subject to be tied in the stocks is a traditional and obvious consequence of being regarded as crazy. Kidul s mother described how her daughter argued with her while tied in the stocks: People think I am crazy. Well, I am just suffering from hypertension. No, you must be crazy (Jav.: edan; BI: gila). You chased your old uncle with a knife in your hand. And your uncle fell into a ditch. That means you are crazy. I told her. Here the mother uses her daughter s running amok as a proof for madness and consequently as a reason or argument for keeping her in the stocks whereas the daughter calls herself *bludrek*[16] suffering from hypertension thus normalizing her state and stating that she is not mad.
It was puzzling for us that, on the one hand, Kidul s parents tied up their daughter like an animal and, on the other hand both before and after this incident spent the last money they had in order to visit her regularly in the mental hospital. We learnt that extremely aggressive behaviour is answered with very drastic physical measures if there is no possibility to delegate control to a mental hospital or other such place. This is consistent with the position of Pak Abri in the case of Kaca: [...] we are cruel; if there was such a person, we caught her, tied her up and took her to the hospital, which meant no more problems. Controlling of aggression is not seen as punishment; it is just a measure, which necessarily has to be taken without the goal of disparaging the person.

VIII. Conclusion

The aim of this study was to find out the specific pattern of perceiving, explaining and dealing with mental illness in a local cultural context of Central Java. Our investigation took place in a society with strong traditional elements, which is being confronted with manifold modern influences and the expansion of Islam. All our cases showed signs of these forces of change.

Following a theory-discovering approach, we found a form of dealing with mental illness on a daily basis which is considerably different to that which could be generalized as the "Western" way of dealing with it. The behaviour of a mentally ill person is in many respects the contrary of what is regarded as normal conduct in Java. In this sense, being aggressive, without shame, being dirty and not properly dressed, not observing social rules, or retreating from social contact all these forms of behaviour are considered highly irritating and deviant in Java.
A person who behaves in this way is called "incomplete", not yet or no longer a Javanese. There is no question that such a person becomes the object of care and control activities by the family and the community. Rising standards of treatment have meant that long or repeated hospitalization is now often regarded as necessary. This is expensive and may include high transportation costs to visit the patient. These expenses can easily exhaust the basic resources of the family and can lead to impoverishment. The extent of support and

control measures mobilized in the family and the community is impressive. However, if local resources are exhausted and there is no possibility of hospital treatment, the mentally ill person may be imprisoned in the house of the family or excluded and end up living on the streets as a psychotic tramp.

Not being normal is explained by different coexisting concepts, the psychological one having become the most influential: the modern term "stress", however, denotes a specific traditional Javanese concept. The "stress" leading to mental illness is the same, which is believed to cause any illness in small children (Frustration, aggression, emotional upset etc.).

It follows that the concept of how to deal with small children seems to include the main ideas on how to deal with mentally ill people. We have discussed how the combination of caring and authoritarian guidance, which is combined in the concept of *mengemong*, does not imply any idea of changing the mentally ill person. Rather, the onus for change is placed on the behaviour of those in the surrounding environment, a concept similar to the idea of relapse prevention found in the Expressed Emotion Concept (s. Leff & Vaughn, 1985). Having a mentally ill member in the family is seen as a disgrace and a serious burden. The intense Javanese emotion of *isin* (specific form of shame) is connected to this fact and leads to a construction of *multiple realities* around this topic with the result that the family and the mentally ill person experience only a *covert devaluation*. We found that the combination of these four overlapping concepts characterizes the unspoken rules of dealing with mental illness in Central Java.

There is an impressive amount of help and control provided by the family and the community and we found social rules and common orientations, which can provide a favourable background for mental patients as long as they are tolerated in the family and community. The construction of multiple realities appeared to be a strategy of problem management, which could be less harmful to mentally ill persons and their families than being confronted with an "objective" reality. We found no blaming of the patient or understanding of his or her illness as a failure. As there is no concept of self-responsibility and self directed control for mental patients there is no expectation or demand of inner change. Devaluation in this context does not aim at the worth or esteem of an individual self. Devaluation is covert and seems to usually amount to no more then an indirectly arranged reduction in the mentally ill individual's rights and duties. When compared to the general Western understanding, we find in Java not only a different concept of identity but also a different form of "management of spoiled identity" (s. Goffmann, 1963). On the basis of the cases we studied, it would seem that the manner in which mentally ill persons in Central Java are dealt with has a rather low tendency to lead to self-devaluation and self-blame as long as they live in the community. Another mechanism which is suspected to contribute to chronicity is the fusion of self and illness (s. Estroff, 1981, 1990, 1991). We found no such adoption of a "mentally ill" role in our cases. Obviously those who experienced mental illness felt a high degree of pressure to "normalize" and to present themselves as normal or already recovered. The position of the psychotic tramp is not considered a social role at all it is rather regarded as a "non-existence" and, in this sense, is quite different from, for instance, the role of the street people in New York as described by Lovell (1992).

