



# Containing Madness: Care for the Homeless With Major Mental Illness in Yogyakarta , Indonesia

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Containing Madness: Care for the Homeless with Major Mental Illness in Yogyakarta, Indonesia

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A Thesis Submitted to the Faculty of

The Harvard Medical School

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Containing Madness: Care for Vagrants with Major Mental Illness in Yogyakarta, Indonesia

**Abstract**

In 2014, as part of an effort to create ordered streets for urban transformation, the Indonesian province of Yogyakarta instituted a vagrancy law (Government of Yogyakarta Special Region, 2014). The vagrancy law mandates that those who are homeless or begging in the streets are to be evicted out of public space and referred to systems of state care. Aimed to provide welfare to the vulnerable, the state brings those evicted from the streets to a temporary encampment called “Camp Assessment” where social workers are expected to perform a series of assessments and formulate care for the vagrant. By June 2015, the state had found itself caring for an unprecedented number of people with psychosis and other disabilities

Homeless people with a major mental illness, are assessed to determine if they have the “potential” to be “productive” and will be referred to a state-owned rehabilitation center called *Panti Rehabilitasi*. In the *Panti Rehabilitasi*, they will be provided with vocational skills with the hope that this will provide employment. This ethnographic project’s aims explored state care for the homeless with major mental illness to expose inadequacies and gaps within the Indonesian social welfare system.

The institutions I describe in this thesis are state-run institutions that try to contain madness by reassembling relations of kin. Discourses of individual responsibility and the nuclear family in Indonesia, outsources the containment of madness to the families. This thesis describes the ways through which the biggest burden for the containment of madness lies within families. Human Rights abuses of people with major mental illness in Indonesia are often framed as one abuses of rights in institutions as a result of families abandoning the person (Human Rights Watch, 2015). I have taken a different approach and instead used these institutions to show that available discourses of recovery cannot successfully contain madness. I also show that these institutions go to large lengths to make sure families contain madness within their household.

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## Preface

In 2014, as part of an effort to create ordered streets for urban transformation, the province of Yogyakarta instituted a vagrancy law (Government of Yogyakarta Special Region, 2014). The vagrancy law mandates that those who are homeless or begging in the streets are to be evicted out of public space and referred to systems of state care. Aimed to provide welfare to the vulnerable, the state brings those evicted from the streets to a temporary encampment called “Camp Assessment” where social workers are expected to perform a series of assessments and formulate care for the vagrant. By June 2015, the state had found itself caring for an unprecedented number of people with psychosis and other disabilities.

In late June 2015, I was invited by the provincial department of social affairs to join and observe their case conference, a routine weekly meeting where social workers would formulate care plans for vagrants. Having worked with them for a couple of years instituting a community-based HIV shelter for the homeless, they invited me to provide potential solutions to the problems they were facing in caring for vagrants in the province. The meeting was held at Camp Assessment, a temporary encampment where vagrants who were evicted were held temporarily for assessment and referral to state care. The hall where the meeting took place was damp, hot and under ventilated. The ceiling was moldy, windows cracked and covered with barbed wires, and walls scratched with words like “get me out of here.” Having noticed my uneasy expression upon entering the room, Susi, a good friend and social worker, explained that the room was previously used to host people brought in.

The case conference was nothing like the conferences I was used to in hospitals. Social workers would read out a case number, a few items describing the client they were handling, and

the proposed management plan. The psychologist would then add comments and the fate of the person would be adjudicated by the head of camp. One particular case struck me.

Siti, a 65-year-old beggar was caught near the traffic intersection of the popular Mali-oboro Street. Siti had some sort of mental disability they labelled as “psikotik” and her physical condition was reported to be deteriorating. Social workers could not formulate an appropriate care plan for her. Siti could neither be returned to her family because one could not be identified nor referred to a state funded shelter and rehabilitation program because she does not of have the “potential” to be “productive.” Siti was stuck in camp for nearly one year. Social workers were extremely worried about the problem because fitting into no scheme of state care, Siti’s daily care expenses was never accounted for in the budget.

“We cannot continue like this, we have no money for Siti,” said a social worker clearly worried about the rising numbers of people “stuck” in these camps. She had tried several times to find a private institution to care for Siti, to realize that the only institution willing to accept her was a religious institution where treatment for her disability was not available. “They just keep on coming, we didn’t expect it at all when designing the law, we really don’t know what to do with them,” added another social worker.

He explained that the nationally stipulated welfare system which they relied on did not foresee someone like Siti requiring state care. Siti was incomprehensible and unprecedented, social workers could not fit her into any scheme of care because it required either a family or the “potential” to be “productive.”

Unfortunately, Siti was not alone. There are 199 people stuck in these temporary camps. “We are struggling, Sandeep,” said the manager of Camp Assessment. “Our seniors at the department just don’t understand, we are left to care for these people on our own.”

“With the limited budget we have, it won’t be long until we start rationing food” said the administrative staff attending the meeting.

The situation was dire, as the number of people “stuck” in these temporary camps increased by the day. With a plummeting budget, social workers were at the point of desperation. At this point one may be as confused as I was in the meeting, as to why the state has found itself in this predicament. Why does the system rely on the family when Siti is obviously displaced and homeless? Why can’t state institutions accept Siti when she clearly needs care? Why does one need to be potential to be productive to receive state care?

By the time I got to the planning of doing the formal research, The Department of Social Welfare had created a new space for Camp Assessment which dedicated a special facility for people with major mental illness. The department’s staff wanted me to do research on the mental health systems within the network of institutions they were managing. This thesis attempts to answer the questions raised above with that frame, exploring the interactions between the social welfare system and the health system as it played out in the institutions.

### **The Setting: Yogyakarta’s Urban Transformation**

Daerah Istimewa Yogyakarta (commonly called Yogyakarta) is a relatively small province in central Java. Known as the cultural capital of Indonesia, the province inhabits four million citizens. With its traditional markets, scenic volcanoes, and archeologic temples, Yogyakarta finds itself catering to an expanding economy of tourism.

Governed by a Sultan in a Kraton (Kingdom) that acts as its mayor, Yogyakarta takes pride in itself as a center of Javanese culture and art. Yogyakarta is also home to major universities and academic centers bringing in an influx of students and professionals from all over the

country. Nevertheless, like other parts of Java, Yogyakarta is undergoing massive change. A stroll down the popular Malioboro streets, the very streets on which Siti was found begging, and one can see first-hand the massive changes that are occurring in Java. Streets that used to be filled with street vendors, pedicab drivers and street buskers are undergoing massive urban transformation as new hotels, department stores and apartments emerge.

In fact, in early January 2015 (Hasanudin, 2016), in an effort to boost tourism, the state “swept” the streets of Malioboro by removing all “wild” street vendors to make it “presentable” for people visiting Yogyakarta. Thus, even though Yogyakarta prizes itself to be center for culture and tradition, it is not immune from the massive urban transformation as a result of globalization and its thriving tourism industry. Indeed, the World Bank (2016) reports that Indonesia has the fastest growing cities in the region. With urbanization at 4.5 % a year, more than half of the people living in Indonesia will be expected to live in urban cities by 2030. However, unlike other countries, these rapid changes were not translated to economic growth. This may be due to lack of investment in public infrastructure and human resources to bring about the economic potentials of urbanization. In response, the Indonesian government has made it a priority to invest in infrastructure and human resource development to improve growth (Amindoni, 2016).

In Yogyakarta, efforts to improve infrastructure is directed toward its tourism industry. This has resulted in the state privatizing land for the buildings of hotels, shopping centers and apartments. In fact, in 2015, the state gave out more than 100 hotel permits (Maharani, 2016). This rapid development however, did not come without its controversies. There have been massive protests by farmers in rural areas trying to stop the state from taking away their land to build an airport (Hidayah, 2016). Moreover, in March 2016, the state issued a moratorium on hotel

permits because massive development was thought to have caused a problem with the clean water supply in certain urban settlements (Khaerur, 2016).

The institution of the vagrancy law cannot be seen removed from this broad narrative of urbanization and development. Aimed to “provide welfare to the vulnerable” and “promote public order” the law mandates that all beggars, buskers and homeless people are to be evicted out of public space. The law was intended to reduce the “phenomena of begging” and maximize the potential of human resources to create productive citizens that would drive the economy. The law thus aims to eliminate any sign of “disorder” from the streets and provide “ordered” (*tertib*) streets for urban transformation (Hegarty, 2016).

## **Methods**

The research project was conducted in three spaces; Camp Assessment, the state-run rehabilitation institution called *Panti Rehabilitasi*, and in homes. In each space, I conducted participant observations from June 2017 to January 2018. Throughout the period, I followed people with major mental illness as they traverse these spaces. I employed this methodology to understand how each space interacted with each other, and with the medical system. Within each space, I participated in almost all activities each institution conducted. I obtained secondary quantitative data from their public reports and conducted a desk review to place these institutions within the network of policies that animate them. In each institution, I conducted multiple in-depth interviews with people who had major mental illness, their families and the staff within the institution. In these interviews, not only did I elicit a biography, I also asked about relationships and aspirations. These interviews were conducted in private spaces within these institutions, chosen by interviewee’s themselves and with their consent. Interviews ranged from a total of three hours

to ten hours with each person. In the following sections I describe how I approached participant observation in each institution in detail.

### **Camp Assessment**

In Camp Assessment, I participated in all assessment interviews, with the consent of the social worker and the client being assessed. In these interview sessions, I actively worked with social workers and clients to assist in the formulation of referral plans. I participated—with the consent of social workers and the managers of Camp Assessment—in all case management conferences conducted during the period. I also spent several hours daily inside residential areas of clients with major mental illness and participated in activities social workers planned for them. These activities included games, exercise sessions and karaoke singing, among others. In total, I interviewed 15 social workers and 20 patients with major mental illness and their families.

### ***Panti Rehabilitasi***

In *Panti Rehabilitasi*, I participated in all activities the institution conducted. This included vocational training and self-help lectures. I also participated in assessment interviews. Social workers conducted these interviews to know if a patient with major mental illness would be eligible for rehabilitation. I observed these interviews with the consent of the social worker, the patient and their family member. I participated in the reintegration of patients into their homes. In *Panti Rehabilitasi*, I interviewed 10 social workers and 20 patients with major mental illness. I interviewed patients in the institution selectively recruited by social workers as ones that had problems with their rehabilitation programs.

## **Homes**

A key activity conducted in both institutions was the reintegration of people with major mental illness into their families. I continued to follow up with families after patients had returned home. I interviewed primary caregivers and patients with major mental illness in their homes. I conducted 10 home visits but intensely followed 5 families with multiple visits and long intensive interviews.

## **Containing Madness**

In Veena Das's (2015) ethnography of mental illness in the urban slums of Dehli, she writes, "[M]y aim is to track the fragility of relations and of experience that is revealed when madness cannot be absorbed in the everyday—yet it is the case that it is only within this every day, corroded and shattered by madness though it becomes, that care can be offered" (p 83-84). Inspired by Veena Das, this thesis attempts to uncover how institutions like Camp Assessment and *Panti Rehabilitasi* attempt to contain madness; absorb it into the everyday. Like Venna Das, I conceptualized madness as one that lies within relationships, as something that constantly threatens relationships but one that needs to be contained within them to receive care. Containment of madness was the frame I used to look at this struggle. The struggle to contain madness is one that is existential and never final, yet, health systems, state officials, families anchored on available discourses of recovery and its associated materiality, struggle to reestablish relations fractured by madness.

The institutions I describe in this thesis are state-run institutions that try to contain madness by reassembling relations of kin. Discourses of individual responsibility and the nuclear

family in Indonesia, outsources the containment of madness to the families. This thesis describes the ways through which the biggest burden for the containment of madness lies within families.

Human Rights abuses of people with major mental illness in Indonesia are often framed as one abuses of rights in institutions as a result of families abandoning the person (Human Rights Watch, 2015). I have taken a different approach and instead use these institutions to show that available discourses of recovery cannot successful contain madness. I also show that these institutions go to large lengths to make sure families contain madness within their household. This thesis is divided into two parts; the first part explores Camp Assessment and the second part explores Panti Rehabilitasi.

#### Part 1 Containing Madness by Categorization

This section of the thesis describes the way through which the homeless are classified within the social welfare systems. The section describes the labor that is required both on the part of the social worker and the client to be made into subjects of care. Clients who arrive at Camp Assessment must be part of a family to get access to legitimate care within the medical system. The section highlights that the dependencies forged within camp assessment – sites for which madness can be contained – are essential not only because it is a necessary component of creating a subject but also because these dependencies sustain people stuck in the institution. In this section, I described the relationship forged within the institution as means through which one can “actively listen” (Good, 2012) and formulate care plans for clients. I describe the ways through which—often unsuccessfully—social workers facilitated the containment within homes.

## Part 2 Containing Madness through Rehabilitation

The second part of the thesis describes the ways through which patients undergoing rehabilitation struggle to accede to the promise of recovery. It documents the ways through which discourses of productivity and responsibility outsource the containment of madness to communities. The section also shows ways through which these discourses deem communities and families as the only legitimate way through which the containment of madness can occur. The sections situate the emergence of these discourses of recovery—discourses through which the materiality of care is anchored on—in a post-authoritarian Indonesian context where the self becomes both object and subject to expertise. Social workers and patients participate in economies that salvage them through recovery as these discourses are anchors through which the materiality of care is available.

## **Making Subjects of Care**

### *Part I: Containing Madness through Categorization*

#### **Introduction**

A small building covered in fresh green paint sits in the center of an expansive complex of short buildings enclosed by tall concrete walls. The building stands at the end of a road leading in and out of this complex, interrupted by tall green gates that remain locked. By the gate's opening, a small post acts a checkpoint. The building had a large sign hoisted across its front that read "Camp Assessment."

Camp Assessment is a temporary encampment for the homeless—a place where people from the streets were kept temporarily for assessment and subsequent referral to a state-run rehabilitation institution. Managed by the provincial government, under the Department of Social Welfare, Camp Assessment was founded in 2014. The institution was built immediately after a bill, which made it illegal for people to live or beg in the streets, was passed by the provincial parliament. As an institution that aims to connect those left vulnerable on the streets with appropriate state institutions, Camp Assessment temporarily houses many who suffer from severe mental illness; nevertheless, when I encountered the Camp, they were having unprecedented difficulties finding places within their network of state intuitions where they could house indigents with major mental illness. With the department's support, I began conducting research in order to understand the problems Camp Assessment was facing.

I entered the small building, which functioned as the central administrative unit of the institution but looked like a classroom with about twenty square tables arranged in six rows. Windows rimmed with yellow paint lined the sides of the room. All the tables faced a whiteboard in-

dicating the number of people then housed at Camp Assessment. All the social workers were sitting uniformly at their respective tables while the manager, a resident psychologist, sat at the front of the room, facing the room full of social workers. I arrived late for a weekly case conference seminar, and my arrival had caused a commotion. The manager of Camp Assessment asked me to sit next to him. At that point, everyone knew me already: I was the researcher and physician to whom they turned when they had problems with the system.

