MENTAL ILLNESS AS A CULTURAL PHENOMENON: PUBLIC TOLERANCE AND THERAPEUTIC PROCESS AMONG THE MOSLEM SUNDANESE IN WEST JAVA

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Introduction

Western sociologists have observed that the social response to illness is similar to that towards social deviance.[1] Episodes of sickness are seen to disturb the normal course of activities, tending to create alarm and anxiety. This idea that illness threatens the maintenance of social order is particularly evident in the treatment accorded chronic mental patients in the West, which frequently involves their banishment to mental institutions.[2]

In contrast, when I lived among Moslem Sundanese in a small rice-farming community of West Java in 1972 and 1973, mental patients lived with their families and enjoyed an exclusive license to deviation.[3] The villagers seemed not only to tolerate sometimes disruptive and threatening behavior from the mentally disturbed, but to prefer to have them living in their midst rather than confined to mental institutions.

Undeniably, practical considerations were involved in this situation, for the nearest mental hospital was several hundred miles away, and the cost of hospitalization was too much for an average peasant family to bear.[4] But these practical

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1. See Talcott Parsons, "Illness and the Role of the Physician: A Sociological Perspective," in *Personality in Nature, Society and Culture*, ed. C. Kluckhohn and H. A. Murray (New York: Knopf, 1953), pp. 609-18. Talcott Parsons and Renée Fox, "Illness, Therapy, and the Modern Urban American Family," in *Patients, Physicians and Illness*, ed. E. G. Jaco (Glencoe, Ill.: The Free Press, 1958), pp. 234-45; Allan Young, "Some Implications of Medical Beliefs and Practices for Social Anthropology," *American Anthropologist*, 78 (1976), pp. 5-24.

2. See Talcott Parsons, "Definitions of Mental Health and Illness in the Light of American Values and Social Structure," in *Patients, Physicians and Illness*, ed. Jaco, pp. 165-87; Thomas J. Scheff, *Being Mentally Ill: A Sociological Theory* (Chicago: Aldine, 1966); Erving Goffman, *Asylum* (Chicago: Aldine, 1962); Jane M. Murphy, "Psychiatric Labeling in Cross-cultural Perspective," *Science*, 191 (1976), pp. 1019-28.

3. Field research on which this paper is based was sponsored in part by the Wenner-Gren Foundation for Anthropological Research and the National Science Foundation.

4. The nearest state-run mental hospital is located in Bogor with a capacity of 1,200 patients. In the early 1960s the staff of the hospital consisted of five doctors, of whom three were psychiatrists, 250 male nurses and 250 female nurses.

concerns are insufficient to explain the public tolerance towards mental affliction. Tolerance in general is not a commonly practiced cultural value in Sundanese society. In contrast with the individualism or a philosophy of "live and let live" which is said to characterize the "loosely structured" Thai society,[5] the Moslem Sundanese openly exercise communal pressures for conformity to *adat* customary law and Islamic precepts against nonconforming deviants who fail in their responsibility to the family, neighbors, and the community.

Public tolerance of mental sickness seems rather to reflect some aspects of Moslem Sundanese world-views and values, specifically the people's religious conception of the place of pain and suffering in human experience. In this paper, I will first discuss Sundanese medical concepts and practices as they relate to mental illness and then show their implications for the types of mental sickness that cannot be treated medically.

Etiology of Affliction

Moslem Sundanese recognize certain behavior disorders as mental illness (*sakit kepala*, illness of the head), and regard them, first of all, as phenomena caused by physiological disorders, like all other illnesses. But these physiological disorders are believed to be a result of the patient's moral-spiritual disorder.

According to the local medical belief, the fundamental requirement for good health is a harmonious balance between the hot and cold substances (*zat*) in the body. The human body is considered as a bounded microcosm in which four vital elements--the soul (*ruh*), mind (*akal*), heart (*hati*), and flesh (*jasad*)--are functionally connected to one another to effect an overall state of equilibrium. Of the four elements, the soul, the invisible life-giving essence, is semi-independent of human will. As if dwelling as a separate entity in the human body, the soul frequently leaves the body in dreams, but, attached by an invisible string, it returns to the person when he awakes. Upon death, however, the string is permanently severed so that the freed soul continues to live in another world of existence in the afterlife. Illness implies a weakness in the tie between the soul and the flesh, but has little to do with the intrinsic quality of the soul itself.

It is the mind that is believed responsible for connecting the soul to the body. Properly functioning, the mind has the authority to direct bodily movements and serves as headquarters of the ordered and yet active movement which takes place within the body's microcosm. The head, where the mind is located, is thus considered as the sacred part of the body, paradigmatically equivalent to the highest center of the universe from which God rules. In an ideal state, that is, when a person has strong religious faith and knowledge, the mind remains "cool" and can tell right from wrong. Religious training is thus believed to be critical for realizing a good life on earth as well as for salvation in the life hereafter.

While the mind is the source of a good life and salvation, the flesh contains the seeds of all evil and destruction. Without the help of a properly functioning

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Nathan S. Kline, "Psychiatry in Indonesia," *American Journal of Psychiatry* (March 1963), p. 810.

5. For discussions on the concept of "loosely structured society," see John F. Embree, "Thailand--A Loosely Structured Social System," *American Anthropologist*, 52 (1950), pp. 181-93; and Hans-Dieter Evers, ed., *Loosely Structured Social System: Thailand in Comparative Perspective* (New Haven: Yale University Southeast Asian Studies, 1969).

mind, the flesh, representing man's animal nature, is "hot," craving limitless pleasures and comforts. The mind and the flesh are thus diametrically opposed.

Mediating between the mind and the flesh is the heart. Here the forces of the mind (faith and knowledge = cool) are found in conflict with those of the body (lustful desires = hot). Both types of forces are called *nafsu*, a word which refers to any driving force or desire motivating a person into action. But the Moslem Sundanese recognize two distinct qualities of human desire: there are positive desires which impel a person towards religious faith and moral deeds; and there are negative desires driving a person to the love of self-indulgence and this-worldly pleasures. These opposing desires are referred to as "good nafsu" (*nafsu anu sae*) and "bad nafsu" (*nafsu anu jelek*). From a functional viewpoint--one that is more real for the believers--it is these conflicting desires that cause inner tensions and the predicament of human vulnerability. The heart, where these inner struggles are believed to be waged, is then regarded as the battleground of what is called the great war (*perang agung*). The outcome of the war will have significant consequences for one's well-being in this and the next world.