It is interesting to discuss the results of the schizophrenic syndrome profile found by Salan (1992 a, 1992 b) on the background of our findings. According to the study of Salan patients from Jakarta are more active; show more incoherent speech and self-neglect and much less depressive features than patients in London. In the interpretation of the data Salan points to the difference that most of the patients from Jakarta did not get medical treatment. Nevertheless the cultural pattern of dealing with mental illness may have a relation to the formation of symptoms. In the pattern of dealing with mental illness we found no condition for the preoccupation with self-blaming, guilt, self-devaluation in Indonesian patients. This is consistent with the lack of depressive features they show in the symptom profile.

We hope we have been able to provide a more specific and clearer picture of how the mentally ill are dealt with in an everyday context in a local South East Asian Culture. We would suggest that further research concentrate on what we have called "covert devaluation". We think that a more detailed analysis of the different mechanisms of devaluation could lead to a better understanding of chronicity especially in Western countries.

The data were collected before the crisis of the Asian Economy. In the last decade we saw a dramatic increase of social and mental health problems in the developing countries (s. Kleinmann et al, 1997; World Health

Organization, 2001; Mezzich et al. 2001). The gap between rich and poor people is increasing and especially in the growing mega cities (like Jakarta) the social resources which we described in our study are lost. We will go back to the participants of our study in 2003 to analyse the changes.

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Footnotes

1. Original: Hilfswissenschaft der Völkerpsychologie .
2. Indonesia: 200 mill. Inhabitants; Java/ Madura: 132 000 sq.km, 115 mill. inhabitants: 871 inhabitants per square km.
3. 3170 sqkm (as big as Rhode Island).
4. Mental Hospitals in Yogyakarta- province: RS Lali Jiva Pakem 225 beds, Sardjito (University) 35 beds; Private Hospital Puri Nirmala 50 beds. To compare: In *Berlin-West* we had 4310 beds in 1982 for 1,87 Mill. inhabitants (i.e. 1 bed to every 434 inhabitants meanwhile there are less beds).
5. *dibelok or dipasung* is officially forbidden by the government.
6. Sometimes it was difficult to determine the length of the illness. For example in the case of Kaca the length is 16 years if we take the onset of pregnancy psychosis as our starting point but only 4 years if we exclude these events.
7. His parents report that Kuat was standing naked on his motorbike while driving through the village.
8. s. Horne, E. C. (1974). Javanese-English dictionary. New Haven: Yale Univ. Press. "Bibit" refers to the biological worth and potential of a person and his family.
9. "Pak" means father and is the equivalent of "Mr" in Indonesian language.
10. This is a general indicator of distress in Indonesia which was often used by our informants. They point to their head and call themselves *mumet* (Jav.) or *pusing* (BI). The Javanese concept of *mumet* is something between experiencing a whirling sensation, feeling dizzy or having a headache.
11. It is rarely possible to get an interview with only one person in Java consequently one often gets changing constellations during one interview and different persons giving comments.
12. The Javanese language has different speech levels which depend on the status of the person being addressed. Krami is the highest speech level, which is used by Pak Durinam here.
13. EE = Expressed Emotion A measure of emotional response of the family to the patient which seems to correlate with relapse risk (s. Leef et. al. 1985, 1987, 1990)
14. We refer to the case of Kuat. There was an alternative model of change by the linear accumulation of inner power to balance the supernatural forces which enter the body.
15. If we take the Philippines in the neighbourhood there may have been different historical conditions which led to a rich discussion about an indigenous personality psychology (see for example: Church, 1987) but we think it is not useful to apply the Philippine constructs to Java.
16. Having hypertension is another popular reason to explain the feeling of pusing which is reported as a symptom of mental illness.

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