Tami, a social worker, took his turn reading his case notes so that the manager and psychologist could evaluate his assessment and the team could decide what to do for his client. To everyone's surprise, he had good news to share: "Today, for a change, I bring to the conference the case of Yus." Yus was sent to camp assessment three months prior and suffered from major mental illness. Tami continued, "He came to us, unable to communicate, he couldn't care for himself, he was very dirty...but now he is able to communicate and remember who he was."

Tami described the complete transformation of his client, who was severely psychotic but upon his medication at Camp Assessment "remembers who he was." Tami shared that not only was he was able to draw out an address and the contact information of Yus's family, he was also able to convince them to take care of the client and house him. This was the ultimate goal of Camp Assessment, to quickly assess the client and find a place to host him or her off the streets. This kind of "successful assessment," however, was fairly rare at Camp Assessment. Thus, the manager rose to proclaim: "See friends, this is how you should work...Tami has successfully done his job with the client...he has singlehandedly discovered what to do with the client...we should all give a round of applause for Tami." The room was instantly filled with thunderous claps.

As soon as the applause subsided, one by one, social workers started revealing how difficult it was to achieve an outcome like Tami's. One social worker remarked, "Even with medications my client doesn't remember where he comes from"; another stated dejectedly, "My client's family won't accept her back." The reality that what Tami had described was uncommon was increasingly revealed by each of his preceding colleague's cases. The psychologist, slightly annoyed at the complaints, silenced the hall by saying, "Everyone needs to stop complaining!... [Tami's] client was very bad...now he knows his family...everyone can do it." With this assertion, the meeting ended abruptly, and the social workers went back to their daunting tasks of finding a place for their clients with major mental illness.

This is the reality of Camp Assessment. Despite its status as a temporary encampment for the assessment and ultimate referral of "clients," social workers found this task exceedingly difficult; clients with major mental illness had begun to accumulate. And yet, such problems were constantly downplayed by administrators within the department. This section unpacks this puzzle. The section describes the work it takes to create a subject of care and highlights the difficulties and struggles social workers, their clients, and family members go through to be subject to care. It also examines the kinds of care that are available at Camp Assessment when one cannot be referred to legitimate institutions. The section therefore describes the forms of abandonment and suffering clients go through as a consequence of not being able to be subject to care within legitimate state institutions.

### **The Magnitude of "The Problem"**

Amidst rapid gentrification and urbanization in Yogyakarta, the province has quickly found itself facing "the problem" of vagrancy. A decree to manage the "problem of vagrancy" was issued to

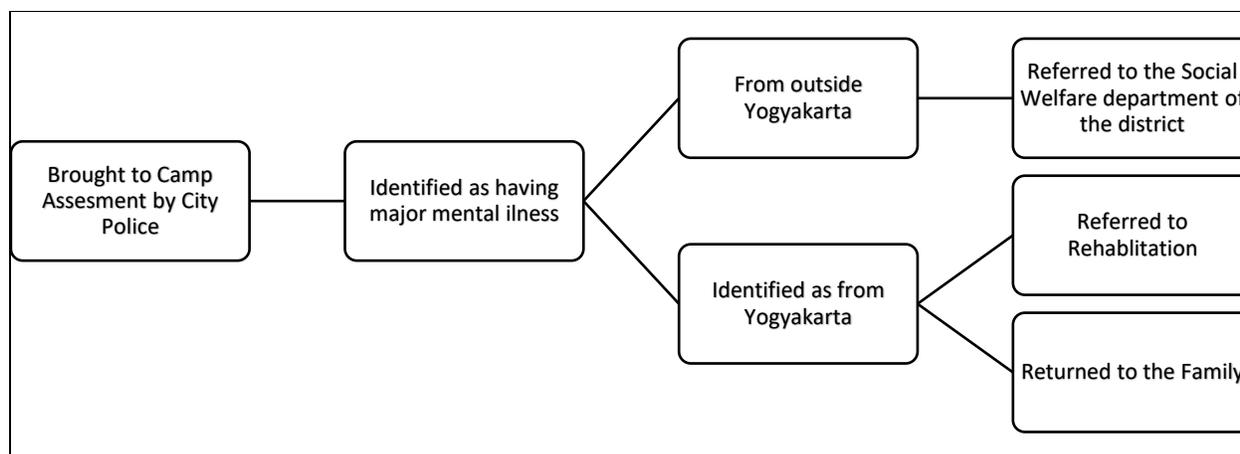
tackle this issue; though framed as providing care for the vulnerable, the law made any form of vagrancy illegal. The law defines vagrants broadly as anyone identified as homeless or observed begging in the streets. It mandates that anyone who fits the criteria of for vagrancy be removed from the streets by city police and brought to Camp Assessment where, as “clients,” social workers then arrange referral to a network of state run intuitions to them (Government of Yogyakarta Special Region, 2014). In practice, however, the law’s passage literally “cleaned up” the street. In my interviews with city police, almost all explained that they lacked a specific definition of vagrancy, and thus rounded up anyone who looked dirty or poor. One police officer remarked: “we round up anyone that doesn’t belong on the streets, we see if they are un-kept, begging or dirty...we bring all of them to Camp Assessment.”

The passage of Law No. 1 in 2014 was followed with a massive governmental campaign to deter charity towards beggars as ultimately deleterious to those in need. Described as “fostering laziness,” the state began fining anyone caught giving money to beggars. The law was promulgated as one that would transform those living on the streets into productive members of society. Camp Assessment was thus instituted as an intermediary step in this transformation wherein the problems those brought in from the streets could be assessed; from this assessment, the state hoped to easily identify the appropriate state institution best suited to complete this transformation.

The Department of Social Welfare, tasked with this transformative responsibility, designed a framework for the categorization of individuals in order to assist with the assessment of vagrants’ problems and accordingly refer them for “rehabilitation” within their network of institutions called *Panti*. Social workers at Camp Assessment classify their clients’ travails according

to what the Department calls “People with Social Welfare Problems” (PMKS) classification system. Within this framework of categorization, people with major mental illness who are brought to camp fall into one of its 26 categories—which range from sex workers to street children. People identified within the system are then referred to a *Panti* that specifically caters to each particular category, hoping they would be able to address these problems through rehabilitation (Department of Social Affairs Republic of Indonesia, 2012).

In 2017, 873 people were brought in from the streets of Yogyakarta and sent to Camp Assessment. 100 (11%) of the total clients were identified as street children. Of the remaining adults, 32% (254) were identified as having a severe mental illness. The prevalence of major mental illness is significantly higher in the indigent population compared to the general population in Yogyakarta (Irmansyah, Prasetyo, and Minas, 2009). The prevalence of mental illness among adults brought to Camp Assessment is comparable to that of the homeless in the United States (Herrman, 2008). With an underdeveloped mental healthcare system, including the lack of a sufficient budget and a shortage of mental health professionals, the vagrancy law has placed unprecedented pressures upon the mental health system of Indonesia (Human Rights Watch, 2015). Data from Camp Assessment also shows that a majority of people brought in are male, and 70% of these men have a major mental illness.



**Figure 1. The Flow of Clients in Camp Assessment**

Figure 1 shows the general flow of those with major mental illness through Camp Assessment. Clients identified as having a major mental illness are given temporary access to medications and psychiatric care until they can “Remember who they are,” as Tami put it. Everyone registered within Camp Assessment is provided access to a special health coverage plan available only while he or she resides within Camp Assessment.

In groups of 10, clients with major mental illness are brought to a district hospital with an outpatient psychiatry unit in order to access psychiatric care. With medications provided on a temporary basis befitting the temporary nature of the Department’s social assistance, social workers hope that clients will be able to be made subjects of care within legitimate institutions. Vany, a social worker who has made it her personal mission to improve care for clients with major mental illness put it thusly: “This temporary insurance gives us some space to find a legitimate place for them to get care, in Camp we are not trained to give care to clients, this is just temporary.” With this temporary access to medical care, social workers are given the daunting task of finding out who the clients are, including where they are from. This can be difficult, as Vany noted: “Sometimes, clients have no homes, they have been on the street for years; we have

to go to great lengths to find the last remaining kin, even if this may be a long-lost aunt, but our system is that way.”

In the case of someone with severe mental illness, where a client is from is dependent on where one’s family is. In Indonesia, a person with a major mental illness has no legal right to give consent regarding his or her own care—it is the responsibility of family members to give primary consent regarding an individual’s treatment (Irmansyah et al., 2009). Institutions like state-sponsored rehabilitation services and primary health centers are also designed only to provide care for patients within a legal regime premised upon familial ties. Legal identification and civil registration in Indonesia is primarily family-based, and requires citizens to be registered in a family in order to access services offered by the state (Nanwani and Siagan, 2017). Clients who end up in Camp Assessment must therefore be made part of a family in order to be subject to care within the network of state institutions that provide it.

The family is the basic unit for the delivery of care in Indonesia, as is the case in many countries (Lo and Horton, 2007). This system arose around the time when selective primary healthcare was successfully championed around the world; UNICEF, with its GOBI initiative, promoted the development of a health care system in developing countries focused solely on maternal and child health (Mukherjee, 2018). Underpinning these initiatives, developed against the backdrop of the Cold War and linked with neoliberal modernization, the nuclear family was advanced globally as the basic model of consumption and production (Leeder, 2004).

In the Indonesian context, these global priorities were adopted by the authoritarian New Order regime as a national development project that was based on “family principles.” During the regime, development and social control were unified through the idealization of the heteronormative family with its correspondingly rigid gendered roles (Sears, 1996). The healthcare

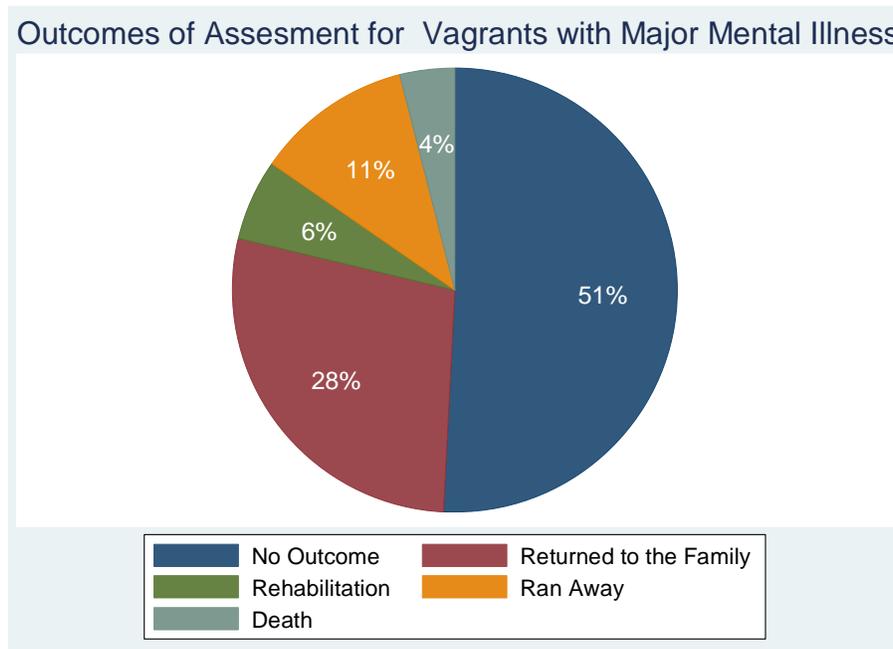
system was designed to cater specifically to women as it was used to assert narrow gender roles (Dwyer, 2000). The regime effectively naturalized and essentialized the family as the basis of the nation state (Suryakusuma, 2011). These processes have primarily positioned heterosexual marriage and membership in a nuclear family as the most notable markers of the Indonesian citizen (Boellstroff, 2005). Not surprisingly, the entire health and social welfare system was developed, and remains, predominantly oriented toward this Indonesian subject.

Social workers at Camp Assessment must labor to transform vagrants with major mental illness into subjects that can be incorporated into the Indonesian welfare and health systems. Once this subject within the family is created, clients can be appropriately referred to institutions that provide care. When a family is identified, clients are classified as either coming from within a particular province or from outside the province. This identification of family origin is extremely important because after the fall of the authoritarian New Order regime, the entire structure of government services—including its health and social welfare system—became decentralized (Ostwald, Tajima, and Samphantharak, 2016). Care is delivered through state apparatuses at the district level. Thus, if a client is identified as originating from outside a particular province, care for the client must be provided by the district from which they came. If that is the case, clients are referred to the department of social welfare of the district. The department of Social Welfare in the corresponding district will then, upon further assessments, decide whether clients will be returned to the family or participate in the rehabilitation services they offer.

If the client is from Yogyakarta, he or she is further assessed to determine whether he or she meets the eligibility criteria to enter a six-month vocational training program as a form of rehabilitation within a *Panti*. Managed under the same Department of Social Welfare, the institutions called *Panti Rehabilitasi* attempt to “rehabilitate” the client so that they become “productive (See

Part II).” The requirements for admission to this rehabilitation program, however, are strict; clients must be under the age of 50 and have the “potential” (as determined by social workers) to be part of this program. If clients do not fit these admission criteria, they are sent back to their family with the hope that within the household they will get access to mental health services in the primary health care centers.

As one can imagine, finding an outcome of assessment, whether it is a recommendation of referral to *Panti Rehabilitasi* or being sent to their families, was extremely difficult. Figure 2, shows that as of June 2017, more than half of the clients with major mental illness could not be referred anywhere and thus remain stuck in Camp Assessment. More strikingly, even though a quarter of the clients with major mental illness were returned to their family, there were more clients who ran away from Camp Assessment than those who were referred to rehabilitation.



**Figure 2. The Assessment Outcome of Clients in Camp Assess-**

State budgets for a maximum stay of 30 days of temporary stay within Camp Assessment. Alarming, it takes an average of 80 days for a client with major mental illness to be returned to his or her family, compared to 32 days for a client without a major mental illness. It also takes an average of 62 days for a client with major mental illness to be referred to rehabilitation compared to 20 days for someone without major mental illness. These data suggest that the systems available for the care of people with major mental illness are designed predominantly for people who have remained within their families and not the indigent population who are ultimately brought to Camp Assessment. Yet, even with this difficulty, social workers still attempt to create subjects of care. The following sections describe exactly how they do it and what difficulties are faced in creating subjects of care.

### **Making Subjects of Care**

Ian Hacking (1990) has described the scientific and technical ways through which people are “made up.” Through statistical counting and enumeration, ways of being are normalized and produced into facts. Social workers in Camp Assessment similarly create subjects that can be enumerated and counted. For this to happen, clients have to be identified as being part of a family with a household. Social workers draw out this subject from their assessment interviews, wherein they attempt to locate a place within the legitimate care systems available for clients with major mental illness.

This practice of statecraft arises out of what philosopher Michel Foucault (2007) calls bio-politics. Bio-politics describes the process whereby bodies are increasingly monitored, surveyed and classified. Instead of focusing on the management of individuals, governments began focusing on things. Populations became the main targets of governments and individuals were

viewed in relation to it. This management of individuals in relation to populations was how governmental operations triangulated with sovereignty and discipline.

