In and Out of Magelang Asylum

A Social History of Colonial Psychiatry in the Netherlands Indies, 1923-1942

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Contents

Map of Central Java published in 1937. *Atlas van Nederlandsch-Indië* (Groningen 1937).

Introduction · Magelang. Center of the Garden of Java

'Come to beautiful Magelang,' a 1936 propaganda pamphlet published by the city council of Magelang exclaimed to its readers enthusiastically. 'How many of us nowadays do not long for a Javanese mountain city, a place with a lovely climate, located in a beautiful environment, and with inexpensive standards of living?' The reasons for moving to the Center of the Garden of Java were numerous. The streets were clean, taxes were low, the schools were excellent, and the price of land was favorable. On top of that, Magelang housed a lively community counting 4,500 European souls — 60,000 if one included Indonesians and Chinese — supplied with every conceivable comfort a modern city could provide. Once a month a tattoo was performed by the local military band at the city's *aloon-aloon* (central square) and no less than two theaters screened the latest movies. Both spectacles could probably be attended with a cold beer and a cigar at hand, as the city harbored a number of ice and cigar factories. From a medical-hygienic point of view, too, Magelang had much to offer. Not only was the town center connected to surrounding kampongs by an elaborate system of drainage-canals that greatly reduced the chance of malaria infection or worse, citizens of Magelang also had several medical institutes at their disposal. Alongside a clinic for phthisis sufferers, a missionary hospital, and the native clinic "Boedi Rahajoe", Magelang's medical arsenal included a first rate military hospital and the reputable mental hospital Kramat. If the city council was to be taken at its word, Magelang was the place to be.[1]

Did any of this cross the mind of Mas Hardjosentono as he was transferred from his son's house in Temanggung to the mental hospital of Magelang? Judged by his background, the answer is possibly yes. At the time of admission, Hardjosetono, a Javanese man of aristocratic descent, had passed the age of 50 and entered retirement. For many years he had worked as a *mantri* (a "Native functionary") for a European finance company where he accrued a respectable pension. Yet,

[1] *Magelang. De Bergstad van Midden-Java. Middelpunt van den Tuin der Java. Een opwekking om kennis te komen maken met Magelang, er te komen wonen en er Uw bedrijf te vestigen* (Djokjakarta 1936).

according to his family, it was financial sorrows that had made him *bingung* (confused). As the father of seven children — six of whom were still minors — Hardjosetono had begun to worry when the pay out of his pension was delayed. As a consequence of this stress, he started to speak to himself and suffered from auditory hallucinations and persecutory delusions. After seven days, his children decided to bring him to the mental hospital near Magelang.[2]

Dimin, a man aged 36, was also hospitalized at Magelang, yet his story could not have been more different. On the first of August, 1940, he and four other people were evacuated from the city of Rembang, where he had been imprisoned for a period of six months. At his admission Dimin told the nursing staff that he had become confused after two weeks of high fever. Police subsequently tied his arms and legs and put him in jail, where he was separated from the other prisoners. 'Aggressive, agitated. Dangerous for others and family members,' an official statement by a physician from Rembang read.[3]

Mas Hardjosentono and Dimin were two of the approximately 7,500 patients who were hospitalized at Magelang Asylum between December 1923 and March 1942. Magelang was the fourth and final psychiatric hospital erected by the Dutch in the Netherlands Indies in the course of 40 years. In the wake of mental health care reforms in the Netherlands, the colonial government had ordered two physicians in 1866 to survey the state of mental health care in the Indonesian archipelago. Their findings, published in 1868, were devastating: Physicians Bauer and Smit heavily criticized the "unscientific" character of the "madhouses" spread across Java and recommended the establishment of two large mental hospitals built according to the latest psychiatric standards. Of course, a European psychiatric hospital had to be adjusted to the world of the Javanese, but the authors maintained that the underlying idea behind the modern asylum crossed cultural boundaries. 'Assisted by science and humanism,' Bauer and Smit expected 'the same benefits from an asylum on Java as from an asylum in Europe'.[4] Due to towering construction costs, it took another 14 years to finish the first mental hospital in the Netherlands Indies, but in 1882 the asylum near Buitenzorg (Bogor) opened up. Three large mental hospitals located near Lawang, Sabang, and finally Magelang would follow. In addition, a number of transit asylums (*doorgangshuizen*) and mental nursing homes were established. During the 1930s, these psychiatric

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[2] Patient record (P.) 4829.

[3] P. 6624.

[4] F.H. Bauer and W.M. Smit, *Verslag van het onderzoek naar den tegenwoordigen toestand van het krankzinnigenwezen in het algemeen en van gestichten en verblijven der krankzinnigen in Nederlandsch Indië in het bijzonder, met aanwijzingen der middelen welke tot verbetering kunnen worden aangewend* (Batavia 1868) 83.

institutions together could accommodate about 800 European and over 9,000 Indonesian and Chinese patients.

Amongst Southeast Asian imperialists, the Dutch colonial administration established the greatest number of asylum beds per capita and its system of mental health care was internationally acclaimed.[5] Care for both European and indigenous mentally ill in the Netherlands Indies was anything but a psychiatric backwater. In fact, colonial psychiatry was very much coextensive with developments in Europe. As in the Netherlands, psychiatric care was primarily centered around mental institutions.[6] Although parts of these hospitals were erected by means of bamboo and wood, in general, brick and concrete were the materials used. The fact that most of these constructions have remained to function as psychiatric wards until the present day might attest to their quality.[7] The building scheme for these hospitals was the so-called cottage system, with several pavilions for different kinds of patients.[8] New psychiatric treatments such as fever therapy in the 1910s, more intensive uses of working therapy in the 1920s, and convulsion therapy in the 1930s entered Netherlands Indies psychiatric culture almost immediately after their introduction in Europe. Attention was also devoted to patients' recreation, such as weekly visits to the local *pasar* (market), the screening of movies in the asylum's *pendopo*, and performances by musicians and puppeteers. Bearing this in mind, it should not come as a surprise that the running of mental hospitals accounted for about 10% of the annual budget of the colonial Public Health Service.[9] In an unpublished annual

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[5] Hans Pols, 'The Psychiatrist as Administrator. The Career of W.F. Theunissen in the Dutch East Indies', *Health & History* 14 (2012) 143-64, 145-6. A newspaper article published by *De Telegraaf* in 1937 contained a small international comparison. British India provided accommodation for less than 10,000 insane on a total population of 350 million. Mental hospitals in Indo-China, which was populated by 18 million people, could accommodate about 2,000 individuals with mental problems and the authorities on the Philippines had exactly one mental hospital at their disposal. See: 'Krankzinnigenverpleging in Ned.-Indië. Op ruimer schaal dan in andere koloniale rijken', *De Telegraaf* (November 26, 1937) 17.

[6] Hans Pols, 'The Development of Psychiatry in Indonesia. From Colonial to Modern Times', *International Review of Psychiatry* 18 (2006) 363-79, 363.

[7] The current *rumah sakit jiwa* (mental hospitals) situated near Lawang, Grogol, Magelang, and Bogor were all built during colonial times. If one views the pavilions of Lawang Psychiatric Hospital from the director's office, one can still discover a little Dutch royal crown on one of the rooftops.

[8]The first Dutch asylum built according to the so-called cottage system was the mental hospital near Buitenzorg and not, as is generally acclaimed, the orthodox Calvinist asylum Veldwijk that opened in 1886. See: Marijke Gijswijt-Hofstra, 'Within and Outside the Walls of the Asylum. Caring for the Dutch Mentally Ill, 1884-2000', in: Marijke Gijswijt-Hofstra *et al.* (eds.), *Psychiatric Cultures Compared. Psychiatry and Mental Health Care in the Twentieth Century* (Amsterdam 2005) 35-72, 64.

[9] Pols, 'The Psychiatrist as Administrator', 143.

report from 1916, the superintendent of the hospital near Lawang, P.H.M. Travaglino, remarked that, in comparison to mental hospitals in the Netherlands, his asylum was heaven on earth.[10]

This study sets out to explore the function of mental hospitals in the colonial society of the Netherlands Indies. Who were the individuals that entered asylums in the colony, what social processes led to hospital admission, and what were the mechanisms that related to hospital discharge?[11] In answering these questions, this thesis seeks to uncover the social and institutional embedment of psychiatric hospitals in the Netherlands Indies. The focus of my research will be on one asylum in particular: Kramat Mental Hospital near Magelang, Central Java. An additional question therefore concerns the similarities and differences between the four main asylums in the Netherlands Indies.

There was no 'great confinement' of individuals with mental problems in Europe and this applies to colonial societies all the more.[12] The capacity of mental hospitals in the Netherlands Indies was perhaps impressive if compared to other colonies, but grandeur soon turned into failure if one brought into account estimations of the total number of mentally ill individuals among the Netherlands Indies population. Hans Pols has therefore maintained that 'the prime significance of colonial psychiatry [in the Netherlands Indies] lay primarily in reinforcing colonial ideologies'. Psychological characterizations of the "native mind" rationalized unequal power relations inherent to colonialism. Some psychiatrists consciously applied these characterizations to the public sphere in order to justify repressive colonial policies.[13] The psychiatrist Travaglino is one example. In his

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[10] P.H.M. Travaglino, *Jaarverslag 1916. Krankzinnigengesticht te Lawang* (Unpublished) 22. A copy of this annual report is kept at the medical library of the Rumah Sakit Jiwa Dr. Radjiman Wediodiningrat at Lawang.

[11] Inspiration for these questions derives from: Joost Vijselaar, 'Out and In: The Family and the Asylum. Patterns of Admission and Discharge in Three Dutch Psychiatric Hospitals 1890-1950', in: Marijke Gijswijt-Hofstra *et al.* (eds.), *Psychiatric Cultures Compared. Psychiatry and Mental Health Care in the Twentieth Century* (Amsterdam 2005) 277-94.

[12] For critical readings of Foucault's notion of the great confinement of the insane, see e.g.: Arthur Still and Iriving Velody (eds.), *Rewriting the History of Madness. Studies in Foucault's 'Histoire de la folie'* (London & New York 1992); Roy Porter and David Wright (eds.), *The Confinement of the Insane. International Perspectives, 1800-1965* (Cambridge 2003). For studies into colonial psychiatry, see e.g.: Waltraub Ernst, *Colonialism and Transnational Psychiatry. The Development of an Indian Mental Hospital in British India, c. 1925-1940* (London 2013); Lynette A. Jackson, *Surfacing Up. Psychiatry and Social Order in Colonial Zimbabwe, 1908-1968* (Ithaca & London 2005); and Jonathan Sadowsky, *Imperial Bedlam. Institutions of Madness in Colonial Southwest Nigeria* (Berkeley 1999).

[13] Hans Pols, 'Psychological Knowledge in a Colonial Context. Theories on the Nature of the "Native Mind" in the Former Dutch East Indies', *History of Psychology* 10 (2007) 111-31 (see p. 112 for citation); Hans Pols, 'The Nature of the Native Mind. Contested Views of Dutch Colonial Psychiatrists in the former Dutch East Indies' in: Sloan Mahone and Megan Vaughan (eds.), *Psychiatry and Empire* (London 2007) 172-96.

publications, Travaglino argued that the Javanese psyche was essentially different from the European mind. According to the superintendent of Lawang, the Javanese were 'highly emotional' and 'closer to the primitive and therefore stood on an older evolutionary phase'. Travaglino insisted that colonial policy should be based on such psychological insights. He promoted his call for psychological colonial policy on several occasions and his views were quoted approvingly by reactionary politicians like Arnold van Gennep.[14]

Historians preoccupied with colonial psychiatry have discussed Netherlands Indies asylums in terms that show similarities to Pols' discussion of the colonial uses of psychology. Pols himself has conjectured that the unusual interest in psychiatric institutions in the Netherlands Indies reflected Dutch attempts to maintain peace and order. In consequence of the late nineteenth-century "pacification" of the Netherlands Indies, 'the indigenous population was expected to conform to legal and general social mores, while the police force and, with it, the prison system increased in size'. 'In the Dutch Indies,' Pols continues, 'main entry to the asylum for indigenous patients was indeed through the courts and the prisons'.[15] Nathan Porath likewise emphasizes that 'admittance to the hospitals was only by court order'.[16] Assertions like these suggest that colonial asylums were akin to prisons that aimed at the oppression of disruptive behavior. In this regard, David Kloos has been particularly outspoken. In a recent article on how the Dutch colonial state responded to the so-called *Atjeh-moorden* (Aceh murders), Kloos portrays the Sabang Asylum as a coercive tool of empire. By means of 'a set of repressive state instruments, which included [...] the asylum on Sabang,' the civilian government of Aceh worked towards the 'disciplining' of the people of Aceh.[17]

Associations between psychiatry, racism, and oppression have become commonplace to scholarship on psychiatry in colonial settings. Yet some historians have come to doubt the historical accuracy of these accounts. In one of her articles, Sally Swartz reflects on 'the colonial psychiatry-oppression link as a "reach-me-down" historical cliché,' a discursive formation about psychiatry and black insane that places 'narrative constrictions on ways of writing about this complex

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[14] For Pols' discussion of Travaglino, see: Pols, 'Psychological Knowledge in a Colonial Context', 121-2. The citations are by Travaglino.

[15] Pols, 'The Psychiatrist as Administrator', 146.

[16] Nathan Porath, 'The Naturalization of Psychiatry in Indonesia and its Interactions with Indigenous Therapeutics', *Bijdragen tot de taal-, land- en volkenkunde* 164 (2008) 500-28, 508.

[17] David Kloos, 'A Crazy State. Violence, Psychiatry, and Colonialism in Aceh, Indonesia, ca. 1910-1942', *Bijdragen tot de taal-, land- en volkenkunde* 170 (2014) 25-65, 29.

relationship'.[18] According to Swartz, the utilization of words like "confined", "repressive", and "deranged" 'summons the ghosts of well-worn arguments from asylum historians to feminists and the anti-psychiatry movement, all characterizing custodial care in mental institutions as political or inhumane, an attempt to discipline unruly bodies or rebellious souls'.[19] In contrast, Swartz urges historians to focus on the contradictions and narrative tensions in colonial psychiatry. To illustrate her point, Swartz discusses the life of Dr. Dodds, superintendent of the Valkenberg asylum in Cape Town and the colony's first Inspector of Asylums. On the one hand, Dodds worked assiduously to improve the living conditions of both colored and European insane. On the other hand, however, Dodds held discriminatory attitudes and was a fierce advocate of a hospital regime based on segregation and unequal treatment.[20] Similar tensions can be found in the writings of Netherlands Indies psychiatrist Travaglino. At times it is difficult to rhyme his pejorative attitudes towards the indigenous population of the Netherlands Indies with his endeavors to improve the position of insane both in and outside the walls of the colonial asylum.[21]

This study seeks to find the tensions in the position of asylums in Netherlands Indies society. Rather than a straightforward European instrument for social control, it argues that the asylum was used by different colonial agents of various ethnicities. Over the last three decades, asylum historians have moved beyond sweeping statements on psychiatric confinement towards a more nuanced understanding of mental hospitals. As Roy Porter maintained, the asylum was neither a site for care and cure, nor a convenient place for custodialism; '[i]t was many things all at once'.[22] Historiography highlights the negotiations between state, police, medical personnel, and family, and interprets the asylum's social position as the product of these negotiations.[23] The walls of the

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[18] Sally Swartz, 'Colonial Lunatic Asylum Archives. Challenges to Historiography', *Kronos* 34 (2008) 285-302, 285-6.

[19] *Ibid*., 289.

[20] *Ibid*., 294-6.

[21] Patrick Bek has made a comparable argument with regard to Netherlands Indies psychiatrist P.M. van Wulfften Palthe. See: Patrick Bek, 'Looking Beyong Positivist and Primitivist Assumptions. Professor Dr. P.M. van Wulfften Palthe's Approaches to Psychiatric Practices and Discourse in the Netherlands Indies between 1925 and 1949', M.A. Thesis, Leiden University, 2014. For a discussion of the tensions in the diagnostics tools used by Netherlands Indies psychiatrists, see: Sebastiaan Broere, 'How to Diagnose their Ills?', *Shells and Pebbles* (November 10, 2014) <http://www.shellsandpebbles.com/2014/11/10/how-to-diagnose-their-ills/>. Last visited on August 1, 2015.

[22] Roy Porter, 'Introduction', in: Roy Porter and David Wright (eds.), *The Confinement of the Insane. International Perspectives, 1800-1965* (Cambridge 2003) 1-19, 4.

[23] Striking example are: David Wright, *Mental Disability in Victorian England. The Earlswood Asylum, 1847-1901* (Oxford 2001); David Wright, 'Getting Out of the Asylum. Understanding the Confinement of the Insane in the Nineteenth Century', *Social History of Medicine* 10 (1997) 137-55. For an overview, see: Susan Lanzoni, 'The Asylum in Context. An Essay Review', *Journal of the History of Medicine and Allied Sciences* 60 (2005) 499-505.

asylum, in other words, have become porous and their construction contingent upon a variety of foundations. With regard to the history of asylums in Southeast Asia, this point has been made particularly clear by Claire Edington. In her analysis of mental hospitals in French Indochina, Edington focuses on the roles played by both experts and non-experts, Europeans and Vietnamese alike, in the daily practices that shaped these institutions. The resulting picture is one of dynamism. Despite the apparent power inequalities of the actors involved, ordinary families and communities made use of mental institutions for their own purposes, at times even opposing the choices made by medical professionals. Colonial psychiatrists, on the other hand, partly relied on the cooperation of families to obtain information about their patients. In Edington's reading, the asylum becomes 'a valuable historical site for reframing narratives of colonial repression and resistance'.[24] So far, Edington has been the only historian to take a social-historical approach to asylums in Southeast Asia.

According to Swartz, tensions in colonial psychiatry should be unearthed by reading along and against the archives of colonial asylums. In his pathbreaking 1985 article on writing medical history from below, Porter likewise maintained that Foucaultian generalizations of oppression should be countered by incorporating the patient's view.[25] Arguably, the characterizations of asylums in the Netherlands Indies by Pols, Porath, and Kloos are the products of research that left colonial asylum archives untouched. Instead of using patient records — which, to be sure, were not available to them —, their accounts are mainly based on official publications by psychiatrists who worked in the Netherlands East Indies. Yet psychiatrists may have had reasons to frame their narratives the way they did. Relating asylums to prisons could be understood as a strategy to generate extra government funding or to consolidate one's position. Both Travaglino and the famous Netherlands Indies psychiatrist P.M van Wulfften Palthe, for example, disapprovingly mentioned hospital admission by court order. If patients were admitted directly, the period between someone's first symptoms and his or her actual treatment could be shortened, which would increase the chances of recovery.[26] The accounts of Pols and Porath are based on these sources. Yet court order admission was for the benefit of the patients themselves, since it reduced, at least in theory, the chances of

[24] Claire Edington, 'Going in and Getting out of the Colonial Asylum. Families and Psychiatric Care in French Indochina', *Comparative Studies in Society and History* 55 (2013) 725-55, 728.

[25] Roy Porter, 'The patient's view. Doing medical history from below', *Theory and society* 14 (1985) 175-98.

[26] See: P.M. van Wulfften Palthe, 'Krankzinnigenverzorging in Ned.-Indië', *Koloniale Studiën* 17 (1933) 341-360; P.H.M. Travaglino, 'Krankzinnigenverzorging in Ned.-Indië', *Koloniale Studiën* 3 (1919) 57-75.

hospitalization on dubious grounds. In the Netherlands, court order was a standard procedure in the asylum admission of mentally ill individuals.[27]

This study seeks to complement colonial psychiatric historiography with a strong focus on the practical and social dimensions of colonial mental health care and by including voices of indigenous patients. Towards this end, 249 patient records were studied. The stories of Mas Hardjosentono and Dimin that were discussed above are based on two medical records kept at an old building of the Rumah Sakit Jiwa Prof. Dr. Soerojo, the post-colonial successor of the Kramat Asylum. In 2014, as research assistant of *Imagining Indonesian Psychiatry. Past, Present, Future* (Assoc. Prof. Hans Pols, University of Sydney, Prof. Byron Good and Prof. Mary-Jo Good, Harvard University), I conducted archival research at this psychiatric hospital. My findings were beyond expectation. Packed in dirty postbags were hundreds of records containing invaluable remnants of a past that was thought to have been lost forever. Out of these documents, I selected at least ten files from each year between 1923 and 1942, which was possible except for the years 1923, 1942, and the period 1930 to 1932. The Rumah Sakit Jiwa Prof. Dr. Soerojo has granted me permission to use these records for research purposes in case the patients themselves remain anonymous (see appendix 1). The names of patients mentioned in this study are therefore fictional.

The records obtained from Magelang Hospital allow to take a new perspective on colonial psychiatry in the Netherlands East Indies.[28] These documents varied considerably from one another. Whereas some contained hundreds of notes accumulated over the course of a decade or two, others were only a few pages thin. Some records included a patient's file from a transit asylum or a referral report issued by a local bureaucrat, others were completely silent on what happened prior to hospital admission. Patients' stories are often incomplete, fragmented, and brief. Yet, once combined, they provide an excellent point of departure for a social history on the functions performed by Magelang Asylum. They contain, first of all, "hard" demographic information such as sex, ethnicity, age, and place of residence. The records likewise detail patient's family situation and occupation, and sometimes even the content of delusions and hallucinations. Of course, as Megan Vaughan writes, hearing the authentic voices of the indigenous insane 'really does involve straining the ears,' but it is by no means impossible.[29] Apart from personal details, these medical records

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[27] Joost Vijselaar, *Het gesticht. Enkele reis of retour* (Amsterdam 2010) 125-8.

[28] Cf. Flurin Condrau, 'The Patient's View Meets the Clinical Gaze', *Social History of Medicine* 20 (2007) 525-40; John Harley Warner, 'The Uses of Patient Records by Historians. Patterns, Possibilities and Perplexities', *Health & History* 1 (1999) 101-11.

[29] Megan Vaughan, *Curing their Ills. Colonial Power and African Illness* (Cambridge & Oxford 1991), 102.

disclose information on the structure of mental health care and the asylum's institutional embedment. On the basis of bits and pieces of data, the social mechanisms surrounding hospital intake and release can be explored.

In analyzing these sources, I have employed a mixed methods approach. Their content was studied qualitatively, focusing both on the written content and the historical context in which these records were created. Due to the number of patient records, the patients could also be studied as a group using simple quantitative methods. A quantitative approach to medical records can be successfully used to investigate the character of psychiatric institutions and inmates in the past.[30] Following the example of Joost Vijselaar's social history on asylums in the Netherlands, this analysis has been performed by means of the research tool NVivo 10.[31] This software program was developed for social scientists to organize and analyze the content of their material by labeling passages and quotes. On the basis of these codes, source material can be interrogated and compared more easily, and it becomes possible to execute simple statistical calculations. Prior to analysis, all handwritten patients records were transliterated and, if necessary, translated from Malay to English. Against my expectations, large parts of the medical records were written in Malay, which attests, once again, to the cultural and social hybridity of these institutions.

In accordance with the findings of other historians, conducting research on patient records proved to be labor-intensive.[32] Doing research while at the same time mastering a new language did not make the task less time-consuming. Due to this, and to my regret, the following analysis will have a rather internalist character. It is, to a large extent, based on source material obtained from Magelang Mental Hospital. I have nevertheless endeavored to include secondary literature where it was befitting. It is hoped that this study will be one step further towards a more complete social history of the Netherlands Indies asylum.

In order to explore the social position of mental hospitals in the Netherlands East Indies, this study is divided into four chapters. The first chapter provides an introduction to the history of asylums in

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[30] Cf. Anne Digby, 'Quantitative and Qualitative Perspectives on the Asylum', in: Roy Porter and Andrew Wear (eds.), *Problems and Methods in the History of Medicine* (London, New York & Sydney, 1987) 153-74; David Wright, James Moran and Sean Gouglas, 'The Confinement of the Insane in Victorian Canada. The Hamilton and Toronto Asylums, *c.* 1861-1891', in: Roy Porter and David Wright (eds.), *The Confinement of the Insane. International Perspectives, 1800-1965* (Cambridge 2003) 100-28.

[31] Vijselaar, *Het gesticht*. *Enkele reis of retour* (Amsterdam 2010).

[32] *Ibid*., 25.

colonial Indonesia. By discussing the main psychiatric institutions erected by the Dutch and the legal regulations on care for the insane, it will provide a general framework for the remaining chapters. This chapter focuses, in particular, on the similarities and differences between mental institutions in the Netherlands Indies and aims to establish if, and if yes, how records from Magelang Asylum can serve as models for the experiences of patients hospitalized at other Netherlands Indies asylums.

After the first chapter, the scope of this study will shift from the macro to the micro in order to answer the three questions raised above: Who were the individuals that entered Magelang Asylum? What social processes led to hospital admission? And what were the social mechanisms that related to hospital discharge? The second chapter seeks to answer the first question by mapping the demography of Magelang Asylum. It will discuss the asylum population's distribution with respect to categories such as sex, ethnicity, and age, and it will be shown that the population of Magelang did not reflect the general demographic makeup of Central Java. This chapter's final section describes the inner worlds of psychiatric patients as they were written down in the medical files by hospital staff. The following chapter aims to set demographic details into motion. Chapter three answers the questions what social processes led to hospital admission and how these processes related to the demographic profile as described in chapter two. Central to this chapter is the distinction between insane who were maintained and insane who were neglected by their families, as someone's social position influenced why, when, and how a lunatic came into contact with the authorities. The final chapter explores the routes travelled by patients as they moved in and out of Magelang Asylum in order to analyze the asylum's institutional embedment. Throughout its history, Magelang cooperated with psychiatric institutions, hospitals, families, prisons, and agricultural colonies. Similar to a patient's admission to Magelang, it will be argued that a patient's social position influenced his or her way out of the asylum.

Before we proceed, three final remarks on language use. First, in this study I apply the phrase "Netherlands Indies" instead of the more common expression "Dutch East Indies". Netherlands Indies is an actors' category. About one hundred years ago, the Dutch used this particular phrase to refer to the geographic area that nowadays is called Indonesia. In historiography, it has come to denote the late colonial state.[33] Second, names of cities, districts, and regencies are provided in modern Indonesian spelling. Names of institutes and geographic entities

[33] See e.g.: Cornelis van Dijk, *The Netherlands Indies and the Great War, 1914-1918* (Leiden 2007); Frances Gouda, *Dutch Cultures Overseas. Colonial Practices in the Netherlands Indies, 1900-1942* (Amsterdam 1995); Robert Cribb, *The Late Colonial State in Indonesia. Political and Economic Foundations of the Netherlands Indies* (Leiden 1994).

that do not exist anymore are spelled in old Malay. A final remark pertains to the use of the word "Indonesians". Since the modern Indonesian state was founded in 1945 — or 1949, depending on which historical event one prefers to take as a start — it would be historically incorrect to refer to the indigenous population of the Netherlands East Indies as "Indonesians". Two reasons made me choose do so nevertheless, one practical and one historical. Patients from Magelang came from all directions of the Netherlands Indies and it would be cumbersome to write "people from Java, Sumatra, Celebes, and Madura" where a much shorter phrase would do. Besides this practicality, it should be pointed out that the expression "Indonesians" was already in use during the colonial era. Indies psychiatrist J.A. Latumeten, for example, spoke about Indonesians and Indonesia when he argued for the establishment of a psychiatric clinic on Java.[34] Because to these reasons, I consider the use of the term "Indonesians" to be legitimate.

[34] J.A. Latumeten, 'De beteekenis van het psychiatrisch-klinische onderwijs voor Indonesië', *Orgaan der Vereeniging van Indische Geneeskundigen* 16 (1928) 25-38.

Chapter 1 · **Asylums in the Netherlands East Indies**

Mental health care in the Netherlands East Indies was a late colonial enterprise. The 1860s witnessed the incentive to various reformations, but the actual number of asylum beds remained insignificantly small until the turn of the century. On January first, 1900, only 528 patients were hospitalized at the asylum near Buitenzorg: 191 Europeans and 337 Inlanders.[1] Yet, despite the fact that few ward beds materialized, the last four decades of the nineteenth century were important to the development of psychiatry in the Netherlands Indies. Over the course of 40 years, Netherlands Indies first mental hospital was erected, a mental health act came into force, and valuable lessons were learned. It was partly because of these first experiences that the number of hospital beds substantially increased between 1900 and 1942. By the end of the 1930s, the Netherlands Indies counted four major mental hospitals, six transit houses, six nursing homes, and several agricultural colonies, together maintaining over 10,000 psychiatric patients.[2]

Except for brief overviews by Hans Pols and Nathan Porath, no history on the development of mental health care in the Netherlands Indies has been written.[3] This chapter discusses the development of psychiatry in the former colony. In doing so, it has two objectives. A historical overview of the institutions involved with care of the mentally ill will provide a background for the next three chapters. This also applies to the discussion of the legal regulations on Netherlands Indies mental health care. It was, after all, within this framework that the actual practices of hospital

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[1] J.W. Hofmann, *Bericht über die Landesirrenanstalt in Buitenzorg (Java, Niederl.-Ostindien) von 1894 bis Anfang Juli 1901* (Batavia 1902) .

[2] 'Krankzinnigenverzorging', *Indisch verslag 1939. I. Tekst van het verslag van bestuur en staat van Nederlandsch-Indië over het jaar 1938* ('s Gravenhage 1939/1940) 398.

[3] Hans Pols, 'The Development of Psychiatry in Indonesia. From Colonial to Modern Times', *International Review of Psychiatry* 18 (2006) 363-79; Nathan Porath, 'The Naturalization of Psychiatry in Indonesia and its Interactions with Indigenous Therapeutics', *Bijdragen tot de taal-, land- en volkenkunde* 164 (2008) 500-28

admission and release took place. This chapter also seeks to establish similarities and differences between the asylums near Buitenzorg, Lawang, Magelang, and Sabang. What can patient records obtained from Magelang tell us about mental institutions in the Netherlands Indies in general?