The Sundanese describe the inner struggle and this folk psychophysiology within the context of a cultural concept called *hawa nafsu*, the climate of the heart. As with the atmospheric climate, they say, the inner climate is influenced by ups and downs of the heart's felt temperature. A gush of anger or anxiety is felt as *panas hati* ("hot heart"). A sense of equilibrium or calm resulting from a resolution of inner conflicts, on the other hand, is described as *hati tiis* ("cool heart"). Like a seesaw--or a hand-scale, which the Sundanese use as a metaphor--the problem of hawa nafsu is its lack of stability.[6] The inner balance, so critical to maintaining health and well-being, seldom remains stable, because of the forces from within and temptations from without the self.

Maintenance of stability is affected by the nature of the macrocosm as it is perceived by the Moslem Sundanese, who regard the world with which they daily interact as threatening to their lives. In their world-view, life's goal is not so much maximizing happiness as minimizing pain and suffering. This is evidenced by the importance the Sundanese attach to harmony as a cultural value and *selamat*, a peaceful existence devoid of suffering (*cilaka*), as their cultural ideal.[7] Happiness is something to look forward to or something that happens only infrequently, while pain and suffering are the immediate reality of life. Good health, economic security, and the well-being of loved ones, the minimum requirements for human happiness, are considered enough for satisfaction. Moderation (*kesedangan*) for the Sundanese is synonymous with selamat. Anything more than that is seen as threatening, for it will invite envy from evil supernatural beings, most notably Satan (*Iblis*).

It is believed that Satan is the source of all the evil forces which exist in the universe. Like God, ever present in the company of man, Satan was created by

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6. In his book *The Rope of God* (Berkeley: University of California Press, 1969), James T. Siegel provides an extensive analysis of the concept of *hawa nafsu* with regard to the Acehnese (pp. 98-133). Evidently the Acehnese use the concept to refer to what the Sundanese mean by evil *nafsu*. In his case, hawa nafsu is treated as a contrast to *akal*.

7. Clifford Geertz defines the Javanese concept of *slamat* as "there is not anything" or "nothing is going to happen (to anyone)." See his *The Religion of Java* (New York: The Free Press, 1964), p. 14. The basic meaning of the word is the same among the Sundanese.

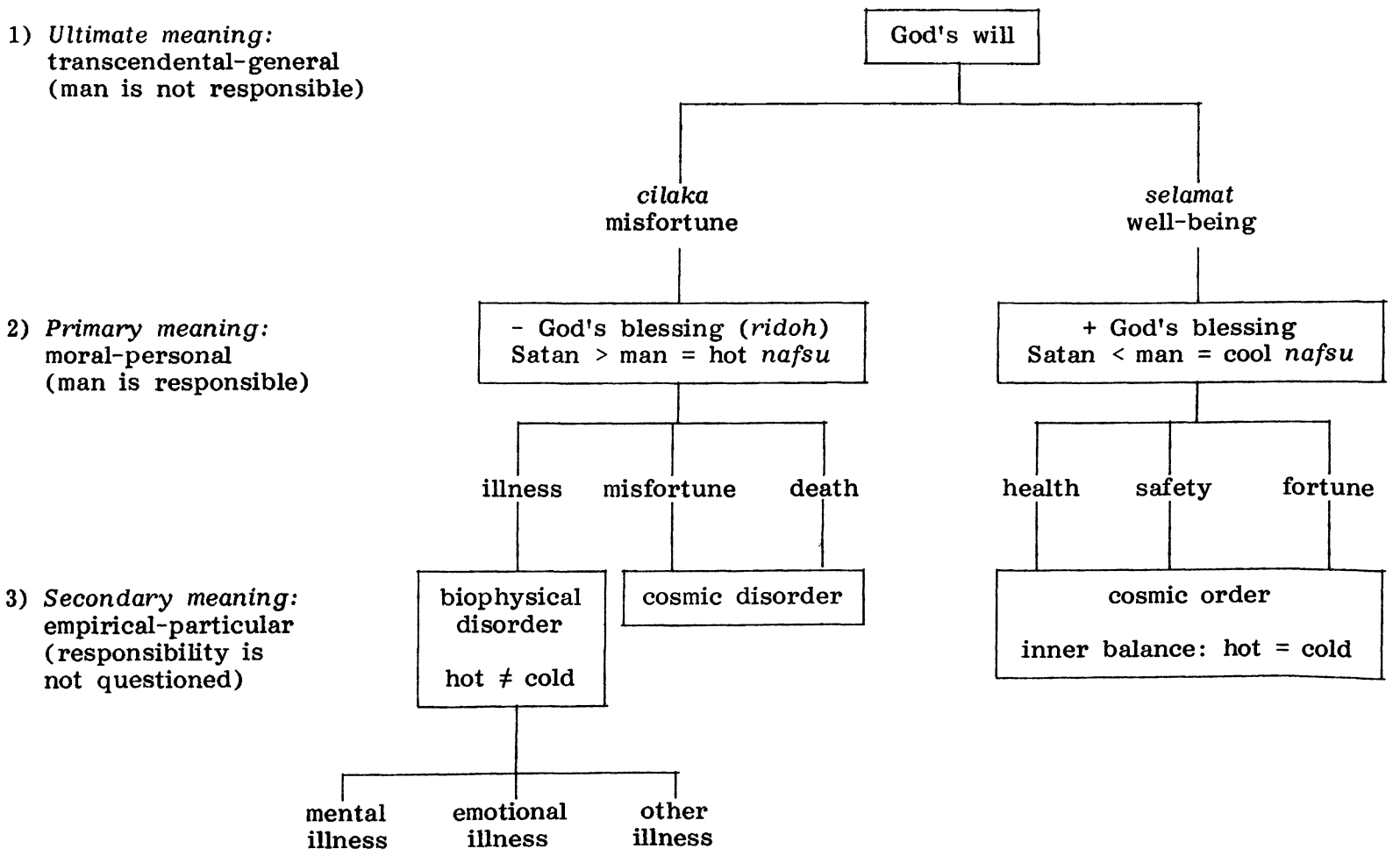

Figure 1. Levels of Meaning

Him from fire ("hot" and hence dangerous) before Adam was created from earth. According to Islamic mythology, Satan refused God's command to honor Adam's superiority, whereupon he was released to the world to prove his own alleged preeminence. Whenever illness or any other suffering befalls a person, it is thus immediately taken as Satan's trick to demoralize him.

At the same time, however, suffering is also paradoxically attributed to man's moral and religious inadequacy. Figure 1 shows the Sundanese concept of cilaka as it is contrasted with selamat, down from the general level to the concrete levels. Since the ideal state, selamat, is achieved only in the absence of pain and suffering, the question which concerns ordinary Moslem villagers is the "way" of avoiding misfortune. Figure 2 shows how this "way" is conceptualized as a system.