There have been numerous studies detailing the bio-political subject and its relation to the idealized gendered ideology and its correlative nuclear family in Indonesia (Stodulka, 2017; Boellstroff, 2007; Samuels, 2016; Hefner and Watson, 2018; Barker, Harms, and Lindquist, 2014). However, many studies assume the subject is a given. In other words, many of the studies start with the certainty of a subject (Das, 2017). While many others, (Stodulka and Röttger-Rössler, 2014; Bennett and Davies, 2015) detail exclusion and marginalization in Indonesia, these studies tend to fall within the glossary of advanced liberalism, confined within the “eventful” dualities of abandonment and belonging (Povinelli, 2011). Moving away from these tropes, social workers in Camp Assessment continuously attempt to create a subject even as conditions abandon their clients. Ethnography also complicates and addresses the limits of statistical and governmental enumeration—it makes relative the truths with which such interventions operate (Biehl and Eskerod, 2007). Taking this approach, I will describe how Ragil was made into a subject.

I first met Ragil when he was brought to Camp Assessment, a few days after I started my research. He caught my attention because, at the time, he seemed like he was in pain. He was crying alone while whispering to himself “get away.” He was sitting in the corner of a large residential hall enclosed by steel gates. One hand was hinged upon the steel gates rocking his body while the other was massaging his shaved head. I asked for a social worker to open the gates and entered this enclosed hall. I sat on the mud floor next to Ragil. When I asked what was troubling him, he looked up at me and smiled, revealing a toothless mouth. He responded, “I was just telling the bad voice to go away. It comes whenever the social worker asks me where I come from.”

Ragil continued to explain to me that there were two sounds that had followed him since he was young. One was an evil voice that commanded his mind and body and caused him a great deal of trouble. The other was the sound of a waterfall that gave him a lot of pleasure. Ever since he started hearing the two sounds, he has struggled to both contain them and to balance the good and the bad.

When the social worker, who accompanied me to see Ragil, left the enclosed hall, Ragil immediately looked towards me and grabbed my arm. I was startled by his sudden movement and asked him what he needed from me.

Ragil: Can you get me out of here?

Me: I can try to get you into a rehabilitation facility, but we need to see if you fit the criteria.

Ragil: I want to go out to find an inner power (*tenaga dalam*). If I don't find it, the bad voice will disturb me.

Me: Where will you find inner power?

Ragil: I have to listen to the good sounds, follow the sounds of the waterfall, I have to get out of here.

Ragil was picked up by the police near a market in the city center. He was sleeping by the traffic lights when he was found. The police who picked him up described the scene of his capture as

dramatic: “When we picked him up, he was only wearing shorts, he was dirty, we told him we will bring him to a place to get food and clothes, but he resisted. He screamed and pushed us, we had to tie him with a rope and bring him to Camp Assessment.” In Camp Assessment, Ragil was very resistant and, in the words of his social worker, “could not be tamed.” They decided not to admit him to Camp Assessment, and instead brought him directly to the mental hospital’s emergency department.

When I began my research in this institution, one of the first changes that the social workers and I advocated for was ceasing admission of patients who were having acute psychotic episodes. Instead, clients were immediately referred to the emergency room of the mental hospital. This policy was applied to Ragil and he was admitted at the mental hospital for 10 days. When he was “stabilized,” he was returned to Camp Assessment so that he could be placed in long term care within his family.

Ragil’s social worker, Susi was in charge of making him a subject upon his return. Susi was a young woman new to Camp Assessment. Freshly graduated from social work training after high school, working in Camp Assessment was one of the two jobs she held down in order to sustain her household. Her parents were killed in a tragic bus accident, and thus she was raised solely by her grandmother; Susi was responsible for providing her household. Susi had limited experience with mental illness, and yet she had the daunting task of placing Ragil within a family so he could receive legitimate state care. She tried very hard to “fill out the form,” and was pushing hard for Ragil to reveal his “identity.”

Ragil, however, did not want to be associated with his family—he did not want to speak about the matter at all. Asserting that even the thought of his family was so agonizing as to bring forth the torment of the evil sound he declared, “I don’t want to think about my family, I want to

follow the good voice.” He explained that “the evil voice is bad, it mocks me, it makes me very angry...I don’t want to think about it.” Susi nevertheless persisted with her questions. Unable to fill out her assessment form for Ragil, yet pressured by her supervisors, Susi became frustrated: “The medicine does not help, he still won’t tell me anything, I tried being hard on him, but he wouldn’t budge.”

On one such occasion, Rail became very resistant and screamed loudly, creating a big scene. “No... No...No....Get me out of here,” he shouted. Susi replied back in a louder, more assertive voice, “If you want to go out of here, you have to tell me where you are from, where your family is...you will be stuck here.” Hearing this, Ragil put his hands over the door knob and began to shake it violently, screaming “No...No...No...” Other staff rushed in to relieve his tension, successfully managing to calm Ragil down without needing physical restraints. Ragil caught the eye of the manager and psychologist in Camp Assessment. After much deliberation, Ragil was brought to the outpatient psychiatric clinic ahead of his planned monthly schedule. The psychiatrist increased his medication dosage and added stronger sedatives to calm him but was also unable to “get a family out of him.” After the incident, Susi was further pressured by her supervisor to quickly assess Ragil, and in the words of the manager “get him out of here.”

My conversations with Ragil up to that point had been only about his everyday life in Camp Assessment. I stayed away from the topic of his family, knowing full- well that bringing it up would cause him distress. Despite avoiding the conversation, he would speak of his struggles to contain the voices in his head. “It’s so difficult...here I only eat and work to suppress the voices...sometimes it works...but it is tiring,” he explained.

I tried my best to make his time in Camp Assessment better. What seemed to give him the most relief, I discovered, was reading the travel sections of the newspaper. Marveling at the

pictures of beautiful beaches in the newspapers, we would spend hours reading. Whenever Ragil needed to relax, he always asked me to show him stock images of waterfalls and beaches. However, even as he would retreat to the images of beautiful waterfalls, he could not escape the painful realities of living within the confines of Camp Assessment. Although he admitted that in the institution he would not feel hungry, he felt extremely uneasy. “If I try to ignore the voice, my whole body becomes in pain, it’s like taking a razor and cutting every inch of the skin,” he described. Medications provided by the psychiatrist provided him with some relief, but they could not eliminate the threatening voice that haunted him.

Two months into Ragil’s stay at the institution, Susi came running towards me and informed me that she has managed to crack the mystery of his family’s whereabouts and draw out a biography from him. She could now successfully complete her assessment form. Despite this “achievement,” she faced a new problem: none of Ragil’s living relatives wanted anything to do with him. All her efforts to find Ragil’s family were useless because nobody wanted him back. According to Susi, after Ragil’s father’s death two years prior, he lived on his own in a rural village outside Yogyakarta. His only living relatives were an older brother and a sister. After losing his job, his older brother decided to sell his father’s then-unoccupied house. Five months after his father’s death, Ragil mysteriously left and never returned. Susi remarked, “The brother is so horrible, how could he do that? How can he forget about his brother?”

Ragil’s brother was struggling economically to support his family by working in a street corner food shop amid the informal and marginal markets of the city. Although the food shop generated some income, it was not stable; his family was very vulnerable to financial shocks. His wife had a complication during a pregnancy and had to be hospitalized in the intensive care unit. Having no insurance—because he was self-employed and was not registered as a poor family—

he urgently needed money for the care of his wife. With consent from his sister, Ragil's other sibling, he decided to sell the house to a neighbor that was looking to expand their property. His brother did not want Ragil in his care because he couldn't take the financial responsibility to care for him.

Reaching what Susi characterized as a "dead end," she tried talking to Ragil's other sibling. "She outright refused to even entertain the idea of having Ragil with her—she doesn't want a mad person near her kids," Susi explained. Reaching yet another dead end, Susi tried arranging for Ragil to be referred to a rehabilitation institution, but every institution required family consent prior to admission. The matter was further complicated bureaucratically. With Ragil's father's death and the sale of his home, Ragil did not have any civil registration documents. In order for the state to pay for any care he received, he needed a family card that documented his membership within a household. This meant that even if Ragil was not to be referred to live with either of his siblings, he had to be registered with one of them in order to receive a place in a state-sponsored rehabilitation institution. However, the thought of having Ragil in their family's care scared his sibling as it meant taking responsibility for Ragil. Like the many others in Camp Assessment, Ragil was "stuck" within the confines of its steel gates. With this development, I decided to raise the topic of his family to Ragil with caution as I wanted to approach the topic for a very pragmatic reason. I wanted to see if I could better navigate the system and find a way out for—to advocate to authorities in order to make his experience in the institution better and to lessen his struggles.

It is useful to take a moment to point out that like Susi, I was also crafting a biography. However, unlike Susi, I attempted to weave together a biography of Ragil that did not aim to fill out "the forms." Although it also referred to institutions and to his family, I had hoped to write a

biography that was singular to Ragil. This task was by no means straightforward. Crafting it took place over the fractured narratives of many conversations, often interrupted by moments of fragile silences, where we would together find solace in images of waterfalls. With every conversation, Ragil and I were not only building a relationship—one that could contain madness within it—but together with Susi, we were scavenging all possible resources to ease Ragil’s struggle.

It is also useful at this moment to enter into conversation with the work of Cheryl Mattingly (2013). Through her ethnography of children with a terminal illness and severe disabilities, she identifies three ways through which a self is constructed in a moral scene: through giving an account of oneself when one is accused; through an experiment of making a self that is oriented toward the future, aligning oneself to a known set of virtues; neither defending oneself, nor aligning oneself with a known set of values, but rather in a mode of living within “possible narrative plot lines.” It may be tempting for me to cast of the social workers demands to fill her forms and Ragil’s answer to it as crafting as subject in the mode of the accusing other, as though Ragil was giving an account of himself (Butler, 2005).

In her ethnography of mental illness in urban slums, Veena Das (2015) points out how these modes of crafting a subject are not opposed with one another but rather “one that cascades between these different modes—now incorporating the voice of the accusing other, now aligning oneself to traditionally deemed ideas of virtue, now demanding it necessary to innovate.” She adds that “ethical experiments do not happen to an isolated individual but to someone who is already within a web of relations with both humans and nonhumans” (118). Therefore, I take this detour to stress that, as Byron Good (2012) suggests, the biography I have crafted for the reader grew out of a dialog between Ragil, Susi and myself, now incorporated in a web of relations.

Ragil was born into a small family in a village outside the province of Yogyakarta. He had two siblings, a brother six year older than him and a sister who was one year younger. In his early childhood, his father worked as a miner outside the region while his mother cared for the household and worked in the fields. Ragil does not remember many details from his childhood but vividly remembers his life in middle school. “This was the time I was most social” he said, describing the only time in his life when he felt he had friends.

However, much as his friends brought him joy and social interaction, it also made him jealous. His other friends had fathers who were present to teach them simple things like how to ride a bike whereas Ragil’s father was off working on an entirely different island. His older brother, who had a bike, did not bother to teach him to ride it because he was busy finding a job of his own. This made Ragil the subject of taunting, as he was the only young man his age who did not know how to ride a bike. Although, he described this point in his life as a moment where he was most social, Ragil stressed to me that he had never felt like he “fit in” with others.

Despite stories of fishing with his friends and enjoying nights out in the village, Ragil’s description of his youth was seemed, to me at least, filled with isolation. Ragil mentioned several times that he was the middle child that did not “fit” anywhere. His sister would help out their mother in the fields and socialize with the other young women in the village, while his brother was frequently absent, working in a factory job. According to Ragil, it was the simple fact that he did not have a bike that, as time passed, his friends stopped inviting him out. As he grew older, his jealousy was overtaken by shame. “I didn’t want to speak to anyone...they were all gossiping about me,” said Ragil while grabbing his t-shirt by the collar and stretching it to calm his bubbling anger. Knowing I was causing him distress by bringing up the topic, I decided to avoid it in the future.

However, this seemed to have been the wrong decision. One rainy day, I came to visit residents in Camp Assessment and got wet on the journey there. I was drying my shoes, when suddenly I heard someone call my name. “I want to speak to you, I want to tell you something,” said Ragil as he pointed his hand in my directions, signaling the social workers to direct me to him. Without hesitation, a social worker unlocked the gates that enclosed the residential hall for male residents with severe mental illness. Barefooted, I walked over to him. On the way, Dianing, another resident in Camp Assessment pointed at me and laughed. She said, “Why are you walking barefoot, that is for us...not for you,” accurately pointing out my position of power within Camp Assessment. A position I was acutely aware of and one of the reasons I had been careful as to what I chose to ask Ragil about.

Ragil, much to my surprise, however, was disappointed at me for not asking him more about his childhood. “Why haven’t you asked me about my childhood? ... I wait here for you to ask me...but you never... did I do something? Did I scare you like the other social workers?” inquired Ragil, grasping my arm and squeezing it hard.

“Ragil, honestly I was scared of you before, but now you are a friend, I didn’t ask you because I thought you felt bad when you spoke about your past,” I replied.

Ragil looked at me confused, gave a rare smile, and said, “Oh, I know everyone is trying hard to find me a place to live, everyone including Susi is trying to help me...but you do it nicely...you allow me to talk...I need to talk.”

Ragil revealed that, as the years passed, his shame and isolation morphed into intense anger, which he directed towards his father and brother. “I was angry...so angry...I am still angry... they left me alone...I had nobody...everyone was talking about me,” explained Ragil. This was the point he became what he characterized as “emotional”: to Ragil, this meant that anything

could trigger rage. He would pick fights with anyone who got in his way. Indeed, his siblings characterized his childhood as colored with fistfights: “He is antisocial...from a young age. He fought with the boys in the village...caused a lot of trouble,” said his brother. Ragil never described any such incident, but emphasized that, growing up, he felt very emotional and angry.

Ragil explained to me that a critical moment in his life was the scandal that ultimately befell his family. Ragil’s father was caught having an affair with a married woman who had been working in the same factory outside Java. This was the time in which the New Order authoritarian government was well on its way towards promoting its “family principle” as a means of transforming Indonesian society in the name of “development.” A number of laws were passed as a result of this ideology, including one that made it a criminal offense to have an affair with a married woman (Shiraishi, 1992). Fortunately, this scandal did not involve the police, but it did not come without its consequences. Ragil’s father was fired from his job and word about the incident spread; soon, Ragil’s neighbors in Java were gossiping about it. Not only was Ragil shunned and isolated from his community, his family had to move to another village because nobody wanted them around. With the loss of a stable income, his family had to sell their land and move to Ragil’s mother’s native village. They were now economically sustained solely by Ragil’s brother. The move enraged Ragil. They were now living in a small house with two rooms. “I hate my father...I had to see him all the time...he was the one who caused me all the problem...he shamed our family,” said Ragil. In this new environment, Ragil became even more isolated from his neighbors: “I didn’t want anything to do with them, I could not stand more gossip, so I just stayed at home.” Ragil was just out of high school when the incident happened, and when the opportunity of working in a factory outside Jakarta was given to him, he took it.