§ 1.1 · The Development of Mental Health Care in the Netherlands Indies

The history of mental hospitals in the Netherlands Indies can be divided into two periods: a period from 1860 to 1900 and a period from 1900 to 1942. During the first, crucial steps towards mental health care for the insane in the colony were taken, yet the number of asylum beds remained rather small. This changed from about 1900 onwards. After the turn of the century, three more asylums, a number of transit houses and nursing homes, and several agricultural colonies were established. This section discusses the development of mental health care in the Netherlands East Indies.

§ 1.1.1 · 1860-1900

'Now that the motherland's financial problems have become troubles of the past, hundreds of millions of national debt are payed off, [and] the slaves are emancipated; [...] now it is our duty to provide our child the care it urgently needs, the child that has contributed so much to the motherland's prosperity'.[4] Conrad Theodor van Deventer chose these words by former Minister of Colonial Affairs Isaäc Dignus Fransen van de Putte (1822-1902) to conclude the latter's obituary. Van Deventer, whose renowned 1899 article "A Debt of Honor" heralded the ethical policy (*ethische politiek*), felt that he and Fransen van de Putte were kindred spirits. A liberal, Fransen van de Putte had been a prominent advocate of the abolishment of the cultivation system (*cultuurstelsel*). The cultivation system was introduced in 1830 to increase the profit made in the Dutch East Indies. Javanese peasants were required to devote a fifth of their land to government crops for export purposes. These regulations were opposed by Dutch liberals, because the cultivation system did not correspond to their conceptions of liberty, private ownership, and free market competition.[5] During Fransen van de Putte's first term of office (1863-1866), initial steps

[4] I.D. Fransen van de Putte, cited by C. Th. van Deventer in: 'I.D. Fransen van de Putte. Ter gedachtenis', *De Gids* 66 (1902) 128-37, 136.

[5] Henk te Velde, 'Van grondwet tot grondwet. Oefenen met parlement, partij en schaalvergroting, 1848-1917', in: Remieg Aerts *et al.*, *Land van kleine gebaren. Een politieke geschiedenis van Nederland, 1780-1990* (Nijmegen & Amsterdam 1999) 97-175, 116.

towards the dismantling of the cultivation system were taken. If it was up to Fransen van de Putte, the winds of change were about to blow through the colony.

Not only did Fransen van de Putte work hard towards the abolishment of the cultivation system. Colonial mental health care, too, was high on his list. When the Dutch parliament debated the financing of Buitenzorg in 1873, the minister remarked that the fate of both European and indigenous insane in the colony was a topic very dear to his heart.[6] Surveys conducted by Head of the Military Medical Service Geerlof Wassink in 1862 and physicians F.H. Bauer and W.M. Smit in 1866 had made painfully clear that care for the insane in the Netherlands Indies was far below an acceptable minimum level.[7] The moment a mentally ill Indonesian became unmanageable or dangerous, he or she was locked up by family members and villagers in a bamboo cage or a hole in the ground. Others were sent to prison. Psychiatric patients from Batavia could be hospitalized at the Chinese Hospital and those from Surabaya and Semarang at a local military hospital, but these institutions were more akin to detention centers. When the Dutch Inspectors of Asylums, C.J. Feith and G.E. Voorhelm Schneevoogt, read the Wassink report, they could only but conclude that mental health care in the Dutch Indies was unscientific and inhumane.[8] As Minister of Colonial Affairs, Fransen van de Putte committed himself to change the situation for the better. During his terms, a decree to establish two asylums was issued by the Dutch king (1865), Bauer and Smit were commissioned to conduct their extensive survey (1866), and the financing of the Buitenzorg asylum was approved by the Dutch Parliament (1873). Fransen van de Putte was eventually named a Honored Member by the Dutch Association for Psychiatry.[9]

In several aspects, the 1868 report by Bauer and Smit was programmatic to the future of mental health care in the Netherlands Indies. It first of all reminded its readers that the construction of two mental hospitals was degreed in 1865 and emphasized that the erection of these asylums was highly necessary. It also established the need for transit asylums (*hulpgestichten*) to accommodate individuals with mental problems before evacuation to a mental hospital was possible. A ward of a hospital, infirmary, or — if these were not available — prison could function as such. Next to

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[6] '24ste zitting - 25 october', *Bijblad van de Nederlandsche Staats-Courant* (1872-1873, II) 340.

[7] D. Schoute, *De geneeskunde in Nederlandsch-Indië gedurende de negentiende eeuw* (Batavia 1934) 307-17; F.H. Bauer and W.M. Smit, *Verslag van het onderzoek naar den tegenwoordigen toestand van het krankzinnigenwezen in het algemeen en van gestichten en verblijven der krankzinnigen in Nederlandsch Indië in het bijzonder, met aanwijzingen der middelen welke tot verbetering kunnen worden aangewend* (Batavia 1868); H. den Hertog, *De militair-geneeskundige verzorging in Atjeh, 1873-1904* (Amsterdam 1991) 61-3.

[8] Bauer and Smit, *Verslag van het onderzoek*, 46.

[9] For the association's membership register, see: *Psychiatrische bladen* 1 (1883).

transit asylums, Bauer and Smit discussed agricultural colonies for mentally ill. In preparation for their report, they paid visits to the colonies in Gheel in Belgium and Fitz-James in France. Although both physicians were impressed, especially by the colony for insane in Gheel, they did not comment on the feasibility to emulate these models on Java. Labor, however, was considered to be 'a true remedy'.[10] Finally, Bauer and Smit recommended that legal provisions on asylum care had to be drawn up. In cooperation with Netherlands Indies bureaucrats, these were eventually designed by Bauer after he had familiarized himself with Dutch insanity law.

The construction of the first asylum in the Netherlands Indies started in 1875. Its location, the city of Buitenzorg (Bogor), had been determined by Bauer and Smit. Because the building project ended up being much more expensive than initially expected, the colonial government decided to abort the program in 1882.[11] When Buitenzorg finally started to receive its first patients, only half of the original design was completed. About 400 beds — available to, above all, European patients — had been realized. Bauer became Buitenzorg's first superintendent.

Considering the small number of hospital beds, it is not surprising that during the last decades of the nineteenth century the shortage of beds for indigenous insane became a topic much discussed amongst psychiatrists. One of them was J.W. Hofmann. Hofmann arrived to the Netherlands Indies in 1881 and started his colonial career as assistant superintendent at Buitenzorg Mental Hospital. He became the asylum's superintendent in 1897 after he had worked at the transit asylums in Semarang and Surabaya. In 1894, he published an article in *De Indische Gids* that caused a stir in both Dutch and Netherlands Indies newspapers.[12] In this article, Hofmann asked a simple question: did Buitenzorg mark a highlight in the development of mental health care for the 'ordinary inlander'? His answer was a resounding "no". On the one hand, Buitenzorg's stone pavilions, furnished according to European standards, did not correspond to the indigenous concept of "home" and this was not beneficial to the recovery of an Indonesian insane. There was, however, another, much more urgent sense in which Buitenzorg did not provide mental health care for indigenous patients: it was much too expensive and much too small. At that time, only 335 beds were available to a population of 30 million indigenous souls.[13] A comparison to the situation in the Netherlands is illustrative. In the Netherlands in 1900, about 8,000 people were housed at officially

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[10] Bauer and Smit, *Verslag van het onderzoek*, 122.

[11] For an extensive discussion of the construction costs of Buitenzorg, see: C. Swaving, 'Het Centraal Krankzinnigengesticht te Buitenzorg', *De Indische Gids* 2 (1880) 337-79.

[12] J.W. Hofmann, 'Krankzinnigenverpleging in Neêrlandsch-Indië', *De Indische gids* 16 (1894) 981-1003.

[13] 'Vreeselijk, indien het waar is', *De Tijd. Godsdienstig-staatkundig dagblad* (June 27, 1894) 1-2, 2.

recognized asylums on a population of just over five million.[14] Other things being equal, this implies that the Netherlands Indies lacked some 48,000 hospital beds. 'I beg you to do something about the deplorable situation of our native insane,' Hoffman wrote, 'but do it in a cheap and practical way'.[15]

Before the turn of the century, Buitenzorg asylum provided a stage for psychiatrists to experiment with different solutions to this challenge. One of these was the establishment of an agricultural colony. The possibility to found one had been a searching criteria for the first asylum's location. Agricultural colonies had several advantages. Patients could live in a rural environment and be productive at the same time. According to Bauer and Smit, it was illusory to think that agricultural colonies were completely self-supportive, but the nursing costs could certainly be reduced. Shortly after the opening of Buitenzorg, an agricultural colony was set up near the asylum.[16]

Another experiment concerned the housing of indigenous patients. Instead of brick, new pavilions were made of bamboo and were occasionally erected by the patients themselves. Paraphrasing European ideas on the ideal asylum location, Hoffman wrote:

> [N]o brick buildings for the inlander, which will only cause stress and a beri-beri-death; no asylums within the setting of a bustling city; house him in accordance with his lifestyle and ethnicity [*landaard*], with his inclinations and his needs.
>
> Allow the Javanese a view of his blue mountains, settle him in a rural area, where nature soothes his soul [*gemoed*] and the morbid fantasies of his tormented mind are distracted, where his physical abilities are strengthened and the risks of infections and diseases are reduced.[17]

Point of discussion remained whether agitated and aggressive patients could be housed in these semi-permanent buildings. According to psychiatrist P.C.J. van Brero, this problem could be solved

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[14] Marijke Gijswijt-Hofstra, 'Within and Outside the Walls of the Asylum. Caring for the Dutch Mentally Ill, 1884-2000', in: Marijke Gijswijt-Hofstra *et al.* (eds.), *Psychiatric Cultures Compared. Psychiatry and Mental Health Care in the Twentieth Century* (Amsterdam 2005) 35-72, 37.

[15] Hofmann, 'Krankzinnigenverpleging in Neêrlandsch-Indië', 1003.

[16] L.B.E. Ledeboer, *Verslag omtrent het krankzinnigengesticht te Buitenzorg over het jaar 1892, benevens eene korte geschiedenis dier inrichting sedert hare oprichting* (Batavia 1894) 12.

[17] *Ibid*., 996.

by combining bamboo houses with permanent bed treatment, which had been introduced around 1890.[18] Under supervision of Hofmann, these ideas were successfully put to the test in 1899.

A final experiment involved family nursing for patients who, because of either minor mental ailments or a forensic past, felt between two stools. These patients were unable to return to their villages or to stay at the hospital. Again copying psychiatric practices from Europe, family housing was implemented in two variations. Sometimes discharged patients would stay at the family of a nursing staff member. In these cases, the accommodating family would receive money from the asylum. It also occurred that a patient's family moved to the asylum. The patients themselves were employed by the mental hospital as guards or servants. The costs of these experiments were covered by revenues from the agricultural colony near Buitenzorg Asylum.[19]

§ 1.1.2 · 1900-1942

Despite attempts to create more hospital accommodation for the insane, lack of space, especially for indigenous patients, remained an issue. The opening of the Sumber Porong asylum near Lawang in 1902 marked the first serious increase in hospital beds. The asylum was officially inaugurated with a so-called *sedekah-bumi* ceremony, a traditional Javanese ritual to celebrate the harvest.[20] The building process of Lawang started two years before, almost two decades after Buitenzorg had opened up. Some of the Buitenzorg experiments could therefore be included in Lawang's construction. The pavilions designed to house indigenous patients combined Javanese elements with typical western hospital characteristics. Bamboo walls, for example, were painted white on the inside.[21] The hospital was finished in 1904. Sumber Porong would become the largest mental hospital in the Netherlands Indies, treating over 8,000 patients during the 1930s.

With Buitenzorg and Sumber Porong situated on East and West Java, the Native hospital (*Inlandsche ziekeninrichting*) "Mangoendjajan" in Surakarta — in colloquial speech also referred to as Solo — functioned as a transit asylum. At Mangoendjajan, patients from Central Java could be

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[18] P.C.J. van Brero, 'De beteekenis der bedrust in de behandeling van krankzinnigen en die der waakzalen in den bouw van tropische gestichten', *Geneeskundig tijdschrift voor Nederlandsch-Indië* 37 (1897) 6-18.

[19] D.J. Hulshoff Pol, 'Verpleging van krankzinnige Inlanders in onze O.-I. bezittingen', *Psychiatrische en neurologische bladen* 9 (1905) 436-458.

[20] Lijkles, *Verslag omtrent het gouvernements krankzinnigengesticht te Lawang*, 16.

[21] P.J. Stigter, 'Krankzinnigenverzorging in Nederlandsch-Indië', *Geneeskundig tijdschrift voor Nederlandsch-Indië* 73 (1933) 1387-1395, 1389. Cf. P.C.J. van Brero, 'The Construction of Asylums in Tropical Countries', *Journal of Mental Science* 47 (1901) 499-503.

hospitalized in anticipation of evacuation to Buitenzorg or Sumber Porong.[22] From 1916 on, newspapers circulated in which the construction of a new mental institution near the city of Magelang was discussed.[23] The hospital near Magelang was planned as a transit asylum (*doorgangshuis*), but in 1919 the initial proposal was revised and a full-blown mental hospital was built instead. The stimulus to change the construction plans of Magelang came from a report written by C.F. Engelhard, who had just been appointed as superintendent of the new transit asylum in Surakarta. Engelhard had conducted a survey on the various locations in Central Java where Javanese insane were kept before they were evacuated to a mental hospital. He estimated that at least 340 individuals were waiting on hospital admission. In light of this survey, the colonial government concluded that the number of ward beds had to be increased permanently.[24] In Kramat, a little village near the city of Magelang, a new asylum would arise.

In December 1923, Magelang Mental Hospital started to receive patients. It encompassed 22 pavilions for disturbed patients and two wards for quiet patients, and had a total capacity of one thousand beds. Engelhard became Magelang's first superintendent. He had the responsibility for coordinating one government physician, two Indies government physicians, two head nurses, and 121 attendants.[25] Most patients arrived from Lawang, Solo, and the Grogol Transit House near Batavia. All these institutions were facing serious problems caused by overpopulation. In 1922, Sumber Porong, for example, reported to house 2,813 patients and added that '[w]ith this number of patients, the asylum is overloaded. Once the new asylum near Magelang is open, it must be reduced.'[26] Two years later, about three hundred patients were transferred from Lawang to Magelang.[27] Grogol dealt with similar problems. In December 1923, the Head of the Public Health Service (*Burgerlijken Geneeskundigen Dienst*, after 1925 the *Dienst der Volksgezondheid*)

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[22] 'Uittreksel uit het Verslag over den Burgerlijken Geneeskundigen Dienst van 1911 t/m 1918', *Mededeelingen van den Burgerlijken Geneeskundigen Dienst in Nederlandsch-Indië* 10 (Weltrevreden & Batavia 1921) 63.

[23] Cf. 'Krankzinnigengesticht te Magelang', *Bataviaasch Nieuwsblad* (January 1, 1916) 1; 'Een nieuw krankzinnigen-gesticht', *Het Nieuws van den Dag voor Nederlandsch-Indië* (December 27, 1916) 2.

[24] 'Jaarverslag van den Burgerlijken Geneeskundigen Dienst in Nederlandsch-Indië in 1919', in: *Mededeelingen van den Burgerlijken Geneeskundigen Dienst in Nederlandsch-Indië* 11 (Weltevreden & Batavia 1922) 53; 'De krankzinnigenverpleging', *De Sumatra Post* (March 22, 1919) 7.

[25] 'Jaarverslag van den Burgerlijken Geneeskundigen Dienst in Nederlandsch-Indië in 1924', in: *Mededeelingen van den Dienst der Volksgezondheid in Nederlandsch-Indië* 16 (Weltevreden & Batavia 1927) 253.

[26] 'Jaarverslag van den Burgerlijken Geneeskundigen Dienst in Nederlandsch-Indië in 1922', in: *Mededeelingen van den Burgerlijken Geneeskundigen Dienst in Nederlandsch-Indië* 11 (Weltevreden & Batavia 1924) 452.

[27] 'Jaarverslag van den Burgerlijken Geneeskundigen Dienst in Nederlandsch-Indië in 1924', 252.

circulated a note addressing all residents to send no more patients to Grogol.[28] Because of these circumstances, the asylum population of Magelang swelled from 33 at the close of 1923 to 762 exactly one year later.[29]

The year 1923 also witnessed the founding of another mental institute in the Netherlands Indies. Located on Sabang, an island to the north of Aceh, it was the only asylum that was erected outside of Java during colonial times. In a recent article, David Kloos has analyzed the origins of the Sabang Asylum with respect to the *Atjeh-moorden* (Aceh murders), suicide-attacks directed at the lives of Dutch citizens committed by the Acehnese population during the 1910s after the so-called "pacification" of Aceh.[30] After 1910, colonial discourse on the Aceh murders became charged with psychological concepts. Stressing the feeble-mindedness of the Acehnese provided an explanation for religiously-motivated acts of violence. The Governor of Aceh, A.G.H. van Sluys, maintained that 'if a murder is committed in Aceh, the perpetrator is always crazy'. 'The lunatics of Aceh,' he continued, 'are instruments, utilized, one could say, for the committing of such murders, and it is these instruments which need to be removed, or at least withdrawn from society'.[31] The origins of the Sabang Asylum, therefore, seem to have differed from those of the other asylums. If these hospitals differed in everyday practices as well cannot be determined. The psychiatrist F.H. van Loon wrote that Acehnese village chiefs responded enthusiastically when they heard about the plans for an asylum, because acts of violence were also often directed against the Acehnese people themselves.[32] This suggests that the Sabang Asylum was not merely a European instrument for control, but a space used by the indigenous population as well.

What was life in these asylums like? A 1934 documentary commissioned by the colonial Public Health Service provides a unique historical insight into the everyday practices of Netherlands Indies asylums, although one should keep in mind its propaganda purposes.[33] Entitled "Work Therapy for the Insane", it showed a variety of tasks carried out by patients from Magelang. These occupations covered a wide range of tasks, such as the cultivation of crops, the

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[28] 'Overvuld', *De Indische Courant* (December 5, 1923) 6.

[29] 'Jaarverslag van den Burgerlijken Geneeskundigen Dienst in Nederlandsch-Indië in 1924', 253.

[30] David Kloos, 'A Crazy State. Violence, Psychiatry, and Colonialism in Aceh, Indonesia, ca. 1910-1942', *Bijdragen tot de taal-, land- en volkenkunde* 170 (2014) 25-65.

[31] A.G.H. van Sluys, cited by: *Ibid*., 45.

[32] *Ibid*., 46-7.

[33] Cf. Andrew Goss, 'Decent Colonialism? Pure Science and Colonial Ideology in the Netherlands East Indies, 1910-1929', *Journal of Southeast Asian studies* 40 (2009) 187-214.

F I G U R E 1. One of the wards for Indonesian patients at the Sumber Porong Asylum near Lawang. Date and source unknown. (Archive Hans Pols.)

manufacturing and painting of batik style clothing, and even assistance in the asylum's administration. Patients who worked were rewarded with asylum money that they could spend at a local shop.[34] As in the Netherlands, work was a prominent feature of asylum life.[35] In other respects, too, the asylum's therapeutic regime had much in common with Dutch psychiatric culture.[36] Agitative or aggressive patients were sedated with drugs such as barbiturates and bromides or, alternatively, were "permanently" treated in bath or bed. During the 1930s, somatic psychiatric treatment made its way to the Netherlands Indies, although it is difficult to determine to what extent these new forms of therapy influenced care within the asylum walls.[37] Due to the favorable weather conditions, the possibilities of so-called "open air treatment" were also explored.

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[34] This documentary can be viewed on the Internet, see: <http://www.kirimkabar.com/site/2014/10/24/terapi-untuk-orang-yang-tidak-waras-1934/>. Last visited on 13-6-2015.

[35] Hans Pols, 'The Psychiatrist as Administrator. The Career of W.F. Theunissen in the Dutch East Indies', *Health & history* 14 (2012) 143-164.

[36] See e.g.: Geertje Boschma, *The Rise of Mental Health Nursing. A History of Psychiatric Care in Dutch Asylums, 1890-1920* (Amsterdam 2003); Joost Vijselaar, *Het gesticht. Enkele reis of retour* (2010) 151-235.

[37] For a discussion of the famous Netherlands Indies psychiatrist P.M. van Wulfften Palthe's uses of somatic treatment, see: Patrick Bek, 'Looking Beyong Positivist and Primitivist Assumptions. Professor Dr. P.M. van Wulfften Palthe's Approaches to Psychiatric Practices and Discourse in the Netherlands Indies between 1925 and 1949', M.A. Thesis, Leiden University, 2014, 58-64.

In patients' spare time, there was ample room for recreation. The asylums near Lawang and Magelang, for example, had a library with popular books and games were available on the wards. Lawang also owned a set of gamelan instruments and Magelang had a collection of shadow puppets.

Asylums in the Netherlands Indies were designed on the so-called cottage system. Different kinds of patients were separated from each other by means of pavilions in order to create a quiet and orderly asylum climate. Patients in the Netherlands Indies were categorized along the lines of sex, ethnicity, class, and manageability. Asylums distinguished between four classes which provide a striking example of unequal treatment of patients of different ethnicities within the walls of asylums. Indonesian and Chinese patients were normally treated fourth class, which was free to poor families and costed fl. 1.00 a day for those who could afford it. Indonesians could also be hospitalized at a higher class, but this needed to be discussed with the asylum's superintendent or, in case the patient under consideration was a former civil servant, the Director of Education and Public Worship (*Directeur van Onderwijs en Eeredienst*) and the indigenous Head of Local Affairs. Chinese patients could also be treated at a higher class, which possibly also needed to be discussed with an asylum's superintendent. As a rule, poor Europeans were hospitalized third class, which was free to them. Those who received a salary or had entered retirement paid fl. 2.00 a day. The daily fees for second and first class were fl. 4.00 and fl. 6.00. All these prices included residence, food, medical treatment and drugs, and nursing care.[38]

Due to the establishment of Lawang, Magelang, and Sabang, the total number of ward beds increased significantly during the first few decades of the twentieth century. Connected to the four mental hospitals were several transit asylum, nursing homes, and agricultural colonies. Apart from Mangoendjajan in Solo and Grogol in Batavia, four other transit asylum were established: Sompok in Semarang and Pegirian in Surabaya, both located on Java, Gloegoer in Medan (North Sumatra) and, finally, the transit house in Makassar on Sulawesi. The size of these institutions varied from 150 to 400 beds. In comparison, mental nursing homes (*verpleegtehuizen voor krankzinnigen*) were much smaller, on average accommodating about 40 persons. All these houses, established between 1925 and 1935, were located outside Java on the islands Bali, Sulawesi, Sumatra, Kalimantan, and

[38] *Handleiding ten dienste van de Inlandsche Bestuursambtenaren op Java en Madoera. No. 20/O.E. Het krankzinnigenwezen in Nederlandsch-Indië. Uitgave van het Departement van Binnenlandsch Bestuur* (Weltevreden 1919) 30-4.

Madura. Except for the number of patients who were hospitalized at these institutions, nothing about these nursing homes is known.[39]

The uses of agricultural colonies intensified during the economic downturn of the 1930s. In 1934, the Sultanate of Yogyakarta established an agricultural colony in Wonocatur and the Sunanate of Surakarta was developing plans to set up a similar facility in Wedi.[40] Both the Surakarta Sunanate and the Yogyakarta Sultanate were principalities that enjoyed a relative autonomy from the colonial state. One year after Wonocatur was founded, the agricultural colony Lenteng Agung was erected under the auspices of psychiatrist P.M. van Wulfften Palthe.[41] At the end of the 1930s, Lenteng Agung could accommodated some 400 patients. Several other agricultural colonies were established, such as the colonies near Ambarawa and Purwosari.[42] Some of these institutions were founded by Christian missionaries, such as the Colony for the Feeble Minded near Temanggung.[43] Agricultural colonies were available to patients who could be discharged from a mental hospital, but who had no place to go after they had left the asylum. In comparison to asylum care, maintenance at an agricultural colony was considerably cheaper for the colonial government. In chapter four, several of these institutions will be discussed in more detail.

On February 28, 1942, Java was invaded by the Japanese Empire and 12 days later a formal surrender was signed by the Allied forces. The Japanese invasion marked the end of Netherlands Indies mental health care. It is uncertain what happened with the mental hospitals between 1942 and 1945. With respect to Magelang Asylum, it seems that Dutch psychiatrist continued to work at Kramat until at least May 1942, but thereafter the hospital entered a new phase in its history. The Dutch language was officially banned and, as shall be discussed in chapter four, the mortality rate increased by 450%.

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[39] A detailed account of the number of ward beds in the Netherlands Indies can be found in the *Indische Verslagen*. These books were published by the Rijksuitgeverij Dienst van de Nederlandsche Staatscourant in The Hague between 1933 and 1939.

[40] 'Jaarverslag van den Dienst der Volksgezondheid over 1935', *Mededeelingen van den Dienst der Volksgezondheid in Nederlandsch-Indië* 25 (1936) 386.

[41] Cf. Bek, 'Looking Beyong Positivist and Primitivist Assumptions', 71-8.

[42] 'Het psychopaten-kamp te Ambarawa', *Soerabaiasch-Handelsblad* (November 14, 1937) 8. 'Landbouwkolonie voor rustige krankzinnigen', *Soerabaiasch-Handelsblad* (May 11, 1940) 14.

[43] 'Voor de Vereenining "Zwakzinnigenzorg"', *De Indische courant (*June 16, 1938) 13; 'Het Zwakzinnigengesticht te Temanggoeng. Het eenige in Nederlandsch-Indië', *Soerabaijasche Handelsblad* (September 17, 1939) 3.

§ 1.2 · Netherlands Indies Regulations on Asylum Care

In their 1868 report, Bauer and Smit recommended the colonial government to drawn up new regulations on asylum care. On Minister of Colonial Affairs Fransen van de Putte's request, Bauer and Smit familiarized themselves with Dutch insanity law. New legal provisions on mental health care were partially implemented in 1882. Another 15 years later, the first Netherlands Indies insanity law went into force.[44] The initial design of the 'Reglement op het krankzinnigenwezen in Nederlandsch-Indië' (Regulations on the care of the insane in the Netherlands Indies) was revised several times and provided a legal framework for mental health care in the Netherlands Indies during the first half of the twentieth century. This section discusses these regulations on the basis of a 1919 brochure issued by the colonial Department of the Interior (*Departement van Binnenlandsch Bestuur*).[45] The booklet was intended for Indonesian civil servants from Java and Madura. It was written in Malay and Dutch and only described regulations pertaining to care of so-called 'Native' and 'Foreign Asiatic' insane (see §1.3). Because Magelang Mental Hospital only maintained non-European patients, this brochure provides all the information further analysis requires.

The colonial government recognized four types of accommodation for indigenous patients: privately-owned asylums, family nursing, government-owned asylums, and temporal accommodations. Privately-owned asylums were considered to be institutions that housed more than three mentally ill individuals who were no member of the family that owned the asylum. Family nursing, on the other hand, involved the maintenance of up to three individuals who were no relatives of the care provider. Since institutionalization involved the deprivation of an individual's liberty and the restriction of his or her freedom to move, these types of accommodation required authorization by the Government General or a Head of Local Affairs. Local authorities also inspected whether care was adequately provided.[46] In case a care provider failed to guarantee a certain level of safety and quality, a care permit could be withdrawn immediately.

Three institutions were allowed to provide temporal accommodation: military hospitals, Native hospitals, and prisons. Military hospitals were primarily allocated to European patients, but could be used to hospitalize indigenous patients in case no other option was available. Likewise,

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[44] Staatsblad no. 54 in 1897.

[45] *Handleiding ten dienste van de Inlandsche Bestuursambtenaren op Java en Madoera. No. 20/O.E. Het krankzinnigenwezen in Nederlandsch-Indië. Uitgave van het Departement van Binnenlandsch Bestuur* (Weltevreden 1919).

[46] The first Netherlands Indies Inspector of Asylums was appointed in the 1920s. To date, nothing about this institution is known.

when no military hospital or Native hospital (*Inlandsche ziekeninrichtingen*) was at the authorities' disposal, patients could be transferred to a prison. The use of physical restraint was to be registered. Contact between the insane and other individuals institutionalized in a space designated as temporal accommodation was to be reduced to an absolute minimum. No mention of medical supervision was made.[47]

Authorization to hospitalize a Native or Foreign Asiatic insane was provided by a land court (*landraad*).[48] On Java and Madura, the *landraad* functioned as an ordinary court for civil and criminal cases. Legislation in the Netherlands Indies was pluralistic: various legal codes applied to people of different ethnical classifications and justice was administered accordingly by different institutions. A few exceptions aside, people who lived on Java and who were classified as a Native or Foreign Asiatic fell under Native government jurisdiction (*Inlandsche gouvernements-rechtspraak*). The *landraad* was one type of Native government court, district courts (*districtsgerechten*) and regent courts (*regentschapsgerechten*) being the two others. Normally, each regency had a *landraad* residing in its capital. In order to be legally effective, a *landraad* had to consist of a president (a juridicial civil servant), at least two members (normally Native local notables), a Native public persecutor, and a registrar.[49]

A request for hospitalization could be submitted by a mentally ill individual him- or herself, his or her family, or by a Native public persecutor. A public persecutor was obligated to do so, if he judged hospitalization to be in the interest of public security. Requests could be submitted orally or by letter to the president of a *landraad*. Ideally, a request included three components: a description of the future inmate's personal history, names of individuals who could provide further information, and a medical certificate. Personal details were summed up in a referral report or admission certificate (*Staat van Inlichtingen*) that accompanied a lunatic on his or her way to the asylum. During its next gathering, a *landraad* was supposed to discuss a request for hospitalization by reading the documents and talking to the witnesses. It was also possible to question the allegedly insane. If a request was approved, the *landraad* could authorize an individual's hospitalization for the maximum period of one year.[50]

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[47] *Handleiding ten dienste van de Inlandsche Bestuursambtenaren op Java en Madoera*, 4-8 (art. 1-7).