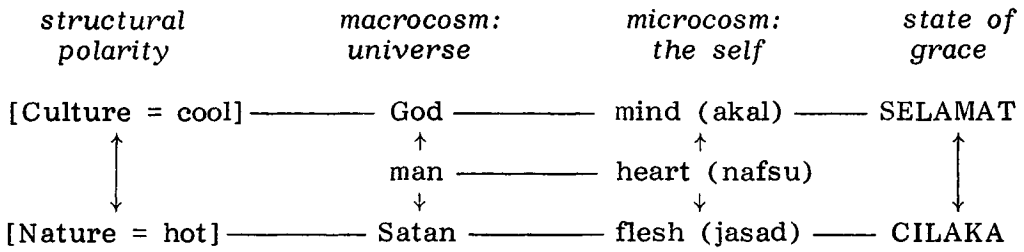

Figure 2. Man and the General Order of Existence

According to this system of thought, the opposition between Nature and Culture is the unarticulated, though nonetheless underlying, structural principle which explains the general order of existence and human experience. Nature is categorically "hot" and destructive, while Culture is "cool" and constructive. In the macrocosm, of which man is but a part, Nature is represented by Satan who, born out of fire, is the source of all chaos and disorder in the phenomenal world. Represented by God and his sacred words (*perintah Tuhan*), Culture on the other hand restores order to the universe. Man exists between these polar opposites and assimilates elements of both destructive Nature and constructive Culture. In the microcosm, the inner self, the mind, which attempts to assimilate God, represents Culture, and the flesh, which assimilates Satan, Nature. The heart, where both forces are represented in the form of hot and cold nafsu, mediates between mind and flesh.

Two related conclusions about the underlying meaning of Moslem Sundanese thought can be drawn from Figure 2. First, man appears vulnerable because "man is heart," with attributes of both God and Satan, or Culture and Nature. Second, selamat is seen to depend on the obtaining of God's blessing (*ridoh*) through the collaboration between all the elements of "cool" Culture--God, mind, and good nafsu. Inversely, submission to the ineradicable forces of "hot" Nature--Satan, flesh, and bad nafsu--will result in cilaka, misfortune. An ordinary Moslem villager, being neither a self-renouncing Sufi saint nor a self-serving disciple of Satan, sees his best chance for selamat lying in strengthening Culture in himself and keeping himself in balance against the forces of Nature. Those people who suffer misfortune are seen as having lost this essential balance and are thus responsible for their own misfortune.

Mental illness is one form of human suffering which results from a loss of Culture. Madness is often said to result from trespassing into dark and dirty places such as graveyards, swampy marshes, or garbage dumps, which belong to sick

and malevolent spirits, or from carelessly disturbing the surface of a lake where powerful spirits are believed to dwell. But it is a firmly held conviction among the villagers that with wisdom, courage, and strong religious faith, these agents of Satan can be fended off. One is advised, for instance, to carry a lamp, recite Bismillah to enlist Allah's protection, or even wear around the neck such amulets as three prayer beads or a piece of cloth with Koranic verses written on it. Some of these practices are condemned by Islamic reformists, but they are nonetheless justified under the doctrine of *ihtiar*, self-help, which places upon man the primary responsibility for leading a good life and earning salvation. Let the mind be wary of Satan at all times, they say; keep the mind occupied with the thought of God, lest Satan strike unexpectedly.

Although for the Moslem Sundanese the moral-religious origin of affliction is the same for all illnesses, symptomatically, mental illness is considered to be the most serious affliction of all. While any illness is seen as a manifestation of inner imbalance, in the case of mental illness, this imbalance has ruined the functioning of the mind, the source of all wisdom and judgment. The excessive heat of the flesh is believed to have boiled the blood, whereupon the contaminated blood (*darah kotor*) has blocked major nerves (*syarap*) leading to the head. This lack of blood circulation in the head then causes malfunctioning of the mind. The unfortunate patient, now believed to be possessed by spirits, has turned into a mere biological entity like a newly born infant. He is now entirely "hot." Figure 3 contrasts the state of mental health and that of mental illness. In the former, the mind overcomes the flesh, thereby enabling the body to maintain the hot/cold balance, whereas in the latter the flesh has overwhelmed the head.

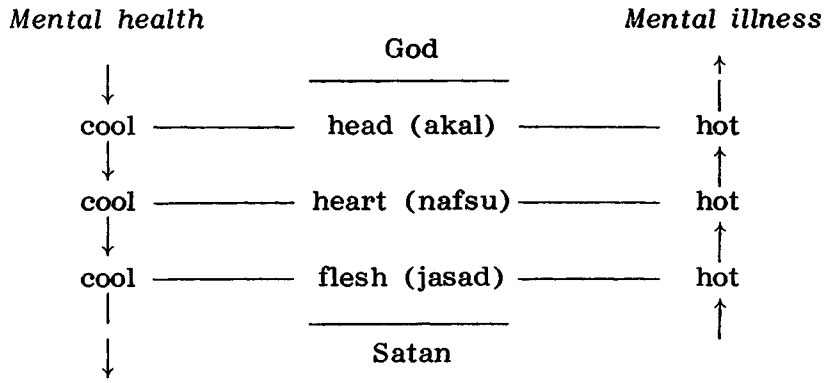

Figure 3. Inner Balance in Relation to God/Satan

Traditional Psychiatry

Among the Moslem Sundanese, medicine is an esoteric knowledge held exclusively by two types of folk specialists: the *ulama*, Islamic religious functionaries, and the *dukun*, local healers. The difference between the two is a matter of status and the perceived effectiveness of their skills.

The ulama learn medicine from the master-ulama as one of the skills necessary for preserving their role as defenders of the Islamic moral community. In earlier times, their knowledge of medicine must have been important in recruiting followers to the faith, but many contemporary ulama, with established positions in the society, no longer practice on a regular basis. Most ordinary peasants, therefore, consult the dukun more frequently than the ulama for medical advice and practical

assistance. Usually dukun acquire skills from their fathers or uncles, although in isolated districts it is not uncommon for self-made practitioners, claiming they mastered the trade through magical means, to make a considerable fortune and reputation. In Islamic communities where both ulama and dukun practice, the dukun occupy an inferior position. They serve as herbal and massage specialists for minor common ailments, such as colds and stomach aches, or emotional problems, while serious cases are referred to the ulama, who, because of their higher ritual status, are believed to possess greater power to heal patients. Both types of specialists, however, practice their skills primarily to gain prestige rather than income.

Despite the well-established Islamic medical tradition, there are few Islamic psychiatric rehabilitation centers with dormitory facilities. This is partly because, as a religious and social leader, the ulama's interests are closely tied to a parochial locality. A network of alliances among the ulama seldom evolves into the type of feasible corporate group necessary to support a large-scale health-care program. Islamic associations tend rather to be formed for educational and political programs directly relevant to the Islamic community *as* a community. The Islamic psychiatric rehabilitation center discussed below is thus rather unusual.