Ragil's struggles during his childhood helped Susi understand him more. On a scorching afternoon, I was doing a quick visit at Camp Assessment to check on how things were. I noticed Susi laughing with Ragil, which intrigued me because it was unusual. Usually their conversations were quick and formal, Susi almost certainly gripping an incomplete form. This time, they were by the corner of the residential area, sitting on the floor laughing, and curiously, with no form in sight. I decided to stay longer in Camp Assessment hoping to ask Susi about her visit with Ragil. Several hours later, Susi approached me and declared "Ragil has gone through a lot, we cannot refer him back to his family without arranging at least rehabilitation." Surprised, I asked her what had made her change her mind. "It's because I understand Ragil more, we have a better relationship...we were laughing about your messy hair just now." Susi had no idea that Ragil had once held down a job in a factory in Jakarta, and she was becoming aware of the nature of his suffering.

In Jakarta, Ragil worked in the packaging department of a garment factory. He worked long hours and lived alone near the factory on the outskirts of the capital city. "I felt really exhausted and the pressure to come to work was tough...In my room alone, the bad voice appeared," explained Ragil. The voice was characterized as a soft whisper, a man that constantly said that people were talking behind his back. With the appearance of the voice, he grew hostile at work. He increasingly failed to do his work properly, and soon was often absent from work. He was quickly fired. "I didn't think much about losing my job. At the time there were many offers," he said. Ragil was describing time that the World Bank (1993) has described as an "East Asian Economic Miracle." The economy was booming under the authoritarian New Order regime. Amidst large foreign investment and increased economic growth, however, social protections for the working poor were almost non-existent and inequality grew rampantly.

Ragil found some happiness in his new job despite of the increasing frequency of the sounds he was hearing. Ragil met a woman working in the factory and quickly developed a relationship with her. “Dewi always reminded me that I was good and that I should not think about gossip,” explained Ragil. Within just few months of their relationship, Ragil and Dewi got married in Dewi’s village. “I was happy with Dewi... I liked her a lot. That was a good moment of my life,” he said. However, things quickly changed. Ragil found himself increasingly suspicious that his wife was cheating on him. Three months into his marriage, he left his home and went back to his village for a few months. Ragil did not share much about his troubles with Dewi but did characterized the marriage as full of arguments and suspicion. At one point, the voices he heard intensified and his body felt weak. He was sure that another man was inflicting black magic upon him.

Ragil’s brother mentioned that he first noticed something abnormal with Ragil during this period. Ragil had attended his sister’s wedding and had a huge fight with his wife. Ragil insulted his wife in front of everyone and made a scene. Everyone, including Ragil’s family, attributed this to “stress” from the city. At the time, the economy was tanking as more and more Indonesians lost their jobs. “Everyone in the city at the time was stressed, so we thought he was stressed too,” explained his brother. Ragil’s marriage lasted only two years; after they both lost their jobs, Ragil and Dewi grew even more hostile toward one another until they decided to finally part ways. Ragil returned to live with his father in his village, and there he further withdrew from his surrounding and began going on excursions. “The bad voice was telling me that everyone hated me. I didn’t want anything to do with anyone...I just wanted to find energy,” said Ragil.

Ragil's behavior grew even more erratic; he started bringing dead animals into the house and disturbed his fellow villagers. He would stay in his room all day. Around this time, everyone assumed he was still just "stressed" from his time in Jakarta. Nationally, there was massive violence between protesters and the military. Ragil's neighbors understood that such violence could make people "stressed" and thus did not confront him with the situation. Instead they helped his father by bringing them food.

His father started worrying about Ragil's condition when he stopped eating and stayed in his room all day. "At the time, the voice intensified and was so loud it occupied me, I don't remember anything but the voice," he confessed. Finally, his father borrowed money from his brother and brought him to a general practitioner. The doctor asked him to go to the mental hospital but Ragil refused and just wanted to return to his room. "I didn't know that a mental hospital would help me...I refused totally...it was not until my brother came around that I went to the hospital...I was surprised that it was good for me," said Ragil.

With the persuasion of his brother, Ragil went to the mental hospital for treatment. He stayed in the hospital for four months. "I was surprised that the hospital was good to me. Everyone was kind. One nurse told me how to live with the voices. She told me to focus on the good voice and sounds and ignore the bad sounds. I will never forget that advice," explained Ragil. He was discharged soon after. However, it did not take long before Ragil's condition deteriorated and he once again began to isolate. But the hospitalization did make it easier for neighbors and his father to convince him to eat. After hospitalization, Ragil also started going on excursions more frequently. "The nurse helped me think of the good sounds more than the bad voice, so I used to go out to get peace. To think about the good sounds," he explained. Despite suffering

with his illness, Ragil felt he had the right balance in the house: “I could go out anytime and I ate. I think that is the best I can do without causing trouble.”

Ragil, Susi and I would have long discussions about how best to get him into a rehabilitation facility. We decided early on that Ragil did not like the confinement in Camp Assessment and would likely do better if we could refer him to the rehabilitation institution. Ragil liked the idea. “I want to do activities, I want to move, not just stay here,” he said. However, getting Ragil into the rehabilitation institution was no easy task. For one, these state-sponsored institutions were highly selective and also required a family member to give consent and participate in the activities of rehabilitation.

After much negotiation, Susi convinced Ragil’s brother to participate in rehabilitation activities in the Panti. This happened through many facilitated meetings between Ragil and his brother. Susi worked and managed to coordinate with the district authorities and primary center where Ragil’s brother lived; she arranged for Ragil to join his brother’s family’s health insurance, paid by the state. His brother remarked that these provisions, especially the access to insurance and the coordination with his primary center, convinced him that he was capable of taking responsibility for Ragil’s care. With the brother consenting to participate in the rehabilitation activities in the state-run rehabilitation institutions, it was now Susi’s task to make sure Ragil would be selected by the staff in the institution.

It was a sunny Friday afternoon. Susi had arranged for the social worker from Panti Rehabilitasi to visit in the morning. She messaged the day before that I should come early to Camp Assessment to help her make sure Ragil would be prepared for the interview. When I arrived, I found Susi sitting next to Ragil. Susi had borrowed her brother’s shirt and made sure Ragil was

dressed neatly. I arrived late, but before the staff from the rehabilitation institution. Susi instructs Ragil, “Remember, when they ask if you will you follow their activities, you should say yes.”

Not long after, staff from the rehabilitation institution arrived in white vans. An old man wearing a white safari suit came out of the van. He greeted the manager of Camp Assessment, and immediately walked to an office. Social workers lined up with their clients for the assessment interview. Susi, having “prepared” Ragil, entered the room first. I did not participate in Ragil’s assessment interview; but according to him, the staff asked what Susi prepared him for. The staff wanted to make sure, Ragil would comply and follow all the activities of rehabilitation. After the interview, Ragil was given the green light to be referred to the rehabilitation institution. In total, Ragil spent four months in Camp Assessment.

In rehabilitation, Ragil continued to struggle with the sounds that tormented him. He felt slightly better because he was not confined in a physical space. Ragil did not like the activities of rehabilitation. Despite that, he felt it was best for him to continue to participate in it because it meant gaining trust and confidence from his brother. Even as I would take him on outings to see waterfalls around the city, he was still distressed and generally unhappy. Rehabilitation was indeed tough and required a lot from him (See Part II). I end Ragil’s case description with an excerpt of a conversation I had with him just as I was about to leave Indonesia and informed him that I would be away for a few months.

Ragil: I am struggling here, but I want to say thanks for what Susi and you have done for me.

Me: Susi and I were just doing our jobs. You deserve better care.

Ragil: No...no...I don’t mean for all the work of getting me here and convincing my brother.

Me: What do you mean then?

Ragil: For talking with me through a bad time.

Me: I don't understand?

Ragil: I really needed someone to talk to about my father. He died, and I could not handle it properly. I was very angry at him.

Me: That is the least I could do. You deserve much better and qualified care. I learned a lot from you. We have to think about how to make your life easier at home now.

As Ragil recognized and taught me, creating a subject of care is not as simple as what professionals in global mental health often refer to as “case finding” (Farmer, Kim, Kleinman, and Bassilico, 2013). Creating subjects of care requires much more than recognizing symptoms and classifying them. Ragil’s case demonstrates that creating subjects of care requires a lot of work, not only to navigate through a complex system and create a bio-political subject who can receive legitimate state care. Creating subjects of care also requires active listening (Good, 2012) in an effort to forge and mend relations, to descend into the everyday (Das, 2007) so as to contain madness within it (Das, 2015).

While Susi never received her due recognition for all her hard work in transforming Ragil into a subject of care, her work was nonetheless appreciated by the manager and Ragil. Getting all the paperwork for Ragil’s brother's family’s insurance and making sure Ragil would fulfil the

criteria to enter the rehabilitation institution required a lot of labor. However, as the data suggests, more than half of clients with major mental illness had not received an assessment as of June 2017.

Clara Han (2012) argues that many analyses that describe the neoliberal subject and its associated nuclear family ignore imminent dependencies (Povinelli, 2006) through which structural violence is dispersed (Farmer, 2003). In Camp Assessment, a subject is not simply abandoned within its confines and left to be made into an individual within a family on their own. This subject making takes place over a web of relations. Ragil drew on his relations with Susi and myself to contain his madness, and he continued to draw upon our relationship during rehabilitation, especially when he needed moments of respite from the tough regimen he was undergoing. In the following sections, I describe these relationships in greater detail.

### **Who Will Make Me?**

One scorching afternoon, just as I was about to leave camp assessment, I noticed a commotion around the entrance gate. Two social workers were shouting from behind closed gates, “No, you cannot come in, only people who are brought in by the police can be admitted here.” On the other side, I heard a woman screaming back, “Let me in...let me in...I was dropped here...I have nowhere to go.” Despite her plea, social workers insisted that the gates not be opened. Witnessing this commotion, I quickly went to the psychologist in Camp Assessment and asked her to handle the situation. She quickly instructed the guards to open the gates to a woman wearing hospital clothes and sitting in the road.

This woman was Dianing, a frequent visitor to Camp Assessment. As soon as the gates were opened, she walked towards the psychologist. She put her hands on her hips and smiled.

She asked, “Who is in charge of making me now?” I was intrigued by her question and decided to talk with her.

Dianing: I have been here so many times, everyone has tried to make me, but I end up here again.

Me: What do you mean by “make you”?

Dianing: (laughing) Yes, every time I come here, I become something new...my old life rejects me, and I come here to make a new life...It’s like I’m dead and alive again.

Me: How do the people make you?

Dianing: They find me new places to live, new people to be with, at the same time, every time I come here, I live with new people and have a new story to tell.

It is useful at this moment to be in conversation with Veena Das’s (2015) exploration of Wells’ (2003) article on the loss of a self in her patients with mental illness. She writes, “What has been lost, I suggest, is some way of being in the world. Thus, a description of this madness would require a description of how to tell the story as if the person were located, not inside the body but in the network of relations, affects, encounters, in which the body comes to be expressive of something we might call a soul.” (p. 87) Similarly, Dianing described her sense of self as imbued in a web of relations, one that madness continues to expel her out of, and one in which Camp Assessment tries to reassemble.

Dianing was newly married when she suddenly began displaying erratic behavior. She started screaming at her mother-in-law and her neighbors, accusing them of hating her. She did not want to take bath, did not want to pray, did not want to perform her daily activities. Her conjugal family initially thought she was a victim of black magic; yet, despite some recovery with the help of a religious preacher, her condition did not improve. Two years into her marriage, bearing no children, she was sent home to her natal family. Her husband remarried soon after.

Having lost both her parents, she had to live with her brother and his wife. They had one son. When Dianing started living with them, there was a lot of friction with her brother's wife. One such occasion sparked the family to bring her to a mental hospital. Dianing woke up early in the morning and broke all the plates in the house; her brother's wife was furious and asked her husband to take Dianing to the mental hospital. Dianing resisted, growing angrier and breaking more things. Men from the village had to come to her house and bind her with ropes. She was brought to the mental hospital forcibly and stayed there for three months. "I was really hurt by what they did, no one took my side, everyone hated me," explained Dianing.

When she returned to her house, her brother prepared her a small space at the back of the house. "She [her sister-in-law] would not allow me to the main compound. I couldn't do anything. I could just go out of the house and sit around my space." At the time Dianing was beginning to feel increasingly frustrated. She felt that she was the one that brought happiness and prosperity to everyone in the house, but no one thanked her for it. "I am the source of power and energy in the house. Everything good that happens to my brother and his wife and children all happen because of my will. God has given me the gift of bringing harmony and happiness but what they do in return is say I am crazy, say I cause them a lot of trouble. They don't have any gratitude for my abilities," she explained.

One particular incident made her relationship with her sister-in-law even more contentious. Without the consent of her brother and his wife, Dianing took her young nephew for a walk. The child was fond of Dianing, but the mother would not allow much interaction, fearing that she would hurt him. Dianing wanted to bring their son to the local park to play with the other kids. “I wanted to show everyone what I had done. He [her nephew] did well because of my blessings and prayers, otherwise he wouldn’t have succeeded,” said Dianing.

Dianing’s sister-in-law, furious with the incident, decided that Dianing needed to be brought to the mental hospital again. She would not allow her to live in the house in her present state. Before they could do anything, however, Dianing left their house in anger and disappointment. “I just walked and walked and walked...I was so hurt by them, I did everything, they wouldn’t be where they are without me...I just had to go” said Dianing. A few days after the incident, she was brought to Camp Assessment by the municipal police. She was reported to have caused a commotion in a local market by shouting at a meat vendor. Her family was quickly identified in Camp Assessment, and she was referred to the rehabilitation institution.

By the time I met Dianing, it was her third time in Camp Assessment and she had circulated through all possible care options. She went through the rehabilitation regimen in the state institution twice. Both of the times, she enjoyed the attention and care she received. “In the rehabilitation institution, everyone listened to me, I was the assistant to the president Mr. Joko, everyone liked me there,” said Dianing. Mr. Joko was indeed the manager of the institution and was called “Mr. President” by Dianing because his name was similar to the president of Indonesia.

Dianing further explained that every time she moved into a new institution, she started a new life in which she had to bring luck and prayers to the new people around her. “I move

around, and I have many names. I am Diana in one place, I am Dina in another, in every institution I modify myself because I have to pray and bless the people around me,” she added. By the time I met Dianing, she had also traversed private institutions including religious institutions. In private, Dianing shared, “In the church institution I am Christian, and I pray to Jesus. In here, I am Muslim, and I pray five times a day. You see, it depends on the people around you, you have different ways of living.” She was convinced that the running of things in every institution rested upon her blessing, and so she had to adapt to the demands of every space she lived in.

Shuttled across various spaces, Dianing had exhausted all options. This worried her social worker. In frustration and exhaustion, the social worker asked me, “Should I scare the brother with the vagrancy law? It says that anyone who forcibly asks someone to beg in the street is subject to prison time. Can I use it to force the brother to take her back?” I convinced her not to go to such an extreme. At the time of this writing, Dianing remains in Camp Assessment.

### **Care of Another Kind**

In an essay exploring the ethics of survival, Didier Fassin (2010) writes that “the binary reduction of life to the opposition between nature and history, bare life and qualified life, when systematically applied from philosophical inquiry in sociological or anthropological study, erases much of the complexity and richness of life in society as it is in fact observed.” With this in mind, throughout this piece, the complexity of lives within Camp Assessment and the relationships forged within its confines put to question these easy distinctions. Between the eventful poles of abandonment and belonging, the complexity of the lives in Camp Assessment show that even as madness makes relationships fragile, social workers continue to work in conjunction with their clients to find ways to create a subject.