[48] *Ibid.*, 12 (art. 22).

[49] N.S. Efthymiou, *Recht en rechtspraak in Nederlands-Indië* (Nijmegen 2013) 110.

[50] *Handleiding ten dienste van de Inlandsche Bestuursambtenaren op Java en Madoera*, 12-6 (art. 22-26).

The 1919 brochure contained an example of how a referral report was to be structured. It was supposed to include three sets of questions. The first 15 questions concerned demographic details such as age, sex, ethnicity, address, occupation, and family and financial situation. A second set of questions related to someone's personal history. In this section, the reasons why hospitalization was requested were discussed. The form also inquired whether someone was likely to recover from his or mental afflictions, whether he or she was neglected by family members, and if there was a chance that someone would commit suicide. A third section involved someone's medical history: did someone suffer from "falling disease" or latah, what could account for his or her disease, and had he or she been mentally ill before? Apart from these questions, an admission certificate was supposed to discussed whether insanity ran in the family, if the person under consideration used opium or alcohol, and if he or she had already received medical treatment or examination.[51] The structure of these referral report was more or less a copy of the certificates used in the Netherlands.[52]

Two other trails could lead to hospitalization. In case of emergency, a *kepala* or *prabot*, two titles that refer to an indigenous head of local administration, could take someone into custody without prior consent by a *landraad*. Place of detention could be either an asylum or a temporal accommodation. The *kepala* was required to inform the president of the *landraad* within 24 hours or, if this was not possible, to send a letter as soon as possible (*met de eerste postgelegenheid*).[53] Another option was to hospitalize someone who was convicted or accused of crime. If evidence suggested that the person under consideration was mentally ill, the president of a criminal court could institutionalize that person in a mental hospital for a maximum observation period of six months. The attending psychiatrist could request a prolongation of another six months if he deemed extended treatment necessary.[54]

The 'Reglement op het krankzinnigenwezen in Nederlandsch-Indië' also established the legal provisions regarding probation and hospital discharge. Every patient was allowed to go on probation for a period of time if the attending psychiatrist gave permission. No further conditions were set. Discharge procedures were slightly more complicated, since a Native or Foreign Asiatic patient could be discharged for several reasons. Discharge was only possible after psychiatrist's approval. The central issue pertaining to hospital release was whether a patient might cause any

[51] *Ibid*., 53-4 ("Bijlage A").

[52] For a discussion of the referral reports used in the Netherlands, see: Vijselaar, *Het gesticht*, 131-8.

[53] *Handleiding ten dienste van de Inlandsche Bestuursambtenaren op Java en Madoera*, 14 (art. 24).

[54] *Ibid.*, 26-8 (art. 48).

accidents or could pose a threat to the public order (discharge, it was stated, was to be 'zonder gevaar voor stoornis van de openbare orde of voor ongelukken'). This stipulation was not mentioned in Dutch insanity law.[55] A patient was discharged, first of all, if he or she did not demonstrate any signs of insanity or if he or she had recovered sufficiently. A request for discharge could also be submitted by the Public Prosecution Service (Openbaar Ministerie) or the Head of the Public Health Service. If the Public Health Service was running short of beds, it could, in consultation with asylum psychiatrists, discharge patients who were considered to be incurable. Lastly, a request for discharge could be submitted by the person who had initially asked for hospitalization or by another family member. A psychiatrist could also discharge a patient in case the family did not pay hospitalization charges.[56]

§ 1.3 · Buitenzorg, Lawang, Sabang, and Magelang Compared

The previous sections discussed the development of care for the insane in the Netherlands Indies and the colony's mental health care regulations. This chapter concludes with a comparative analysis of the four main mental hospitals with respect to population size, ethnicity, and sex. To date, these are the figures available to compare these asylums. Transit asylums and mental nursing homes will not be considered, since the objectives of these institutions were different from the aims of mental hospitals. The basis for this analysis is provided by the *Indische Verslagen* (Reports on the Netherlands Indies) on the years 1931 to 1938, published annually by the Dutch government between 1933 and 1940. Because the Netherlands was occupied by Nazi Germany in May 1940, statistics on the period after 1938 are lacking. These voluminous books contain a brief section on mental health care that provides information on the asylum population. Unfortunately, this section can only focus on the 1930s, because statistics from the second half of the 1920s are missing. In the next chapter, official statistics will be used to check if the sample of patient records obtained from Magelang is representational for the asylum's entire patient population.

There are two ways to compare the size of Buitenzorg, Lawang, Sabang, and Magelang: by looking at the total number of ward beds and by looking at the total number of patients treated annually. As table 1.1 indicates, Lawang was the largest mental hospital (also see appendix 2). On average, throughout the 1930s, the Sumber Porong asylum could provide accommodation to 3,151 patients and treated 3,759 patients each year. These high numbers are partly explained by the fact

[55] This was pointed out to me by Prof. dr. Joost Vijselaar.

[56] *Handleiding ten dienste van de Inlandsche Bestuursambtenaren op Java en Madoera*, 18-22 (art. 34-5).

T A B L E 1.1. Average capacity, number of treated patients, efficiency, and admission and discharge rates of the four main asylums between 1931 and 1938. See appendix 2 for an exact overview of these figures.

	Lawang	Buitenzorg	Sabang	Magelang
Number of beds	3151	2000	1348	1371
Number of patients treated annually	3759	2240	1488	1744
Efficiency	1.19	1.12	1.11	1.27
Annual admission rate	19%	17%	15%	22%
Annual discharge rate	11%	9%	9%	15%

Note. In interpreting these figures, one might be surprised that admission figures continuously exceeded discharge rates. Discharge, however, was not the only way for a patient to leave the hospital. Some patients died, others run away. In general, hospital input and output were equal to one another (see appendix 2).

that Lawang expanded significantly during the 1910s. Under the directory of superintendent D.J. Hulshoff Pol, the secondary asylums (*annex-gestichten*) Soeko and Sempoeh were built in the hills close to the main asylum. Combined, these institutions could house over 1,000 patients.[57] Buitenzorg was the second largest mental hospital in the Netherlands Indies: its wards counted 2,000 beds on average. The average number of patients treated annually was slightly higher, namely 2,240. With regard to the number of ward beds, the hospitals in Sabang and Magelang were more or less equal in size. Magelang, however, treated significantly more patients each year. Whereas Sabang, on average, accommodated 1,488 inmates, the average annual number of patients hospitalized at Magelang was 1,744.

In comparison to Lawang, Magelang and Sabang may seem to have been rather small. Yet, compared to mental hospitals in the Netherlands, both institutions were huge. In 1936, the Netherlands counted 39 asylums which together maintained 25,600 patients; with a capacity of 1,300 beds, the Meerenberg asylum in Bloemendaal was the largest by far.[58] In the Netherlands Indies, asylums were much more centralized.

Next to the number of ward beds and patients, the four asylums can be compared in terms of what might be called efficiency, understood as the number of patients treated by means of one

[57] For more information on Soeko and Sempoeh, see: D.J. Hulshoff Pol, 'De organisatie van het krankzinnigenwezen in Nederlandsch-Indië', *Psychiatrische en neurologische bladen* 17 (1913) 94-123; D.J. Hulshoff Pol, 'De bouw van annex-gestichten te Lawang', *Psychiatrische en neurologische bladen* 21 (1917) 166-183.

[58] Gijstwijt-Hofstra, 'Within and outside the walls of the asylum', 44.

hospital bed during the course of one year. This can be determined by the ratio of the number of beds to the number of annually treated patients. In this respect, Magelang was leading. During the 1930s, a bed of Magelang Asylum was used to hospitalize 1.27 patients each year. At Buitenzorg and Sabang, the bed to patient ratio was much lower, namely 1 : 1.12 and 1 : 1.11. The efficiency of Lawang was somewhere between these extremes as one bed was used to accommodate 1.19 patients. These figures correspond to the admission and discharge rates of the four asylums. These rates were highest at Magelang and lowest at Sabang. As table 1.1 shows, at Magelang, 22% of the patients who were treated during the course of one year was admitted within that year and 15% of the annually treated patients was discharged. At Sabang, on the other hand, newly admitted patients accounted for 15% of a year's total number of treated patients. Only 9% was discharged.

In contrast to colonies such as the British Raj, asylums in the Netherlands Indies housed inmates of different ethnicities, including Europeans.[59] Under Dutch colonial rule, the population of the Indonesian archipelago was categorized along racial lines: European, Foreign Asiatic (*Vreemde Oosterling*), and Native (*Inlander*).[60] Table 1.2 represents the number of patient treated at the four asylums, specified according to their ethnicity (*landaard*). On the basis of this table, it can be calculated that Native inmates accounted for 81% of the total number of patients hospitalized at either one of the main hospitals. The number of Foreign Asiatic and Europeans was much smaller: 11% and 8%.[61] These figures can be contrasted with demographic statistics for Java and Madura as provided by the population census of 1930. In that year, the population of Java and Madura consisted of 98.4% Indonesians, 0.4% Europeans, and 1.2% Chinese and other "Foreign Asians".[62] Both Foreign Asiatic and European patients, in other words, were overrepresented among mental

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[59] Waltraub Ernst, *Mad Tales from the Raj. The European Insane in British India 1800-1858* (London & New York 1991); Waltraub Ernst, *Colonialism and Transnational Psychiatry. The Development of an Indian Mental Hospital in British India, c. 1925-1940* (London 2013).

[60] These classifications functioned as legal categories and were fundamental to the Netherlands Indies system of legal pluralism. For discussions, see: Bart Luttinkhuis, 'Beyond Race. Construction of "Europeanness" in Late-Colonial Legal Practice in the Dutch East Indies', *European Review of History. Revue europeenne d'histoire* 20 (2013) 539-558; Cees Fasseur, 'Corner Stone or Stumbling Block. Racial Classification and the Late Colonial State in Indonesia', in: Robert Cribb (ed.), *The Late Colonial State in Indonesia. Political and Economic Foundations of the Netherlands Indies, 1880-1942* (Leiden 1994) 31-56.

[61] One's legal classification, however, did not necessarily correspond to one's ethnicity. In both the *Reglementsregeling* of 1854 (art. 109) and the *Indische Staatsregeling* of 1925 (art. 163), it was provided that — citing the *Indische Staatsregeling* — '(5) De Gouverneur-Generaal is bevoegd om in overeenstemming met den Raad van Nederlandsch-Indië de bepalingen voor Europeanen toepasselijk te verklaren op personen, daaraan niet onderworpen'. See: Efthymiou, *Recht en rechtspraak in Nederlands-Indië*, 31-4.

[62] *Volkstelling 1930. Voorloopige uitkomsten. 1e gedeelte. Java en Madoera* (Batavia 1931) x.

T A B L E 1.2. Number of patients treated at the four main asylums between 1931 and 1938 specified according to *landaard*.

	Lawang		Buitenzorg		Sabang		Magelang		Total	
	no.	%	no.	%	no.	%	no.	%	no.	%
Native	6804	82	3039	67	2501	87	3932	89	16276	81
Foreign Asiatic	694	8	710	16	368	13	468	11	2240	11
European	790	10	763	17	12	0	22	0	1587	8
Total	8228		4512		2881		4422		20103	

hospital patients. With regard to the European population, this may not come as a surprise, but the relatively high number of Chinese patients deserves further analysis. I shall return to this point in the next chapter.

Table 1.2 shows that all Netherlands Indies asylums accommodated people of different ethnicities. Yet in what configuration was unique to each hospital. In general, patients of European descent were hospitalized at Buitenzorg or Lawang. The number of hospitalized European patients seems to have stayed remarkably constant throughout the 1920s and 1930s, shifting between a minimum of 601 patients in 1921 and a maximum of 679 patients in 1938. As an explanation, one could hypothesize that Buitenzorg and Lawang together provided sufficient beds for the European population of the Netherlands Indies. As we have seen, Dutch mental institutions housed 25,600 insane in 1936. By that time, the Netherlands counted 8.5 million people. If this ratio of insane to the total population is applied to the European population of the Netherlands Indies, asylums in the colony should have housed, other things being equal, 583 European patients.[63] In other words, in the Dutch colony, there seem to have been enough ward beds available to Europeans. Besides, European patients were occasionally repatriated and hospitalized in the Netherlands.[64] According to

[63] In 1930, the European population of the Netherlands Indies counted 193,618 people. See: *Ibid*.

[64] In 1921 seventeen patients of Buitenzorg were transported to Holland. 'Jaarverslag van den Burgerlijken Geneeskundigen Dienst in Nederlandsch-Indië over 1921', in: C.D. de Langen *et al.* (eds.), *Mededeelingen van den Burgerlijken Geneeskundigen Dienst in Nederlandsch-Indië. Waarin opgenomen: Mededeelingen van het Geneeskundig Laboratorium* (Batavia 1923) 367.

Adrian Vickers, poor whites and disabled were often sent back to Europe. 'Maintaining white status,' he states, 'meant that local people saw only what was an ideal white society'.[65] A comparable strategy was used by the British colonial state. According to Waltraud Ernst, repatriation was 'the ultimate means of making invisible those who failed to live up to contemporary standards of rational behavior and the noble image of the ruling class'.[66]

All asylums hospitalized Native and Foreign Asiatic patients (table 1.2). Compared to the other hospitals, the relative number of Native patients was considerably lower at Buitenzorg. Foreign Asiatic and European patients, on the other hand, accounted for a relatively large segment of Buitenzorg's asylum population. Native patients constituted between 82% and 89% of the total number of admissions at Sabang, Lawang, and Magelang. About 40% of all Native patients was hospitalized at Lawang and a quarter was accommodated by the hospital near Magelang. Foreign Asiatic patients, on the other hand, account for about one-tenth of the populations of Sabang, Lawang, and Magelang. Both Lawang and Buitenzorg housed about 30% of all Foreign Asiatic patients.

In contrast to the number of European patients, admission rates for both Foreign Asiatic and Native rose considerably during the final decades of colonial rule. Whereas 3049 Native patients were hospitalized in mental hospitals on December 31, 1921, no less than 6640 patients were institutionalized 17 years later. During the same period, the number of Foreign Asiatic patients rose from 395 to 877. These trends did not go unnoticed by the historical actors themselves and there was speculation on the causes. Physician J.H.F. Kohlbrugge, for example, maintained that the increase in Native patients reflected a diminishing fear of the asylum among the Javanese. Families had become more inclined to send insane beloved ones to a mental hospital.[67] Though this might indeed have been the case, it should be kept in mind that there was a continuous shortage of beds for Native insane in the Netherlands Indies. Ward beds were occupied the moment they became available. Hofmann's 1894 question whether Buitenzorg marked a highlight in the development of care for the Indies insane could therefore be repeated with respect to mental health care in the Netherlands Indies in general. Between 1931 and 1938, over 16,000 Indonesians were admitted to a

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[65] Adrian Vickers, *A History of Modern Indonesia* (Cambridge 2006) 19.

[66] Waltraud Ernst, 'Idioms of Madness and Colonial Boundaries. The Case of the European and "Native" Mentally Ill in Early Nineteenth-Century British India', *Comparative Studies in Society and History* 39 (1997) 153-81, 173.

[67] J.H.F. Kohlbrugge, *Blikken in het zielenleven van den Javaan en zijner overheerschers* (Leiden 1907) 51.

T A B L E 1.3. Patient populations of the four main asylums admitted between 1931 and 1938 specified according to *landaard* and sex.

Lawang Asylum

	Male		Female		Total
	no.	%	no.	%	no.
Native	4893	72	1911	28	6804
Foreign Asiatic	570	82	124	18	694
European	491	62	299	38	790
Total	5954	72	2334	28	8288

Buitenzorg Asylum

	Male		Female		Total
	no.	%	no.	%	no.
Native	1992	66%	1047	34%	3039
Foreign Asiatic	527	74%	183	26%	710
European	590	77%	173	23%	763
Total	3109	69%	1403	31%	4512

Sabang Asylum

	Male		Female		Total
	no.	%	no.	%	no.
Native	1825	73%	676	27%	2501
Foreign Asiatic	313	85%	55	15%	368
European	9	75%	3	25%	12
Total	2147	75%	734	25%	2881

Magelang Asylum

	Male		Female		Total
	no.	%	no.	%	no.
Native	2203	56%	1729	44%	3932
Foreign Asiatic	309	66%	159	34%	468
European	11	50%	11	50%	22
Total	2523	57%	1899	43%	4422

mental hospital, yet thousands and thousands of others were in desperate need of professional care.

A final point of comparison is sex (see table 1.3). Sex distribution in the asylum population in the Netherlands Indies conformed to the colonial pattern of a significantly high male to female ratio.[68] Overall, 68% of all asylum admissions between 1931 and 1938 involved male patients. Male to female ratios for the European and Native hospitalized were in accordance with this general figure. If we focus on Foreign Asiatic patients, the ratio between male to female admissions was slightly higher: 77% of the Foreign Asiatic asylum population was male. As with ethnicity, the distribution of males and females among inmates could differ considerably from asylum to asylum. In comparison to the other mental hospitals, Magelang had a relatively equal sex distribution as 43% of its admission concerned female patients. Here, the relative number of both Native and Foreign Asiatic females was relatively high, namely 44% and 34%. At Sabang, on the other hand, the male to female ratio was the highest: as much as 3 : 1. Interesting as it is, it will be difficult to account for these differences. Such an explanation does not only presuppose detailed demographic information on both the asylum population and the population in general, but also an accurate understanding of the structure of families, an area's political situation, gender differences, and the influence of religion, all specified along the lines of ethnicity. This should be reserved for future studies.

The previous analysis points out that no two asylums in the Netherlands Indies were alike. Whether it concerned size, ethnicity, or sex ratio, each hospital presented a rather unique composition of demographic factors. After Sabang, Magelang was the smallest Netherlands Indies mental hospital. Yet it was the most efficient. On average, each year 1744 patients were treated by means of 1488 beds. Magelang Mental Hospital had the highest admission and discharge rates. Most of its patients, 89%, were classified as Natives; the other 11% was constituted by Foreign Asiatic inmates. Altogether, 22 Europeans were accommodated at Magelang between 1931 and 1938. In this respect, Magelang differed most from Buitenzorg and Lawang, where European patients were hospitalized on a regular basis. Magelang differed from these institutions in yet another respect. Male to female ratios of admission were relatively equal at Magelang Mental Hospital. Females inmates accounted for 43% of the entire asylum population. In short, in comparison with other mental hospitals in the Netherlands Indies, Magelang presented the highest admission and discharge rates; it had the highest relative number of Native patients; and its male to

[68] Cf. David Wright, James E. Moran and Sean Gouglas, 'Hamilton and Toronto Asylums, Canada, 1861-1891', in: Roy Porter and David Wright (eds.), *The Confinement of the Insane. International Perspectives, 1800-1965* (Cambridge 2003) 100-27, 111-2;

female ratio was most equal. Unfortunately, it cannot be discovered whether there was a correlation between these factors.

§ 1.4 · Concluding Remarks

Magelang Asylum was part of a network of medical and psychiatric institutions. Although incentives towards mental health care reforms were given in the 1860s, most of these institutes were established between 1900 and 1942. The role of Minister of Colonial Affairs Fransen van de Putte during the 1860 and 1870 deserves further analysis. After the turn of the century, under the heading of "ethical policy", more politicians were willing to support initiatives to raise the living standards of the Indies population, which possibly also stimulated the further development of psychiatric institutions. Although most of these were established by the colonial government, others were erected by local associations and missionary organizations, sometimes with support from the principalities of Surakarta and Yogyakarta. Apparently, the colonial government was not the only actor interested in the erection of mental health facilities in the Netherlands East Indies.

Admission and discharge to mental institutions was regulated by the 'Reglement op het krankzinnigenwezen in Nederlandsch-Indië'. A request for hospitalization could be submitted by several people: a mentally ill individual him- or herself, his or her family, or an Indonesian public persecutor. In case of emergency, a *kepala* or *prabot* could take someone into custody. Convicts could be institutionalized as well. The Regulations also established legal provisions regarding probation and discharge. Discharge from a mental hospital was authorized by an attending psychiatrist. An inmate could only be released if discharge did not involve the risk of danger — a stipulation unmentioned in Dutch insanity law. A request for discharge could be submitted by a patient's family, the Public Prosecution Service or the Head of the Public Health Service. Regardless of what may have been the actual processes surrounding admission and discharge, these regulations indicate that there were several ways of getting in and out of a mental hospital. Hospitalization was not necessarily imposed by the authorities, but could be requested by the family of a mentally ill individual as well. This in itself raises the question in what sense psychiatric institutions in the Dutch colony were repressive *state* instruments as it seems that different actors were allowed to use asylums. Everyday practices, however, do not mirror legal stipulations. Chapter three and four will therefore analyze the practices of hospital intake and release.

Based on the previous analysis, it seems safe to state that no two asylums in the Netherlands Indies were alike: each mental hospital had a unique history, was located in a specific geographic

area, and presented a particular configuration of demography factors. It could therefore be concluded that — and perhaps this was to be expected — patient records obtained from Magelang Mental Hospital tell us something, first and foremost, about mental health care as it was provided in Central Java during the last decades of colonial rule. Interesting, however, is the remark by psychiatrist Van Loon that historian David Kloos incorporated in his article on the Sabang Asylum. In Kloos' analysis, the Sabang Asylum is an repressive tool of empire. Yet, according to Van Loon, Acehnese village chiefs responded enthusiastically when they learned that a mental hospital was to be built on Sabang. Dangerously confused individuals, it seems, were not only a problem for the colonial government. Aggressive insane could attack anyone. And as it is likely that the distance between Indonesian insane and the Indonesian population was smaller than the distance between indigenous insane and the European population, it could be conjectured that aggressive Indonesian lunatics were, above all, a danger to Indonesians themselves. Of course, the Indonesian population had their own ways of dealing with these issues. Violent lunatics were confined by means of bamboo houses, chains, and wooden blocks. But village chiefs in Aceh were nevertheless pleased to hear that they would have a new option at their disposal in the near future. Is it then historically accurate to characterize the colonial asylum as an oppressive tool of empire? Or was it, in practice at least, the solution to a problem shared by many inhabitants of the Netherlands Indies? To answer these questions — in particular with respect to Central Java — let us first turn to the people who ended up as patients of Magelang Asylum.

Chapter 2 · Patients and their Afflictions

Between December 1923 and May 1942, Magelang Asylum hospitalized some 7450 patients. This chapter seeks to portray the patients of Magelang under Dutch colonial rule. Part of their demographic profile was already discussed in the previous chapter. At Magelang, nine out of ten patients were classified as Native and 44% of the asylum population was female. In the next pages, the demographic profile of patients from Magelang will be further developed. In doing so, this chapter will follow the structure of the medical records and focus on age, place of residence, and occupation. Apparently, these factors were of importance to the asylum administration. An examination of these categories may hint why certain groups of people entered Magelang. Yet many other factors that may have worked towards hospitalization of the insane — e.g., gender differences, the structure of Chinese and Indonesian families, the attitude of Chinese and Indonesian communities towards western medicine — remain unexplored. Above all, this chapter describes pieces of a puzzle that needs to be completed by further research.

Inmates of Magelang, however, were more than simply percentages and numbers. They were human beings with emotions and ideas. In this chapter's final section, I therefore examine the symptoms of mental disease as experienced by the patients themselves and recorded in their medical files.

§ 2.1 · The Demography of Magelang Asylum

Who were the patients that entered Magelang Asylum? In answering this question, this section seeks to compare the composition of the asylum population and the demography of Central Java.[1]

[1] For a similar approach, see: David Wright, James Moran and Sean Gouglas, 'The Confinement of the Insane in Victorian Canada. The Hamilton and Toronto Asylums, *c.* 1861-1891', in: Roy Porter and David Wright (eds.), *The Confinement of the Insane. International Perspectives, 1800-1965* (Cambridge 2003) 100-28.

On the basis of this analysis, the specific character of the patients of Kramat will be highlighted and two hypotheses on the causes of hospitalization will be formulated. Central to these hypotheses is a question of agency. Was Magelang Asylum an instrument used by the colonial authorities to maintain peace and order or was the asylum an institute accepted and utilized by actors of various ethnicities, possibly for various purposes? In the following chapter, we will return to this question by examining the actual social processes that led to hospital admission.

Figures on the population of Java will be obtained from the *Census of 1930 in Netherlands India*.[2] Published in eight volumes, the 1930 census provides ample information on the population's age, occupation, ethnic composition, and civil status. These figures are by no means foolproof — according to the editors, it had been particularly difficult to collect reliable data in cities — but the 1930 census is the only source available to study Java's demography during this period. Information on the asylum population is mainly derived from patients' referral reports and has been supplemented with data from patient interviews conducted by hospital staff. Referral reports were often included in patients' medical records. These referral reports, too, are not unproblematic. They were filled out by different actors — village headmen assisted by family members, physicians, psychiatrists from Magelang, police — and, accordingly, their content may be more or less reliable and complete. Yet, again, these records are the only sources that provide insights into the composition of Magelang's asylum population. A historian can only but roll with the tide.

§ 2.1.1 ▪ Sex, Age, and Ethnicity

Table 2.1 represents the population of Magelang Mental Hospital specified along the lines of sex and ethnicity. As discussed in the previous chapter, between 1931 and 1938, Native patients made up 89% of the entire population. Since the number of European patients was negligible, it is safe to state that the remaining 11% consisted of patients classified as Foreign Asiatic. These official figures and the sex and ethnicity distribution as found in the collected patient records show a considerable degree of conformity. In both samples, Foreign Asiatic males accounted for 7% of the population; the relative number of Foreign Asiatic female patients was a bit higher among the patient records. With regard to patients classified as Native, it seems that men were slightly overrepresented in the sample taken from the records kept at Magelang. Whereas official figures

[2] In particular, I use: *Volkstelling 1930. Deel II. Inheemsche bevolking van Midden-Java en de Vorstenlanden* (Batavia 1934) and *Volkstelling 1930. Deel VII. Chineezen en andere Vreemde Oosterlingen in Nederlandsch-Indië* (Batavia 1935). The official English titel of these volumes is *Census of 1930 in Netherlands India*.

T A B L E 2.1. Population of Magelang Asylum specified along the lines of sex and ethnicity as officially reported and as found in the patients records obtained from Magelang Asylum.

	Native Male		Native Female		Foreign Asiatic Male		Foreign Asiatic Female		Total
	no.	%	no.	%	no.	%	no.	%	no.
Officially reported	2203	50	1729	39	309	7	159	4	4400
Patient records	140	56	78	31	17	7	13	6	248
Patient records (1931-1938)	76	55	46	33	11	8	6	4	139

from the 1930s indicate that Native males comprised 50% of the asylum population, 56% of the collection of medical records belonged to Indonesian males. Natives females, on the other hand, were somewhat underrepresented among the records obtained from Magelang. As table 2.1 shows, if pre-1931 and post-1938 medical records are removed from the sample, female patient admissions remain underrepresented. The 249 patient records obtained from Magelang therefore seem to provide a fairly accurate representation of the sex and ethnic distribution of the total population of the Magelang Asylum.

With one exception, all patients classified as Foreign Asiatic were of Chinese descent. The anomaly was a 35-year-old Arabic woman from a little village near Semarang. Her case will be left aside in the following discussion. Instead of Foreign Asiatic patients, the more accurate term "Chinese" shall be used. Native patients shall be called "Indonesians".

How old were the patients of Magelang? In referral reports, age was seldom precisely determined. Most of the reports simply stated 'About 40 years old' or '± 40 years' and this was copied into the medical records.[3] Official registration of newborns was still an unusual practice for Indonesian families and local bureaucrats. Bearing this in mind, it is estimated on the basis of 243 patient records — five records did not mentioned someone's age — that the average age of a patient

[3] See for example referral reports of patients 2954, 4212 and 6042: '4. Oemoer: kira-kira oemoer 45 tahoen,' '4. Oemoer: ± 40 tahoen' and 'Oud naar gissing 23 jaar'.

T A B L E 2.2. Age distribution among the patient population of Magelang Asylum specified along ethnicity and sex.

	Indonesian male		Indonesian female		Chinese male		Chinese female		Total	
	no.	%	no.	%	no.	%	no.	%	no.	%
< 20	8	6	6	8	1	6	1	8	16	7
20-9	47	34	30	39	9	53	3	25	89	37
30-9	49	36	25	32	4	24	5	42	83	34
40-9	22	16	11	14	2	12	1	8	36	15
50-9	8	6	4	5	0	0	2	17	14	6
60-9	3	2	1	1	1	6	0	0	5	2
Total	137		77		17		12		243	
Average	32.5		30.2		30.8		33.6		31.7	
Median	30		30		26		30		30	
IQ range	25 - 38		21.5 - 35.5		23.5 - 37.5		26.5 - 39.5		25 - 38	
n/a	3		1		0		1		5	

at the time of admission was 31 years and 8 months (see table 2.2). This number remained consistent throughout the 1920s and 1930s. Nine patients were younger than 18 — the youngest a 10-year-old Javanese boy diagnosed with “imbecillitas” — and only five patients were older than 60 — the oldest a Javanese woman estimated to have reached the age of 65.