The institution, referred to as an *asrama* (dormitory), is located in the middle of a rice field on the outskirts of a small village near the town of Garut. It was established by one ulama's family in 1953 to accommodate the increased incidence of mental illness evidently resulting from the political crisis of the time (the Dar ul-Islam terrorist movement).[8] The founder, an old ulama, appeared more like an ordinary religious functionary than a charismatic curer. Wearing a Moslem *sarong* and a white *pici* he spoke softly in an archaic form of the Sundanese language. He identified himself with the *kolot* (conservative traditionalist) community rather than with the modernist reformists with whom many of the Islamic private clinics are affiliated.

The main building complex is divided into a meticulously clean reception room with rows of chairs neatly lined along the bare white walls, an adjoining small sunroom, a roomy kitchen in the back, and the patients' wards (fourteen rooms of various sizes). At the time of my visit a total of forty-four patients (31 males and 13 females) were being treated. Two-thirds of them were young adults between the ages of eighteen and thirty-five; most were Sundanese, but there were also a few Javanese and Chinese. The ulama referred to the effects of political and economic change being a factor causing mental health problems. For example, he said that, between 1965 and 1970, after the massacres which took place in rural communities following the abortive Communist coup, the institution was completely filled. Most of the patients were young and old women from the rural areas suffering from acute grief or fear of imminent death in the family. Since 1970, however, by which time the political crisis had subsided, the majority of patients have been urban males suffering from anxiety caused by financial and social crises in their families.[9]

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8. See Horikoshi Hiroko, "The Dar ul-Islam Movement in West Java," *Indonesia*, 20 (1975), pp. 59-86.

9. Kline ("Psychiatry in Indonesia," pp. 810-11) reports that both in Bogor and in the Grogol mental hospital near Jakarta, there are more male than female patients. The therapists described in this article made a joking comment on the cause of male anxiety. It is called 3H referring to *halal*, *haram*, and *habek*; it is difficult to support oneself through legitimate means (*halal*), but one does not want

Most patients being treated at the institution evidently have manic tendencies, as has been observed in mental hospitals elsewhere in Indonesia.[10] This is not surprising considering the fact that the local definition of mental illness does not readily encompass withdrawal syndromes, and most such patients are categorized as simply having emotional problems (*sakit jiwa*) and are referred to local healers. Upon his arrival at the institution, the patient's behavioral disorder is carefully observed, the episode marking the onset of his disorder is discussed with his family, and he is screened for admission by the therapist. Unlike in Western psychiatry, under which psychopathology is classified into subcategories based on behavioral symptoms, Islamic specialists base their diagnoses of mental illness on acute/chronic and organic/nonorganic distinctions. Autism, mental retardation, and chronic psychosis are usually denied admission in favor of acute cases. The ulama justifies this policy in terms of the shortage of facilities and the small size of the staff (four young men in their thirties, two of them being his own sons), but he also said that acute and manic patients tend to recover sooner, and with a higher cure-rate, than chronic or depressive patients.

Treatment Process

This discussion of Islamic psychiatry among the Sundanese is based on two days of observations, and interviews with the specialists at the asrama. Although far from complete, it should nonetheless shed some light on the nature of the Islamic psychiatric tradition as it is practiced among the Sundanese.

I have pointed out that mental illness is seen primarily as a physiological disorder (hot/cold imbalance) resulting from the patient's moral-spiritual breakdown (see Figure 4).

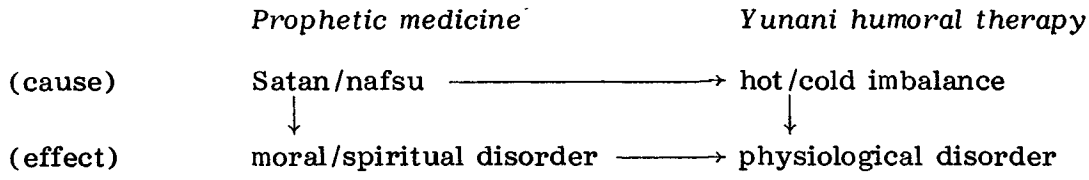

Figure 4. Etiology of Illness

As a medical system, the treatment consists of two separate and yet related sets of practices: one attempting to restore the hot/cold balance by reducing excessive "heat," and the other restoring the patient's moral-spiritual order (refer to Figure 5). The treatment practices follow a specific set of sequences reflecting what psychiatric treatment is intended to accomplish. Although the precise manner of application is distinctly Sundanese, the treatment practices reflect some of the

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to engage in illegitimate and forbidden activities (*haram*), so that the only means left is to take chances with gambling (*habek* = strike).

10. E. Kraepelin, "Vergleichende Psychiatrie," *Zentralblatt für Nervenheilkunde*, 15 (1904), pp. 433-37; reviewed in Hans Lauter, "Kraepelins Bedeutung Für Die Kulturpsychiatrie" (Munich: typescript, 1964); Wolfgang M. Pfeiffer, "Psychiatrische Besonderheiten in Indonesien" [Psychiatric Peculiarities in Indonesia] (Erlangen, West Germany: typescript, n.d.), reviewed in *Transcultural Psychiatric Research*, 3 (October 1966), pp. 116-19. See also Kline, "Psychiatry in Indonesia," p. 813.

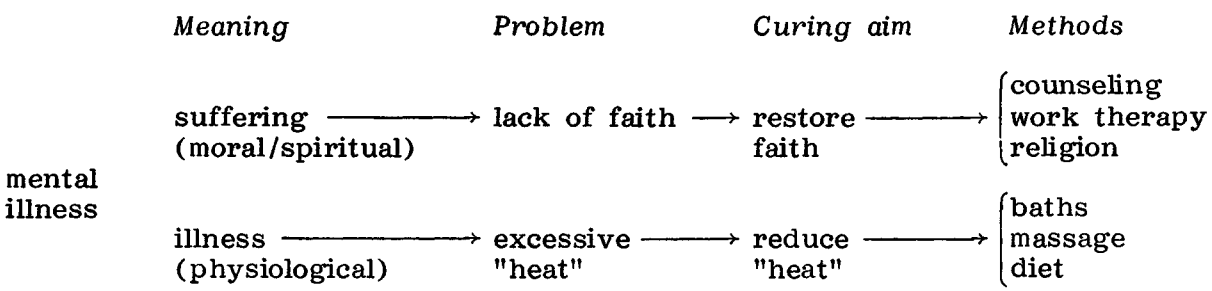

Figure 5. Meaning-Action System of Mental Illness Treatment

fundamental aspects of the Islamic medical tradition, namely, Prophetic medicine and Yunani (Graeco-Arabic) therapy.[11]

The therapists say that to reduce excessive heat in the patient three "cooling" techniques are employed simultaneously: bathing, massage, and diet control. Therapy begins on the day of the patient's arrival, when he is first given a glass of water ritually prepared by the ulama. Both media, the glass of water and the religious words the ulama reads into it, are "cooling" agents. While this practice frequently occurs in other situations, its purpose on this occasion is to provide the recipient with added religious strength and supernatural protection from threatening evil forces. At this point, the patient's family is sent away and advised not to call on the center until notified. Shortly thereafter, the patient is taken to one of the two large pools located at the back of asrama to take a cold bath with the other patients. The length of time each patient remains in the water indicates the stage of his recovery: The shorter his immersion, the further his progress towards recovery. No patient, however, is left in the pool any longer than one hour--a patient on the road to recovery should take no more than ten minutes before beginning to feel "too cold." After his bath, a new patient is immediately put into bed to warm his chilled body, while the other patients wait for a glass of hot water to counterbalance the effects of bathing. Early the next morning, the same process is repeated, after which the patients spend the rest of the morning sun-bathing.