Moving away from dualisms of abandonment and belonging, this ethnography of Camp Assessment reveals the micro-politics of survival (Biehl and Eskerod, 2007). Clients and social workers participate in economies that continue to try to make subjects of care. But even as referral becomes impossible, what social workers term “care of another kind” is practiced. Care of another kind does not draw on available discourses of recovery and its associated categorization, but rather relies on imminent relationships forged within Camp Assessment (Povinelli, 2011). Against enormous barriers to finding access to care, social workers continue to forge relationships and provide care for their clients. Care of another kind was often the idiom used by staff and social workers, sometimes even clients, to describe the range of activities and practices that fell outside established guidelines or the mere “filling the forms.” To illustrate this care of a kind, consider the case of Bambang.

I first met Bambang in Camp Assessment. Ratri, his social worker, had asked me to meet him because she was worried about him. “I really don’t know what to do, you have to meet him and help us find a solution,” she said while pointing out to me where Bambang was sleeping. Bambang was a thin man, clearly in his late 50s. He was bald and wore a loose t-shirt and shorts with holes in them. He was in his room, staring out the window, smoking and smiling. Many other residents looked burdened, but Bambang looked calm.

When Bambang was admitted to camp, he was thin and could not communicate with others. He withdrew from any activities Ratri would come up with to make time in the camp somewhat bearable. “Bambang was speaking to himself a lot. He would only answer with yes or no, but listened to the instructions we gave him. He was very cooperative,” explained Ratri. When it came to Bambang, everyone in Camp Assessment knew that he would stop any conver-

sation about his family and walk away. However, he did not refrain from revealing the whereabouts of his family. For almost four months, Ratri would attempt to fill out Bambang's assessment form by asking him to remember the whereabouts of his family. "With medications, he finally told me his story. He comes from a very poor home. I cannot send him back, but he can't stay here too long," explained Ratri.

Bambang had only his sick mother to take care of him, though she was bedridden with congestive heart failure. She had no one to care for herself, let alone Bambang. Her other son, and the household's sole source of income, was in Kalimantan doing construction work. Bambang's mother lived in the smallest brick house in a large urban slum in Yogyakarta. The roof was covered with shards of aluminum and the mud floors were lined with old newspaper. Neighbors would drop by every day to make sure Bambang's mother was eating. The local primary healthcare center knew about his mother's condition and a volunteer nurse would visit her to check on her condition. Bambang's mother was surviving on the edge with whatever informal social support her neighbors provided for her.

By the time I met Bambang, he had already been diagnosed with schizophrenia and was routinely going to the district hospital to meet a psychiatrist. Below is part of a conversation I had with him.

Bambang: There are just sounds, someone crying, some faint screams, sometimes I hear birds and frogs.

Me: Has it always been like this?

Bambang: No there's a man's comes when I'm home. That voice is so bad.

Me: Oh, is the voice gone now? What did the voice say?

Bambang: The voice becomes softer when I leave home and follow his instructions. He tells me that I am wrong, I am the cause of all the trouble, my mom hates me, I am a burden at home...He tells me to leave the house because I cause trouble all the time, he asks me to kill my mother...she is sick...and suffering and I cause all her problems...she is stressed and sick...I am the reason for it.

Me: Why do you say so?

Bambang: I am a burden to the house, I give stress to everyone...I know I have the disease...but the voice is real...it makes me do bad things...it tells me what everyone thinks of me...I am hated.

Ratri (interrupts): Tell Sandeep why you ran away from home.

Bambang: I don't run away from home, I just follow the sounds, the sounds make me move to it...I go to the sounds and the bad voice goes away.

Me: What sounds are these?

Bambang: Sometimes it's sounds of the water. But I have to be careful with water sounds, it wants me to jump to the well...Sometimes I hear birds...I follow the birds...Sometimes it's like a drum...A beating sound...boom...boom...boom, and it makes me go to find it.

Me: Where do you go to find the sound?

Bambang: I just walk, I walk...walk...walk...it's so hard...I get hungry sometimes but the voice continues to push me...The streets are very hard...The rain can make you sick ... but sometimes there are nice people who give me left-over food...Here I am happy...I get food...the medicine is making the sound less powerful to push me to find it.

Despite pressure from her supervisor, Ratri insisted that Bambang not be returned to his family. She also went out of the way to facilitate Bambang's mother's inclusion into the poverty scheme. Ratri constantly had arguments with the psychologist in Camp Assessment, who often reminded her that her job was to get people out of the temporary encampment. Yet Ratri knew that Bambang was doing well in Camp Assessment. She had tried very hard to prepare him for referral to the rehabilitation institution. None of the institutions, however, wanted to admit Bambang because of his advanced age. "Rehabilitation is for those who are of productive age. There is no way out for Bambang apart from returning him home. But even with accesses to health insurance and other welfare entitlements, I don't think he should go home," explained Ratri

Ratri had worked in Camp Assessment since its inception. She knew full well how the institution operated, but she had enough experience to understand how difficult it was to provide care for someone like Bambang. However, she had another kind of attachment to Bambang. She said, "Bambang is very important to me. I care about him. It's the rare kind of attachment you have with a client, not the usual one." Indeed, Ratri treated Bambang differently from her other clients; she brought him snacks, occasionally clothes, and made sure he had his cigarettes. Cigarettes calmed Bambang, and Ratri made sure he always had stock.

“At home, his mother cannot afford cigarettes and he used to hit her. I use my money and buy him cigarettes. I know he is happier [in Camp Assessment] because in his house he finished one pack a day. Here he needs only one per day,” explained Ratri. Bambang also appreciated Ratri’s attention and care. He said, “Ratri has helped me, I was really angry before, now I am more calm and I feel happier.” I have probed Ratri several times regarding her care for Bambang. I always to get responses of silence, or “I don’t know.” It was not until Ratri’s argument with the Camp Assessment psychologist that I got some sense of why Ratri was so attached to Bambang.

On a Tuesday afternoon, just as I was about to leave Camp Assessment, I heard some commotion in one of the offices. I noticed some social workers surrounding the room. I made my way across the room and look at what was happening. The psychologist and Ratri sat in a table surrounded by other social workers. The psychologist said in a firm voice, “You need to send Bambang home as soon as possible.” Ratri looked worried and replied, “He is happy here. At home there is nobody to care for him.” The psychologist was not convinced by Ratri’s pleas, she said she would write a recommendation for his return. Ratri was frustrated and left the room.

I decided to bring Ratri to a nearby roadside food stall to calm her down and try to see what we could do to help Bambang:

Ratri: You know, I know how difficult it is to see a mother sick.

Me: Yes, it’s hard, my mother was also sick, and I saw her suffer through cancer.

Ratri: Yes, my mother has heart failure, just like Bambang’s, I am taking care of her...you know Bambang hears voices that tell him all his mother’s suffering is his fault...it’s really difficult.

Me: Yes, I cannot imagine how hard it must be.

Ratri: I can understand, everyone in my village thinks that I am not providing adequate care for my mother, but we are trying. I arranged for her insurance, I bring her to the doctor every month, but I cannot be at home all the time. I have to keep some money to myself.

Me: Yes, It's difficult.

I was able to convince the authorities to keep him in Camp Assessment, and up to the point of this writing, Bambang remains in Camp Assessment. It is useful at this point to be in conversation with Clara Han's (2011) elaboration of the temporality of the credit economy in the urban Santiago, Chile. She writes, "Domestic relations and mechanisms of credit are crucial resources in holding onto 'the possible' within its bounds: through an active waiting, time can do its work and produce the unexpected." The possible in Han's analysis does not refer to a temporality oriented towards a future possible but rather relies on indeterminacy. Similarly, Bambang drew upon his relationship with Ratri, using it to hold on to the possibility of indeterminacy in Camp Assessment.

What, then, is *care of another kind*? I draw on Angela Garcia's (2010) exploration of care and intimacy in an addiction treatment facility to shed some light on the term. She writes,

"In the clinic I would also witness such expressions in the fleeting moments between patients—in the way addicts touched each other's aching limbs or the way they regarded each other's tattoos. I witnessed it when a group of women gathered around a mother who had just learned that her daughter, also a heroin addict, had died of an overdose.

They were moments of rupture and of shared singularity. These were moments when I could imagine the possibility of a new kind of care.” (50)

Ratri and Bambang indeed shared many such moments of shared singularity, ruptures between their defined subject positions within Camp Assessment. Such intimacies animate the lives of those “stuck” within the institution; these intimacies sustain them, and clients draw on these relations to survive.

Care is often described as caring for the “bio-political life.” Social scientists often describe this kind of care at the level of population, and examine exclusion and its consequences (Redfield, 2013). Others examine the violence perpetrated in the name of care (Ticktin, 2011). I follow Stevenson (2014) and instead of reproducing care within these established tropes, I examine care as an object—care as practices within the confines of Camp Assessment, which includes sets of practices that “makes one a subject,” as well as other forms of care that rely on the imminent dependencies forged within the institution.

Letting die in the setting of Camp Assessment, occurs within the relations that are forged within the enclosed space (Das, 2015). In highlighting the kinds of care that operate within the institution, I am in no way insinuating that these practices successfully preserve life. Social workers are constantly haunted by losses that occur in Camp Assessment; data from the camp reveal that 4% of people died in Camp Assessment in 2017.

I end this section by describing the tension and the immense difficulties that “letting die” entails. I describe how one is driven to improve conditions in settings where suffering is proximate. Vany was tense. A new client, an old man, was found on the streets and looked very sick. As soon as Vany saw the man, she immediately picked up the phone and called for the car owned by the Department of Social Welfare. The man was quickly placed in a bed; he was

breathing heavily and seemed to be in pain. He had to be brought to the emergency room. The van from the district office arrived 20 minutes after Vany placed her call, and we rushed the man to the ER in the back seat of the van, his head sitting on my lap and his leg resting on Vany's.

Within 15 minutes we reached the hospital. The man was brought to the emergency room while Vany and I registered the client with the hospital administration. As soon we reached the administration booth, Vany and I looked at each other. We realized that we did not have any paperwork with us, we did not even know the man's name. We shared our predicament with the administration officer, only to hear her reply, "Why don't you know anything? We need a name." For the moment we decided to call the man Mr. X, but policy states that within three days Vany had to arrange for some kind of temporary insurance so that the man could receive treatment. To arrange for the temporary insurance, Vany had to traverse four offices and get paperwork from each to successfully secure the temporary insurance. This meant that on top of the usual work required for treatment of her clients, she also had to spend hours among these offices preparing this paperwork.

The nurse in the emergency room demanded that Vany sign the consent forms for the patient. As has been repeatedly highlighted in this thesis, the Indonesian healthcare system is family-based; hence, even in the hospital a family member is required to fill out any and all forms for a patient. In addition to fulfilling the bureaucratic need for family members, we also had to perform the duties typically performed by kin. The nurse asked us to change the man's diaper, brush his teeth, and alert them whenever his IV fluid needed replacing. Two days into admission, the man died and Vany had to arrange the paper work for the man's funeral and burial. Throughout the process, however, what bothered Vany was not all the work we had to do to get the man

something approximating decent care, but rather that the system that required a sick man be brought to Camp Assessment before going to the hospital.

Over the next few months, Vany became so animated by the incident that she went to the municipal police office. With their assistance, Vany was able to introduce a new guideline in which every municipal police officer who finds a visibly ill individual in the streets bring him or her directly to the hospital. A memorandum of understanding with Camp Assessment was quickly developed to ensure that every person sent directly to the hospital by the police would be assigned a social worker to complete the required paperwork.

## **Conclusion**

I end the with the story of Vany and her determination to fix a broken system in order to highlight the fact that far from working in a “zone of abandonment,” social workers at Camp Assessment continue to make changes to the system in order to find care for their clients (Biehl and Eskerod, 2005). Ethnography in such a setting highlights the importance of relationships and the micro-politics of survival, as these relations drive long term social change. My approach to understanding Camp Assessment arises from my commitment improving it. Analysis of abandonment, marginalization and exclusion are often aimed solely at revealing truth. In approaching how those in Camp Assessment endure, I had hoped to get a picture of how I could improve conditions there and participate in social change. Ethnography helps us understand how social change operates outside these kinds of projects and eventful interventions (Povinelli, 2011) and reveals that processes of abandonment and exclusion are never final.

## **Making Productive Citizens**

### *Part II: Containing Madness through Rehabilitation*

#### **Introduction**

Fahmi was the star patient in *Panti Rehabilitasi*, a state-run institution that provided rehabilitation for patients with major mental illness. “A total transformation, he is a hardworking man now,” said the head of the institution. Fahmi was one of the rare patients that could complete the regimen of rehabilitation within the stipulated six months. He was interning in a waste processing factory as part of his rehabilitation. I had met Fahmi, few months before he was placed in this institution, right after he was evicted from sleeping in the streets and brought to Camp Assessment. Fahmi was young, communicative and deemed as having potential to be “productive” by his social worker and was quickly sent to *Panti Rehabilitasi*.

Fahmi was in his last year of high school when his father died and when he started going on excursions. He heard voices and started wrecking the property of his neighbors soon after. With the help from his village leaders, his widowed mother, brought him to a psychiatrist in a mental hospital. He was diagnosed with a major mental illness and given medications. To make up for the loss of their sole breadwinner in the household, Fahmi’s sister migrated to the city leaving his mother as his sole caregiver at home. In the care of his mother, Fahmi started becoming hesitant towards medication and stopped going to the doctor. His excursions became more common, until one day he never came back. He was brought to Camp Assessment 7 months after he left home, sleeping in the streets 10 kilometers from where he used to live.

In his dormitory room in *Panti Rehabilitasi*, Fahmi laid on one of the mattresses, littered with packets of food, staring at the molded wall. I approached him and sat by his side, he was startled to see me.

Fahmi: I am tired of this. They said rehabilitation will make me better, but it is not helping.

Me: Why do you say that?

Fahmi: The voices are not going away. I am tired all the time. I just feel like a disappointment.

Me: Isn't working helping you keep your mind off the voices?

Fahmi: The voices still tell me that I'm bad...That I'm useless ...Everyone hates me...I come back from work and I am very tired ... The voices become louder when I am tired, there are screams ...Baby crying ...So many voices.

Me: The medication is not helping you?

Fahmi: The medication makes me lazy. I cannot think. I cannot work. They give me medicine that makes me paralyzed and yet they say I have to work. How will I do it? Tell me how will I live like this?

Me: Have you said this to your doctor or the social worker? Maybe they can adjust your dose and ask you to do less work.

Fahmi: All they say is the problem is in my head. To recover I have to have the will to work, the will to be productive.

Fahmi, represents a very small percentage of vagrants with major mental illness for whom, social workers could find a place in a rehabilitation institution. Yet, within the rehabilitation institution, where care is available, a new set of challenges arises; the struggle for recovery. The contradictory effects of the numbing medications and the pressure to work form vocational trainers becomes a daily struggle for Fahmi. The struggle that he is required to go through to complete his tough regimen of rehabilitation.