How did sex and ethnicity relate to age? Indonesian women were, on average, about two years younger than Indonesian men and three-and-one-half years younger than Chinese women. Although the median for both Indonesian men and women fell on the age of 30, the inter-quartile range (the middle 50% of a group of patients) of women’s age was about three-and-a-half years lower than the inter-quartile range of men’s age. In short, Indonesian female patients were slightly younger than Indonesian male patients. Chinese men, on the contrary, were about three years younger than Chinese women. For these groups, the median fell on the age of respectively 26 and 30, and the inter-quartile range was about three years lower. Be that as it may, while interpreting

these figures, one should be reminded that the actual number of Chinese patient records is too low to have any real authority. The evidence momentarily suggests some sex and ethnical differences in the age of patient at the time of admission.

The age structure of the Chinese asylum population can be compared to demographic data on the Chinese population of Java. This is not possible for Indonesian patients. The editors of the *Census of 1930* did not publish age figures of the Indonesian population as it had proven to be too unreliable. Not unlike the officials who wrote down a future inmate's age into the referral report, census rapporteurs usually estimated someone's age. Therefore, the *Census* only distinguished between Indonesian "babies", "other non-adults", and "adults".[4] Although the census of the Chinese population had met with similar difficulties, figures on the age distribution among the Chinese were published.[5] On the basis of these, it can be assessed that Chinese patients who were in their twenties and thirties were overrepresented among the Chinese inmates of Magelang. If one focuses on the Chinese residents of Java and Madura who had passed the age of 14, about 52% was between 20 and 39 years old.[6] Within the walls of Magelang Mental Hospital, this percentage was much higher, namely 72%. People older than 40, on the other hand, were underrepresented in the population of Magelang Mental Hospital (see appendix 3). The tenability of these figures should be tested when additional patient records from Magelang Asylum have been archived and analyzed.

In short, 71% of all patients were aged between 20 to 40 at the time of admission. Apparently, people within this age category were more likely to be admitted to Magelang Asylum. As shall be discussed in the following chapter, what could partially account for this, is that it might have been more difficult to cope with the behavior of mentally ill individuals within this age group. Younger and older people had less physical strength and were therefore possibly easier to maintain at home. This does not explain the sex and ethnical differences in the age of patients. In particular, the age of Chinese women stands out. According to C.F. Engelhard, to whom we shall return shortly, Chinese families were less inclined to bring female beloved ones to hospitals.[7] This may

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[4] *Volkstelling 1930. Deel II*, 33-5.

[5] *Volkstelling 1930. Deel VII*, 60-1.

[6] Children between 0 and 14 accounted for a large part of the Chinese population, yet children rarely entered Magelang. In comparing the ages of Chinese in- and outside the asylum, it is reasonable to leave children between 0 and 14 out of the calculations. Without this group of youngsters, Java and Madura together counted 317,549 Chinese people. The number of people who were between 20 and 29 was 93,576 (29.5%) and the number of people between 30 and 39 was 75,534 (23.8%). See: *Volkstelling 1930. Deel VII*, 60. Also see appendix 3 for a relative comparison between the Chinese patients of Magelang and the Chinese population of Java and Madura.

[7] C.F. Engelhard, 'Psychiatrische cijfers uit Java', *Psychiatrische en neurologische bladen* 29 (1925) 326-44, 336.

explain why the number of Chinese female patients was relatively low and why Chinese female patients, on average, were older. Due to a reluctance among the Chinese to institutionalize female family members, mentally ill women stayed at home for a longer period of time and were taken to a hospital only when the situation had become unbearable. At this moment, however, all this is but a matter a speculation.

Only 7% of the asylum population was younger than 20. This suggests that, as in the Netherlands, the mental hospital was no place for troubled youth or children with behavioral disorders. If the situation at home became untenable, children were probably first sent to other institutions, such as state reformatories. Extrapolating from the previous paragraph, it could be hypothesized that people who had passed the age of 40 were underrepresented in the asylum's population. This is not to say, of course, that mental disease was relatively rare among the elderly population of Java, only that elderly people were less likely to be admitted to a mental hospital. Once again, this might be explained by the fact that it was easier to deal with mentally ill who were older than 40.

§ 2.1.2 · Ethnicity and Geographic Distribution

Although many personal details are lacking from the medical records, recording someone's ethnicity was a procedure that apparently did not cause much trouble. With a few minor exceptions, each medical record specified a patient's ethnic descent. Between 1923 and 1935, nursing staff used the category *landaard* to write down someone's ethnicity, after 1935 it was turned into *ras* (race), and by the middle of 1938, it was changed back into *landaard*. As discussed in the previous section, the Native patients to Foreign Asiatic patients ratio in the medical records roughly conformed to the ratio officially reported by the Public Health Service. No files from European patients were collected. Because nursing staff recorded a patient's ethnicity and not his or her legal classification, the patient records allow to delineate the ethnic make-up of the asylum population more precisely. Most Indonesian patients were Javanese, namely 80%. Chinese inmates constituted the second largest group: 12%. Apart for the Arabic woman mentioned above, the remaining medical records belonged to non-Javanese Indonesians. Among them were two Sundanese, two Madurese, and two Batak. Five patient files simply read "Inlander".

At least as interesting as the asylum's ethnic make-up is the question where patients resided before hospitalization. The late colonial period is characterized by increased migration. Many Javanese moved to Sumatra and Borneo to work as *koelies* in the mining industry or on agricultural

estates.[8] Apart from that, a number of transit asylums and nursing homes was established on and outside Java, which suggests that patients might have come from afar. Kramat Asylum, however, seems to have been a regional hospital. The patient records obtained from Magelang indicate that most patients arrived from the principalities Yogyakarta and Surakarta and from the residences located in the province (*gewest*) of Central Java: Kedoe, Semarang, Banjoemas, Djapara-Rembang, and Pekalongan (see p. 5 for a 1937 map of Central Java).[9] Together, these patients accounted for 87% of the collected files. Only three patients came from the outer regions (*Buitengewesten*). The remaining 23 patients resided in the eastern and western parts of Java. Interestingly, many of these patients entered the asylum within its first two years of operation. No less than 38% of the patients admitted before 1926 (n = 32) did not reside in Central Java. With regard to patients who were hospitalized after January first, 1926, the number of non-local patients was much lower, namely 14 out of 217 (6.5%). This discrepancy is explained by the history of Magelang Mental Hospital itself. By the time Magelang received its first patients, the transit asylum in Batavia and the mental hospital located near Lawang were overcrowded.[10] After Magelang opened up, hundreds of patients from East and West Java were evacuated to the new asylum. The number of patients from residencies located outside Central Java became much smaller after these years.

In her study *Surfacing Up,* Lynette Jackson has analyzed the relationship between colonialism and psychiatric institutions in Zimbabwe between 1908 and 1968. The title refers to the social process that, according to Jackson, transformed mentally ill Africans into inmates of Ingutsheni Lunatic Asylum. The visibility of the African insane and the perception of their behavior as a disturbance to the colonial order of things were fundamental to that process, hence the title of the book. 'Indeed,' Jackson maintains, 'within the context of colonial Zimbabwe, the visibility of the behavior that would not only be construed as madness, but treated within the framework of psychiatry, was, in large part, contingent on the African individual moving outside of the African-oriented social and cultural milieu of the rural reserve […] and into the gaze and interpretive framework of the colonizer and his biomedical logic which held that the ailment was localized

8 Hans Gooszen, *A Demographic History of the Indonesian Archipelago, 1880-1942* (Leiden 1999) 53.

9 Because the composition and names of these residences have changed since the colonial era, I have chosen to use old-style spelling.

10 'Overvuld', *De Indische Courant* (December 5, 1923) 6; 'Jaarverslag van den Burgerlijken Geneeskundigen Dienst in Nederlandsch-Indië in 1922', in: *Mededeelingen van den Burgerlijken Geneeskundigen Dienst in Nederlandsch-Indië* 11 (Weltevreden & Batavia 1924) 452. See also §1.1 of this study.

within the sufferer's body'.[11] The colonial authorities possessed the power to demarcate space and to incarcerate those African mentally ill who crossed boundaries.

Jackson's argument is interesting and raises the question if and, if yes, how the visibility of Indonesian and Chinese insane related to their admission to Magelang. If this was indeed the case, one might expect that patients who resided in an area populated by a relatively high number of Europeans were overrepresented in the asylum population of Magelang. Was this indeed the case? Demographic information derived from the 1930 census provides a chance to investigate a possible relation between the two.[12] If we focus on the patients who resided in Central Java, it appears that 51 Indonesian patients arrived from areas with a relatively high number of Europeans. These were the districts Magelang (4.2% of the population was classified as European) and Semarang (5.8%), and the cities of Yogyakarta (3.9%) and, to lesser a degree, Surakarta (1.7%). Together, these individuals constituted 24% of the patients from Central Java. Yet slightly less than 4% of the entire population of Central Java lived in either one of these areas.[13] Based on these results, it seems likely that patients who resided in an area populated by a relatively high number of Europeans were overrepresented in the population of Magelang Asylum. In other words, the presence of Indonesians lunatics within the gaze of Europeans may have been a factor that worked towards their submission.

One might, however, question whether it was European presence in these cities that was decisive in the process of hospital admission; possibly the urban environment itself played a key role. As regional hubs, urban centers often harbor several medical and police services, due to which mentally ill insane are more likely to be noticed by authorities. In a 1925 article, C.F. Engelhard, the first superintendent of Magelang, remarked that many of the inmates of the Surakarta Transit Asylum arrived from the urban area of Surakarta.[14] He provided two explanations. First, Surakarta city, as the center of the Sunanate, attracted people from the entire region. Many patients who had run away from their homes ended up wondering through the town center. Others became insane while visiting or traveling through Surakarta. Based on these remarks, one might conjecture that the

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[11] Lynette A. Jackson, *Surfacing Up. Psychiatry and Social Order in Colonial Zimbabwe, 1908-1968* (Ithaca & London 2005) 12.

12 *Volkstelling 1930. Voorlopige uitkomsten. 1e gedeelte. Java en Madoera* (Batavia 1931) published by the Department of Agriculture, Industry, and Trade. Pages 6 to 41 contain extended information on the population of each district, regency, and residency in the Netherlands Indies. For the numbers given in this section, please see this booklet.

[13] Magelang, Semarang, Surakarta and Yogyakarta together counted 598,100 Indonesian inhabitants. In 1930, the total population of Central Java was 15,265,487. If we divide 598,100 by 15,265,487, the result is 0,039, hence 3.9% of the total population resided in either one of these areas.

[14] Engelhard, 'Psychiatrische cijfers uit Java', 328.

relative number of people with mental health problems was, in general, higher in urban spaces. Yet, even if this was the case, a higher density of mentally individuals does not necessarily imply that more people from these areas were admitted to a mental hospital. There were several other districts as big as Magelang and Yogyakarta, but the number of patients that came from these areas was significantly smaller. Wonosari, for example, a district about 50 kilometers southeast from Yogyakarta, had a population size of over 110,000. Yet although its population was about a tenth bigger than that of Magelang, only one patient ended up at the asylum, while 20 patients came from Magelang. Districts like Mranggen and Kudus in the Kudus Residency, and Taju and Jakenan in Rembang provide similar cases. In the Netherlands Indies, the city as a regional hub does not seem to have been a key factor that worked towards hospital admission.

Engelhard, however, had a second explanation. Long traveling distances between center and periphery were often obstacles to transferring troublesome individuals from local prisons or hospitals to the Surakarta Transit Asylum. Mentally ill from distant villages were therefore more likely to stay where they were. Moreover, he conjectured, many of the Javanese who lived on the country side were simply unfamiliar with the existence of the transit asylum. Ignorance of psychiatric institutions, of course, reduced the number of options available to people who had to cope with the behavior of insane family members or villagers. Seen from this perspective, it is significant that the four cities mentioned above — Magelang, Semarang, Surakarta, and Yogyakarta — all had a psychiatric facility and several other medical institutions at their disposal. In other words, Engelhard's second explanation states that people who lived close to European institutions both had the knowledge and the resources to bring mentally ill people to a medical institution.

There is an important difference between Engelhard's explanation and the Jackson interpretation discussed above. The keyword is agency. In Jackson's account, agency is foremost attributed to the colonizer: black insane enter the white man's gaze and the white man decides over the lunatic's fate. The white man sees; the black man is seen. In Engelhard's interpretation, visibility works in two directions. On the one hand, future Indonesian inmates are perceived by colonial police as they wonder through the city of Surakarta. Crucial, however, is the idea that the asylum, too, has visibility and that its visibility may vary in accordance with the distance between asylum and viewer. The asylum's visibility influences the choices made by Indonesians. Discussion of the social mechanisms surrounding hospital admission in the next chapter will bring more clarity to the matter.

Indonesian patients from the four districts mentioned above were not the only group of inmates overrepresented in the population of Magelang. The same was true of Chinese patients. Whereas the Chinese population of Central Java, including Surakarta and Yogyakarta, accounted for only 1% of the entire population, Chinese patients constituted 11% of the asylum population between 1931 and 1938.[15] Following Jackson's account, an explanation might be that most Chinese lived in districts or cities where a relatively high number of Europeans resided as well. This interpretation, however, is unconvincing: the ratio of Chinese patients from these districts was more or less equal to the distribution of the Chinese population in Central Java.[16] Perhaps Indonesian patients had been "surfacing up" before they were admitted to a mental hospital, but, in general, this does not seem to apply to Chinese mentally ill. What could explain the overrepresentation of Chinese inmates? Once again, Engelhard's 1925 article might provide some hints. First of all, Engelhard remarked that five out of six Chinese resided in cities, because of which transportation of insane was less of a problem. Yet, according to Engelhard, equally important was the fact that Chinese families 'are further developed [*hun meerdere ontwikkeling*] and have a different life style; they provide better treatment for ill and are more inclined to invoke European physicians'.[17] Moreover, he argued that rumors — Engelhard used the Malay phrase *kabar angin* — about mental health facilities spread more easily in a tight-knit community such as the Chinese. The mental hospital, in other words, was more visible to the Chinese population and they possessed the financial means to take insane family members there. In the next chapter, we return to this discussion.

§ 2.1.3 · Occupation and Financial Situation

The "occupation" column was often left blank as nursing staff filled out the cover page of a medical history. About 50% of the patient records (n =126) provides information on somebody's daily activities prior to hospital admission. Not all of the entries, however, qualify as a professional occupation. In eight cases, a patient's former occupation was described as *rajat* or *minta-minta*,

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[15] Central Java, including Yogyakarta and Surakarta, counted 164,224 Chinese inhabitants. In 1930, the total population of Central Java was 15,265,487. If we divide 164,224 by 15,265,487, the result is 0,011, hence 1% of the total population was Chinese. For these figures, see: *Volkstelling 1930. Deel VII*, 168-71.

[16] Together, Magelang, Semarang, Yogyakarta city, and Surakarta city counted 60,674 Chinese residents: 37% of the entire Chinese population of Central Java (164,224). Among the Chinese asylum population from Central Java (n =28), ten inmates (36%) came from either one of these cities. For these figures, see: *Volkstelling 1930. Deel VII*, 168-71.

[17] Engelhard, 'Psychiatrische cijfers uit Java', 330-1.

T A B L E 2.3. Occupation rates for patients from Magelang Asylum, Magelang's patients who came from Central Java, and the general population of Central Java.

	Patients	Patients from Central Java	Central Java
	%	%	%
Indonesian male	51	54	88
Indonesian female	33	35	45
Chinese male	35	31	83
Chinese female	23	22	23

meaning "poor person" or "beggar". A 13-year-old Javanese girl was listed as a *regeeringspupille* (a juvenile delinquent incarcerated at a governmental institution) and the file of a Chinese woman simply read "housewife".[18] Five other records, all belonging to male patients who had passed the age of 40, informed that the patient had entered retirement. If these and similar cases are subtracted from the 126 files mentioned above, 108 out of 249 patients had a job prior to state submission. As in the last two sections, these figures can be specified along the lines of sex and ethnicity. With respect to Chinese patients, 35% of all males and 23% of all females had previously practiced a profession. The relative number of Indonesian patients who formerly had a job was somewhat higher: 51% of all men and 35% of all women (see table 2.3).

These figures can be contrasted with occupation figures of the population of the Netherlands Indies. For the sake of clarity, this comparison will be restricted to patients from Central Java — including Yogyakarta and Surakarta — and who were older than 18 (n =210). The 1930 census only provides ratios of the working population to the entire population, including both adults and non-adults.[19] However, because, as discussed above, the number of children among the asylum population was rather small, it is more accurate to compare occupation figures of the patients to the adult population of Central Java. By combining census tables on the entire population, the ratio of adults to non-adults, and the number of people who had a job, the relative number of adult professionals can be estimated. As table 2.3 indicates, the relative number of people who practiced a profession was significantly smaller among the asylum population of Magelang. This discrepancy may reflect two things. Firstly, the actual number of patients who had practiced a job was higher

[18] See p. 2243 and p. 7160.

[19] *Volkstelling 1930. Deel II*, 256.

than the number of patients as reported by nursing staff. Secondly, the gap is an indicator of the severity and the duration of the afflictions these individuals were suffering from. As shall be discussed in the next chapter, 34% of the patients of Magelang had been ill for over one year prior to hospital admission (see table 3.1), which suggests that the second interpretation might indeed have been the case.

The records obtained from Magelang Mental Hospital indicated that most patients were from a low socioeconomic background. Only 20 out of 219 Statements of Information (9.1%) which recorded someone's financial situation described the person under consideration as prosperous. In these cases, either the patient or his or her family was able to cover, at least in part, the costs of hospitalization. In all other cases, the person under consideration was poor and the costs of hospitalization were transferred to the colonial government or, in case of patients from Yogyakarta and Surakarta, to the Sultanate or the Sunanate. A brief comparison to the financial situation of asylums in the Netherlands indicates that the number of poor patients was rather high in the Netherlands Indies. In her dissertation, Catharina Bakker provides an overview of the fees covered by patients and their families for individuals who were hospitalized at a psychiatric facility in the municipality of Leiden in 1939.[20] Although only a very small number of psychiatric patients could cover the costs of hospitalization entirely (approx. 2%), about 60% of the patient population was able to pay at least a part of the nursing costs. In the Netherlands Indies, it seems, this figure was much lower.

Table 2.4 shows the division of labor among patients who had practiced a profession prior to hospitalization. Most Indonesian men and women had previously been employed in the primary sector of the economy exercising heavy manual work. Some had worked as a laborer (*boeroeh* or *koelie*) or farmer (*tani*). Others were skilled laborers such as sawyers, bricklayers, or tinsmiths (*blikslager* or *smidsknecht*). Various patients had owned a paddy field (*sawah*) before entering Magelang. Five patients, four men and one woman, had been employed as a *contract koelie* in the Deli Sultanate in Northeast Sumatra. They were sent back to their villages on Java because of their mental condition.

Most other patients who had practiced a profession prior to hospital admission had been engaged in the manufacturing or service industry. Basically all skilled artisans worked at clothing companies. Nearly all men were formerly employed as a tailor or dressmaker and many female patients as batik craftswomen. Patients described as "clerks" had held administrative jobs at Dutch

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[20] Catharina Th. Bakker, *Geld voor GGZ. De financiering van de geestelijke gezondheidszorg en de invloed van geld op de zorgpraktijk (1884-1984*) (Amsterdam 2009) 54.

T A B L E 2.4. Previous occupations of patients at the time when a referral report was filled out.

	Indonesian male		Indonesian female		Chinese male		Chinese female		Total	
	no.	%	no.	%	no.	%	no.	%	no.	%
Laborers	19	26	7	26	1	17	0	0	27	25
Farmers	23	32	5	19	0	0	0	0	28	26
Military & police	8	11	0	0	0	0	0	0	8	7
Merchants	2	3	1	4	3	50	0	0	6	6
Shop-assistants	1	1	4	15	1	17	1	50	7	7
Servants	1	1	6	22	0	0	0	0	7	7
Student	3	4	0	0	0	0	0	0	3	3
Skilled artisan	6	8	3	11	0	0	1	50	10	9
Clerk	7	10	0	0	0	0	0	0	7	7
Other	3	4	1	4	1	17	0	0	5	5
Subtotal	73		27		6		2	100	108	
No occupation / information	67		51		11		11		140	
total	140		78		17		13		248	

companies or were former civil servants. Table 2.4 also shows that, in comparison to the Indonesian population, relatively many Chinese people made a living as either merchants or salesmen. This is in line with general figures for Java and Central Java.[21]

It is interesting to contrast the division of labor among Indonesian patients with the division of labor among the Indonesian population of Central Java, including, once again, Yogyakarta and Surakarta. According to the *Census of 1930*, about 87% of the entire Indonesian working force was

[21] The relative number of Indonesians employed as a merchant or salesman was below 10% of the entire Indonesian working population. Chinese merchants, on the other hand, accounted for about 60% of the Chinese workforce. See: *Volkstelling 1930. Deel II*, 94-8 and *Volkstelling 1930. Deel VII*, 136.

engaged in the production of raw material or craft-related industry.[22] If we focus on the Indonesian patients from this area, those described as laborer, farmer, or skilled artisan accounted for only 61% of all patient who had a previous occupation. In other words, if the figures for the patient population are accurate, inmates working within these sectors were underrepresented in the group of patients who had formerly practiced a profession. The contrary seems to have been the case for servants, and for former police agents and soldiers. Soldiers and policemen constitute 7.5% of the group of patients under consideration and servants 6.5%. Yet, following the *Census of 1930*, only 2% of the entire workforce was engaged with domestic services and less than 0.4% was employed by the police or the military.[23] In other words, former servants, police men, and soldiers were overrepresented in the asylum population. What is more, a young patient studied at the Military Academy of the Royal Netherlands East Indies Army in Magelang and three retired patients were former soldiers. These findings suggest that soldiers in particular were represented relatively strongly among previously occupied patients.

To be sure, there was some overlap between the group of patients who came from either Magelang, Yogyakarta, Surakarta, or Semarang and the sample of patients who were former police men, soldiers, or servants. Six soldiers, for example, came from Magelang or Yogyakarta. Yet the fact that these groups were overrepresented, and that farmers were underrepresented, suggests, once again, that visibility was a factor that worked towards the hospitalization of Indonesian insane. Soldiers, servants, and policemen stood in close contact to the European population of the Netherlands Indies. In addition, insane policemen and soldiers were possibly more dangerous than "normal" insane, as they could carry around weapons. They also had a major social responsibility and represented the colonial state. These were all factors that may account for the overrepresentation of police officers and soldiers among the population of Magelang.

§ 2.1.4 · Javanese Aristocracy

Nineteen patients were member of the *priyayi*, Java's governing upper class. From the time of the VOC onwards, the Dutch had entertained a system of indirect rule to secure political authority. Dutch colonial power was partially based on the cooperation of the Javanese aristocracy — nobles and officials, court-based administrators, and local chiefs — who derived social status from custom and tradition. As colonialism progressed towards a full blown system during the nineteenth century,

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[22] See: *Volkstelling 1930. Deel II*, 94-8.

[23] *Ibid*.

the function of these aristocrats changed. Gradually subordinated to the Dutch interior administration, the highest officials, the regents, eventually only maintained symbolic authority and lower officials became enmeshed in local or colonial bureaucracy.[24] This is reflected in the occupations previously practiced by patients of aristocratic descent. Two boys, for example, were visiting a Dutch M.U.L.O. school for advanced primary education and someone else had been employed as a member of the military elite at the court of Yogyakarta (*abdidalem mudji punokawan*).[25] Two others had maintained positions at the *Algemene Volkskredietbank* and at a *gouvernement pandhuis* before they entered retirement.[26] A woman from Surabaya was the wife of an inspector of the Netherlands Indies Railways. In only four cases, however, the Statement of Information stated that a patient was from a wealthy background. Unfortunately, no figures on the absolute number of *priyayi* is known, so it is not possible to establish whether they were overrepresented among the patients of Magelang or not. Considering the fact that most of them had receive European education and were in relatively close contact to the colonial authorities, it seems likely that members of the *priyayi* were overrepresented among the asylum population.

§ 2.2 · Afflictions

Up to here, the patients from Magelang have been discussed as a group by using percentages and numbers. As a result, we may have lost sight of the fact that the asylum's inmates were, above all, real people, each with a unique story to tell. What were their feelings, experiences, and ideas? With respect to patient records from the Valkenberg Asylum in the city of Cape Town, Sally Swartz has remarked that '[t]he folders say much about doctors, a system of asylum governance, evolving psychiatric knowledge: but the subaltern voice, the subject of it all - the patient - is herself a black hole in the centre of the archive'.[27] This applies to medical histories from Magelang as well, yet to a lesser degree. During their first interview, hospital staff often inquired how the patient felt and whether he or she had seen or heard anything weird. Patients often replied by simply saying 'I don't

[24] Heather Sutherland, 'The Priyayi', *Indonesia* 19 (1975) 57-77, 66-74.

[25] P. 2258.

[26] P. 4829 and p. 3798.

[27] Sally Swartz, 'Colonial Lunatic Asylum Archives. Challenges to Historiography', *Kronos* 34 (2008) 285-302, 291.

know'.[28] It also happened that new inmates were unable to answer, because of confusion or severe agitation. Yet others freely talked about their thoughts and experiences. By scraping together bits and pieces of notes taken by the staff, it is possible to catch a glimpse of patients' inner worlds.

Strictly speaking, it is not the inmate's voice that was recorded in the medical records. Over the last decades, historians of medicine have been debating whether it is attainable to write a real medical history from below at all. At the same time as Roy Porter famously pleaded for a history that incorporated the patient's view, sociologist David Armstrong, following the Foucaultian notion of a "clinical gaze", reminded historians that patient files only present what was heard and selectively reported by the nursing staff or a physician.[29] Armstrong pointed out that the much-desired patient's view is actually the product of an interrogation process and cannot be 'isolated simply as what is said; fundamentally the patient's view is bound up with what is heard.'[30] Hospital staff reduced patients' stories to a few lines, selected and highlighted what they thought was important, and ignored all the rest. The following section therefore contains the voices of Indonesian and Chinese insane as mediated by the staff from Magelang Mental Hospital. Today, about 80 years after the event, this is the closest a historian can get — unless, of course, personal documents of former patients are found.

The word most frequently mentioned to describe an inmate's state of mind is the Malay word *bingung* (n =49). The term is used by both Indonesian patients and European staff and means "confused". Patients referred to themselves as feeling or being *bingung* or *sakit bingung* (literally "confusion sickness") and at times they clarified the causes of their mental state. Several patients told staff members that they became *bingung* after the death of a family member or a divorce.[31] Feelings of *bingung* were also caused by stress. A young man from Yogyakarta, for example, explained that after he was employed as an assistant-writer, he started to doubt whether he was

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[28] According to Lawang superintendent Travaglino, there was 'a good old joke' (*oude geestigheid*) that the Dutch colony was inhabited by people of three different races: *tidataoeërs* (I-don't-know-ers), *tidamaoeërs* (I-don't-want-ers), and *belompriksaneezen* (not-yet-checked-ers). See: P.H.M. Travaglino, 'De psychose van den inlander in verband met zijn karakter', *Geneeskundig tijdschrift voor Nederlandsch-Indië* 60 (1920) 99-111, 99.

[29] Roy Porter, 'The Patient's View. Doing Medical History from Below', *Theory and Society* 14 (1985) 175-98; David Armstrong, 'The Patient's View', *Social Science and Medicine* 18 (1984) 737-44.

[30] Armstrong, 'The Patient's View', 743.

[31] According to a 46-year-old Javanese father, he became confused after the dead of his son. The traumatic experience kept him from working, eating, and sleeping. Another man explained that he had become *bingung* because his wife had fallen in love with someone else and she was about to leave him. See: p. 4093 and p. 4931.

F I G U R E 2. A group of insane dressed in rags and kept at the local prison (*districtsboei*) of Solo. This picture was probably taken by C.F. Engelhard himself. It was published in his 1925 article on the Surakarta Transit Asylum.

adequate to the job. Eventually, this stress drove him crazy.[32] Other causes mentioned by the patients involved poverty and fever.

There were several other Malay words patients used to describe their afflictions. One was *gila,* which roughly translates as "insane" or "crazy". *Gila* seems to have had a more negative connotation than *bingung* and only a very small number of patients described themselves as such. Patients more often acknowledged that they were "confused", but denied to be "insane". One patient told the nursing staff that he had been hospitalized at the asylum near Lawang, because his villagers had claimed that the man was *gila*. He himself, however, insisted that he was not insane, only a little bit *bingung*.[33] Likewise, one of the former *contract koelies* from Deli explained that he had been *bingung*, not *gila*. Interestingly, this patient also used a Dutch phrase to describe his condition. He suffered from grandiose delusions (*grootheidswaanzin*).[34] There is one more word that a few patients used to describe their own feelings: *susah hati* (upset).[35] *Susah hati* was often mentioned in opposition to *sakit* (sick). A Javanese woman, for example, who was brought into the

[32] P. 1469.

[33] P. 2017.

[34] P. 4005.