Every other day (once at nine in the morning and again at four in the afternoon), the patients also receive massage treatment to reduce nervous tensions and relax voluntary muscles leading to the brain. First, a cool herbal ointment (rather than a "heat"-inducing oil) is applied along the main nerves and blood vessels, and massage proceeds from the extremities of the limbs towards the heart, ending with the neck and the head. From time to time, massage sessions erupt into a ritual drama between the patient and the therapist. As pressure-point massage is directed against the armpits and temples to exorcise spirit forces, the patient, obviously in great pain, cries out for help, often impersonating the voices of the spirit. In response, the therapist uses all his religious authority to demand that the spirit reveal its identity, and return where it belongs. The drama seems to serve the therapist by establishing his position as the patient's ally in combat against the inflicter of the patient's suffering. When the massage is over, the patient is again offered a glass of ritually prepared water to strengthen his inner power.

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11. For a brief survey of Arabic medicine, refer to E. G. Brown, *Arabian Medicine* (Cambridge: Cambridge University Press, 1962); Christoph J. Bürgel, "Secular and Religious Features of Medieval Arabic Medicine," in *Asian Medical Systems*, ed. Charles Leslie (Berkeley: University of California Press, 1976), pp. 44-62.

Both bathing and massage are intended to reduce inner "heat" by eliminating agents of Nature and introducing those of Culture. Diet control sustains the change thus effected. In the initial stage of treatment, the patient must fast for a day or two to prevent spirit forces from regaining strength. The fasting period will then be followed by a regular diet which consists of carefully chosen foods classified locally as "cool." They include avocadoes, cucumbers, and other non-fibrous vegetables, sometimes supplemented with protein-rich foods such as fish, or chicken (neutral). "Hot" foods, such as fibrous tubers, hard-to-digest corn, tough meat (goat or buffalo meat), beans, and other stimulating and odorous fruit and vegetables are excluded. Vitamin pills (neutral) and other modern medicines are also introduced to remedy malnutrition and internal parasites.

During the first few weeks, the patient spends much of his time sleeping in a cell-like single room with a window facing east. The patient is deliberately kept away from the yellowish sunlight of the late afternoon and from lamplight in the evening to prevent the possessing spirit from getting agitated, and to help the patient sleep well. At night, the rooms are locked, and the ulama's assistants take turns to go around and check the patients every two or three hours. After a week or two, when the patient no longer suffers pain from the massage and his period in the pool shortens, he is recognized for the first time as being free of spirits and ready to complete his physiological treatment. He will now have to move to a room shared with two other inmates.

From an analytical viewpoint, this first segment of the treatment can be seen as a ritual fetalization and rebirth of the patient. The beginning of a new life is symbolically represented by a pool of water in which the patient bathes and by the fetus-like experience imposed upon him, whereby he must sleep in a dark room, avoid light at certain regular times, and spend hours without food. The fetalization is then followed by rebirth as soon as the patient begins to be able to distinguish days from nights (marked by the "disappearance of yellow lights" in the mind's eye). Like an infant, he can now "see" but, not having yet learned Culture, cannot identify what he sees. He is still very "hot," and like a baby must be fed easily digestible baby food that is "cool." Only when the body is seen to have "cooled" and the patient's behavior shows signs of awareness of the surrounding world, is he recognized for the first time as a social being sharing the world with others. He is then removed from a single lightless room to a room shared by others, and at this stage, when he is seen as a small child, he must begin to learn elements of Culture.

The next segment of the therapy, the treatment of the heart and mind as the therapists call it, is aimed at restoring the patient's mental and spiritual strength and integrating his inner microcosm with the outer world. It consists of three interdependent programs; counseling, religious training, and work therapy.

The face-to-face counseling takes various forms and occurs as a part of daily activities rather than as formal sessions in isolated rooms. Such encounters may occur during sun-bathing hours, or when the ulama visits the patient in his room; or the ulama may ask the patient to help him in the fields, and, while they are out working together, initiate conversations on various issues. He will encourage the patient to talk about his family, his experiences, or the episode of his breakdown. Some patients with difficulties in communicating with the ulama are encouraged to resort to nonverbal means of communication. Most patients with manic tendencies are eager to continue talking about their problems until they begin to repeat themselves, but the ulama will not stop them. The fact that the patient does not really recognize the ritual authority of the ulama and continues to talk on heedlessly indicates that, like a small child, he is unaware of the rules of social discourse. One

fellow we met was at this level of recovery. His sometimes incoherent expressions and repetitive jerky motions were indications of the nature of his original problems. He had been a student of mathematics for the past ten years, but, because there were no jobs and his family was relatively well-off, he never finished school. He had begun feeling stressful (*tekanan jiwa*), he said, when his parents disapproved of his wish to marry a woman of lower social standing. Subsequently, the girl married an older man and moved away, and his parents tried to pacify him with a brand-new motorcycle. He repeated this story several times, always ending with a self-addressed question: "What can one do if one's parents prefer a motorcycle to the woman one loves?" In response the ulama nodded his head several times as if to express understanding of the man's suffering, but then he said, "Maybe it is not a good thing to expect too much out of the present state of social equilibrium."

In general, the counseling technique is very similar to that in Western psychotherapy. Instead of directing change, the therapy is aimed at guiding the patient to recognize (*mengakui sendiri*) when and where he has gone wrong and to acquire a new perspective on the reality of his life. The major difference between Western psychotherapy and the Islamic process emerges not in the technique or underlying philosophy, but in the values that are stressed as being necessary for the patient to adapt and orient himself to life. Rather than self-assertiveness, the ulama emphasize moderation (kesedangan), patience (*kesabaran*), and harmony (*keseimbangan*) with the social universe. The patient is discouraged from hoping for change and urged to adjust himself to the demands of his situation. It is emphasized that a well-adjusted person is one who maintains a proper balance with the forces of his inner universe and the external social universe in which he participates. (This ideology is, of course, congruent with the values of the larger society.)