When Fahmi's social worker was broached with his problem, she explained, "This is why he needs rehabilitation, to repair his will to work, when he is productive he can be a part of society, rehabilitation will make him able to enter the society." In this chapter, I unpack how the social worker makes Fahmi productive. I describe how *Panti Rehabilitasi*, transforms people like Fahmi in the hope that they can be absorbed into social worlds. I examine the discursive anchors social workers use, against a backdrop of very limited resources, to provide care and conceptualize recovery for patients with major mental illness. I examine the struggle through which someone with major mental illness accedes to this promise of recovery (Jenkins, 2015).

### **"Social rehabilitation is not medical rehabilitation"**

*Panti Rehabilitasi* falls within the network of institutions that provides "social rehabilitation." Managed under the Department of Social Welfare, *Panti Rehabilitasi* is part of many institutions that houses what the department refers to as "people with social welfare problems" (Ministry of Social Welfare Republic of Indonesia, 2012). Patients with major mental illness fall as one of the

27 subcategories that is deemed as needing rehabilitation in these institutions. Rehabilitation is directed towards transforming the person into productive members of society. “Simply put, rehabilitation transforms unwanted people with problems to people who participate actively in society,” explained one staff at the Department of Social Affairs.

The regimen of rehabilitation in these institutions are uniform across the different sub categories to whom rehabilitation is provided. (Ministry of Social Welfare Republic of Indonesia, 2012). “The actives of rehabilitation for sex workers, vagrants without and with psychosis are the same. All of them centered around vocational training,” explained a state official.

Through the bureaucratic structure that allows *Panti Rehabilitasi* to plan its actives, vocational training is also gendered and highly specific. “In all rehabilitation institutions, for women it’s training them so they can open a salon or a small food business, and for men it’s training them for construction work,” explained a vocational trainer. When asked about this peculiar uniformity of rehabilitation across a diverse range of populations, staff at the social rehabilitation department explained that across the categories of social problems, the problem lies within the person’s inability to be a productive member of society. As one social worker puts it, “they are marginalized because they cannot lead a good life, we teach them how to live.”

Another feature of social rehabilitation is that it is distinct from medical care. Social rehabilitation does not address symptoms of medical illness but provides the person with behavioral resources and skills to live productively. “The medical system takes care of the physical problems, we help patients with their behavior and skills to live properly” explained the manager of *Panti Rehabilitasi*. However, in the medical system, there is a notable absence of discourses and policies directed towards rehabilitation.

With the advent of universal social insurance, the landscape of medical care for people with major mental illness has shifted towards primary care. (Republic of Indonesia, 2004) In this scheme, mental hospitals can only accept patients with emergent acute psychosis. This has shifted the goals of care within the hospital. “We discharge as soon as the person has achieved an activities of daily living score of seven,” explained the staff and the provincial mental health hospital. He also noted that the length of stay of patients with a major mental has reduced significantly as the hospital is pressured to discharge patients quickly and refer them to their primary care providers.

Moreover, in the frame work of policies that provides guidance for primary care, rehabilitation is also absent. In the minimal standards that primary centers must comply with, care for patients with major mental illness is only limited to providing medications and home visits (Ministry of Health Republic of Indonesia, 2014). This lack of policy for rehabilitation within the medical system and the shifting role of mental hospitals in the framework of medical care has crystalized *Panti Rehabilitasi* as the main source of rehabilitation services for patients with major mental illness. Not surprisingly then, psychiatrists and medical professionals use the same discourses to conceptualize rehabilitation. As one psychiatrist puts it, “What we want is that the person can be productive. Not only that they must be accepted within homes, they must also help out the family by working.”

With a general lack of resources and political attention allocated for mental health care (Human Rights Watch, 2015), staff in *Panti Rehabilitasi* are put in a difficult and onerous position of implementing these policies and providing care for patients with major mental illness. In the section which follows, I describe exactly how this is done.

## **Entering Panti Rehabilitasi**

Upon entering the large gate that enclosed *Panti Rehabilitasi*, one is met with an expansive garden and a small building in the center. In front of the building, a large pole hoisted with an Indonesian flag sits in the center of the garden. “To build a sense of national solidarity, we have a flag hoisting ceremony every Monday,” explained a staff. The building adjacent to the flag, was the administrative office of the institution. The office was overshadowed by tall steel gates, topped with barbed wires that enclose the residential and vocational training area where most of the activities of rehabilitation were conducted. A small door penetrates the steel gates. “The door is not locked, and remains open until midnight, anyone can come in and out” explained one social worker.

Within *Panti Rehabilitasi*, there were four main residence dormitories; two for each sex. There were also four vocational training workshops used for different training sessions. Each dormitory hall was filled with twenty to thirty foam mattresses that lay haphazardly on the floor. The dormitories looked un-kept, with packages of food littered throughout the floor. The rooms were damp, and the ceilings were leaking. Walls were covered with mold and had creaky fans screwed to them. “Self-care and cleaning their own rooms is part of rehabilitation,” explained a social worker when I asked regarding the conditions of the housing dormitories.

Vocational training workshops in *Panti Rehabilitasi* looked barren and empty. Dust lined the floors and chairs were stacked at the corner of the empty space. “We have had to improvise with our vocational trainings. The stipulated training schemes were too difficult for patients with major mental illness,” said a vocational trainer explaining that vocational trainings only focused on the basic components of work skills. “If it is construction work, we only train them to lay

bricks. They cannot learn complicated work skills, although the stipulated training scheme requires them to do it. That is why these rooms are empty,” explained the head of *Panti Rehabilitasi*.

Residents of *Panti Rehabilitasi* wake up at six in the morning for breakfast and an hour later were expected to be ready for their daily exercise session. An aerobics instructor stood in front of residents in the garden and instructed them to dance as large speakers play music. Residents force their bodies to follow the instructor. Social workers and Panti staff prepare medications in small cups as patients exercise. After the exercise session ends, residents line up to take their cups with medicine.

Once a month, residents of *Panti Rehabilitasi* rode a bus in groups to visit the outpatient psychiatry clinic at the mental hospital. The hospital provided a dedicated psychiatrist and clinic space for patients to get care. Care is paid for by the provincial government. The main activities in *Panti Rehabilitasi* can be divided into two major components; *Pembinaan Mental* and vocational training. In the section which follows, I describe how patients are selected and these activities in greater detail.

### **Who has the “Potential?”**

In *Panti Rehabilitasi*, staff made do with the rehabilitation arrangement stipulated by state policies and improvised to cater to patients with major mental illness. The manager of *Panti Rehabilitasi* explained that the main way through which rehabilitation could be successful, given the policy framework, was that if they were highly selective in admitting a patient to this state-run program. “The key is to select the right people, the people who has the potential,” he explained.

It is with this rationale that only few people from Camp Assessment make it into this institution (See Part I).

<b>Criteria of Potential</b>
Eks- Psikotik
Below the age of 50
Consent of a family member or village authorities

Figure 3. Criteria of Potential

*Panti Rehablitasi* had a clear inclusion criterion stipulated by the department of social affairs (See Figure 3). One of the main criteria was the age of the person. No one above the age of 50 was allowed to undergo rehabilitation. “This is because they have to be productive age, if they are old we cannot train them,” explained a vocational trainer. A psychologist working in the institution added that, “When you are old you don’t need rehabilitation, what is needed is therapy to the family so that they care for the old person with psychosis.” Limited resources for rehabilitation were therefore rationalized to be allocated for people under 50 deemed as productive age because they have the biologic “potential.”

Another important criterion for admission to *Panti Rehabliatsi* was that one had to be deemed “eks-psikotik.” This peculiar term was circulated only within the Department of Social Welfare to describe people with major mental illness who do not need urgent psychiatric care. Patients that needed emergent psychiatric care, often referred to as “the acute phase,” were immediately referred to the provincial mental hospital. The “eks-pyscotic,” referred to a person that was diagnosed with a major mental illness who had the capacity to care for themselves. “The

eks-psycotic has undergone medical evaluation and care such that they can perform their activities of daily living,” explained a psychiatrist.

In choosing people who have “potential,” the criteria that was most important, according to many social workers, was the presence of a consenting family member that was willing to host the patient after rehabilitation. As claimed by the manager of *Panti Rehabilitasi*, “Key in making rehabilitation successful is the presence of a family that will host and support the productive patient after rehabilitation.” Without a consenting family member, patients would not be accepted for rehabilitation. This was primarily the reason why it was so hard for people in Camp Assessment to get into rehabilitation (See Part I).

There was also a subjective dimension in the process assessing one’s potential. Dewi for instance, was brought by her mother and some of her neighbors to rehabilitation to seek some help and although met all the formal criterion stipulated by the institution was determined as not having the potential for rehabilitation.

Dewi lived in one of the poorest urban settlements in Yogyakarta and was in her late twenties. She lived alone with her mother, who made a living through collecting garbage across the city center. Dewi at the time, had just returned from Jakarta where she worked as a domestic helper after completing high school. She left her job in Jakarta because she didn’t have energy to work. She saw and felt a shadow absorbing all her energy. She was pressured by the shadow to sleep and pray all day. Unable to work in Jakarta, she moved back to Jogjakarta with her mother. Few months after returning to her natal home, her condition worsened. The shadow pulled her towards her neighbor’s house to break the windows with a rock. This made the village worried and aware of her problems. With the help of her neighbors, Dewi’s mom was able to get some money to get her some medical care. When she was brought to the primary health center, the

shadow pushed her heavily. She could not move. She started screaming when she was forced by her friends and neighbors to go to the doctor. With the help from the primary health nurse and a neighbor who was a religious preacher in the local mosque, Dewi was brought to the mental health hospital. She was in the mental hospital for ten days and discharged with medication. Upon her discharge, the village leaders suggested that Dewi could benefit from rehabilitation. Below is an excerpt of Dewi's discussion with a social worker.

Social worker: If you want to undergo recovery here, you have to abide by the rules?

Dewi: What is the shadow comes back? What if I cannot move again?

Me: Is the shadow still bothering you?

Social worker: Are you taking your medications? If you take your medications, you will be able to do rehabilitation.

Dewi: Do I have to wear the green uniform? Whenever I wear green, the shadow disturbs me.

Social worker: Yes, you have to wear the uniform.

Dewi: I don't want to wear the uniform.

Social worker: If you don't wear the uniform, you cannot undergo rehabilitation.

Me: Is there a uniform with another color?

Social worker: She must be able to abide by the rules if she wants rehabilitation to be successful. Appearance and clothes is an important part of rehabilitation.

Dewi: If I wear the green uniform, then I must meet Pak Joko (the local religious leader at her mosque).

Social worker: We have a mosque here. You can go the mosque inside *Panti Rehabilitasi*.

Dewi was deemed by the social worker as not having the potential to do rehabilitation. This was because she still needed medical care so that she could comply with rehabilitation. “Maybe after adjusting the dose of her medication she would have less worries about the shadow,” said the social worker. Dewi was not allowed to undergo rehabilitation and was left in the care of her mother even though she fit all the criterion stipulated by the institution. The huge disconnect between the medical system and social welfare system becomes grounds in which the responsibility of Dewi’s care was outsourced to her mother.

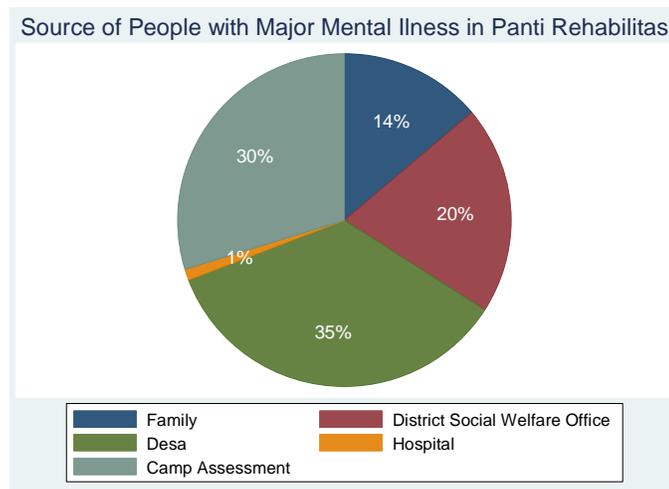


Figure 4. Source of referral of patients with major mental illness in Panti Rehabilitasi

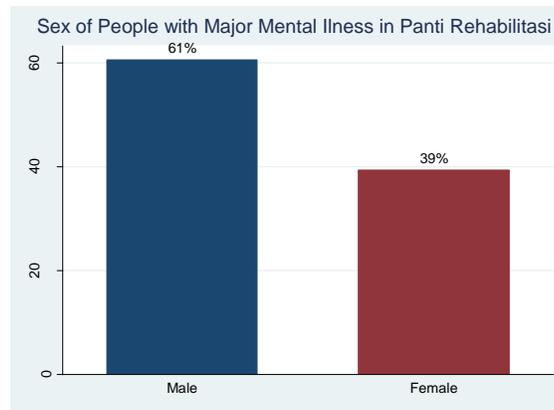


Figure 5. Gender of People with major mental illness in Pantih Rehabilitasi

Dewi’s story also provides a useful way to understand who makes it into *Pantih Rehabilitasi*. From the 2016 cohort of patients (94 people) that underwent rehabilitation; majority of the patients were referred to the institution by the village community whether directly (35%) or through their district social welfare office (See Figure 4). “Most often these people cause huge trouble in the village and the communities send them here. What we do is then to transform them, so that they can be accepted back to society,” explained a social worker. Many other social workers also suggested that just like the patients in Camp Assessment, patients sent by the villages were unwanted. This also explained the gender discrepancy of people who undergo rehabilitation (See Figure 5). According to the manager of the institution, men who suffer through psychosis are more violent and cause conflict in villages and therefore are more likely sent to rehabilitation. But he adds, “To transform them we need to make sure they have been treated in the medical system, they must have the potential.”

***Pembinaan Mental: Drawing out one’s potential to be productive***

A vocational training hall was lined with six rows of chairs. A picture of an old man laying bricks was projected on a cracked wall with faded paint. The room was quiet, and patients were

sitting in in a uniformed manner. A social worker stands in the front of them, standing out in the dim lit room as her face is shined by the projector. She said, “All you need to do is to control yourself and become hardworking. With these qualities you can achieve anything,” while pointing out the case from the newspaper in which a man who was physically disabled and living alone in a poor slum was able to muster resources and find a job laying bricks in a construction project. “You see, despite his limitation. He is still can work. He has self-worth,” she added.

This statement however seemed to have made one of the patients uncomfortable. Fahmi, whom I described in the first part of this section, looked uneasy and angry. I approached him and asked him what was going on. He replied, “How can she say I have no self-worth? I am working very hard to live with this. It’s difficult. I have self-worth. I am trying my best. How can she say I have no respect for myself?” Fahmi had to undergo series of sessions like this called *Pembinaan Mental*.