[35] For more information on the concept of *hati*, see: Cliff Goddard, '*Hati*. A Key Word in the Malay Vocabulary of Emotion', in: Jean Harkins and Anna Wierzbicka (eds.), *Emotions in Crosslinguistic Perspective* (Berlin 2001) 167-196.

asylum by two policemen in a deplorable condition, did not understand why she was hospitalized. She was *susah hati*, she assured one nurse, not sick.[36]

Except for these more general terms, about a fifth of the records described the experiences of patients in more detail. Several records belonged to individuals who felt larger than life. Their beliefs often involved the possession of wealth and women or the identification with influential persona. Although mainly male patients demonstrated to have feelings of grandeur (n =13), a couple of women showed similar symptoms (n =3). A Javanese woman told that she was Wilhelmina, Queen of the Netherlands, and another Javanese explained to be employed as a servant of 'K.J Ratoe [queen] Perajoen'.[37] A man from Wonosari bragged about having many offices, fabrics, women, and children. He also claimed to be one thousand years old.[38] Except for being widely known as a *dukun* (a traditional healer) who healed many different diseases, another patient's wealth related to the fact that he was already dead. Invincible as he was, no bullet could kill him.[39] Occasionally, delusions of grandeur blended with the patient's perception of the asylum. At the moment of his admission, for example, one inmate told that he was to be pleased by the nurses, because the Queen of Yogyakarta and Mount Merapi had ordered so.[40] The man who had worked at the *Algemene Volkskredietbank* was convinced that his visit to the asylum would be short. At Magelang, colonial officials would test whether he was qualified to be appointed as a regent. Somewhat ironically, he was fully conscious of the fact that Magelang Asylum was a mental hospital.[41]

Sometimes, kings and queens would appear before patients' eyes and tell people what to do. When she was still living in her village, a senior woman had often heard voices and was afraid to be robbed by her neighbors. Someone who looked like "Ratoe Sijan" had urged her to go to a better place where she would be taken care off.[42] That these delusions could have real consequences is

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[36] P. 7156. Also see: p. 7185.

[37] P. 1273 and p. 6090. Another patient at times told that his wife was Wilhelmina or, alternatively, Adaninggar, a queen from the Majapahit Empire. He called himself Mangkoeboemi, a prince for the Majapahit Empire. See: p. 1810.

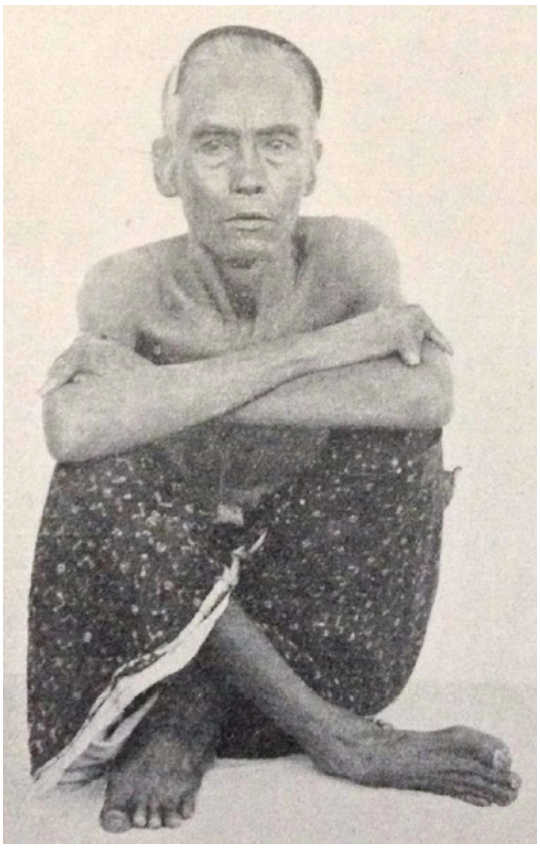
[38] P. 5276. Another patient, a former batik artist, said that he had ten brick houses. See: p. 2954. Apparently, brick houses and tile roofs were perceived by Indonesians as signs of wealth. A 35-year-old Javanese man told the nursing staff that he had established an association entitled *Warno Wisma* (Literally: "Color House") to protected the rich people of his village 'who owned houses with roof tiles'. He felt sorry for these people when they were robbed. See: p. 6627.

[39] P. 5492.

[40] P. 4846: Goesti Ratoe Djoeja bokal jadi Ratoe Goenoeng Merapi.

[41] P. 5331

[42] P. 4526



F I G U R E 3 and F I G U R E 4. Two patients treated by C.F. Engelhard. According to Engelhard's commentary, the man on the left identified with a king. The man on the right described himself a *dukun*. Both pictures are published in Engelhard's 1948 article that appeared in the *Maandblad voor geestelijke gezondheidszorg*.

also shown by the well-documented file of a 46-year-old Batak man from the village Tapanuli in North Sumatra. About ten years before a village chief filled out his Statement of Information, this man had become extremely religious. According to the future patient, *Raja Sisinga*, an abbreviation for King Sisingamangaraja XII, was still alive. Sisingamangaraja XII had been the last priest-king of the Batak people and had waged a lengthy guerilla war against the colonization of Sumatra before he was killed in 1907. The priest-king had been born in the same village as the patient. After convincing another man that their leader was still alive, the man's psychiatrist states that 'their fanatic delusions had caused chaos and an uprising in the region'. In consequence, the man was imprisoned and he ended up in Magelang. According to the patient, the *Raja* still visited him at night to reassure that there was nothing to be afraid of.[43]

Apart from the patient who thought he was bullet-proof, surprisingly little mention is made of patients whose ideas involved magic or religion. The preprinted patient records forms had a column to register someone's religion, but after 1935 this column was filled out only sporadically.

[43] P. 362

Pre-1935 patients files indicate that basically all Javanese patients were Muslims and all Chinese inmates Confucians. Yet, one exception aside, no patients made references to the Islam. Only one man, who was loved by "Nona Sultan Agoeng" and who possessed tons of cash, told the treating psychiatrist that he was Mohammed.[44] Several others reported to have heard the voices of devils and on one occasion a patient spoke about having heard a call from the prophets.[45] A 17-year-old boy had aggravated his parents by — among other things — destroying his father's watch and singing out loud throughout the entire day. In answer to the question why he had done these things, the boy explained that he was a wizard and that he could have repaired the watch easily if he had wanted to. He sang the entire day, because spirits and gods (*geesten en goden*) told him that he was a first-class singer.[46]

At night, however, the visions of this patient were less cheering: he was visited by tigers and other creatures that made him scared. He was not the only person whose experiences were seriously discomforting. Sixteen records attest of feelings of persecution and intense fear. Some patients reported to be chased by policemen or other armed forces and others were afraid to be poisoned or robbed. A soldier in his late thirties from Yogyakarta, for example, had been marching through his kampong with drawn saber, according to him, because there was an enemy underneath the road's surface.[47] This is one example of a "dangerous soldier" (see §2.1.3). Other patients were afflicted by voices of people who threatened to kill them. One woman had even tried to commit suicide after voices had threatened to slaughter her. At home, her file notes, she would have heard voices that told her to walk away. Thereafter, several *wayang* characters had entered her house and told her to be careful and not go astray. Then five of them penetrated her belly and departed by means of a what her psychiatrist called a 'flatus'.[48] Instead of killing herself, a Chinese woman from Muntilan tried to kill her child, because she thought the little one to be possessed by a spirit. She also told that she was afraid for her husband, because he wanted to bury her alive.[49]

Like the woman who witnessed *wayang* figures entering her body, several other patients experienced their bodies to have undergone profound changes. In conversation with her doctor, a 50-year-old Javanese woman denied to be *bingung*, but she told that blood-colored liquid poured

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[44] P. 6584

[45] See: p. 6041, p. 7263, p. 6037, and p. 2278.

[46] P. 4098.

[47] P. 4198.

[48] P. 6037.

[49] P. 5342.

from her body as it was full with holes.[50] One patient confided to her psychiatrist that she had no stomach and that all her intestines had been cut into pieces.[51] Not unlike this case, another patient reported that all the flesh had been removed from her body.[52] Someone else claimed to be unable to walk, because her legs were much too thick. At admission, she was carried into the hospital on a gurney.[53]

Interestingly, many of these delusions and hallucinations show resemblances to the experiences of psychiatric patients in the Netherlands as described by Joost Vijselaar.[54] In a collection of 160 medical records obtained from three Dutch asylums, Vijselaar, too, found individuals with feelings of grandeur, religiously-oriented hallucinations, and persecutory delusions. At times, patients' experiences are even more or less identical. Both a woman from the Dutch province of Friesland and a Javanese man from Banjoemas, for example, had the feeling that they received messages by means of a telegraph. Vijselaar also discusses a 'restless and depressive woman' who, similar to the patient described in the previous paragraph, thought that her stomach had been removed. Looking back in 1948 on his years spent on Java, Engelhard came to a similar conclusion: '[W]ith respect to their nature, their symptomatology, and their development, psychoses of Javanese individuals do not differ from the psychoses experienced by us [Europeans]'.[55] Engelhard realized that this point of view was in many respects far from what Netherlands Indies psychiatrists had maintained during the pre-war years. Instead of emphasizing the similarities, psychiatrists like Travaglino and Van Loon had stress the fundamental differences between the European and Native psyche.[56] Engelhard doubted the validity of their conclusion: 'in the past, it

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[50] P. 4826.

[51] P. 6634.

[52] P. 4313.

[53] P. 7154.

[54] Joost Vijselaar, *Het gesticht. Enkele reis of retour* (Amsterdam 2010) 29-58.

[55] C.F. Engelhard, 'Psychiatrische ervaringen bij Javanen in Midden-Java (1919-1922)', *Maandblad voor geestelijke gezondheidszorg* 3 (1948) 231-251, 249.

[56] For a discussion of these views, see: Hans Pols, 'Psychological Knowledge in a Colonial Context. Theories on the Nature of the "Native Mind" in the Former Dutch East Indies', *History of Psychology* 10 (2007) 111-31; and Hans Pols, 'The Nature of the Native Mind. Contested Views of Dutch Colonial Psychiatrists in the former Dutch East Indies' in: Sloan Mahone and Megan Vaughan (eds.), *Psychiatry and Empire* (London 2007) 172-96.

seems that psychiatrists were often but all too happy to drawn racial-psychiatric conclusions on questionable grounds'.[57]

§ 2.3 · Concluding Remarks. The Historian vs The Psychiatrist

Please allow me to do some iffy-history: Had Engelhard read Lynette Jackson's account on the Ingutsheni Lunatic Asylum in Zimbabwe, would he have echoed these last words and postulated that, in the past, historians of psychiatry seem to have been too much inclined to structure their narratives on the trope of race? Had he done so, historian Sally Swartz would have agreed wholeheartedly. According to her, it is 'through [accounts by Lynette Jackson and others that] a discursive formation takes root, a system of expectations, *despite* the archive, and in fact despite the often nuanced analyses in which they are embedded'.[58] Swartz argues that what the historian expects to find — or, alternatively, is expected to find — is psychiatric oppression based on racial discrimination. Yet she objects that history is rarely black-or-white and maintains that this is what a nuanced study of colonial psychiatric archives should make clear.

In this light, it is interesting to note the differences between the interpretations of asylum admission by Netherlands Indies psychiatrist Engelhard and historian Jackson. Jackson, associate professor of Gender and Women's Studies and African American Studies at University of Illinois, thinks of asylum admission in colonial Zimbabwe as a top-down process. Agency is foremost attributed to the white colonizer. Engelhard, one of the historical actors involved in the processes that this research aims to study, had a rather different view. In his account, visibility works in two directions: although indeed some patients "surfaced up" and were arrested by the authorities, others were taken to the hospital by family members. In other words, Engelhard and Jackson understand the function of a mental hospital in a colonial context differently. Differences in the points of view of Engelhard and Jackson can be understood by looking at their historical context. To Engelhard — the 1925 Engelhard who wrote an article on the Surakarta Transit Asylum — colonial rule and medical power were probably phenomena that did not require much critical analysis. In Jackson's view, on the other hand, the perspective of a historian raised in the traditions of Foucault and Fanon, colonialism and psychiatry are important topics when it comes to the discussion of unequal power relations, racism, and oppression. It is anything but surprising that the accounts on hospital admission by Jackson and Engelhard differ from each other.

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[57] *Ibid*., 231.

[58] Swartz, 'Colonial Lunatic Asylum Archives. Challenges to Historiography', 289.

Both interpretations — at least with respect to Indonesian future inmates — are compatible with the findings presented in this chapter. About 70% of the patients were aged between 20 and 40. Minors and elderly people were probably underrepresented in the patient population of Magelang. In Jackson's account, these people were more likely to be perceived as a threat by the authorities; Engelhard might have argued that it was easier to maintain young and old people with mental problems at home. Overrepresented as well were inmates who lived in a district or city with a relatively high number of Europeans and patients who, because of their occupation, were in close contact to colonizers, such as policemen, soldiers, and servants. Jackson interprets the processes that account for these findings as "surfacing up". Engelhard, on the other hand, provided a number of alternative factors to account for these findings, such as the distance between asylum and village and the socioeconomic status of a patient and his or her family.

An analysis of the social processes surrounding hospital intake will make it possible to argue in favor of either one or the other. To this, we shall turn in the next chapter.

Chapter 3 · The Reasons for Hospital Admission

The previous chapter has shown that the population of the Magelang Asylum did not reflect Central Java's demography. In comparison to the total population, people aged between 20 and 40, patients of Chinese descent, former soldiers and servants, and individuals who resided in a district populated by relatively many Europeans were overrepresented among the inmates of Kramat. This chapter sets out to interpret these findings by exploring the practices surrounding hospital intake. What social processes led to hospital admission?

Two possible explanations for the configuration of Magelang's asylum population have been discussed. Following Jackson's research into an asylum in colonial Zimbabwe, it was hypothesized that certain groups of insane were perceived by European authorities as a threat to the colonial order of things. In this interpretation, Chinese and Indonesian lunatics entered the colonizer's gaze more or less by accident. Engelhard's views, on the contrary, stressed that visibility worked in two directions. In his article on the Surakarta Transit Asylum, he did mention that the intensity of police supervision was higher in urban areas, yet this was only part of his discussion. In cities, especially those with psychiatric facilities, asylum care was more visible and easier available to Chinese and Indonesian communities, which influenced their decision of whether or not to submit a request for hospital admission.

On the following pages, it will become clear that Engelhard's account is a more accurate description of asylum intake on Central Java. Jackson's work might be applicable to colonial Zimbabwe, but the social mechanisms that worked towards admission to Magelang Asylum were of a different kind. The asylum was no tool of empire that aimed at the oppression of dangerous mentally ill; the mental hospital was used by multiple actors for various purposes.

This chapter unfolds in three stages. The first section surveys the lives of Chinese and Indonesian insane at home. Central to this discussion is the distinction between individuals who

T A B L E 3.1. Period of time Indonesian and Chinese patients suffered from mental illness before hospital admission was requested.

	Indonesian		Chinese		Total	
	no.	%	no.	%	no.	%
< 1 month	56	36	7	28	63	35
1 - 6 months	34	22	5	20	39	22
6 - 12 months	18	12	1	4	19	10
> 12 months	46	30	12	48	58	34
Total	154		25		179	

were neglected and individuals who were maintained by their families. Someone's social position influenced why, when, and how a lunatic came into contact with the authorities. The second section provides an overview of the motivations for submitting a request for institutionalization of an individual with mental health problems. Hospital admission, it will be argued, was the result of specific behavior exhibited by certain groups of insane. The final section, then, examines the actors who issued referral reports — e.g., police, Native village chiefs, and European psychiatrists — and shows that various institutions were concerned with the hospitalization of neglected and maintained lunatics.

§ 3.1 · Neglected or Maintained? Sick at Home and in the *Desa*

As discussed in the previous chapter, Engelhard witnessed a stark difference between newly admitted Chinese and Indonesian patients. In general, Chinese lunatics were better off. At home, most of these sufferers received medical care from a European physician and, in comparison to Javanese families, the Chinese population was more inclined to take mentally ill to a hospital. As a result, less Chinese patients ran away from their homes and, again compared to Javanese insane, the period of time between the first symptoms of mental disease and hospital admission was shorter.[1]

Table 3.1 presents the period of time patients had suffered from mental illness before hospital admission was requested, specified according to their ethnicity. Information on the duration of this period is provided by 72% of all patient records. With respect to Chinese patients, this table

[1] C.F. Engelhard, 'Psychiatrische cijfers uit Java', *Psychiatrische en neurologische bladen* 29 (1925) 326-44, 330-3.

T A B L E 3.2. Relations between patients and their families among Indonesian and Chinese patients.

	Indonesian		Chinese		Total	
	no.	%	no.	%	no.	%
Looked after	43	24	12	41	55	27
Looked after, but cannot be kept at home any longer	84	47	8	28	92	44
Neglected	51	29	9	31	60	29
Total	178		29		207	

shows a rather different picture to that given by Engelhard. Relatively speaking, and in contrast to Engelhard's findings, less Chinese insane were taken to a hospital within the first month of mental disease: 28% of all Chinese admissions against 36% of all Indonesian patients. On the other hand, the number of inmates who had been ill for over one year prior to hospital admission was much higher among Chinese inmates. In comparison to Indonesian lunatics, Chinese insane were kept at home for a longer period of time. Overall, there is some disagreement in the findings by Engelhard and myself. This should not be taken to imply that either one of us is right or wrong, as our figures concern different institutions — a mental hospital in Magelang and a transit asylum in Surakarta — during different time periods.

Table 3.1 shows that insanity as such often was no motivation to request hospital admission. After all, about a third of the patients of Magelang entered the asylum after they had been ill for over one year. What can be said about the lives of mentally ill individuals before their admission to a hospital? And what were the differences in the maintenance of Chinese and Indonesian insane?

§ 3.1.1 · Maintained by Family

By combining patients' Statements of Information and notes taken by hospital staff, it can be estimated that about 70% of all lunatics was looked after by family members (see table 3.2). This group can be divided into two: individuals cared for by their families and individuals about whom it was explicitly stated that their family was not able to provide care any longer. In section 3.2.2 it will become clear why it makes sense to distinguish between these two categories of maintained

patients. In comparison to Indonesian insane, the number of Chinese mentally ill looked after by their families was about twice as high. The number of Chinese lunatics who could not be kept at home any longer was, on the other hand, considerably lower.

Whether it concerns Chinese or Indonesian patients, it remains difficult to establish what kind of lives these people had prior to hospital admission. It can be assumed that, in general, as long as Indonesian lunatics did not cause any trouble, they stayed with their families and could walk around their *desa* or city. As table 3.1 already indicated, many insane lived outside of mental institutions for many years. Deviant behavior was no indicator for hospital admission. Chinese families, on the other hand, were more inclined to bring relatives to a mental hospital, also when the person under consideration was quiet (see §3.2.2).

It is likely that Javanese families were responsible for the deeds of insane relatives. Costs of damage caused by a lunatic were probably borne by his or her family. In 1931, anthropologist J.P. Kleiweg de Zwaan published an article in which he discussed, among other things, indigenous custom law (*adat*) on insanity. With respect to the Batak people from Sumatra, Kleiweg de Zwaan remarked that family members were held responsible for mentally ill relatives. Different fines could be imposed in case the family failed to safeguard public order. When someone else's possessions were destroyed, the family of the insane had to offer compensation.[2] Whether similar regulations applied to Javanese society deserves further investigation. At least one person from Banjoemas could not be kept at home any longer for exactly this reason. His family was poor, the referral report stated, and 'this insane person goes out and destroys the possessions of others, where after people ask the family for replacement.'[3]

The existence of such custom law could be an important reason why, at times, Indonesian families or villagers found themselves forced to incarcerate mentally ill individuals.[4] Physical restraint by means of chains, small bamboo houses, or wooden blocks (*pasung*) was often mentioned in articles written by Netherlands Indies psychiatrists, usually to convince readers of the absolute necessity to invest more money in mental health care for Indonesian insane. When Hoffman argued in 1894, for example, that more ward beds should be created, he strengthened his

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[2] J.P. Kleiweg de Zwaan, 'Bijgeloof in den Indischen Archipel in zake krankzinnigheid. Samenvattend overzicht', *Tijdschrift van het Koninklijk Nederlandsch Aardrijkskundig Genootschap* 48 (1931) 609-38, 615.

[3] P. 4524: 'Ia selaloe didjaga sadja oleh sanak familienja, akan tetapi dari sebab sama miskin maka tida koeat piara, sedang sigila itoe soeka membikin roesak lain orang poenja barang, jang mana achirnja sama minta ganti pada familienja'.

[4] Practices of *pasung* are still used today in Indonesia. For a film-documentary, see: Erminia Colucci, *Breaking the Chains* (2013).

plea by recalling a trip in the Buitenzorg area. Moving into the direction of the sound of 'someone who was moaning continuously,' Hoffman discovered a chained lunatic locked up in a cage.[5] By adding to his article a series of photos of mentally ill individuals in *pasung*, psychiatrist J.A. Latumeten used a similar strategy to argue that Indonesia was in desperate need of a psychiatric and neurological clinic.[6]

Prior to admission, several patients from Magelang were confined by family or villagers. One example is a woman who had passed the age of 50. The Javanese female had been ill for about two-and-a-half years when she had started to smash pieces of furniture and beat other people. Her family had asked the *prabot* (village chief) to confine her. Due to the woman's dangerous behavior, her family declared themselves incapable of looking after her.[7] Likewise, the records of a 25-year-old Javanese man mention that he was kept at 'an isolated place' in the house of the *kepala desa* (head of the village). Prior to his incarceration, the family was regularly assisted by *politie desa* (village police). The man screamed, spoke to himself, and chased women. He also burned down the cage of a goat.[8] From the descriptions of patient bodies by nursing staff more cases of restraint can be discovered; yet one has to be careful interpreting these passages. At least three patients had red and white stripes on their palms, according to one of them because his family had tied his hands together.[9] Other patients had scars on their ankles and feet. Remarks on confinement always related to Indonesian insane.

While at home, both Indonesian and Chinese lunatics received medical attendance. With regard to Indonesian individuals, about a quarter of the Statements of Information for which the "prior medical treatment" column was filled out recorded that someone had medical treatment prior to state submission. Among Chinese patients, this number was much higher: five out of six. At least 19 Indonesian and 4 Chinese patients received medical treatment from a Western physician. The

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[5] J.W. Hofmann, 'Krankzinnigenverpleging in Neêrlandsch-Indië', *De Indische gids* 16 (1894) 981-1003, 988.

[6] J.A. Latumeten, 'De beteekenis van het psychiatrisch-klinisch onderwijs voor Indonesië', *Overdruk uit het orgaan van den Bond van Ind. Geneeskundigen* (Weltevreden 1928). Other examples are to be found in: C.F. Engelhard, 'Psychiatrische cijfers uit Java', *Psychiatrische en neurologische bladen* 29 (1925) 326-44; F.H. van Loon, 'Het krankzinnigenvraagstuk in Atjeh', *Mededeelingen van den Burgerlijken Geneeskundigen Dienst van Nederlandsch-Indië* 9 (1920) 2-49.

[7] P. 4826: '19. Mengoewatirkan boeat dirinja sendiri dan orang lain dan di harep semboehnja kalau berobat, soedaranja tidak dapat memiara karena berbahaja. [...] 22. Soedah 3 hari di djaga oleh prabot desa'.

[8] P. 1774: 'Warisnja sendiri tida koewat mendjaga, maka tiap-tiap hari dibantoe pendjaganja oleh 1-2 orang politie desa, diroemahnja kepala desa'.

[9] P. 6584, p. 5279, and p. 2250.

referral report of a young Chinese man, for example, read that '[b]efore his insanity became more severe, he often visited the mental hospital in Kramat, where he received treatment from a psychiatrist who gave him pills.'[10] Several mentally ill people received medication such as quinine, bromide, or a neurotic (*zenuwmiddel*).[11] Only three of the Indonesians who received medical care were members of the *priyayi*, which suggests that about 8% of non-aristocratic families consulted a European or Indies physician while a mentally ill relative was still at home. Two referral reports that belonged to Indonesians mentioned that the patient had been treated by a *dukun*, an indigenous healer, although it is not discussed what kind of treatment this was.[12]

§ 3.1.2 · Sick and Neglected

Apart from patients who were maintained by their families, there was a group of insane who were — following the vocabulary used in referral reports — "entirely neglected by their families". At Magelang, 30% of the patient population belonged to this group of patients (see table 3.2). This figure applied to both Indonesian and Chinese patients.

As with patients who were looked after, it is difficult to determine what "entirely neglected" exactly meant. At least one third of these medical histories belonged to patients who had been wandering for some time. It remains unclear why these people became homeless. According to Engelhard, insane simply walked away from their homes, never to return. In the previous chapter, the example was discussed of a woman who had walked away from home because one "Ratoe Sijan" had told her to do so. It could also be that some insane were "released" by their families in order to reduce stress on family life. The number of female Indonesian tramps was twice as high as the number of Indonesian male homeless people. An interesting question remains what the significance of this finding could be. Female insane were possibly less closely guarded by their relatives, which made it easier for them to get away. One reason that might account for this is that female insane were perceived by families or villagers to be less dangerous than male lunatics and could therefore walk around more freely. Alternatively, it might be possible that men were of more importance to Javanese families, as males were a family's breadwinner. As a consequence, male

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[10] P. 4529: '34. Toen de krankzinnigheid nog niet zoover gevorderd was, kwam de lijder dikwijls in het gesticht der krankzinnigen te Kramat Magelang om zich te laten behandelen door een arts aldaar, waar hij pillen kreeg'.

[11] P. 1002, p. 1804, and p. 1813.

[12] P. 2954 and p. 2288. A *dukun* is mentioned in one other file. In answer to the question why the person under consideration had become ill, it was stated: 'We don't know, we only know that the *dukun* said that anybody who lives on the land of Tjabangsa [the person's father] can become insane without doubt'. See: p. 1961.

insane were more closely supervised. More contextual information is needed to interpreted this finding.

Most homeless insane were found by police on the side of the road in a state of confusion or agitation. On December 28, 1933, for example, a nurse from the Semarang Transit Asylum noted: 'Javanese woman, an unknown tramp, according to her Statement of Information she was arrested, she speaks nonsense and is a danger to the community. […] Exhibitionism, plays with her genitalia'.[13] Another vagabond was taken into custody because he took furniture out of houses owned by Europeans. His referral reports reads that he was confused and was neglected by his family. He was not a danger to others, but dangerous for himself, 'because he behaves like a thief'.[14]

Not every neglected insane, however, was homeless in the strict sense. Considering the fact that a 40-year-old woman 'kept her neighbors' awake, it could be inferred that she still owned a place where she resided.[15] Two others, both still minors, were maintained at charitable institutions founded by missionaries: the White Cross Colony near Salatiga and the Asylum for the Feeble Minded near Temanggung.[16] The patient from Temanggung was a Chinese girl whose parents had died when she was only seven years old. Also described as entirely neglected were two soldiers who resided at the military camp in Magelang. One of them was still with his wife, but he had beaten her up. His referral report states that he acted strange and that his behavior had become completely unmanageable.[17] Both men were wearing their uniforms as they entered Magelang Asylum.

Neglected insane accounted for 30% of all Chinese and Indonesian admissions. If this finding is combined with the previous discussion on mentally ill who were maintained by their families, it seems safe to conclude that there were differences between the home situation of Chinese and Indonesian mentally ill. In comparison, more Chinese insane received medical care prior to hospitalization and more Chinese were maintained by their families, without it being mentioned that the situation at home had become untenable. In addition, more Chinese insane were brought to the asylum personally by their relatives. Altogether 22 patients were accompanied by

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[13] P. 4140: 'Jav. vrouw, onbekende zwerfster, volg. St. v. Inl. opgepakt geweest, verward praten en gevaarlijk voor samenleving, naaktloperij. [...] Exhibitioneert, speelt met haar genitaliën'.

[14] P. 4202: 'Haalt des nachts meubilair uit Europeesche woningen weg en deponeert het ergens anders. Rustig, doch gevaarlijk voor zichzelven, aangezien hij zich gedraagt als een dief'.

[15] P. 5848: 'Naakt lopen, met haar ontlasting en urine spelen, schreeuwt de heele omgeving uit de slaap'.

[16] P. 4089 and p. 4843.

[17] P. 5341. The other soldier is p. 4198.

family members on their way to Magelang: 11 Indonesians (5% of all Indonesian admissions) and 11 Chinese (37%). Yet the Chinese patient population also included individuals who had been neglected. In this respect, there were no differences between Chinese and Indonesian inmates.

§ 3.1.3 · Accused or convicted

Before this section closes, a special group of patients should be mentioned, namely patients who had been convicted or accused of crime.[18] Altogether, this group consisted of three women and eleven men. In general, there were two reasons why these individuals were hospitalized. On the one hand, Magelang provided clinical observation for suspects for the purpose of a forensic-psychiatric assessment in court cases. These cases, eight in total, involved individuals suspected of molestation, murder, arson, and theft. According to a former *contract koelie* from Deli, the police had locked him up on alleged forgery. Yet, after the treating psychiatrist asked a couple of questions, the man admitted that he hit his mother and wife — but, he added, 'not really hard'.[19] Another man had been accused of theft at work. He was employed at Lindeteves in Semarang, at the time a widely known warehouse for technological novelties. According to his case file, he had stolen a bike; an accusation he initially denied, arguing he could not ride one.[20] Magelang also hospitalized individuals who had already been convicted. In these cases, prisoners were transferred from prison to the mental hospital, because their behavior had become a disturbance to the detention-center-discipline. The referral report of a male from Semarang stated that, over the last few months, he had been very aggressive towards jail employees and that he screamed in his cell. To diminish the burden on his environment, he was put in an isolation cell, but that, apparently, did not help to calm the man's nerves.[21] The sample of patient records contains five similar cases. All in all, about 5% of the population of Magelang consisted of patients with a criminal past.

§ 3.2 · The Motivations for Hospital Admission

In chapter one, the composition of Statements of Information as used in the Netherlands Indies was briefly discussed. The motivation to institutionalize someone usually included four components.

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[18] The files of these patients had written "Beklaagde", "Veroordeelde", or "Jusitie-patiënt" on it, most of the time in red.

[19] P. 4005.

[20] P. 2919.

[21] P. 1870.