I saw in on one such session between the ulama and a patient whom the ulama had described to me as well along the road to recovery. Probably in his late thirties, the patient had been an ulama himself and the son of a well-known charismatic religious leader in the district of Tasik. According to his own account, the onset of his disorder was related to the sudden death of his father and the difficulty of coping with the new and overwhelming responsibility of heading the family's *pesantrèn* (Islamic educational institution) and assuming the role of religious leader in the region. The patient calmly admitted that, in retrospect, his problem had begun when he resorted to practicing Sufi mysticism to overcome his anxiety. The ulama agreed with the patient and added that undertaking such a strenuous task when one is already distressed by the difficulties of the situation only weakens and confuses the mind. The patient then continued recounting his story: Apparently because of his conspicuously disorderly conduct, he had been suspected of being a Communist sympathizer and put in jail, where he claimed to have been abused beyond endurance by the prison officials. Giving a detailed account of this experience, the patient referred to the cognitive errors he had made in attempting to comprehend his suffering. He had mistaken the hardship for God's test (*percobaan Tuhan*) and had responded to it with joy and ecstasy, whereas it had only been a trick of Satan. The ulama and his patient exchanged cultural idioms and religious perspectives in order to put the patient's suffering in some kind of comprehensive order.

The therapeutic aim of converting the patient's value orientation from self-centered indulgence to harmony between the self and the outer world is further carried out through the program of work therapy, in which each patient is assigned a specific task, usually related to his former occupation: an ex-farmer with agricultural work; a former office clerk with paper work; a petty trader with shopping

in the local market; and a bicycle repairman with repair of all the bicycles in the village. The women are assigned to cook and perform other household chores around the place. The work therapy, called *percobaan* (trying out), is designed so that the patient can rediscover his personal worth by serving others and by participating in socially meaningful activities, while at the same time becoming reacquainted with the world outside the immediate context of the therapeutic community.

At the time of my visit, one speechless Chinese youth was repairing bicycles in the yard. It was revealed to me later that he had suffered acute fright when a mob of youngsters attacked his father's shop during the 1965 anti-Communist and anti-Chinese riots in Bandung. For several years he had hidden himself in his room for fear of assaults upon his life. The therapist had been reluctant to admit the patient, because he anticipated that a long time would elapse before the patient could recover from his traumatic experience. After three months of treatment, however, the young man was already beginning to relate to the villagers through written communication, although he was still unable to speak.

To effect a long-term rehabilitation, religious training is considered most important. This training aims first of all at restoring the patient's proper relationship with the Divine, and, second, at helping the patient build the firm moral foundation and strong religious faith necessary to ward off evil temptations and spirit forces. Patients without any previous religious training attend local classes held for the children, or join adult Koran-reading groups which meet in the evening. Followers of non-Islamic religions are encouraged to attend a church or temple of their choice, although it is not unusual for them to be converted to Islam (as, for example, the above-mentioned Chinese youth who was formerly a Catholic).

By the time the patient begins to participate in work therapy, restrictions previously placed upon his activities are lifted, and he now shares a much larger room with four or five others. He is allowed to take a bath in a normal fashion, attend religious gatherings with other villagers, and spend nights sleeping in the *madrasah* (school) with the students enrolled in the ulama's pesantrèn. The only requirement he must meet is to sleep for two-and-a-half hours every afternoon and go to bed by a certain hour. More or less completely independent of the therapists, he is now incorporated into the local daily activities.

This second half of the therapy can be equated with the socialization process of a young child growing up to be an adult. Like all Moslem children, the patient learns to conform to the social order by identifying categories of visible and invisible elements of the universe and by acquiring cultural values such as the importance of maintaining harmony, moderation, and religious faith. The patient will then learn to become autonomous of others and assume responsibility for himself. He now acquires roommates and participates in social activities meaningful for the collectivity as a whole, while at the same time he takes charge of his own activities. Through work therapy, the patient, like a young adult, acquires the skills necessary to earn his own living. He is now ready to establish his adulthood, the final stage in the socialization process, by getting "married" and having a family of his own. This is accomplished by a reunion with his spouse and family.

Reuniting him with his family is the final step before sending the patient back to society. Previously forbidden from visiting the center, towards the end of the period of work therapy the patient's family is called in for a number of counseling sessions with the therapists prior to being permitted to meet the patient. These sessions are designed to inform the family about the patient's progress and the diagnosis of his problems. In this sense, the therapist serves as a mouthpiece for

the patient and as a mediator preparing a bridge for his reentry into family and society.

The transition process is handled with the utmost caution and sensitivity. After several sessions, the spouse is sometimes called in first to see the patient, and, if it seems appropriate, permitted to spend the ("bridal") night with the patient in a room reserved specifically for that purpose. The patient is allowed to make his first visit home the following day, but must return to the center the next day. After several such temporary visits, when the patient has been completely reintegrated into society, he is permanently released from the center. For the next few months or so, however, his family is still expected to report on his readjustment, and, should any relapse occur, the patient will be readmitted for further treatment and rehabilitation.

From the viewpoint of Moslem Sundanese psychiatry, the underlying aim of the treatment described above is to reinstall Culture in the patient through exposing him to the experience of rebirth and resocialization. The patient, who began the therapy as a mere biological entity, like a "hot" fetus, is now transformed into an enculturated being possessing the ability to maintain a balance within and without the self. Figure 6 shows this process of transformation.

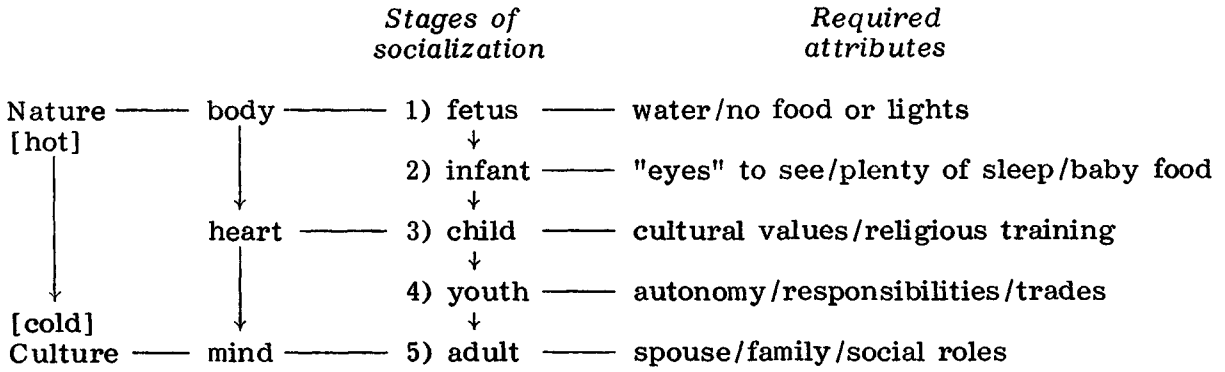

Figure 6. Therapy as Rebirth and Resocialization

While the experience of symbolic rebirth informs the patient about the new life he is to begin, the resocialization training replaces his evidently faulty orientations to life with more adaptive and proper ones. The underlying message being stressed in this movement away from Nature towards Culture is that one's well-being (selamat) may be achieved only through one's own efforts (ihtiar); one encounters misfortune (cilaka) when one fails to sustain faith and begins to lose Culture. Unlike the traditional Hindu-Buddhist belief, the message is that life does not necessarily have to be only suffering; faith and effort are just as relevant for this-worldly well-being as for the attainment of salvation in the life hereafter.