*Pembinaan Mental* was a series of lectures given by social workers, to help patients with the information they need to cultivate themselves. These sessions were given so that residents can actualize their potential. In these sessions, residents were informed that there are certain qualities that when cultivated, allows one to be productive. These sessions are divided into three components; Acceptance, Spiritual Guidance and Gratefulness.

### **Acceptance**

In the first phase; acceptance, participants were encouraged to accept that they have a mental illness. “The first step is insight. Usually patients with major mental illness don’t know they have a disease. The first stage is to make them understand they are sick. Once they understand, they will

want to change their behavior,” explained a psychologist who supervises *Pembinaan Mental*. Patients were informed that they have a biological illness which had treatment and that adhering to the regimen of medicine would allow one to undergo recovery understood as being productive. Patients in *Panti Rehabilitasi* were constantly reminded that if they take their medicines they would be able to recover.

Fahmi used to get extremely upset in these sessions. He could not take the constant reminders that he was sick. He felt that these constant reminders did not help him. “I have to get away from the voice and ignore it. I don’t want to get reminded of it,” he remarked. Even though Fahmi was considered by many staff as one the star patients of rehabilitation, they would still remind him that he was ill. He was tired throughout the activities of rehabilitation and wanted to work through his regimen quickly so that he could start working to support his family. He said, “I am doing this so that I can help my family. My sister is in Jakarta supporting us, soon she will be married. I have to take care of my mother. Before my father died I promised him I will take care of the family.”

In private, Fahmi vented his frustrations. “They say that medication is not enough! That to be productive, I need more than that. I have tried everything, but they always say I have to work hard,” he explained. I tried my best to motivate him, but our conversations would often veer off to how his social workers would constantly remind him that to work hard. Accepting one’s illness, as I learned from his social worker, was not only accepting that one has a mental illness and needs medication, but also that one needs to cultivate one’s body. Fahmi social worker put it as follows: “Medication alone is not enough for the recovery. Fahmi needs to accept that. He needs to accept that he will have to work hard to be productive. It’s not as simple as taking medication.”

Indeed, in the conceptualizing of major mental illness, medications were understood as foundational to a body that could be manipulated to actualize its potential. As a social worker puts it “the medicine is the baseline...to remove symptoms...but to be productive, the body needs to be cultivated through rehabilitation.” Patients in *Panti Rehabilitasi* were given access to medication as means to create a body that had the potential to be drawn out as productive. *Pembinaan Mental* was thus a series of sessions that informed patients how to craft this medicated body. According to the manager of the institution, this explained the divide between the medical system and the social welfares system, “The medical systems prepares the body and the social welfare system helps the person to cultivate it. That is why the medical systems is not enough. Just medical care will not make someone productive. They need to be taught to cultivate their medicated body.”

It is useful to note here that in a different context, anthropologist Joao Biehl (2005) described how the “unwanted” penetrated social worlds with medical signifiers as they struggle across the complexity of different institutions that reconfigures their subjectivity as a will to live. Similarly, patients who come who undergo rehabilitation are transformed to enter social worlds, where one is required to be productive. The medicated body acts as scaffolding through which a self can be actualized (Mahmood, 2012). Rehabilitation was thus understood as providing skills, so that individuals can actualize a productive self through ascribing to social norms. Medications in the imaginary of recovery, just prepared the body. The process of recovery was achieved only through cultivation of the self through following norms prescribed by lectures in *Pembinaan Mental*. This conceptualizing of medications was different to the way medications was understood in the United States. Atypical antipsychotics, in the United States, was understood as causing “awakenings” that treat the “chemical imbalances” which causes psychosis (Jenkins, 2015).

## **Spiritual Development**

The second skill that *Pembinaan Mental* focused on was what the Department of Social Welfare called “spiritual guidance” (*Bimbingan Rohani*). In this series of sessions, participants were informed that cultivating one’s devotion to God is a key driver of hard work and success. Through the discipline of prayer rituals, patients were expected to succeed in attaining productivity. These sessions were aimed to instill qualities that would allow one to lead a good life. Religious preachers were called in as experts to teach patients how to recite Quranic verse. “Religious discipline is important, it stabilizes their emotions...to be productive you need to stabilize emotions,” explained a preacher. Patients were required to attend all religious activities to complete rehabilitation.

Social workers often described the use of *Pembinaan Mental* as means through which an ethical subject could be cultivated. Honesty, discipline, and devotion were qualities that were conceived of by experts as essential for recovery. Although every staff in *Panti Rehabilitasi* put much emphasis on the importance of cultivating one’s spirituality, in practice, sessions involving spiritual guidance centered mainly on Quran reciting. One social worker explains this as follows: “With people who have major mental illness, we have had to modify these sessions. We focus just on Quranic recital, so it can help stabilize their emotions.” One is constantly pushed to suppress one’s emotion in order to achieve recovery. Through the discipline of learning to recite the Quran and wearing the appropriate attire for praying, patients were expected to have the right attitude that would lead them to productivity. As one religious trainer summarizes, “They should be wearing the right clothes and reciting the right way, it’s important, even though they don’t know the significance. The discipline of reciting and praying properly will help them be productive by stabilizing their emotions.” However, these sessions did not go so well with Nur.

Nur came from one of the poorest districts in the province. Her ailing, 80-year-old mother lived alone, sustained by the little amount of money she gets from her son who was working in a palm oil field outside Java. Unlike other residents, Nur did not cause a lot of disturbance in her village. Neighbors would just report hearing her cry alone in the fields at night. Due to the ailing conditions of her mother, her neighbors arranged for some help from the district's Social Welfare Department. Nur was discovered by the authorities as having a major mental illness and was sent to *Panti Rehabiliatsi* to recover.

One rainy afternoon, Nur sat on the steps of the dining hall, dipping her legs in a puddle and splashing around. A social worker came up to her and asked her to stop playing in the puddle. She was asked to change her uniform and join the Quran reciting classes. "You need to learn to concentrate and suppress your emotions. Following these classes will help you," said the social worker. Nur looked distressed. She stood up, scratched her head and said, "I tried going to the classes. It's not stabilizing my emotions. I cannot suppress it. The medicine just makes me weak. I still feel angry and sad, it doesn't change my emotions. Praying makes me very sad because it gives a chance for God to whisper that I am sinful." The social worker walked up to her, put her arm around her, and said, "God will not give you problems if he knew you cannot go through it. You have to pray and with discipline and full devotion, you can suppress your emotions and lead a productive life." This appears to have consoled Nur and she agreed to participate in the day activities.

However, as time passed, I realized Nur seemed much more distressed. Nur was initially very social, always trying to speak to anyone she meets, often being playful, trying to make the best out of the situation she was in. But as she spent more time in *Panti Rehabilitasi*, she spent more time alone in her room. She looked more unkempt and seemed generally disinterested.

Fearing that she may be overmedicated, I consulted with her psychiatrists, only to hear that “she sleeps well and follows all the activities, her medication is helping her.”

After many unsuccessful attempts of asking Nur how she felt, Nur revealed that she was not happy in *Panti Rehabilitasi*. “I need someone to talk to. I need a distraction, something new to do. If I pray, I feel sad. To suppress my emotion, I cannot do routine repeating activities. I need some distractions,” she explained. For Nur, rehabilitation wasn’t helping; it was, in fact, creating more distress. “When I follow the Quran reciting class. I get very angry. The whispers become more powerful and it can control me. I have to have so much effort to control it. I have to suppress a very powerful thing that controls me,” she adds. Nevertheless, staying in institutions meant access to medication that really helped her with sleeping. As she put it, “I need to stay here. I get pills. It helps me sleep. Before, I couldn’t sleep for days, but now I can sleep. I have to survive rehabilitation, so I can sleep.”

### **Gratefulness**

Soft instrumental music played in a dim lit room hosting patients. A trainer whispered in a soothing tone, “We have to thank God for what he has given us. We have to thank our family for all their support, no matter what they have done to us. We have to be grateful.” Patients were asked to close their eyes and imagine their families. The trainer went on to say in a soft but affirmative tone, “You have to be grateful to your family, especially to your parents. You cannot be productive without being grateful. Grateful to family and God.” Joko, who often skips these sessions, looked unusually engaged in the particular session. He closed his eyes, looked at the floor, and whispered to himself. As the session continued, Joko was visibly shaking, scratching

his hair while knocking at the chair. Everyone else seemed disinterested in Joko's increased movements. The trainer persisted with her chants.

Joko was one of the few patients in *Panti Rehabilitasi* that was very responsive to his medications. The terrorizing whispers that told him to set fire to his neighbor's livestock immediately vanished when he consumed his medication. It was not until the incident, that Joko and his family discovered he had severe mental illness. Joko, living in rural farm since he was small had always been characterized as shy and loved to stay at home. The incident came as a sudden shock to Joko's mother and her neighbors.

Joko started to feel different after his father died. He felt that his dead father was following him. This made Joko extremely cautious in finding work, always finding an excuse to not accept any offers he got. Joko was the only son in the household, and so the pressure for him to migrate and work was enormous. With the death of his father, his aging mother was the only one to provide for the household through selling the crops from her farming. Joko's family was the poorest in their neighborhood of rural farmers. Constantly facing food shortages and rising commodity prices (World Bank, 2017), their household fell into huge debt. Survival required constant borrowing from neighbors all of whom demanded that Joko had to work.

With the increasing pressure to find a job, Joko's symptoms worsened. He started hearing whispers. Characterizing these whispers as evil, for a few years he could ignore it, but that required isolation. It was not until his neighbor commented that his mother was lazy, that the voice took over. He burnt his neighbor's livestock, the police were called, and deemed him as having a major mental illness. After a week of treatment in the mental hospital, he was sent to *Panti Rehabilitasi*.

As the session continued, Joko looked more distressed. I approached him and asked if he would come outside with me to take a break. He agreed, and we went to an empty hall just by the space the training was conducted. It was this time that Joko revealed that what was troubling him. Joko's father was an alcoholic, and in the few times a year that he would visit his home from his work place outside Java, he was both verbally and physically abusive. Joko explained that nobody knew of his father's behavior: "He was very good at hiding it, acted innocent to the neighbors but in the night, he came home and hit my mother." Brought up entirely by his mother, Joko was really affected by the insults his father threw at her. "He [Joko's father] always used to say my mother is lazy. I cannot take that, she worked hard in the field. ...She took care of me, he never sees," explained Joko. On another occasion, Joko revealed that this was also the reason Joko felt really offended when the neighbors accused his mother of being lazy.

Joko was affected by the sessions, which called for gratefulness. He remarked, "What do I become grateful for? For having no money...For causing my mother trouble, because I am sick?" Joko's destroying of his neighbor's livestock meant that his mother had to work harder in the fields to pay for all the extra debts incurred. Joko resented his social worker who constantly asked him to be grateful to his father. However, he forced himself to remain in *Panti Rehabiliatsi* because, that meant, "One less stomach to feed at home...And medicines."

Hoping that Joko's social worker would be able to make Joko's experience in *Panti Rehabilitasi* better as she too was raised by a single mother, I approached her with his situation. Below is an excerpt from the conversation I had with her.

Social Worker: That's part of rehabilitation. He must be thankful, before he can work.

Me: But his condition at home is really bad. His family is poor, they don't have access to care.

He finds the sessions of gratefulness difficult to follow.

Social worker: God will not give you problems if you cannot solve it. He has to realize what he has before he can address the problems. What we are saying is not that he doesn't have problems, but what is important is that he has to be grateful for what he has, and use the potential to solve his problem.

Me: He had a bad experience when he grew up, his mother had to work very hard. It's difficult to be grateful.

Social worker: It is very hard to accept that, but we should still be grateful to our parents. The family is very important. Whatever they have done to us, we have to be grateful to them. We have to be grateful to whatever family we are in.

Despite my constant pushes, Joko's traumatic history and the structural conditions of his household, the social worker would not change her mind regarding her position on the importance of gratefulness in the process of rehabilitation. This was also noted by other social workers, all of whom explicitly mentioned that rehabilitation was not aid or charity. As the head of *Panti Rehabilitasi* put it, "Rehabilitation is not aid. It is giving skills to people so that they can live a normal productive life. The person has to cultivate themselves. We just show the direction and nudge them."

Social workers would often invoke a sentiment of shame when they talk about aid. Underpinning every component of *Pembinaan Mental* is the need to cultivate a productive self and

not fall into the un-respectful position of needing charity. “You have to work hard and legitimately earn money, just receiving money through begging or without hard work is not respectful, it’s shameful” summarized the psychologist. Self-worth and dignity is ultimately linked to cultivating a self that is able to be productive (Han, 2012).

### **Vocational Training: Becoming Productive**

Although the rhetoric of productive was commonly used by social workers in *Panti Rehabilitasi*, almost no one could define what this goal was. Descriptions of productive ranged from “being able to provide for their family” to “not causing trouble in the village.” Consider the following excerpt from a conversation I had with a vocational trainer.

Vocational trainer: They don’t have to be able to actually work to be productive.

Me: What do you mean?

Vocational trainer: they just have to be able to use the tools right. They must try to look normal

Me: So productive is not making money?

Vocational trainer: Earning money is not important. Some can’t even communicate well, even with medicines. They have to be able to look right.

Me: Look right?

Vocational trainer: Yes, look right using the equipment, wear proper clothes. Look neat.

Me: so productive is being able to look right?

Vocational trainer: Yes, they have to be neat. Wear the right stuff. If you are a woman, you have to dress right, cover your legs. If you're Muslim, wear a headscarf.

The more time, I spent attending vocational training sessions, the more I realized most of the sessions focused on the aesthetic components of being able to work. Wearing the right clothes, holding the equipment's right, looking neat were highlighted in almost every vocational training offered in *Panti Rehabilitasi*. Although what productive meant was different in each context it was used, it generally referred to consumption that was highly gendered. Women and Men are only allowed to take classes of specific vocational skills according to their gender. Men were trained mostly in construction and women were trained in cooking and stitching. The regimen of vocational training was also uniform for everyone regardless of their cognitive abilities and the severity of their mental illness.

### **Rehabilitation in Post-Authoritarian Indonesia**

These practices of rehabilitation stem out of a context where there is increasingly an assemblage of pious and capitalist ethics. Spirituality has become an object of manipulation through which one attains economic success, as work become a form of worship (Rudnycky, 2012). These changes, commensurate with neoliberalism arises out of a long period of authoritarian regime where national identity was linked with modernity and development. The rhetoric "*pembinaan*," comes out of this authoritarian regime. It refers to a process of self-development where one manipulates oneself, in the form of an awakening, and aligns oneself to a national identity (Heryanto and Lutz, 1988).

The fall of the authoritarian regime has given way to hybrid political formations through an assemblage of factors; including the recent memory of authoritarianism, popular Islam and transnational media flows (Heryanto, 2006). Rehabilitation of the medicated body then, becomes the lens through which these political formations materialize.

The post authoritarian period also created a context where expertise is appealing, as it creates a “confidence from following rules through technical mastery of the world and a related allure of revelation and truth in conditions of uncertainty” (Jones, 2010). The body then becomes both the subject and object of expertise, a site where the logics of modernity and neoliberalism are naturalized. (Mitchell, 2002). Recovery is thus understood as drawing out a potential that is supposedly naturally given. Put simply by the manager of *Panti Rehabilitasi*, “We are just giving them direction of what we humans are inclined to do already.”