One of these was examined in the previous section: the question whether or not someone was looked after by his or her family. Two other components concerned a description of what were called the "most prominent signs of insanity" and the "other reasons that necessitate hospital admission". In practice, however, the difference between the two was not completely clear to those who filled out the form, with the result that secondary causes were listed as prominent signs and vice versa. A final factor involved the level of danger someone posed to him- or herself and others. To understand the social mechanisms that worked towards asylum admission in the Netherlands Indies means to unravel the relations between these factors.

In his analysis of the social mechanisms surrounding mental hospital intake in the Netherlands between 1890 and 1950, Joost Vijselaar distinguishes two main factors: the severity and character of one's mental affliction and the support his or her social environment was able or willing to provide. The decision to institutionalize a beloved one was often a consequence of an imbalance between the two. On the one hand, an increase in the burden of living with a mentally ill person might overstretch a family's ability to maintain that individual, which could give an impetus towards hospitalization. On the other hand, the balance between a person with mental problems and his or her environment could be disturbed by changes on the supporting side of the equation, such as the death of a caretaker or the need to work and leave the house during the day.[22] Metaphorically speaking, there are two ways in which a river can overflow: the amount of water can increase or the dykes that are supposed to keep the water in place can be lowered. A similar logic applied to hospital admission in the Netherlands Indies. This section will therefore first discuss the signs of insanity. Thereafter, it shall focus on the relation between symptoms and social environment.

§ 3.2.1 · Signs of Insanity

Table 3.3 presents an overview of the most prominent signs of insanity ordered along the duration of one's mental illness. Please note that the sum of the percentages mentioned behind the absolute numbers surpasses the number of one hundred. This is, because these percentages indicate the relative number of patients who presented a certain symptom and individuals always showed a number of different symptoms. Take a male of aristocratic descent from the Kedu district as an example. He was said to speak nonsense, destroy goods, become angry and hit his family and other persons without any reasons, leave the house and sleep somewhere else, dress improperly, destroy

[22] Joost Vijselaar, *Het gesticht. Enkele reis of retour* (Amsterdam 2010) 84.

T A B L E 3.3 Signs of insanity as listed in patients' referral reports ordered according to the period of time patients suffered from mental illness before hospital admission was requested.

	< 1 month		1-12 months		> 12 months		n/a		Total	
	no.	%	no.	%	no.	%	no.	%	no.	%
Aggression	11	19	24	41	34	62	6	17	75	36
Arson	1	2	6	10	2	4	1	3	10	5
Dementia	0	0	1	2	1	2	0	0	2	1
Depression	1	2	0	0	1	2	1	3	3	1
Disorientation	4	7	0	0	1	2	3	8	8	4
Hallucination	2	3	4	7	2	4	0	0	8	4
Negativism	2	3	0	0	2	4	2	6	7	3
Inappropriate behavior	8	14	11	19	4	7	5	14	28	14
Agitation	20	34	13	22	14	26	11	31	57	27
Nuisance	9	15	5	9	5	9	7	20	27	13
Suicide	5	9	6	10	1	2	1	36	13	6
Vandalism	12	20	22	38	19	35	4	11	57	27
Confusion	33	56	18	47	28	51	20	56	108	52
Delusion	6	10	3	7	3	6	0	0	13	6
Wandering	5	9	6	10	9	16	3	8	23	11
Total	59		58		55		36		208	

his body, and bother other women.[23] Therefore the file of this person is subsumed by several categories, such as "aggression", "vandalism", and "confusion".

About half of all patients was described as confused (n =108). A quarter of these individuals displayed aggressive behavior as well (n =26). A 28-year-old male, for example, who studied at the Military Academy in Magelang, was said to 'act crazy, to laugh without any reasons, and to speak nonsense. He walks away and does not obey the rules of the army camp'. Judged by his actions, however, "disobeying the rules" seems to be somewhat of an understatement. Not only did he bite, hit, and scratch others, he had also chased children with a *klewang* (a single-edged long sword).[24]

[23] P. 5281: 'Soeka bitjara tida karoean (dleming) soeka meroesak barang-barang, soeka marah dan poekoel pada familie dan orang lain jang tida bermaksoed, tida soeka tinggal tetep di roemah, senantiasa pergi dan tidoer di mana-mana tempat, tida soeka berpakean jang pantes, badanja roesak, soeka masoek di roemah orang lain dan mengganggoe kepada orang rempoean bikin koeatiran kepada dirinja sendiri dan orang lain serta bikin maloe kepada pemandangan'.

[24] P. 4313: '18. Maakt steeds. ruzie - is dan weerspanning - slaat, bijt en krapt. Doet mal, lacht (...) praat onzin. Loopt weg, volgt de regels niet op van de kampementsbewoners. Heeft nu met een klewang de kinderen nageloopen, is dus onrustig en gevaarlijk voor anderen'.

Many other examples of aggressive behavior could be provided. According to a referral report drawn up by the *kepala* of Sawan and checked by the *wedono* and *assistent wedono* of Pengasit, a Javanese farmer, who was admitted to Magelang in 1928, 'spoke nonsense and wanted to attack other people, he wanted to hit other people'.[25] A 30-year old woman, lastly, had been crazy for about a year, but she had not bothered anyone up until about one-and-a-half months before her Statement of Information was filled out. She had started to speak nonsensical, persecute other people, and bombard them with stones.[26]

Confusion was also mentioned in combination with vandalism (n =22). Destructive behavior was often directed towards human possessions and sometimes towards plants. A tradeswoman from the Salaman district, who spoke 'inconsistently and nonsensical,' chased people who passed by her house and was said to be dangerous for other people's houses, because she liked to destroy anything.[27] In some cases, destructive behavior included incendiarism. Above we have already discussed the example of a male who burned down a goat cage, but there were more examples. The people in Bocor, a village to the southwest of Magelang, were worried that one of their female villagers would set their houses on fire, because she was confused and played with torches during the night.[28] Only ten individuals were described as confused, aggressive, and destructive. A very extreme example was a Javanese female who had been transferred from the transit asylum in Solo. According to her referral report, this woman had stolen other people's possessions, destroyed plants and the walls of houses, was an arsonist, screamed, and left her dwelling at night. On one occasion, she had attacked her mother with a sharp object.[29]

This woman also displayed inappropriate behavior as she alternately dressed up as man or woman. Likewise, 13 other confused individuals acted in a way that was seen by their milieu as a symptom of insanity. Walking around completely naked or tearing one's cloths apart were regularly mentioned in the Statements of Information (n =21). A 37-year-old male from Grosak dressed himself in black shirts and shorts and claimed to be a boy-scout. According to his file, he often went

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[25] P. 2246: 'Tandanja poenja sakit gila bitjaranja loewar biasa dan maoe mengambil poenjaknja orang lain, kalau jang poenja tidak boléh lantas dia maoe moekoel'.

[26] P. 6037: 'Sampai sekarang (...) 1 tahoen, tadinya tidak mengoewatirkan, tetapi kira 1/2 boelan sampai sekarang laloe mendjadi mengoewatirkan. [...] memoekoel pada lain orang, pakai batoe dan sebagainja'.

[27] P. 4095.

[28] P. 4538.

[29] P. 1265.

to the *pasar* (market) of Gondang to give lectures and attacked everyone who got in his way.[30] Inappropriate behavior could also involve the mixing up of languages, such as a man from Surabaya, who spoke intermingled Malay, high Javanese, and low Javanese.[31] Four referral reports explicitly mention an aversion to work. Finally, confusion was also discussed in relation to agitation (n =10), wanderlust (n =11), and disorientation (n =5). Some of these people were reported to scream and shout while roving through a *desa* or city.

Next to confusion, aggression (n =75), agitation (n =57), and vandalism (n =57) were frequently mentioned as signs of mental affliction. As in the examples discussed above, these categories often overlapped. Some referral reports mentioned aggression, agitation, and vandalism in relation to confusion, but that was not always the case. If the cases of confusion are subtracted from the total numbers of aggressive, agitated, and destructive insane, 57 reports of aggression, 51 reports of agitation, and 35 reports of vandalism remain. These Statements of Information often contained rather extreme examples of aggressive behavior, such as molestation or even murder. A female from Yogyakarta, about 30 years old, was judged to be a danger to herself and others. Not only had she committed arson, she also attempted to violate her mother and to commit suicide by throwing herself into a well.[32] Likewise, a man in his mid-forties from Surakarta destroyed other people's possessions, seized and beat up people who brought him food, walked around naked, and abused his wife and children. 'This man', his referral report states, 'is not a danger to himself, but he is dangerous to others'.[33] Five patients had run amok. On the night of July 6, 1938, an old Chinese man had smashed cups and plates and had tried to kill his daughter and a house servant.[34] A Javanese man from Losari had committed amok as well. Armed with a machete, he had threatened everyone who got on his way and entered houses of strangers. Because his family and the other villages fled, no one got injured.[35]

As the examples discussed above indicate, aggression and destruction were often mentioned in the referral reports. Aggression was directed towards both family and community members: 17 files recorded that family members were beaten up and no less than 27 Statements of Information describe that other people fell victim to the aggressive behavior of mentally ill. Seven cases

[30] P. 1807.

[31] P. 544.

[32] P. 4095.

[33] P. 4523.

[34] P. 5339.

[35] P. 6959.

mentioned that the insane under consideration threw stones. At least four records mention that a lunatic had threatened others with sharp objects and, on two occasions, had actually stabbed someone. About a quarter of the referral reports made mention of aggressive behavior in a more general sense. One report, finally, discussed aggressive behavior towards animals. An 18-year-old woman from the Kutowinangun district was said to catch and kill baby chickens, after which she tore them apart and ate them. In addition, she took off her clothes and spoke nonsense.[36]

Yet a considerable number of individuals did not pose a direct threat to their environment. All in all, 113 Statements of Information mention people whose behavior was troublesome rather than dangerous. Many of them were described as confused (n =67), often in combination with agitation or restlessness (n =30), public nuisance (n =19), or socially undesirable behavior (n =15). A Javanese woman, for example, who was initially hospitalized at Solo, walked around naked, played with her urine and excrements, screamed, and kept the neighbors out of their sleep.[37] A Chinese woman in her early fifties suffered from hallucinations and delusions, and she was agitated. Although she was not dangerous, the referral report stated that she could not be kept at home because she was bothersome to her environment.[38] Another example was a 12-year-old girl from the White Cross Colony near Salatiga. She suffered from convulsions and did not speak anymore. The girl chewed on her cloths and on her fingers, ate her own feces, and needed to be washed and fed. According to her referral report, she was a burden to her environment and a danger to herself.[39] Only three people were described as depressed. A Chinese woman from Magelang was said to suffer from ‘taedium vitae’ (weariness of life): she was depressed, she cried and did not eat or sleep. ‘Professional help is necessary’, a psychiatrist from Magelang wrote in her referral report, ‘she is not really restless, but she is annoying because she cries all the time. Danger for herself is not completely excludable’.[40]

As these final examples indicate, occasionally one’s mental condition did not pose a threat to others but rather to oneself. In 12 Statements of Information an attempt to commit suicide or the fear that someone might commit suicide was mentioned. One example is a woman from Yogyakarta who imagined that she was persecuted by ‘police and other armed persons’. In these moments of

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[36] P. 7152.

[37] P. 5848.

[38] P. 2287.

[39] P. 4089.

[40] P. 5325.

intense fear, the people who looked after this female feared that she would hurt herself.[41] A soldier, also from Yogyakarta, had tried to commit suicide by cutting his throat with a bread knife. According to notes taken by a Magelang psychiatrist, the patient was antagonized by fellow soldiers, because he never went out with them. Instead, he saved money to send to his parents.[42] Most suicide attempts involved jumping into a well.

Except for amok, another mental syndrome unique to Southeast Asian culture is mentioned in the referral reports: latah. In academic literature, latah is often described as encompassing three symptoms, namely 'involuntary blurting of obscene words or phrases, compulsive imitation of the words or actions of others, and compulsive unquestioning obedience, when ordered to perform actions which may be ridiculous, improper, or even dangerous'.[43] Whereas amok is usually ascribed to males, latah is typically seen as a female syndrome.[44] Interestingly, the referral reports show a rather different picture. Six males — one of whom was of Chinese descent — and six females were reported to suffer from latah. No mention was made of compulsive mimicking, only excessive laughing and talking. Females were, however, overrepresented among the reported cases of exhibitionism. At least 12 females (15%) and 9 males (6%) took off or tore their clothes apart in public.

§ 3.2.2 Symptoms and Social Environment

In this chapter's first section, a distinction was made between two categories of insane: insane who, prior to hospital admission, were maintained by their families and patients who were formerly neglected. Subsequently, the group op maintained individuals was divided into two: individuals who were looked after and future inmates who could not be looked after any longer. The signs of insanity discussed above were not equally distributed among these three groups. It rather seems that the decision to request hospitalization was the outcome of a particular combination of a lunatic's situation in life and the symptoms he or she presented. For the sake of clarity, the aforementioned signs of insanity shall be divided into two groups: behavior that involved aggression, violence, and/or destruction; and a group that includes all other signs of insanity, such as agitation and improper behavior. On the basis of this distinction, it will become clear that the three categories of insane

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[41] P. 1872.

[42] P. 2379.

[43] Hildred Geertz, 'Latah in Java. A Theoretical Paradox', *Indonesia* 5 (1968) 93-104, 93-4.

[44] M. Bartelsman and P.P. Eckhardt, 'Geestesziek in Nederlands-Indië — vier psychiatrische syndromen: amok, latah, koro en tropenneurasthenie', *Nederlands tijdschrift voor geneeskunde* 151 (2007) 2845-2851, 2847.

were hospitalized for different reasons. Among individuals who were maintained by relatives, and in contrast to neglected individuals, aggressive behavior was often the deciding factor in hospital admission. In other words, the threshold to request hospital admission for homeless insane was much lower, in the sense that, the presentation of non-aggressive symptoms was enough to trigger institutionalization.

In addition, this section will discuss three so-called "other reasons that necessitate hospital admission" that were mentioned in the patient records: someone is a danger to others; someone poses a danger to him- or herself; and admission is requested for the sake of medical treatment (these are listed in table 3.4). In the following analysis, the more general classification "danger to others" has been copied from the referral reports *only* when the record makes no explicit mention of aggressive or destructive tendencies. After all, if someone abuses his wife this means by definition that that person is dangerous to others. The file of this person is therefore subsumed only under the category of "aggressive or destructive behavior" and not also under the category "danger to others". In this way, we might get an idea of who was perceived to be dangerous although possibly no explicit violence was used. The following pages shall first discuss neglected individuals, then maintained mentally ill, and finally insane who could not be looked after any longer.

As table 3.4 shows, aggressive and/or destructive behavior was least reported among neglected individuals: it was mentioned in a quarter of their referral reports. Another quarter of these Statements of Information made reference to dangerous behavior towards others, yet without further specification. A 23-year-old beggar, for example, whose referral report was signed by an official from Kroja, was said to 'speak nonsense and use dirt to cover his own body. In the desa Kroja he has no acquaintance or family. He walks around naked and is dangerous to other people and his body'.[45] Another example is a male from Surabaya. He screamed, spoke in a confused manner, and suffered from auditory hallucinations. According to the Indies physician of the Central Civil Hospital of Surabaya who filled out his form, the man should be sent to a psychiatric institute to receive medical treatment. Also, he was 'very restless and a danger to himself and others'.[46] In six other files, medical care was provided as an additional reason for hospital admission. About one fifth of the reports recorded that an insane posed a danger to him- or herself, sometimes in combination with a danger to others. A tramp who was dropped off by police at the transit asylum

[45] P. 3628: '18. Bitjaranja tida karoean (tida matok) dan badannja dibedaki pake dia poenja kotoran. 19. Didalem desa Kroja tida poenja kenalan atau achliwaris'.

[46] P. 2241.

T A B L E 3.4. Signs of insanity — divided into aggressive and non-aggressive symptoms — and so-called "other reasons that necessitate hospital admission " ordered according to patients' social environment. The other reasons that were provided to argue for hospitalization were: someone is a danger to others; someone poses a danger to him- or herself; and admission is requested for the sake of medical treatment.

	Neglected		Looked after		Looked after, but		Total	
	no.	%	no.	%	no.	%	no.	%
Aggression	14	25	22	42	67	74	103	52
Other	42	75	31	59	23	26	96	48
Dangerous	15	27	14	26	17	19	46	23
Dangerous for oneself	12	21	17	32	28	31	57	29
Medical attendance	7	13	4	8	7	8	18	9
Total	56		53		90		199	

of Semarang posed a threat to herself and others as she constantly stood in the middle of the road in a confused state of mind. If the woman was asked something, she would only laugh in return.[47]

Yet about half of the Statements of Information that belonged to this group of lunatics did not mention aggression or danger at all. It therefore seems that the primary reason of asylum admittance for neglected individuals was that they exhibited disruptive, inappropriate, and sometimes potentially dangerous behavior, while no one was around to keep a watchful eye on them. Most neglected insane were completely left to themselves. One example was already discussed above, the Javanese woman who undressed in public, played with her excrements, and kept her neighbors out of their sleep. It is important to remark that she was not married and had no children who could look after her.[48] This woman probably still owned a house, yet many others had become homeless. A woman, estimated age 25, who was found on the side of the road, was said to talk a lot to herself and laugh without apparent reasons, to use dirty language, and she 'poked her

[47] P. 4137.

[48] P. 5848.

nose into other people's business'.[49] The file of another man stated, with telegraphic brevity, 'restless, fear, disoriented, insomnia, not dangerous'.[50]

In comparison to neglected insane, aggression and perceived danger played a considerably more prominent role in the admission of patients who were looked after by relatives. Two out of five Statements of Information referred to aggressive or destructive behavior, which, moreover, often was of a more violent character than aggression conducted by neglected individuals. Twice as many insane, for example, physically assaulted someone before a request for hospital admission. About a quarter of these Statements of Information simply described a lunatic as a danger to others. Not only was the number of aggressive insane higher, it was also more often mentioned that a lunatic's conduct posed a threat to him- or herself. A Javanese woman, for example, who was diagnosed with catatonic schizophrenia, posed a danger to herself, because of her 'total inability to move'.[51] In general, however, a danger to oneself and a danger to others were mentioned in the same breath. Perhaps surprisingly, medical treatment was less often provided as a reason for hospital admission. This is possibly explained by the fact that, as compared to neglected insane, less Statements of Information were filled out by medical or psychiatric institutions (see table 3.5 and section 3.3).

As opposed to the other two categories of lunatics, it is difficult to pinpoint the main factors that worked towards the asylum admission of people with mental health problems who were looked after by their relatives. Request for hospitalization was probably caused by the combined action of a number of elements of which none really stood out. Chinese insane were slightly overrepresented among these patients as they comprised about a fifth of the group. The number of patients who were a member of the *priyayi*, the Javanese aristocracy, were overrepresented as well, yet to a very small degree. About 19% of these patients were taken to the hospital by their families.

Referral reports on individuals who were looked after, but for whom the family was not able to care any longer, constituted the single largest group of Statements of Information. Various reasons were provided to clarify why a family could not continue to maintain an insane relative. Aggression was, without doubt, the main cause. No less than 75% of these records contained references to aggressive and/or destructive activities and an additional 19% described an individual as a danger to others, yet without further specification. In other words, only six of these records did

[49] P. 25.

[50] P. 1811.

[51] P. 2424.

not mention aggression or danger to motivate a request for hospital admission. Both family and community members fell victim to aggressive and violent insane. One man had drowned one of his children and four others had attempted to murder someone. A rather exceptional story comes from a 60-year-old man from a little village in Kedu. The man had been confused for a couple of days, when he attended a children's parade on *Hari Mulud*, the feast to celebrate the birth of the prophet Mohammad. While watching the celebration, he became extremely angry and destroyed the *dandang*, a traditional Javanese pan. A day later, he beat up another villager, where after he ran away.[52]

Aggression, however, was not the only reason provided to explain why admission to a psychiatric hospital was deemed necessary. Another motivation concerned the age of caretakers. The referral report of a craftsman from the Salatiga district, for example, stated that the man 'is guarded by this father Wongsokario [who has passed the age of 80], but his father is not strong enough and unable to guard him anymore, because he is already very old'.[53] Lack of financial resources was another reason mentioned in the Statements of Information to clarify why someone with mental problems could not stay at home any longer. Poverty could prevent family members from looking after insane relatives. The family of 'a confused, old man' was unable to take care of him, because they needed to go out and search for food.[54] Likewise, a 30-year-old woman from Ambarawa could not always be attended by her parents, because they needed to leave the house to work and trade.[55] Above, another financial argument to consider institutionalization was discussed: family members were possibly required to offer compensation for the damage caused by insane relatives. At least one person could not be kept at home because of this reason.[56]

As Vijselaar has argued, the decisive step towards institutionalization was often the consequence of an imbalance between support demand on the side of the insane and the help that

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[52] P. 4090.

[53] P. 6580: 'Jang mendjaga ia papahnja nama Wongsokario terseboet diatas, aken tetapi papahnja itoe tida koeat dan tida sangoep oentoek mendjaga ia, lantaran papahnja soeda toea sanget'. See also: p. 7156 and p. 4095.

[54] P. 6522: 'Tiada didjaga, sebab familinja teroes mentjari makan'. The family of another patient was "too poor" as well. See: p. 7200.

[55] P. 1273: 'Didjaga oleh orang toean (...), tetapi dari sebab bapan(ja) sering pergi menggarap (...) waknja dan boeroeh matjoe, djadi pendjagaan kurang baik'.

[56] P. 4524: 'Ia selaloe didjaga sadja oleh sanak familienja, akan tetapi dari sebab sama miskin maka tida koeat piara, sedang sigila itoe soeka membikin roesak lain orang poenja barang, jang mana achirnja sama minta ganti pada familienja'.

his or her environment could provide.[57] In the Netherlands Indies, both factors seem to have played a role as well. The threshold to take someone to a mental institution was lowest for homeless and neglected lunatics. As opposed to individuals who were attended by relatives, these people probably had no one to reply upon and to keep their behavior within socially-accepted boundaries. Their insanity could therefore turn into a social problem rather easily or, alternatively, was perceived to be a hindrance to public life. This was different for people who were maintained by families. In these cases, it was often aggressive and destructive behavior that led to an official request for hospital intake. The number of people who showed these symptoms increased as the duration of illness progressed. About 42% of the insane admitted within their first month of mental illness behaved aggressively; among individuals who had been ill for over one year, this figure was 75% (see table 3.3). This suggests that many mentally ill stayed at home until their behavior escalated.[58] Yet the mechanisms that surrounded hospital admission of maintained insane did not only, and did not always, involve violence and devastation. A considerable number of those looked after by family members showed symptoms that were cumbersome rather than dangerous. In these cases, it remains difficult to determine why families chose to send someone to a mental institution. One motivation was to receive professional care and cure, another concerned the danger mentally ill posed to themselves.

§ 3.3 · Filled Out by Whom?

So far, it has been argued that different categories of patients were hospitalized for various purposes. The institutions involved in requesting hospital admission differed as well. Altogether, 190 out of 215 referral reports provided information on who filled out the form. These reports were issued by four institutions: mental institutions, hospitals, the police, and Native local administration. Table 3.5 provides an overview of the records as distributed by these institutions. About 45% of all referral reports were signed by a civil servant employed by local administration: a *kepala* or *prabot* (village chief), an *assistant wedono* (assistant district chief), or a *wedono* (district chief). Only seven of these records belonged to Chinese insane (8%). In seven other Statements of Information on Indonesian lunatics, it was explicitly mentioned that the requested was submitted on behalf of family members. In one case, a request for institutionalization was signed by the future patient

[57] Joost Vijselaar, *Het gesticht*, 84.

[58] Cf. *Ibid*., 98-109.

T A B L E 3.5. Patients' social situation ordered along the lines of institutes who filled out a referral report.

	Hospital		Mental		Kramat		Local administration		Prison		Totaal	
n/a	1	4	2	9	4	14	0	0	2	8	9	5
Neglected	16	57	14	61	8	29	9	10	5	21	52	27
Looked after	4	14	5	22	12	43	20	23	6	25	47	25
Looked after, but	7	25	2	9	4	14	58	67	11	46	82	43
Total	28		23		28		87		24		190	

himself. According to the file, this 30-year-old Javanese man hallucinated and had abused his wife and parents.[59]

Next to local administration, most Statements of Information were filled out by mental institutions (27%). With respect to these institutions, a distinction could be made between the Magelang Asylum and other psychiatric facilities: slightly more than half of the records created by these institutions was filled out by a psychiatrist from Magelang. About 20% of these Statements of Information (n =10) belonged to Chinese patients. The remaining referral reports were signed by staff members of either a hospital or a prison. Both accounted for about 12 to 15% of the entire sample of referral reports. As with mental hospitals, the relative number of requests for Chinese insane at these institutes was higher than figures for local administration: 18% of all hospital requests and 13% of all prison requests. The records filled out by hospitals include five records created by a military hospital. Whereas the lion's share of requests by Native bureaucrats was filled out in Malay, most of the Statements of Information created by the other institutions were written in Dutch.

Table 3.5 does not only provide an overview of the distribution of records among the requesting institutions involved. It also contrasts these institutions with the three categories of insane distinguished in the first two sections of this chapter: neglected people with mental health problems, insane who were maintained by their families, and lunatics who could not be attended anymore. As with the symptoms of mental illness, these individuals were not equally distributed among the institutions involved with care for and accommodation of insane.

Neglected individuals were particularly present among mental patients submitted via regular hospitals, transit asylums, and, to a lesser degree, Magelang Asylum itself. Most of these

[59] P. 7185.

individuals had been arrested by police for reasons discussed above. A man from Kotagede, one of the oldest town centers of Yogyakarta, recalled that he was simply walking down a street when policemen took him into custody. Thereafter, he was brought to a police office that was located on the west side of the *alun-alun* and was locked up.[60] Although it could be doubted whether this man was indeed only walking about, the man's recollection of the event might be accurate.[61] At that time, this police office had a ward that was reserved for people with mental problems. In newspapers, it was described as dilapidated and dirty.[62] Not many neglected insane, however, were locked up in a cell after police had arrested them. About three quarters of homeless or neglected lunatics were brought by the police to a medical institution. Least requests for hospitalization of unattended lunatics came from Native local bureaucrats.

The second largest group whose request for hospitalization was submitted by mental institutions consisted of patients who were looked after by their families. This group accounted for 43% of the requests by Magelang and 22% of the referral reports filled out by other psychiatric facilities. At the moment of admission, at least five of them were accompanied by family members. Several patients whose Statement of Information was filled out by a Magelang psychiatrist entered the asylum after they had been treated at a regular hospital, though not necessarily because of insanity. The wife of an *assistant wedono* from a district on East Java, for example, was nursed at the sanatorium near Pakem for a couple of months, when she suddenly became confused. 'I cannot keep her here like this,' a physician from Pakem wrote to his colleague at Magelang.[63] Attended lunatics also constituted a significant part of the requests filled out by Native bureaucrats and prison staff. One of them was the son of an *assistant wedono*, the boy who sang all day because he heard voices telling him that he was a first-rate singer. After he had been hospitalized for a month at a clinic in Temanggung and his referral report was signed by a local police officer, his father brought him to Kramat. At least four other insane, whose referral reports were issued by local bureaucrats, travelled to Magelang in the company of family members or the head of their village. Three reports made explicit that they were submitted on behalf of family.

Lunatics who were maintained, but who could not be attended any longer by their families, constituted the largest groups among referral reports created by Native local administration and

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[60] P. 2256.

[61] The medical record of this man contained no referral report, so it cannot be determined why he caught police's attention.

[62] 'Bewaarhuis voor krankzinnigen', *Soerabaiasch-Handelsblad* (April 12, 1935) 10.

[63] P. 5338.

prisons, and they accounted for a quarter of requests submitted by hospitals. Most Indonesian patients entered Magelang Asylum after the situation at home had become untenable and a Statement of Information was filled out by a Native local bureaucrat. It is not always clear whether the impetus to request hospitalization came from the family alone or from other villagers. Perhaps it was a combination of the two. When the situation at home escalated, the safety of both family and community, as well as the safety of the mentally ill person, was at stake. Four Statements of Information were co-signed by family members and, as discussed above, another document was signed by someone with mental problems himself. At least seven others — five Indonesians and two Chinese — were brought to the hospital by either one or several relatives, assisted by police.

§ 3.4 · Concluding Remarks

Thrilling as it may sound, only one quarter of the mentally ill who ended up as patients of Magelang entered the hospital because they had been "surfacing up". These were foremost the homeless and neglected — confused individuals who walked the streets of a city or village and who for some reason caught the eye of the police. In stark contrast to Jackson's argument that these lunatics were arrested because authorities perceived them to be dangerous, about half of the formerly neglected insane were picked up *despite* the fact that their behavior was not described as particularly dangerous or aggressive. It therefore seems unlikely that these insane were seen as a threat to a so-called "colonial order of things". Had that been the case, probably many more Statements of Information on neglected insane had been filled out by prison employees. Instead, police officers brought confused homeless people to regular hospitals and mental facilities. It is also telling that medical treatment was more often mentioned in these referral reports as a motivation for hospitalization. In short, rather than a tool to oppress dangerous neglected insane, Magelang Asylum was, at least in part, a space to accommodate and care for a group of mentally ill people who, for one reason or another, were completely left to themselves. Admission of these people was mainly via medical and psychiatric institutions.