The ulama claimed that practically every patient treated at the center eventually recovers, a claim I found no way to prove or disprove. I noted, however, that a considerable number of the patients I met at the center had been there for more than two years, some of them being described to me as "cured," and others being termed "slow" patients. The cured patients had evidently either decided to enroll at the pesantrèn as students to continue with their religious studies, or had found the therapeutic community the most congenial place to live for the time being. These former patients prepare meals, wash clothes, and attend religious classes

like the students, and also help the ulama with farm or other work in exchange for a guarantee of minimum subsistence.

The "slow" patients, on the other hand, had become assimilated into the routine of the institution's activities, also engaging in simple tasks, while the therapists and the families waited for their recovery. The center allows these "slow" patients to remain because time is not part of the therapists' concern. They see the reward for their services in the afterlife. Since they are merely practicing their ihtiar doctrine, it is inconceivable for them to admit failure, give up treatment, and send the patient back home. It is up to the patient's family to make such a decision.

Public Tolerance towards Chronic Mental Patients

While the therapists aim to prevent the patient's condition from becoming chronic, what happens to the patient should treatment fail and his family decide to bring him home? Back in their communities, most former patients will gain a ritual status, along with other sufferers from chronic mental sickness, and will enjoy a special "privilege of deviation" without being ostracized. In the village where I stayed, eight out of three hundred and fifty people were said to suffer from chronic mental illness. Of the eight, two were evidently organic cases, to which the villagers referred as *rusak kepala* (ruined head). The rest were said to suffer from sakit kepala, nonorganic mental illness, potentially curable. Some of them stayed at home and were seldom seen, but others moved in and out of the village engaging in deviant and antisocial behavior. One well-built man, for instance, used to roam around the village with children trailing behind, giving religious sermons in front of a mosque, or begging food and drinks from neighbors. There was an elderly woman who once a month or so had an attack, throwing stones and yelling obscene words at anyone who approached her. Others were simply a nuisance, like a young man who went around the village urinating into ponds where the villagers took ritual baths before prayers, or a woman who sang religious songs before congregations. Their uncensured disorderly conduct remained conspicuous in a community which otherwise presented itself as a fairly "rigidly" structured society.

What was surprising to me was that such annoying and sometimes even threatening behavior by the afflicted was ignored and tolerated as if it was no more significant than the obnoxious behavior of a young child throwing a temper tantrum. Undeniably, there was an element of compassion in the villagers' tolerance, for they all knew the difficulties and traumatic experiences each patient had undergone prior to the onset of his disorder. In addition, however, there was an underlying feeling of ambivalence which seemed closely allied to the way the Sundanese related their own state of grace with those of the afflicted.

The attitude towards chronic mental illness among the Moslem Sundanese seems to reflect the ambiguity of their world-view in its determination of the causes of human suffering.[12] On the one hand, it defines man's relationship to Culture and Nature, and the actions he should perform to achieve salvation and sustain well-being. On the other hand, it also recognizes that the degree to which man can

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12. In his book *Mythology and the Tolerance of the Javanese* (Ithaca: Cornell Modern Indonesia Project, 1965), Benedict R. O'G. Anderson focuses on the issue of moral ambiguity as a key to understanding the Javanese tolerance for non-Javanese. While assimilating his ideas, this article emphasizes the ambiguity of meaning.

actually achieve these goals is limited by forces beyond his own control. As a consequence, the extent to which man should be held morally responsible for irreversible misfortune appears indeterminable, and tolerance is an expression of the community's acceptance of this reality of life.

The ambiguity of the cultural theory of suffering stems from an ultimate belief in God's role in determining man's fate. When it first occurs, suffering is seen as a consequence of God withdrawing his blessing (ridoh) because of a person's inadequate religious faith; but, when this unfortunate situation persists despite all efforts to the contrary, the misfortune is interpreted as a manifestation of God's will, a predetermined fate which neither one's faith nor one's efforts can change (refer to Figure 1). The unfortunate victim can not then be held morally responsible for his misfortune.

Intellectually, this belief in God's will or predetermination (takdir as opposed to ihtiar, self-help) helps satisfy man's quest for an explanation for phenomena that are inexplicable by logic or common sense. At the same time, however, such a belief denies man's moral efficacy, the basic premise of the people's religious life.

The problem is not a lack of congruence between the system of meaning and the perceived reality, and that therefore the morality is seen as all too relative. Rather, the system of meaning consists of multiple levels of interpretation, so that the most consistent theory of causation may be the one that is most ambiguous; depending upon God's will things can happen with or without man's moral efforts. Madness, for instance, is both a cosmic fate (takdir) and also a consequence of moral failure against Satan's temptations (ihtiar). The first of these principles supersedes the latter, for belief in God's power, beyond human understanding, is more fundamental to religious faith than the doctrine of self-help.

Fatalism, thus conceived, provides little remedy for anxiety, for both in theory and practice there is no end-point for ihtiar, an end-point where takdir begins and man is released from the burden of self-help. According to the ihtiar doctrine, under no circumstance may one give up hope and effort. Much of the time, however, life seems to go on regardless of man's actions, and as a passive participant he has no choice but to hope for the best until eventually and uneventfully he becomes resigned to the fate of an unalterable situation. One must make an effort to achieve salvation, but the outcome is beyond human control. Against that reality, self-effort gains meaning only as a man's sincere attempt to prove to God his worthiness for salvation.[13]

The villagers' tolerance of the mentally afflicted can be understood only in the light of this tragic sense of man's existence. Misfortune befalls the sane and the insane without an apparent cause. In the same way, the virtuous man can no more be sure of a good life and salvation because of his uprightness than can a non-virtuous man be certain of punishment. Why then should a chronic madman be penalized and expelled from society, when he cannot ultimately be held responsible for his misfortune? To do so would be to defy God's will, unless the madman actually threatens the moral order of the community. The Islamic community exists as a coherent unit because of its commitment to that moral order and a sense of communitas that emerges from a sense of sharing in the indeterminacy of fate. What is being tolerated symbolically through the acceptance of the mentally afflicted in the community, therefore, is the ultimate meaning of human suffering, the sacred and all-powerful will of God.

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13. For a discussion of moral worthiness in relation to social action, see Siegel, *Rope of God*, on the Moslem Acehnese.

While the community's tolerance of the mentally ill is thus an outcome of its world-view regarding the uncertainty of life, the villagers' ambivalent attitude to the mad also involves the relationship between a mad person's ritual status and their own. To clarify the issue, let us return to the doctrine of predetermination.

According to the doctrine, the normal Moslem's fate in the life hereafter is withheld from him, and his state of grace is always uncertain. A mad person's fate, on the other hand, is believed to be fixed and predictable, setting his status before God apart from that of the rest of the community. According to the belief, a mad person will neither suffer in hell nor enjoy the pleasures of heaven, for his actions in life do not reflect his faith or moral decision. He is seen to be innocent like a child, unable to gain either religious merit or demerit, and not to be held responsible for his actions at the Last Judgment. He will be sent instead to an island, suspended between heaven and hell, where he will feel no pain or pleasure (it is in fact the same island where the souls of the young deceased are believed to dwell). The irony of this belief, of course, is that this "island of no senses" closely resembles the expectations of most Sundanese regarding the condition of blissful existence. In other words, a mad person not only enjoys freedom from the burden of ihtiar in this life, but may even fare better than the faithful in achieving the cultural ideal. He is, in fact, free of the anxiety that characterizes the normal Moslem villagers, who live in fear of damnation in the next world.

There is, however, one alternative to the constraints exercised by the doctrine of faith and anxiety regarding one's fate: the way of the Sufi mystic. Many people in their mid-thirties undertake Sufi spiritual training at least once, by apprenticing themselves to Sufi masters.[14] They are usually trained privately under the guidance of a learned scholar of *ilmu Tasawwuf* (science of devotion). The training requires the pupils to engage in intensive meditation upon the power of the Divine and to purify their souls (*membersihkan diri*) of bodily desires, the vanity of self-aggrandizement, and other this-worldly attachments and social conventions. The pupils receive lessons from the masters, chant *mantra*-like formulae, and undergo self-imposed physical hardships (usually involving fasting and deprivation of sleep and other comforts). The objective of such training, called *ilmu Hi'mat* (science of ecstasy), involves an attainment of certain perspectives on man's existence and an active emotional experience with the personal, rather than doctrinal God, without necessarily escaping existing social realities. After some time, most of these young disciples return to their normal life to resume their social roles. But a few, particularly among the aged, become permanent Sufi mystics by adopting self-renunciation as a way of life, abandoning family and property, and wandering from village to village to test and prove their total devotion (*tawakkal*) to God. They do not necessarily engage in regular prayers or follow social conventions, but are nonetheless revered by the community as God's friends, who have achieved a high level of consciousness, possessing transcendental powers to foresee the future and control events.

One such mystic was an old man from Cirebon who had been known to the community for at least the past twenty-five years. Carrying an umbrella in one hand and a bundle wrapped in a sarong over his shoulders, he would appear unannounced in the village, and disappear mysteriously without a farewell. He wore long hair and a beard, talked very infrequently, and most of what he said or did made little sense to the villagers. For instance, he would beg for a cup of sugar

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14. The young men usually undertake a Sufi discipline shortly before or after their wedding in order to prepare themselves for the role of family head. In the village, marriage marks full adulthood for Moslem men.

from one family and give it away to another. He would sit for hours by the window looking outside with tears in his eyes. But, above all, he appeared fearless and undisturbed by events taking place around him.

The villagers believed that this saintly-looking deviant possessed extraordinary powers that might influence their lives, and his words and actions were often interpreted as having a significant message concerning things of which the villagers were unaware. Their belief in his transcendental power was sometimes "substantiated" after the fact. One time, for example, Aki ("grandfather")--the name by which the old man was fondly referred to--asked us for a batik scarf to tie around his head. We did not have one at the time, so could not comply. A week later, my jeep collided head to head with an oncoming truck, and the family head immediately associated the event with Aki's previous request (with its emphasis on "head"). It was not that Aki was believed to have caused the accident, but that it could have been avoided had we cooperated, for Aki "must have known the accident was imminent."

The villagers are intrigued by the similarity between the behavior of the mentally disturbed and that of the self-renouncing Sufi mystic: they come and go as they please, ignore social conventions, abandon their families and property, and sometimes demonstrate incomprehensible abilities. Beneath these superficial similarities, a madman and a saint are also perceived to share a lack of ego-centered self-concern. In contrast to normal people who tend to be self-concerned, morally vulnerable, and thereby blind to God, these selfless individuals are pure, sinless, and open to God. Like a Sufi mystic, therefore, an annoying mad person may be blessed with supernatural powers to influence the villagers' lives.

I have argued that chronic mental illness has significant implications both for man's existential problems with pain and suffering, and for the question of how reality is perceived. The phenomenon of madness raises more questions than it can answer: madness may result from an individual's moral weakness or from a supernatural fate; a mad person may be a crazy fool or a saintly deviant with supernatural abilities. In a similarly ambiguous fashion, faith requires moral actions and self-effort but it does not in return guarantee salvation; God does not cause suffering but the irreversibility of fate is willed by God.

Whenever I pointed out these ambiguities, the wise laughed and the less intelligent were perplexed by my intentions in questioning matters which to them were so clear and self-explanatory. Most people seemed able to live with such ambiguities and contradictions, not because they were blinded by their hope for grace, but because their faith was rooted in their acknowledgment that perceived reality and man's fate are ultimately undeterminable. The existence of unknown forces, which the Sundanese describe as *alam gaib* (mysterious realm), is too overwhelmingly real to be ignored or systematized according to man's logic. As the therapists can only do so much to help a patient recover, so man can only make so much effort to achieve his objectives, with the consequences never totally within the reach of his power and comprehension.

For the Moslem Sundanese villagers the phenomenon of madness is not an isolated, objective incident taking place outside the realm of experience of ordinary "normal" people. Neither is it regarded as deviance that must be eliminated for the sake of preserving social order in the community. They perceive the phenomenon as an exemplary statement of the truth that God is almighty and beyond human logic, and man's fate is simply undeterminable. Like the wooden corpse-carrier displayed at all times by the entrance to the local mosque, a chronic madman appears as a living symbol reminding the faithful of that ultimate and undeniable truth, and inducing in them awe and faith.

The villagers' tolerance towards the mentally disturbed is nothing simple. It reflects multiple cultural values and aspects of their world-view. Ambiguous and inconsistent, a deviant such as a madman or a Sufi saint is a significant reference point in ordering the world of experience the villagers daily encounter.