To be sure, in many cases aggression and vandalism clearly were the main causes of hospitalization. No less than 52% of the Statements of Information contains references to episodes of violent, assaultive, and/or destructive behavior, and 48% of the remaining referral reports indicates that the person under consideration was a danger to others, without it being further specified what exactly constituted that danger. These people, however, did not enter the "gaze" of Western psychiatrists because they accidentally transgressed moral or geographic boundaries

established by the colonial authorities. In general, insane were maintained by family members — possibly because the actions of insane relatives was the family's responsibility — until the situation at home became untenable. In case the point of escalation was reached, families were assisted by local authorities and possibly also by villagers to deal with the situation. This often meant that people with mental problems were physically restrained by means of *pasung*. Considering the lack of asylum beds in the Netherlands Indies, it is likely that thousands of insane were illegally kept in little bamboo houses, wooden blocks, and prisons. Yet some of them — and, dare I say, the lucky ones — were officially reported to the state. A referral report was filled out and in case the individual was found to be insane hospitalization was authorized by the *landraad*. In other words, most of the Indonesian insane did not enter the asylum by share chance; many of those who entered Magelang did so, because they were reported, that is, brought into the gaze of the authorities by the Indonesian community. The asylum provided an opportunity to release both family and community from the burden of living together with someone who had to deal with serious mental problems. At the same time, the insane under consideration would receive medical attendance.

Next to these groups, there were at least two other categories of inmates: patients who had been maintained by their families and patients who were either convicted or accused of crime. Statements of Information on insane who were looked after by family members reported less cases of aggression and vandalism, and about half of these documents were filled out by doctors of medical or psychiatric institutions. Slightly overrepresented were patients of Javanese aristocratic and Chinese descent. It could be conjectured that these groups possessed the means, be it financial or otherwise, to take family members to an institute to receive medical attendance and, by doing so, to prevent the situation at home from escalation. Foucaultian terminology is not particularly helpful to analyze these events: how would a concept as "the colonial order of things" or the "disciplining" of the population of Central Java fit the case of a father who takes his confused son to a mental hospital? Of course, regardless of its national and cultural context, institutionalization at an asylum always involved a degree of coercion. Patients were, after all, deprived of their freedom. Yet it is important to be reminded that the family of a mentally ill individual who brought someone to Magelang Asylum hoped that the patient would receive care and possibly a cure in return. The colonial asylum was many things all at once.

Chapter 4 · The Routes Into and Out of Magelang Asylum

In the previous chapter, it was discussed that patients entered Magelang for various reasons and in different ways. The trip to the hospital was relatively short for those insane who were directly admitted to Magelang and whose referral report was signed by a psychiatrist. For many others, the creation of a referral report marked the beginning of a journey that could take up several years. In anticipation of admission to a mental hospital, lunatics could stay at a number of institutions such as transit asylums, prisons, and regular hospitals. Some of them, in particular insane from Central Java, ended up at Magelang Mental Hospital. Unfortunately, asylum life and psychiatric treatment cannot be analyzed within the confines of this study, which is why the hospital's daily routine will remain a black box left for future research. What can be discussed are the pathways out of the mental hospital. For most mentally ill, Magelang was no final destination. Although some patients died at the asylum, many others recovered from previous disease and returned to their families and villages. Another group of inmates was transferred to other mental hospitals or colonies that accommodated — citing a 1938 newspaper-article — 'those who have a miserable live if society leaves them all to themselves'.[1]

This chapter discusses the routes travelled by patients as they moved in and out of Magelang Asylum. The asylum was part of a network of institutions concerned with maintenance and care for the insane. What kind of institutions were these? How long did patients stay at these institutes? And how did a patient's home situation influence his or her departure from the asylum?

§ 4.1 · Routes to Magelang

The 1897 'Regulations on the Care for the Insane in the Netherlands Indies' distinguished between temporary and long-term accommodation for mentally ill individuals. Recognized as long-term

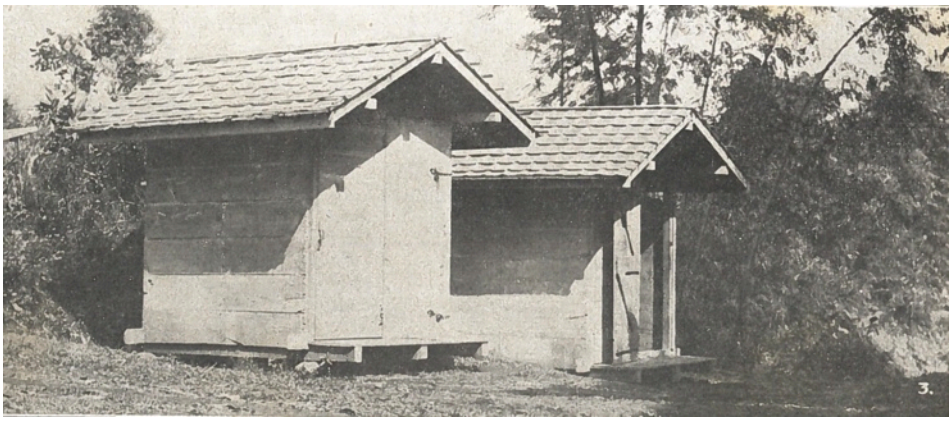
[1] 'Armenkolonie "Blondo"', Bataviaasch niewsblad (January 21, 1938) 10.

psychiatric facilities were privately-owned asylums, family nursing, and government-owned asylums. Before hospitalization at either one of these institutions, insane could be temporarily accommodated by prisons, military hospitals, and Native hospitals (§1.2). Patient records obtained from Magelang show that, roughly speaking, there were two trajectories to the asylum. Some mentally ill were first maintained at a temporary facility, after which they were either transferred to Magelang or a transit asylum. Others were directly taken to a long-term accommodation and were subsequently evacuated to Magelang. On the basis of 198 patient records, it can be estimated that the average period of time between admission to a temporary or long-term accommodation for mentally ill and transfer to Magelang was six months. As argued in the previous chapter, a patient's social position prior to admission influenced how and why he or she came into contact with authorities. A hospitalization request for a neglected insane or a Chinese patient was more likely to be filled out by the employee of a medical or psychiatric institution; Statements of information on maintained individuals, especially of Indonesian descent, were created by local bureaucrats. This section discusses temporary accommodation and long-term accommodation — except for mental hospitals — of Indonesian and Chinese individuals with mental health problems in the Netherlands Indies.

§ 4.1.1· Temporary Accommodation for Mentally Ill

In anticipation of admission to a long-term psychiatric facility, many future inmates of Magelang were maintained at hospitals and prisons. Because patient records are not always clear whether or not a future inmate had been incarcerated, it is difficult to determine exactly how many of them stayed at a prison. In total, 87 Statements of Information were filled out by employees of local administration and 25 by prison staff. Of these records, three belonged to individuals who were first convicted of crime and started to show signs of mental disorder afterwards. If these records are subtracted from the aforementioned referral reports, it can be estimated that at least 56% of the patients of Magelang had previously been locked up without having participated in any criminal activities.

According to Engelhard, temporary confinement meant, in practical terms, that a patient was locked up in a cell. In his 1925 article, he included pictures of places where mentally ill individuals were kept (see fig. 5 and fig. 6). The medical records from Magelang do not reveal much about the living conditions of patients in prisons. The documents suggest that circumstances under which mentally ill individuals were kept could vary substantially from one another. The clothes of one



F I G U R E 5 and F I G U R E 6. Two places used to temporarily accommodate mentally ill individuals. Above are little wooden houses without windows and furniture located near one of the district capitals in Central Java. Below are cells at the local prison of Solo. These photo's were published by Engelhard in his 1925 article on the Surakarta Transit Asylum.

woman, for example, were completely wet when she entered Magelang asylum four days after she was arrested by the police. To a nurse, the patient explained that she was not given anything to drink and that she had tried to scoop out water from a lavatory.[2] The prison environment for a patient from Rembang seem to have been more favorable. During the mornings, he did various household chores like sweeping the floors and garbage disposal. In the afternoon, the man was isolated.[3] This

[2] P. 7153.

[3] P. 6624.

man was quiet, which was probably the reason why prison wardens let him out of his cell. Two others were more difficult to keep in custody. One of them even hit other prisoners, which suggests that separation from others convicts was not always possible.[4] Despite the fact that remarks on prison experiences of insane are rarely mentioned in the medical files, these examples show that the conditions of prison life could vary.

If we take the day a referral report was filled out by prison staff or local bureaucrats as the beginning and the day a patient was transferred as the end, individuals, on average, were evacuated after seven weeks of confinement (based on 104 reports[5]). About 88% of the patients kept at prisons were relocated within three months. Most of these patients were sent to long-term accommodation for the insane: 70 insane were transferred to Magelang and 32 mentally ill to either a privately-owned asylum or a transit asylum. Six others were moved to a regular hospital.

In contrast to the number of patients who had been imprisoned, it is easier to establish how many insane were temporarily nursed at a hospital, because this was often explicitly mentioned in their records. Altogether, 58 inmates of Magelang had been maintained at a hospital prior to their transfer to a long-term psychiatric facility. A quarter of these inmates were looked after on a military hospital ward — foremost the Military Hospital in Magelang (n =11) — and at least 60% (n =35) were hospitalized at a regular hospital, such as the Central Civil Hospital of Semarang (n =13) and Surabaya (n =5). Five other patients were treated at a missionary hospital, either the Petronella Hospital in Yogyakarta or a hospital in Salatiga.

Although it is easier to determine the number of patients treated at a hospital, as with the living conditions of confined mentally ill, the records do not expose much of the policy towards insane treated at hospitals. Some referral reports recorded that a patient had been in observation and that transferal to a mental hospital was recommended on that basis.[6] Other files indicate that patients received medication, such as the antiluetic drugs Salvarsan and Neo-Salvarsan. Fever therapy by means of bismuth was administered as well.[7] Some patients received sedatives such as bromide or the barbiturate Somnifen, though, in case of the latter, not to induce prolonged narcosis. Somnifen was given to a young woman hospitalized at the Military Hospital in Magelang. According to her referral report, she caused ‘problems for the nursing staff [and other patients], pat. cannot be left alone — anxious though not a danger to herself and others’. After three days of

[4] P. 6038 and p. 5278.

[5] Altogether 112 referral reports were filled out by prison staff or local bureaucrats, but a date is not always mentioned.

[6] P. 1268, p. 6040, and p. 6631.

[7] P. 1955, p. 2601, p. 5492, and p. 7154.

arousal, unmotivated laughter, climbing out of bed, and rolling over the floor, she was evacuated to Kramat. Seventeen other referral reports described behavior that was disruptive or dangerous towards others. Clearly, similar to the situation in prisons, separation of regular patients and patients with mental problems was not always an option. Trouble caused by patients with mental problems was one reason why these people were transferred to a mental hospital.

Following the same reasoning as used to determine how long patients had been incarcerated, it can be estimated on the basis of 27 records, that the average period of hospitalization was six weeks. About 80% were transferred to a different institute within three months. Four out of five were evacuated to Magelang, the rest was first sent to a transit asylum.

§ 4.1.2 · Long-Term Facilities for Mentally Ill

Next to temporary accommodations, the colonial authorities recognized three types of long-term care for the insane: privately-owned asylums, family nursing, and government-owned asylums. Throughout its colonial history, Magelang foremost cooperated with five mental institutions: the transit asylums at Grogol, Solo, and Semarang, and the privately-owned asylum at Wonocatur and its successor, the agricultural colony for insane at Pakem. About 35% of the entire population of Kramat was institutionalized at a mental health institute prior to transfer to Magelang. This figure was much lower among Chinese patients, as only five inmates (17%) had been maintained at a long-term psychiatric facility prior to admission to Magelang. This is partly explained by the fact that many Chinese insane were directly submitted to the mental hospital. Among the records analyzed for this study, no examples of family nursing were found.

Medical and psychiatric care at transit asylums seems to have resembled treatment at regular hospitals to some extent. Similar to medical institutions, several patients were subjected to a Wassermann test — an antibody test for syphilis — and received antisyphilitic drugs in case the test results were positive. As transit asylums were built to accommodate patients with mental problems, it is likely that these institutions had isolation rooms and bathrooms to facilitate hydrotherapy. Such was at least the case at Grogol and Solo, where prolonged baths were used to calm down the nerves of agitated and aggressive patients.[8] During the 1930s, working therapy concurred a more prominent position within the treatment arsenal of transit asylums. Patients who did not recover or improve during their stay at a transit asylum could be transferred to a mental hospital once ward

[8] P. 85, p. 1328, and p. 1706.

beds had become available. Inmates were, more often than not, transferred in groups, possibly to reduce the costs of transportation.

The time spent by patients at transit asylums exceeded the time spent at hospitals or prisons considerably. On the basis of 64 records, inmates stayed at these institutions for about 15 months. A third of these patients was transferred to Magelang within half a year and a fifth stayed at a transit house for longer than two years. Most of these individuals had been taken in at Grogol in 1920, which at that time faced serious problems due to overpopulation. Most of them were relocated to Magelang in 1924. The records indicate that Semarang had troubles concerning overpopulation during the 1930s as well.

Patients hospitalized at the privately-owned asylum Wonocatur and Pakem accounted for a quarter of all patients maintained at long-term institutions. The Wonocatur Asylum, located on the site of a sugar factory four kilometers west of the city center of Yogyakarta, opened in 1934 and was the private initiative of an association of local notables. It was firmly supported by the Sultan, because the Yogyakarta Sultanate — and, for that matter, the Surakarta Sunanate as well — was required by the colonial government to pay one guilder for every day someone with mental problems was hospitalized at Magelang.[9] This was not the case for patients who stayed at Wonocatur and Pakem, which explains the Sultanate's financial support. Though Wonocatur could accommodate about 20 patients at the same time, between March 1934 and April 1935, over 180 patients were hospitalized. Its main goal was to provide acute care. Once someone had calmed down, he or she was sent back to his or her desa, even if the patient had not completely recovered. In case someone experienced a relapse and returned, transfer to Magelang was considered. In 1938, the asylum was relocated to Pakem, a district in the north of Yogyakarta. Its size increased significantly compared to the institution in Wonocatur: from 20 to 200.[10] The fact that no period of confinement is given for patients from neither Wonocatur nor Pakem might tell us something about the level of administration at these institutes. It suggests that patients simply went in and out of these institutions and that referral reports were not necessarily filled out by staff members.

§ 4.2 · Discharge, Transfer, and Morbidity Rates

Irrespective of the cause of departure, half of the patients treated at Magelang left the asylum within their first year of hospitalization. Inmates institutionalized between one and five years and insane

[9] 'Bewaarhuis voor krankzinnigen', *Soerabaiasch-Handelsblad* (April 12, 1935) 10.

[10] 'Krankzinnigenzorg. Plannen voor Midden-Java', *De Indische Courant* (April 4, 1938) 6.

T A B L E 4.1. Period of hospitalization at Magelang Asylum for Indonesian and Chinese patients.

	Indonesian patients		Chinese patients		Total	
	no.	%	no.	%	no.	%
< year	103	47,2	19	63,3	122	49
1-5 years	57	26,1	5	16,7	63	25,3
> 5 years	58	26,6	6	20	64	25,7
Total	218		30		249	
Average number of months	47		37		46	

nursed for a period of over five years both accounted for a quarter of the sample of patient records analyzed for this study. Table 4.1 shows the differences between Indonesian and Chinese inmates. Whereas two out of three patients of Chinese descent got out of the asylum in a period of one year, this figure was less than 50% among Indonesian patients. As a consequence, the percentage of Chinese patients hospitalized for over twelve months was relatively low: 37% against 53% of all Indonesian patients.

An overview of the reasons why patients left Magelang Asylum can be found in table 4.2. In presenting these figures, it was chosen to focus on the patients who departed from Magelang before May 1942. After the Japanese invasion of Java, Magelang Mental Hospital entered a new phase. This is not only reflected in the languages used in medical records. On the basis of contrasting death rates prior to and after May 1942, it can be concluded that the conditions of asylum life at Magelang Mental Hospital deteriorated tremendously. Before the Japanese invasion, about 20% of all patients passed away while they were hospitalized at Magelang. During the Japanese occupation and its aftermath, no less than nine out of ten patients died, probably due to exhaustion and starvation. As a result, the number of deaths among the total sample of patient records is significantly higher than the death rate among pre-May 1942 departures, namely 35% against 20%. Including the records of patients who departed from Magelang after April 1942 in the following analysis would therefore give a false impression of Magelang Asylum under Dutch colonial rule (see appendix 4 for a

T A B L E 4.2. Outcome of patients.

	< 1 year		1-5 years		> 5 years		Total	
	no.	%	no.	%	no.	%	no.	%
Recovered	49	41	14	28	4	18	67	35
Improved	25	21	9	18	0	0	34	18
Sub-total	74	62	23	46	4	18	101	52
Not recovered	8	7	1	2	0	0	9	5
Not insane	4	5	0	0	0	0	4	2
Total discharge	86	74	24	48	4	18	114	59
On family's request	5	4	2	4	0	0	7	4
Transferred	11	9	13	26	11	50	35	18
Lost	3	3	1	2	0	0	4	2
Deceased	20	17	13	26	7	32	40	21
Total	120		51		22		193	

comparison between the overall causes of departure and the causes of departure among patients who left Magelang before May 1942).

In popular culture, mental hospitals have been depicted as closed institutions: once you got in, there was no chance of getting out alive.[11] This image does certainly not apply to Magelang Asylum. Altogether, three out of five patients returned to Indies society after hospital discharge. Most of them could leave the asylum because their mental state had recovered or improved. Inmates discharged for these reasons accounted for 60% of the patients who departed from Magelang within one year after admission. Table 4.2 suggests that this number declined as the period of hospitalization progressed. Yet 18% of the patients who left Magelang after over five years of asylum life were discharged because they had "sufficiently recovered". Slightly less than 5% of all patients were discharged despite the fact that their condition had not improved. In most of these cases, patients were discharged because their families submitted a request. After one year of hospitalization, only one individual was discharged without improvement or recovery. These figures applied to both Chinese and Indonesian patients, which suggests that, although Chinese patients

[11] Miloš Forman's movie *One Flew Over the Cuckoo's Nest* is but one of the many examples.

stayed at Magelang for a shorter period of time, the reasons for discharge did not differ. In comparison, however, twice as much Chinese patients were sent back home on request of their families.

There were three other ways for a patient to leave the asylum. A small number of them escaped or got lost. Among them was the 13-year-old juvenile delinquent who was incarcerated at a governmental institution.[12] In a 1916 annual record of the asylum near Lawang, superintendent Travaglino wrote that most missing patients were accidentally left behind after they had worked in the fields. As a justification, Travaglino emphasized that the asylum was no prison: the fact that people at times escaped or got lost was the logical consequence of a treatment that was truly unrestrained (*eener vrye verpleging*). Besides, in case an escaped insane did not return within a couple of weeks, this only meant that that patient had been kept at Lawang too long and that, apparently, he or she had regained the ability to take care for him- or herself.[13] At Magelang, missing patients were removed from the asylum's register after one month of absence, the same period of time a patient was sent on probation.

Two ways to depart from Magelang remain: evacuation to another institution and what in Malay is called *meninggal dunia*, departure from the world. About 18% of all inmates was transferred to another institution. These were not necessarily psychiatric institutions and included poorhouses and agricultural colonies. In section 4.2.2, more information on the destinations of transferred insane will be provided. One out of five patients died at Magelang Asylum. Both the number of transfers and the number of patients who passed away rose in proportion as the period of hospitalization became longer. Whereas only 10% of all patients were evacuated within their first year of admission, one out of every two inmates was transferred after five years of institutionalization. In the same way, the relative number of deaths almost doubled from 17% to 32%. The rates of morbidity and evacuation were more or less the same in the Chinese and Indonesian segments of the asylum population.

To judge the significance of these figures, it will be elucidating to compare them briefly to discharge rates of asylums in the Netherlands. In a word, the difference can be called remarkable. On the basis of patient records obtained from three different asylums, Vijselaar found that, between 1890 and 1950, 36% of the patients were discharged as recovered or improved and 8% were

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[12] P. 2443. See chp. 2.

[13] P.H.M. Travaglino, *Jaarverslag 1916. Krankzinnigengesticht te Lawang* (Unpublished) 11-2. A copy of this annual report is kept at the medical library of the Rumah Sakit Jiwa Dr. Radjiman Wediodiningrat at Lawang.

discharged even though their mental condition had not improved. As discussed above, the discharge rate of Magelang amounted to 60%. The number of deaths, on the other hand, was about twice as high in the asylums studied by Vijselaar, namely 41% against 21% in the patient population of Magelang Asylum. Patients who were evacuated, lastly, accounted for 13% of the departures from the three Dutch asylums. At Magelang, this was 18%.[14]

In order to explain these differences, one must incorporate a dazzling amount of factors, ranging from the living conditions inside the asylum to the patients' physical condition at the time of admission. With respect to the number of deaths, one decisive factor might have been differences in the age of patients. In chapter two, it was shown that elderly Chinese were underrepresented among patients of Magelang and it was conjectured that this applied to Indonesian patients as well. Most of Magelang's inmates were aged between 20 and 40. Asylums in the Netherlands, on the other hand, provided accommodation to both younger and older people. This is also reflected in the symptoms presented by patients of Dutch asylums: whereas dementia, for example, was virtually absent among patients at Magelang, this disease accounted for a quarter of all admission to the asylums studied by Vijselaar.[15] Hence, the reason why more patients died institutionalized at a psychiatric hospital in the Netherlands might be related to the fact that, in comparison to Magelang, more older patients were accommodated by Dutch asylums.

§ 4.2.1 · Discharge from Magelang Asylum

In the 'Regulations on the Care for the Insane in the Netherlands Indies' it was established that there were several ways in which a patient could be discharged from a mental hospital. He or she could, first of all, be released in case no symptoms of insanity were demonstrated or if the patient had recovered sufficiently. In these instances, a patient was discharged at the instigation of an attending psychiatrist. Alternatively, discharge could be requested by the patient's relatives, by the Public Prosecution Service, and by the Head of the Public Health Service. Independent of who submitted a request for discharge, the central issue pertaining to hospital release was whether the patient could posed any possible threat to public security after he or she had left the asylum (see §1.2).

Four patients got out of Magelang who were not found to be insane. All of them were suspected of committing a crime. Among them was a man who had stolen a bike from warehouse Lindeteves in Semarang. One of the last entries in his file recorded that the man had been calm

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[14] Joost Vijselaar, *Het gesticht. Enkele reis of retour* (Amsterdam 2010) 272.

[15] *Ibid*., 90.

throughout his hospitalization and that he only socialized with patients whose mental illness was less severe (*de betere patiënten*). He was also perfectly well oriented in space and time. The patient admitted that he had stolen a bike, but explained that he committed the crime because he was *bingung*. What followed was an interesting question-and-answer between psychiatrist and patient:

> Psychiatrist: Who steals is a...?
> Patient: A bad person.
> Psychiatrist: What happens to someone like that?
> Patient: He must go to prison (*boei*).
> Psychiatrist: So what should we do with you?
> Patient: I must go to prison too.

Thereafter, the man assured his psychiatrist that he wanted to start working again the minute he got home. He would steal no bikes anymore. 'And what if you become *bingung* once more?' the physician persisted. No, the man replied, he would never steal again.[16]

This entry in the bicycle thief's medical record contains many of the criteria applied by psychiatrists to judge whether someone had recovered sufficiently during his or her period of hospitalization. Firstly, a psychiatrist would take into account an inmate's daily behavior and functioning in the asylum's milieu: how did a patient relate to fellow patients, was he or she calm and disciplined, and did a patient do the work that he or she was expected to do? Questions such as these were regularly discussed in the medical records. In January 1930, for example, a nurse wrote down the following lines in the record of a Javanese man:

> January '30: Pat. works well in the women's ward at the batik section. When he returns to his ward from work, he plays the game *dam daman* with his friends [i.e., fellow patients]. He provides clear answers to questions, although he still laughs while answering. He eats and sleeps sufficiently.[17]

[16] P. 2919:

[17] P. 2602: 'Pat. bekerdja di vrouwen afdeeling menggar dibatikan dengan baik, dizaal kalau soedah poelang dari bekerdja ia laloe main² sama teman²nja jaitoe dan-daman, kalau ditanjai ia ada terang kalau mendjawab ia masih dengan tertawa². Hal makan tidoernja tjoekoep'. It remains a question what kind of work this man exactly did at the women's ward.

If a patient behaved "normally" and in accordance with the rules of asylum life, release from the hospital was considered by hospital staff. The inmate who was employed at the women's section was released one month after the January note quoted above had been written.

Yet, as illuminated by the entry in the bicycle thief's medical record, behavior was not the only yardstick to determine a patient's qualification for hospital discharge. Another set of questions concerned an inmate's mental and cognitive condition: did the patient know where he or she was, was a patient conscious of how long he or she had been hospitalized at Magelang, and did a patient realize why he or she had been institutionalized in the first place? By the end of her hospitalization, a 18-year-old woman was described by her psychiatrist as '[q]uiet and willing to work, she eats and sleeps well, and is oriented in space, time, and circumstances. She shows insight into her own situation and she considers herself to be recovered. She says she wants to go home'.[18] The woman was first sent on probation and was discharged from Magelang one month later. It was no exception for a patient to personally ask hospital staff for release. On May 27, 1939, a psychiatrist wrote:

> Patient came to me on his own initiative and asked in a polite and orderly manner if he could get permission to go home. Patient is quiet, he stutters, is well oriented in time, identity, environment, and situation. Has insight. On the ward, he has been orderly all the time and he has been hardworking.[19]

Once again, assessment of a request for discharge involved the combined evaluation of behavior and mental state. This man, too, was released shortly after he submitted a request to his psychiatrist.

Yet, as it was stated in the 'Regulations on the care for the insane', decisive was the question whether someone could become a threat to the public order once he or she was released from Magelang. Danger to the public safety was interpreted rather broadly and did not necessarily involve physical aggression and violence. In chapter two, the case of a 46-year-old Batak man from Northern Sumatra was briefly discussed. The man was convinced that Sisingamangaraja XII was still alive and, galvanized by this delusion, he caused an uprising against the colonial authorities. His record contains a six-page-long document on diagnosis and possible hospital discharge. 'On first sight,' the author remarked, 'this man behaves completely normal and he definitely does not distinguish himself from others in a way that might be called insane'. The man remembered that he came from Sumatra and that he had been hospitalized at the transit asylum near Grogol for about a year prior to his evacuation to Magelang. It was only after a long conversation that one discovered

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[18] P. 4216:

[19] P. 6038:

that the man hold on to ideas that did not correspond to reality. 'Can a person as such be discharged?' the psychiatrist asked in the document's final paragraph. His answer was: no. The author listed a number of recent incidents with 'religious maniacs' (*godsdienstwaanzinnigen*) in both the Netherlands and the Netherlands East Indies and concluded that one has to be careful with such people. 'Among a fanatic population,' he stated, 'someone like this patient will find new followers easily, which may result in major disasters'.[20] After he was hospitalized at Magelang for over 12 years, the man was transferred to the Lenteng Agung agricultural colony near Batavia. It is unknown what happened to him afterwards.

The man from Northern Sumatra was not released from Magelang despite the fact that he acted fairly normal. Another group of patients left the mental hospital, although they had not recovered sufficiently or had not recovered at all. In most of these cases, a request for hospital discharge was submitted by the patient's family. One example was a Chinese woman from Semarang who was brought to Magelang by her husband because she suffered from compulsive speech and movements. Even though she received permanent bath treatment and Veronal powder during her stay at the asylum, her behavior did not show any improvement. Eight days later, she returned home against medical advice and together with her husband who had petitioned for her release.[21] The record of a 50-year-old Javanese woman tells a similar story, though her condition did improve during hospitalization. Before she was admitted to Magelang, she had refused to sleep, eat, and drink. According to her referral report, the woman was *bingung* and a danger to herself and others. Her family was unable to maintain her. Some five months after her admission, the woman's husband requested discharge from institutionalization. Her psychiatrist did not object and she was sent home on probation.[22]

Most patients had to complete a one-month probationary period before they were discharged from Magelang. Relatives had to agree to take the patient back into their family again, which meant that, at times, family members had to be found first. This was not always an easy task. According to Engelhard, relatives of insane occasionally changed their names on advice of a *dukun* after the lunatic had left the house. It was hoped that changing the family's name would confuse the evil spirits responsible for their relative's insanity attack and that, as a result, these spirits would never

[20] P. 362.

[21] P. 1864.

[22] P. 5277.

strike again.[23] At least one patient from Magelang told hospital staff that his name was changed 'at a society' because he was sick.[24] In other cases, the search for patient's relatives was difficult because it simply was unknown where family members resided. The record of a woman for example read: '23-III-29. Could be discharged if family can be found. Otherwise, patient could possibly be transferred to Gambong Waloh [the Asylum for the Feeble Minded near Temanggung]'. On the same day, hospital staff sent letters to a head of local affairs to obtain information on the patient's family. Family members were found and the woman was released shortly afterwards.[25]

If the mental hospital had details on a family's place of residence, they would normally inquire whether a patient could return to their original homes. On November 27, 1941, the husband of the woman who killed little chickens and ate them received a letter in which it was asked whether 'he wanted to have her back' and, if so, that the man should come to Magelang and pick her up. On the second of December, the patient returned home and she was discharged one month later.[26] Not every family, however, was keen to see their insane relatives coming back home. A 60-year-old farmer, for example, was not welcome at his family anymore. Instead, the man was evacuated to the colony for poor people near Blondo, a little village to the southeast of Magelang.

In case a patient was sent on probation, he or she would receive a small amount of money from the hospital to make sure the patient and his or her family could afford the necessities of life during the patient's first period out of the asylum.[27] At the end of the probation period, the family was required to fill out a form to evaluate the patient's behavior during his or her first month after hospital discharge. It is likely that families were often assisted by a local official who could write. Important points concerned the question whether the person under consideration had started to work again, how he or she got along with other villagers, and if he or she had caused any trouble since the return to the village. Once filled out, the form was sent back to Magelang Asylum. Some patients, of course, were brought back to Magelang before they completed their probation. A young Chinese man, for instance, went on probation twice, only to be returned to Magelang by his family. The man eventually died during the Japanese occupation.

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[23] C.F. Engelhard, 'Psychiatrische ervaringen bij Javanen in Midden-Java (1919-1922)', Maandblad voor de geestelijke volksgezondheid 3 (1948) 231-51, 239-40.

[24] P. 4537.

[25] P. 1265.

[26] P. 7152.

[27] 'De Gouverneur Generaal in Magelang', *Soerabaiasch-Handelsblad* (September 30, 1937) 8.

Table 4.3. Outcome of patients ordered along patients' social situation.

	Neglected		Looked after		Total	
	no.	%	no.	%	no.	%
Recovered	12	20	46	33	58	29
Improved	5	8	30	21	35	18
Sub-total	17	28	76	54	93	47
Not recovered	0	0	4	3	4	2
On family's request	0	0	7	5	7	4
Transferred	11	18	14	10	25	13
Lost	0	0	2	1	2	1
Diseased	32	53	44	31	76	38
Total	60		140		200	

§ 4.2.2 · Neglected or maintained? Death and evacuation

In the previous chapter, it was argued that the decision to request hospital admission was the result of a particular combination of a lunatic's situation in life and the symptoms he or she presented. The number of aggressive and violent mentally ill was much higher among insane who were maintained by their families, which suggested that, in comparison to neglected individuals, the threshold to institutionalize this category of insane was higher. The examples discussed throughout this chapter indicated that an inmate's relation to his or her family also influenced his or her way out of the asylum. Family members could, for example, request hospital release and if relatives were not prepared to take a recovered patient back into the family, the hospital would consider alternative destinations to where an inmate could be transferred. The aforementioned 60-year-old farmer was sent to the colony for poor people near Blondo and the woman would have been sent to Gambong Waloh in case her family had not been willing to take her back. How did a patient's social situation influence his or her way out of Magelang Asylum?

Table 4.3 shows a clear difference between neglected and maintained patients with regard to their departure from Magelang. Whereas discharged patients accounted for 28% of all neglected individuals, this figure was about twice as high among patients who, prior to hospital admission, had been maintained by their families. As one might expect, the number of patients who either died

at Magelang or were evacuated to another institution was much higher among the formerly homeless and abandoned. Whereas some 30% of the maintained inmates passed away at Magelang, the mortality rate in the population of individuals who had been neglected was over 50%. The number of transfers also differed, namely 10% of all inmates who had been looked after by relatives against 18% of formerly neglected patients. How can these differences be interpreted?

With regard to the differences in discharge and mortality rates, it could, first of all, be conjectured that neglected individuals were in a relatively worse physical condition at the moment of hospital intake. As this study will not discuss the actual causes of death and patients' medical conditions, it cannot be examined whether this indeed was the case. Another option might be that the living conditions for neglected patients at Magelang were less favorable than the treatment received by patients who had been maintained by family members. This seems unlikely. In the Netherlands Indies, mentally ill were accommodated according to four classes and most patients at Magelang Asylum fell into the lowest category, regardless of whether they were maintained by relatives or not. The influence of a final factor seems to be more probable: neglected patients were hospitalized for longer periods of time. Whereas 58% of all maintained patients left the asylum within one year, no less than 70% of all formerly neglected individuals departed from Magelang *after* at least one year of institutionalization. As discussed above, the mortality rate among patients rose as the period of hospitalization became longer. On top of that, many long-term patients were still treated at Magelang when the Japanese invaded Java and the living condition at the asylum subsequently worsened.

Formerly neglected individuals stayed at Magelang Asylum for a longer period of time, probably because, and in contrast to patients who were still in contact with their families, they had no other place to go after hospital discharge. A patient's family seems to have played an important role in the re-socialization of Magelang's former inmates. Not only did families, at times, request for a patient's release. More importantly, they provided discharged patients accommodation and were trusted with the supervision and evaluation of the former inmates' behavior within the first month after hospital release. With respect to neglected individuals, a control mechanism such as the family was lacking. This may have resulted in a reluctance among psychiatrists to discharge formerly neglected insane. After all, the police did not pick up homeless insane, only so that they could be thrown out into the streets again after hospital release.

The fact that the ties between patient and family were cut loose in the case of formerly neglected patients might also be an explanation for the finding that, relatively speaking, more patients from this group were evacuated to other institutions. Just like patient's families, these

institutes had the double function to accommodate former patients and to keep an eye on them. Between 1923 and 1942, 18% of all departures from Magelang involved the transfer of a patient to either another psychiatric facility or to an institute that provided post-asylum care. About two third of the evacuated patients were transferred to a mental institution. Nine patients departed for a mental hospital: four to Buitenzorg and five to Lawang. Unfortunately, the patient records of these inmates contain no references as to the causes of their transfer. It is not the case that patients were moved to an asylum that was closer to their place of origin, although two out of four evacuees to Buitenzorg had been hospitalized at Grogol — the transit asylum most close to Buitenzorg — prior to their transfer to Magelang.

Sixteen patients were sent to privately-owned asylums, most of them (n =13) to the asylum near Wonocatur and its successor, the agricultural colony for insane at Pakem. Interestingly, nine of them also had initially arrived from these institutions. This suggests that, during the second half of the 1930s, individuals with mental problems were permanently housed at Pakem and were temporarily transferred to Magelang in case the agricultural colony was unable to cope with their behavior. One patient was sent to Lenteng Agung, the agricultural colony that was founded by famous Netherlands Indies psychiatrist P.M. van Wulfften Palthe.[28] Two others were transferred to the Asylum for the Feeble Minded near Gambong Waloh, Temanggung. In contrast to Wonocatur and Lenteng Agung, Gambong Waloh was founded by Christian missionaries in 1927. According to the so-called Association for the Care of the Feeble Minded (*Vereeniging "Zwakzinnigenzorg"*), the asylum's aim was to nurture and maintain mentally disabled children and women regardless of their ethnicity and religious conviction. Magelang Asylum and Gambong Waloh were closely connected to each other, as the superintendent of Magelang was responsible for admission to the colony. In 1939, the asylum had a total capacity of two hundred beds[29]

Next to psychiatric facilities, Magelang Asylum transferred patients to a number of non-medical institutions. Similar to Gambong Waloh, at least two of these had been established by missionaries: the Poor Men's Colony near Blondo and the White Cross Colony near Salatiga. Blondo provided daily accommodation to about three hundred people and the number of individuals maintained at Salatiga surpassed that of one thousand. Of course, not everyone at Blondo and

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[28] For more information, see: Patrick Bek, 'Looking Beyong Positivist and Primitivist Assumptions. Professor Dr. P.M. van Wulfften Palthe's Approaches to Psychiatric Practices and Discourse in the Netherlands Indies between 1925 and 1949', M.A. Thesis, Leiden University (2014) 71-8.

[29] 'Voor de Vereenining "Zwakzinnigenzorg"', *De Indische courant (*June 16, 1938) 13; 'Het Zwakzinnigengesticht te Temanggoeng. Het eenige in Nederlandsch-Indië', *Soerabaijasche Handelsblad* (September 17, 1939) 3.

Salatiga was a former mental hospital patient, as was nicely put in a newspaper-article published to raise financial support for Blondo:

> At the colony, you will find old men and women, who are not able to care for themselves any longer. You will see people who are blind and crippled [...] and people who lost a leg or even both legs, and who are viewed by Society as useless. There are kind-hearted lunatics who do not need to be treated at a mental hospital, but who have nowhere else to go.[30]

Other destinations for Magelang's departing patients were the agricultural or labor colonies (*arbeidskolonie* or *werkkolonie*) near Wedi, Djajengan, and Kalimati. Similar to Wonocatur and Pakem, the colony at Wedi was financially supported by the Surakarta Sunanate. At these institutions, patients could continue doing the manual labor they were used to from their time at the asylum.

§ 4.3 · Concluding remarks

Magelang Asylum was a link in a chain of institutions concerned with the care for and maintenance of mentally ill individuals in the Netherlands Indies. The ways in which patients moved through this network depended on their social relations. At the front, Magelang was connected to prisons, hospitals, and transit asylums. The time lunatics spent at these institutions varied considerably. Whereas the average time of maintenance at a prison or hospital was six to seven weeks, inmates of transit asylums were hospitalized for the average period of fifteen months. This raises the question in what sense transit asylums were literally *transit* asylums. Considering the fact that about half of all patients at Magelang were discharged from the asylum within their first year of hospitalization, it is very well possible that many inmates left a transit asylum before their evacuation to a mental hospital was considered by hospital staff. It might therefore be better to think of transit asylums as small mental hospitals that differed from the main mental hospitals foremost in size. Only those who did not recover during their stay at a transit asylum were transferred to a mental hospital. Future research into the daily routines of both institutes might further clarify this matter.

At the back, too, Magelang Asylum was connected to a number of institutions, including agricultural colonies, other mental hospitals, and — in case it is interpreted as an institute — the patient's family. Which direction a patient could take after discharge depended on two questions: did release involve the risk of danger and was the person under consideration still in touch with his

[30] 'Armenkolonie "Blondo"', *Soerabaijasche Handelsblad* (January 5, 1931) 10.

or her family? For most inmates, admission to Magelang was no one-way ticket. About 60% of the patient population re-entered society and the asylum took afford to ensure that re-socialization would be a success. A patient's dealing with fellow inmates and his or her ability and readiness to work were therefore important criteria for hospital release, unless the patient's family requested discharge and, by doing so, indicated that they were willing to bear the responsibility for an insane relative once again. In case a patient was sent on probation, the asylum provided a small amount of money and stayed in contact with the family to monitor the person's behavior. In part, the patient flow in Magelang Asylum depended on a family's willingness to cooperate.

Yet the exit of Magelang was less cheerful for patients who either had no social network to reply upon or who were perceived by hospital staff to be dangerous. About half of them eventually died at Magelang, others were sent to a mental hospital somewhere else or to an agricultural colony. As the file of the 46-year-old Batak man showed, what it meant to be dangerous could have clear political connotations. The ideas of this man were a threat to Dutch attempts to maintain peace and order and therefore his psychiatrist decided that it would be better to keep the man safely within the asylum's walls. His case, however, seems to have been an exception. In general, Magelang was no tool to suppress and discipline; the asylum was a hybrid space that provided a solution to a problem that was shared by all the actors involved: the colonial authorities, Indonesian and Chinese communities, the patient's family, and — last but definitely not least — the patient him- or herself.

Concluding Remarks · In and Out of Magelang

When Mas Hardjosentono and Dimin — the two patients whose stories were briefly discussed at the beginning of this study — entered Magelang Asylum, they did so in very different ways. Mas Hardjosentono, a member of the *priyayi*, was brought to the mental hospital by one of his children. Due to financial stress, the man had become *bingung* and his relatives judged it best to have him hospitalized at Magelang. Dimin, on the other hand, was taken to the asylum by the police. According to an official statement by a physician from Rembang, Dimin was aggressive and agitated, and therefore he was a danger to his family and others. He was incarcerated at a prison in Rembang and was subsequently transferred to the mental hospital of Magelang.

These two examples nicely illustrate this study's main point: that Magelang Asylum was a hybrid space used by various actors for multiple reasons. Among its population were confused homeless people who had been found by the police on the side of the road, aggressively insane family members who could not be kept at home any longer, and people whose confinement was politically motivated. To cast Magelang's daily activities only in a vocabulary of discipline and punishment would understate the variety of functions performed by this mental hospital.

Both Mas Hardjosentono and Dimin were admitted to Magelang in the 1930s, a time when mental health care in the Netherlands Indies had transformed into a network that included mental hospitals, transit asylums, nursing homes, and agricultural colonies. The development of these institutions was a long-drawn-out process. Although incentives to reform care of the insane on Java were given as early as the 1860s, it was only after the turn of the century that the number of psychiatric ward beds increased substantially. By the end of the 1930s, mental institutes in the Netherlands Indies together accommodated over ten thousand patients. This figure is impressive if compared to the number of ward beds established by other Southeast Asian imperialists. However, this figure was much too small to house all the mentally ill people among the population of the

Netherlands Indies. It is therefore conceivable that many insane were maintained at prisons or were illegally incarcerated by Indonesian communities by means of bamboo houses and wooden blocks. Considering the rather severe symptoms presented by psychiatric patients of Magelang Asylum, it seems that incarceration was often a necessity. Out in the *desa*, a lunatic could cause serious problems that affected villagers, the lunatic's family, and a mentally ill individual him- or herself. There were probably solid reasons why village chiefs of Aceh were happy to learn that an asylum was to be built on the island of Sabang.

In several respects, the 1868 report by Bauer and Smit was programmatic to the future development of the care of the insane in the colony. It established the awareness of the need for transit asylums, it explored the benefits of agricultural colonies, and it contained the recommendation that legal provisions pertaining asylum care had to be drawn up. A Netherlands Indies insanity law came into force in 1897. It regulated, among other things, hospital admission and discharge. Contrary to what one might expect to find in a law on "repressive state instruments", family members of someone with mental problems and even a lunatic him- or herself were able to request hospitalization. A patient's family could also ask for asylum release. In many respects, Netherlands Indies insanity law resembled Dutch legislation on care of the insane. One important difference, however, was the stipulation that discharge in the Netherlands Indies was only permitted in case release from the hospital did not involve the risk of danger. Maintaining peace and order, in other words, was one of the aims of asylums in the Dutch colony, yet peace and order were not only beneficial to the European population.

Between December 1923 and May 1942, about 7450 patients were admitted to Magelang Asylum. Most of the patients hospitalized at Magelang came from Central Java and the principalities of Surakarta and Yogyakarta, which suggests that the mental asylum was foremost a regional psychiatric facility. In comparison to the overall population of Central Java, several groups of patients were overrepresented in Magelang's asylum population. This applies, first of all, to mentally ill individuals who came from the cities of Surakarta, Yogyakarta, Magelang, and Semarang. Although slightly less than 4% of the entire population of Central Java resided in these areas, patients from these cities accounted for one fifth of the medical records obtained from Magelang Mental Hospital. Chinese patients, too, were relatively strongly represented among the patients of Kramat. Whereas Chinese people made up less than 1% of the entire population of Central Java, about 10% of Magelang's inmates were of Chinese descent. Two other groups were

clearly overrepresented at Magelang Asylum as well: individuals aged between 20 and 40 and patients who were former soldiers, policemen, and servants.

In order to interpret these findings, contrasting accounts on asylum admission by historian Lynette Jackson and psychiatrist C.F. Engelhard were discussed. The disagreements between their views on the social processes surrounding asylum admission were a thread running through the chapters two and three of this study. With regard to psychiatric care in colonial Zimbabwe, Jackson has argued that those admitted to the Ingutsheni Lunatic Asylum were lunatics who "surfaced up", i.e., insane who moved outside of the areas that were allocated by the colonial rulers to the African population and who were perceived by authorities as a threat to the colonial order of things. In her account, agency is foremost attributed to white colonizers.

In Engelhard's account, on the other hand, agency is attributed to multiple population groups of the Netherlands Indies such as Chinese families, Indonesian communities, and the colonial authorities. Whereas some lunatics indeed "surfaced up" in the sense that they were arrested by police and taken to a hospital or asylum, others — especially inmates of Chinese descent — were taken to psychiatric facility by their families. Distance plays a key role in Engelhard's discussion, as the space between a psychiatric facility and the place where a mentally ill individual resided or was kept influenced the likeliness of that person entering a psychiatric facility. Therefore, it can be assumed that the closer a mental institution, the more visible and available this institute was to the indigenous population.

Engelhard's description of admission to Surakarta Transit Asylum is more attuned to the nuances of the ways in which insane entered Magelang Asylum. The asylum population of Magelang can be divided into three groups: neglected insane, mentally ill individuals who were looked after by their families, and lunatics who were maintained by their families, but who could not be looked after any longer. In general, the mechanisms that led to the hospitalization of these people and the actors that were involved in the hospitalization process differed in accordance with these three groups. The main reason why hospitalization for neglected individuals was requested was that they exhibited disruptive, inappropriate, and at times potentially dangerous behavior, while no one was around to keep a watchful eye on them. Involved in the process of hospitalization were the police, psychiatrists, and physicians of regular hospitals. Aggression and perceived danger played a considerably more prominent role in the admission of patients who were looked after by relatives. Other factors, however, were involved in the admission of maintained insane as well and no cause really stood out. Concerned with their hospital admission were the patient's family,

psychiatrists, local officials, and prison employees. The same actors were involved in the process of hospitalizing someone who was looked after, but for whom the family was unable to care any longer. Most of the inmates of Magelang belonged to this third group. In their cases, aggression and violence were, without doubt, the main causes to request institutionalization.

The mechanisms surrounding hospital admission varied considerably from one another. If this finding is combined with the specific demographic configuration of the patient population of Magelang, the following picture, which is based on the premise that all over colonial Java mentally ill people could be found, arises. Some of them were neglected, others were looked after by their families. If the situation at home escalated — which, considering the average age of patients of Magelang, probably often happened with insane aged between 20 and 40 — someone was incarcerated by his or her family, possibly in cooperation with other villagers or local officials. A confined insane would stay at his village *unless* a psychiatric institute was relatively nearby. In that case, the asylum was more visible and available to Indonesian communities, which increased the chance of someone to be hospitalized at a psychiatric facility. This is partly an explanation of why people from the cities of Surakarta, Yogyakarta, Magelang, and Semarang were overrepresented among the patient population of Magelang Asylum. To be sure, psychiatrist Hoffman claimed that he, to his own surprise, discovered someone in *pasung* in the immediate surrounding of Buitenzorg Asylum during a 1894 trip. The picture presented in this analysis describes a trend, not a general law.

The patients who entered Magelang Asylum in this way accounted for about half of its population. About a quarter of all patients were described in their referral reports as entirely neglected. It remains unclear why some patients were neglected: some may have walked away from their homes, others were possibly abandoned by their families. At least 30% of Magelang's neglected insane were arrested by the police. This is another explanation why patients from the areas of Magelang, Surakarta, Yogyakarta, and Semarang were overrepresented among Magelang's patients. As Engelhard maintained, these cities were more closely supervised by police forces and homeless insane were attracted to urban centers. In Central Java, these were the insane who "surfaced up", although it should be emphasized that 50% of the Statements of Information on neglected insane did not mention dangerous or aggressive behavior as a motivation for hospitalization. In other words, in the Netherlands Indies, mentally ill individuals did surface up, but the reasons for hospitalization seem to have been different from the motivations provided by Jackson in her analysis of the Ingutsheni Lunatic Asylum in colonial Zimbabwe.

Proximity to the authorities, or to the European population in general, also played a role in the institutionalization of former soldiers, policemen, and servants. In the case of policemen and soldiers, other factors that may have worked towards their hospitalization were that they represented the colonial state and that they possessed weapons, which made them relatively dangerous. This means that hospitalization of mentally ill policemen and soldiers was probably considered more urgent compared to the hospitalization of lunatics who were not in possession of weapons.

Magelang Asylum also hospitalized people who were accused or convicted of crime. These individuals entered Magelang for two reasons. On the one hand, Magelang provided clinical observation for suspects for the purpose of a forensic-psychiatric assessment in court cases. On the other hand, prisoners were transferred to Magelang, because their behavior had become a disturbance to the detention-center-discipline.

A final group of inmates that can be distinguished among the population of Magelang Asylum consisted of patients who prior to hospital admission had been looked after by their families. Some of them were personally taken to the hospital by their families, others entered Magelang via local officials. Members of the *priyayi* and patients of Chinese descent were overrepresented within this group. It is conceivable that these groups possessed the means to take family members to an institute and, by doing so, to prevent the situation at home from escalation. Cases of aggression and violence were less reported among these patients. With respect to the Chinese asylum population, the distance between a psychiatric facility and a mentally ill individual seemed to have been less of a factor working towards hospitalization: Chinese patients from the cities of Surakarta, Magelang, Yogyakarta, and Semarang were not overrepresented among the Chinese patient population of Magelang. According to Engelhard, other reasons accounted for the fact that Chinese patients were relatively strongly presented among psychiatric patients. Rumors about the availability of a mental institute spread more easily among the Chinese, the Chinese population was of a different socioeconomic status than the Indonesian, and, in comparison to the Javanese, Chinese families treated their ill relatives differently. More Chinese patients got to see a doctor prior hospital admission and over a third of the Chinese patients was brought to Magelang by their families. All these factors deserve further analysis in future research in order to understand why the Chinese stood out among the patients of Magelang Asylum.

In short, admission to Magelang was no simple top-down process. On the contrary, the routes to Magelang travelled by mentally ill individuals were often bottom-up in the sense that

admission was requested by Chinese and Indonesian families and communities. The connections between asylum, family and community, and insane were rather dynamic as the relations between these actors varied from case to case and influenced how, when, and why a person with mental problems was hospitalized. Psychiatrists and the colonial authorities were by no means the only actors involved in the process of hospitalization.

This is also shown by the social mechanisms that were involved in hospital release. There were several ways in which a patient could leave the hospital. Magelang was no closed setting: about 60% of the patients returned to society, 21% of the patients died at Magelang, and 18% was transferred to another institute. Similar to the processes that were involved in hospital admission, patient outcome was influenced by a patient's relation to his or her family. To successfully discharge an inmate, the hospital depended, in part, on the patient's family's willingness to help a former patient to reintegrate into society. During hospitalization, reintegration was prepared. This is one of the reasons why working therapy took a central position in asylum life: it was hoped that patients would learn a useful occupation that they could continue to practice after they had left the asylum. Yet the family was expected to supervise a patient's reintegration. Therefore, the asylum would send out a letter to the family in order to inquire whether a patient could be returned to his or her original home. In case the family agreed, a patient was sent on probation. In case relatives did not agree, the hospital had to search for an alternative destination. These included agricultural colonies and privately-owned asylums.

In short, a patient's relation to his or her family was an important factor in hospital discharge. Inmates who did not recover could still be released from the hospital in case the family declared themselves willing to look after a mentally ill individual once again. Yet — as was stipulated by the 1897 Insanity Law — decisive was the question whether a patient's release involved the risk of danger. It seems that the interpretation of "danger" could occasionally involve political considerations. The 46-year-old man from the Batak is the only example found among the patient records from Magelang Mental Hospital which clearly shows the asylum as a Dutch tool of empire. It could be conjectured that, seen through the eyes of the Indonesian population, the man's behavior and ideas were not necessarily a social problem that required hospitalization. In stark contrast to many of the other cases that were discussed throughout this study — the woman who ate baby chickens is but one example — some people may even have thought of this man as a zealous freedom fighter. According to notes taken by the man's psychiatrist, his behavior was acceptable and it seems that he would have been able to function in the colonial society. Yet, instead of being discharged, the man was hospitalized at Magelang Asylum for no less than 12 years, only to be

transferred to the agricultural Lenteng Agung afterwards. In this patient record, we catch a glimpse of what — according to Sally Swartz — many historians of colonial psychiatry expect or wish to find in the archives: the mental hospital as a repressive tool of empire.

In general, however, Magelang Asylum was no place to incarcerate colonial McMurphies — the protagonist in Ken Kesey's *One Flew Over the Cuckoo's Nest*. Hospitalized at Magelang were neglected lunatics who wandered in the streets in a state of confusion and who were completely left to themselves; nursed at Magelang were fathers, mothers, and sons and daughters, who were brought to the hospital by their families in the hope that they would recover from their mental disease; and treated at Kramat Asylum were insane who could no longer be maintained by their families because of their aggressive and violent tendencies. Seen in this light, Magelang Asylum was in general no tool to restrain the indigenous population of the Netherlands Indies. Though available to a relatively small number of people, the asylum offered Indonesians and Chinese an alternative to deal with the troubles a lunatic in the family might cause. Magelang Asylum, however, was not only of benefit to these families and communities; it offered the mentally ill themselves a safe environment, a place where they could recover from their mental problems and find a way back into society.

Appendix 1: Approval of Rumah Sakit Jiwa Prof dr. Soerojo Magelang to use the archived patient records for research purposes.

KEMENTRIAN KESEHATAN R.I
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SURAT PERNYATAAN
STATEMENT

Saya yang bertandatangan dibawah ini :
I'm the undersigned :

Nama : Sebastiaan Broere
Name
Umur : 25
Age
Alamat : Koningsweg 256, 3582 GM Utrecht, Belanda
Address
Pekerjaan : Mahasiswa
Occupation

Sebenar-benarnya menyatakan bahwa peminjaman berkas rekam medis atas nama ..... No RM ..... hanya untuk keperluan riset.
Loaning the Medical Record on be half of ..... Number of Medical Record ..... only for research.

Hormat saya,
Regards,

Sebastiaan Broere

Kasubag Rekam Medis

Sofyo Purnomo A.Md., S.Kom.
NIP. 19870129 201012 1001

Appendix 2: Number of beds, patients, efficiency, and admission, discharge, and mortality rates of the four main asylums between 1931 and 1938.

Lawang Asylum

	Beds	Patients	Efficiency	Admission		Discharge		Death	
1931	2802	3266	1.17	563	17%	296	9%	183	6%
1932	2802	3338	1.19	551	17%	328	10%	143	4%
1933	3105	3640	1.17	773	21%	453	12%	150	4%
1934	3300	3816	1.16	779	20%	413	11%	178	5%
1935	3300	3866	1.17	641	17%	323	8%	286	7%
1936	3300	4022	1.22	765	19%	448	11%	289	7%
1937	3300	4035	1.22	750	19%	476	12%	233	6%
1938	3300	4085	1.24	758	19%	478	12%	301	7%
Average	3151	3759	1.19	698	19%	402	11%	220	6%

Buitenzorg Asylum

	Beds	Patients	Efficiency	Admission		Discharge		Death	
1931	1945	2303	1.18	595	26%	271	12%	128	6%
1932	1965	2233	1.14	329	15%	164	7%	154	7%
1933	2015	2274	1.13	359	16%	203	9%	125	5%
1934	2015	2295	1.14	349	15%	187	8%	164	7%
1935	2015	2174	1.08	330	15%	225	10%	129	6%
1936	2015	2167	1.08	347	16%	146	7%	139	6%
1937	2015	2230	1.11	348	16%	225	10%	120	5%
1938	2015	2242	1.11	357	16%	273	12%	89	4%
Average	2000	2240	1.12	377	17%	211,8	9%	131	5,75%

Appendix 2 (continuation): Number of beds, patients, efficiency, and admission, discharge, and mortality rates of the four main asylums between 1931 and 1938.

Sabang Asylum

	Beds	Patients	Efficiency	Admission		Discharge		Death	
1931	1222	1485	1.22	325	22%	217	15%	59	4%
1932	1328	1488	1.12	280	19%	149	10%	52	3%
1933	1328	1451	1.09	164	11%	142	10%	48	3%
1934	1328	1460	1.12	199	14%	115	8%	57	4%
1935	1328	1462	1.12	174	12%	96	7%	65	4%
1936	1400	1454	1.04	153	11%	87	6%	74	5%
1937	1400	1549	1.11	256	17%	78	5%	88	6%
1938	1450	1555	1.07	172	11%	102	7%	72	5%
Average	1348	1488	1.11	215	15%	123	9%	64	4%

Magelang Asylum

	Beds	Patients	Efficiency	Admission		Discharge		Death	
1931	1294	1562	1.21	371	24%	191	12%	50	3%
1932	1294	1568	1.21	247	16%	201	13%	55	4%
1933	1294	1738	1.34	426	25%	325	19%	77	4%
1934	1294	1626	1.26	290	18%	216	13%	71	4%
1935	1406	1709	1.22	370	22%	229	13%	64	4%
1936	1422	1797	1.26	381	21%	261	15%	76	4%
1937	1422	1820	1.28	360	20%	270	15%	68	4%
1938	1542	2132	1.38	650	30%	431	20%	94	4%
Average	1371	1744	1.27	387	22%	266	15%	69	4%

Appendix 3: Relative age distribution (%) in the Chinese population of Central Java (including and excluding 0- to 15-year-old children) and in the population of Magelang Asylum compared.

	Chinese population	Chinese population (>15)	Asylum pop.
0-20	51,8	18	6,9
20	15,8	29,5	41,4
30	12,6	23,8	31
40	9,2	15,7	10,3
50	5,7	9,6	6,9
60	3,2	5,5	3,4

Appendix 4: Outcome of patients excluding and including post-May 1942 patient records.

Outcome of patients (1923-1942)

	< 1 year		1-5 years		> 5 years		Total	
	no.	%	no.	%	no.	%	no.	%
Recovered	49	41	14	28	4	18	67	35
Improved	25	21	9	18	0	0	34	18
Sub-total	74	62	23	46	4	18	101	52
Not recovered	8	7	1	2	0	0	9	5
Not insane	4	5	0	0	0	0	4	2
Total discharge	86	74	24	48	4	18	114	59
Family request	5	4	2	4	0	0	7	4
Transferred	11	9	13	26	11	50	35	18
Lost	3	3	1	2	0	0	4	2
Deceased	20	17	13	26	7	32	40	21
Total	120		51		22		193	

Outcoming of all patients

	< 1 year		1-5 years		> 5 years		Total	
	no.	%	no.	%	no.	%	no.	%
Recovered	49	41,9	14	22,2	5	7,8	68	27,9
Improved	25	21,4	10	15,9	2	3,1	37	15,2
Sub-total	74	63,3	24	38,1	7	10,9	105	43,1
Not recovered	4	3,4	2	3,2	0	0	6	2,5
Not insane	4	4,9	0	0	0	0	4	3,5
Total discharge	82	71,6	26	41,3	7	10,9	115	49,1
Family request	5	4,3	2	3,2	0	0	7	2,9
Transferred	11	9,4	13	20,6	13	20,3	37	15,2
Lost	3	2,6	1	1,6	0	0	4	1,6
Deceased	21	17,9	23	36,5	44	68,8	88	36,1
Total	117		63		64		244	

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