The gendered form that one is expected to embody in this post authoritarian context is thus also subject to expertise. Carla Jones (2010) describes how the female form in post authoritarian Indonesia has become an object of analysis through which individuals can manipulate themselves both their bodies and personality to become more successful. More recently, Hegarty (2017) described gender in the Indonesian context as embodied work. Similarly, productivity in *Panti Rehabilitasi* was understood as the embodied work that is required to actualize a self through consumption.

### **Containing Madness**

In the context of *Panti Rehabilitasi*, consumption is intimately linked with the family. In order to be productive one not only needs to consume according to prescribed norms by experts, but also do it within the family. Social workers describe being able to be accepted within the family as

the ultimate goal of rehabilitation. One trainer puts it as follows: “They come here because they cannot be accepted in the family, we have to make them look right so that they can be accepted in their family and their community.” The patients in *Panti Rehabilitasi* matter to the social welfare system not because of the struggles patients and their families experience (Subandi, 2015), but because madness reveals the fragility of kinship, the only legitimate way through which madness can be absorbed (Das and Addlakha, 2001). Put concisely by the head of the Social Rehabilitation Department in the Provincial Social Welfare office: “Ultimately, the family has to take care, we are not responsible.”

Boellstroff (2005) describes the relationship between consumption and heteronormativity in Indonesia, through “personhood as career” where the self becomes a “profession of a story the self tells it self about itself.” This may be the reason why a sense of failure which is mutually caused by failure to provide for and maintain gendered kin relations with the family, pervades subjectivities of patients undergoing rehabilitation in Panti. From Joko, to Nur, almost everyone I spoke to undergoing rehabilitation, was constantly reminded of their failure. Dignity was only afforded to people who could ascribe to the norms of consumption which includes maintaining kinship obligations within the family. In this context, shame is often experienced when one fails to maintain kinship relations. Joko, Nur, Fahmi and the many other patients in Panti Rehabilitasi struggled with these burdens as they scavenge to accede to the promise of recovery.

Veena Das (2015) in her ethnography of disease in the urban slums of India, describes madness within the fragility of relations it reveals. She adds however, “It is the case that it is only within this every day, corroded and shattered by madness though it becomes, that care can be offered.” (p. 84). Rehabilitation in this context aims to assist in the absorption of madness

within the confines of the family. Through “suppressing emotions” and “being grateful,” rehabilitation was understood as means to mend the relations within the family, relations that madness has made fragile. From burning livestock to breaking windows, patients were sent to the institution because madness has made it increasingly difficult for them to be absorbed within their family. Rehabilitasi thus attempts to mend these relations by informing patients how to cultivate themselves.

The family here is the only legitimate unit through which madness can be contained. This is particularly the reason why, as an inclusion criterion to enter Panti Rehabilitasi, the presence of family is essential. This is also could be the reason why rehabilitation is explicitly differentiated from medical care in which the biological family is required to provide. Even as madness, poverty and violence create conditions that make maintaining these relationships a daily struggle, families are expected to care for their kin.

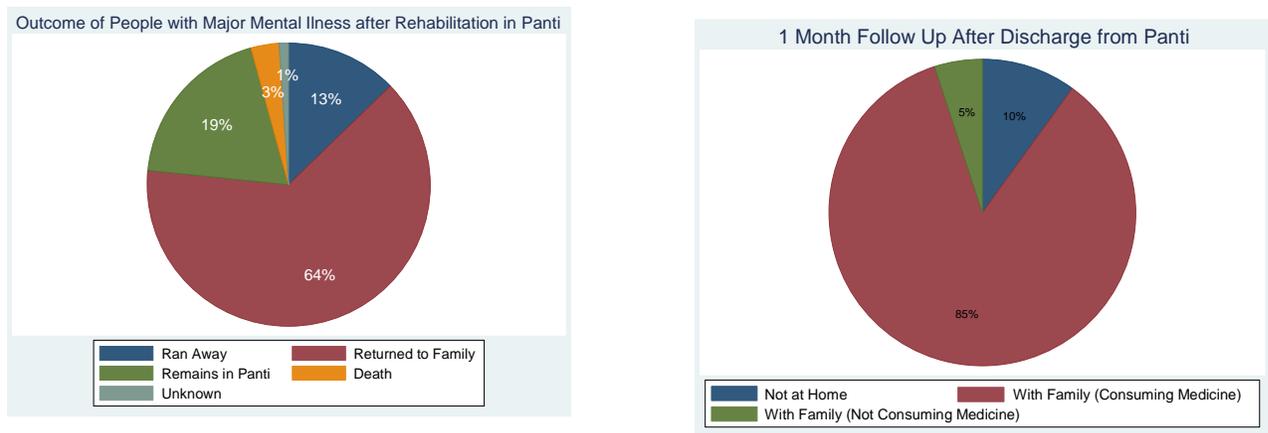


Figure 6. Outcomes of Panti Rehabilitasi

### Salvaging Through Recovery

Figure 6 shows the outcomes of a cohort of 94 people who underwent rehabilitation. A substantial portion (60) of the cohort finished rehabilitation and was returned to the family. Although a

significant number of the patients ran away (13) or remains in *Panti Rehabilitasi* even after the stipulated six months regimen. There were even three deaths in the cohort, all of whom had undetected infections which became severe generalized infections, a testament to the poor quality of care even as patients get regular monthly follow-ups by psychiatrists and are under care of a state-run institution.

The cases in this piece along with the data shows that, despite the prevailing sense of failure that one experiences in *Panti Rehabilitasi*, one continues to struggle through the constant pushes to “stabilize their emotions” even as terrible whispers scream at you, as in the case of Nur. Or in the case of Joko, even as one is pushed to be grateful for his violent past and the suffocating poverty he lives in, he is still able to push himself through rehabilitation because it would mean access to medicines and food. Against all odds, a tough selections process, a looming sense of failure and shame reproduced by caregivers, patients still salvage themselves through the process as these are the only discourses that allow them access to materiality of care.

Against a backdrop of very limited resources (Human Rights Watch, 2015), caregivers whether social workers, trainers, or psychiatrists rely upon “productive” as an imaginary of recovery to provide the material resources for care. Discourses of the family and of individual productivity are cited as patients and caregivers participate in economies that salvage them through this imaginary of recovery (Biehl, 2005). Ultimately, the “containment” of madness, even as one completes rehabilitation lies within the family. Data of one month of follow up after returning to the families, as shown in Figure 4 shows that even as majority of patients remain with their families consuming medicine, a significant number of patients cannot be “contained” either because they ran away or don’t want to consume medicine.

I end this piece by describing the story of Suhli, a resident in *Panti Rehabilitasi* who remains in limbo within the institution. I end with Suhli to show how difficult it is to “contain” madness. Suhli was twenty years old when he started feeling what he described as “agitated.” According to him, this sense of agitation came after he was rejected by someone he loved, a young woman in his urban settlement who ultimately married a man with more money. At the time, Suhli was also facing difficulties finding a job. He was pressured to become the breadwinner of the house, supporting his two younger brothers because his father had just suffered a stroke which left him bed ridden. His father’s affliction pushed the household which was previously enjoying stable income to poverty. Surviving for the next few years relied on incurring debts. Suhli managed to get a few jobs in construction and even in garment factories, but none of his employees allowed him to work long term because he was often involved in conflicts. He would pick arguments with his colleagues and that often leading to dramatic fist fights. On one such occasion, the police were involved, and the family had to pay for the victim’s medical care.

Suhli’s agitations progressed to what he and other would call “ngamuk” (Good, 2012). During these states, Suhli would feel as though he was possessed. He would inflict physical violence to anyone that would come in his way. In his words, “It was not that I couldn’t remember what was happening. I knew I hated the person I hit. It was as though my rage took over.” His family and neighbors characterized Suhli as always being suspicious. He accused everyone of talking behind his back, for thinking bad about him. Suhli never revealed to me that he heard voices, but he did say that as he grew older, he had a strong pressure in his head and a sense that everyone was against him.

It was not until, at the age of 32 that Suhli, suspecting his mother had spoken badly about him to his neighbors, beat his mother. She sustained a fracture in her hand. This incident

prompted the whole neighborhood to arrange for his immediate treatment in the mental health hospital. Suhli spent 3 months in the hospital. His family had to be convinced by hospital staff to take him home.

Suhli was very hurt to know that nobody wanted him back. His treatment had generally stabilized his mood and he would not have acute psychotic episodes, but he felt sad. He had low energy and preferred to withdraw himself from any conversation. “At the time, I felt betrayed. I felt alone, nobody cared. I had nothing to live for,” said Suhli.

After much pushing from the hospital nurses, his family accepted him back home. During his time home, Suhli did not socialize with others. He used to go out on excursions to the city. Suhli’s youngest brother and his mother was in charge of his care. After about 3 months of discharge from the hospital however, he became hesitant towards medication, often screaming and breaking objects when pushed to take them. Despite that, neighbors and his family would tolerate his behavior mainly through avoiding contact.

Suhli’s mother died of pneumonia a year later. “Nobody knew it, but I was very sad when she died. I was depressed and angry...I never made her happy,” he shared. The death of his mother led to further isolation and anger. Suhli became hostile to his brothers, who at the time were both newly married and were working hard supporting their own families. Suhli was left on his own to live in the old house, while his brothers built new houses a few meters away.

“In isolation, I was like in my own world...I didn’t feel hunger...Food was to be provided by my brothers at the door step...I was down...there was a shadow...and I wanted to hit my head with a brick...I wanted to be hurt, “ said Suhli, recounting the isolation he felt after his mother died. A few months after his mother died, Suhli fell into a fight with neighbor whom in Suhli’s opinion wanted to kill him. Shortly after the fight, Suhli broke into his neighbor’s house

at night and hit him with a brick until he died. In the wake of this violence, his neighborhood called the police who sent him to the mental hospital. His community decided in a written statement with 60 signatures to never allow Suhli in their area.

Seven months after the incident, Suhli sat by the steps of the administrative building in *Panti Rehabilitasi*. He was bald, looked thin in a large t-shirt and was staring at the cracked old floors of the building. He had visible scars in his hands and legs and gave out a smell that indicated he had not showered for days. Many social workers approached him and tried to converse with him as they come in and out of their offices. He would respond with a smile and an occasional word or two. He seemed nervous. He was awaiting his brother.

Claiming that his family and their neighbors don't know what mental illness is and when properly educated will accept Suhli, his social worker arranged for the family to meet Suhli once in a month. "They [Suhli's family] just need education. We have rehabilitated him already, he is able to suppress his emotions. We tamed him," explained the social worker.

Suhli's brother walked in the building with his six-year-old son. He brought some cookies and cigarettes, giving them directly to the social worker. Suhli kept his head down while his brother talked to the social worker to ask her how he was. The social worker insisted that Suhli answer the question. He responded with "I am okay," in a soft tone. The social worker insisted that the boy shake Suhli's hand. The boy hesitated, looking terrified at the idea of coming to close to him. The boy looked at his father, the father smiled at the social worker, who pushed further and said, "It's okay, the boy can go close to Suhli." The father carried the boy and brought him close to Suhli. The boy put out his hand while looking at his father, refusing to look at Suhli.

Privately, Suhli's brother revealed to me that it was extremely difficult for him to take on the burden of hosting and caring for him. "How could I do it? How could we forget what he has done in our place...The trouble he caused my mother and the family," he said, explaining that caring for Suhli was extremely painful for him. "I can bring him food once in a while in *Panti Rehabilitasi*, but I want him away from my family. He has done enough to cause us a lot of trouble," he said. Despite being aware of his brother's illness, he would still prefer his brother receive care somewhere else outside his home. "I hope you understand ... We are not bad people... We are also struggling to survive... We cannot do this... Can you please explain to the social worker?"

Meanwhile, Suhli privately also explained to me that he wanted to move on from his family. "When I see them, I remember the horrible person that I am... I feel destroyed and ashamed ... Ashamed of what I have done... What I have become," explaining that if he went home he feared that he would inflict more violence. "I am stable here... I cannot go back home... I'm scared I will do bad things again," said Suhli.

In between both these demands, I tried to reason with his social workers, hoping to find Suhli another place after he is finished his rehabilitation. The social worker acknowledged that Suhli was not ready to be returned to his family but insisted that, in time, the family would accept him. Up to the time of writing, Suhli remains in *Panti Rehabilitasi*.

## **Conclusion**

Suhli's case is a profound testament to the difficulties in caring for people with major mental illness. Rehabilitation via *Panti Rehabilitasi* ultimately leaves the responsibility of caring to the

families. Patients are asked to contain their madness within them and their legitimate kin relations only to find that, within their homes, there is no support. Access to quality care and support within households remains difficult, yet families try to contain madness in an effort to provide care.

## **Conclusion: Madness in Communities**

### *Containing Madness in the Household: Ethnographic Fragments*

In this thesis, I have documented the many cases and conditions that make it difficult for families to contain madness. As Part I of the thesis documented, medical care for major mental illness is chiefly delivered in primary health centers that cater towards families in households. One has to be “made into subjects” within families to have accesses to medical care. Moreover, the ethnography of *Panti Rehabilitasi* further revealed that the ultimate goal of recovery—imagined by state institutions—is the containment of madness within families.

As the manager in Panti Rehabilitasi put it, “Ultimately, the responsibility of care is with the family.” State institutions go to large lengths to make sure this is the case. Ultimately, the making live and letting die occurs at homes. Even as immanent dependencies with social workers attempts to provide care by drawing on the possibility of indeterminacy, social workers are constantly pressured by their supervisors to “create subjects of care” or “make productive patients.” These activities outsource the containment of madness to the relationships of kin.

Mental health problems in Indonesia are often painted as violations of human rights in institutions (Human Rights Watch, 2015), where people with major mental illness are often described as “abandoned” by their families. In this thesis, I have taken a slightly different route and instead highlight the conditions under which madness fractures relationships of kin. Relations are often reconstituted, sometimes violently, by the institutions I describe. Not dismissing the difficulties that letting die can be on the everyday life of these institutions, I hoped to have shown that the responsibility of preserving life is mostly outsourced to families and communities. At the same time, managers of these institutions downplay the immense difficulties families go through to care for people with major mental illness.

Will Ragil be accepted in his brother's home? Will Suhli be forced to live with his family? Will Daining find a place? Will Bambang continue to stay in Camp Assessment? These are questions that haunt me. What haunts me most however, is the thought that communities and families bear the biggest burden for the containment of madness. What happens when madness cannot be contained? How do families and communities continue to forge fragile relationships that are constantly threatened by madness? How do we create conditions that make enduring or containing madness bearable? These are questions I hope to explore further outside the premise of the thesis.

I end the thesis with ethnographic fragments of my interactions with a family. I end with these data to give some sense of the difficulties and struggles of containing madness in communities.

### **Hidden in Sight**

Rizal was picked up from the streets and brought to Camp Assessment two months into my research. The police who picked him up characterized his capture as unusual. "Rizal looked really confused and withdrawn from his surroundings. We were called by people in the vicinity because they were worried about him. We tried communicating with him, but he would not respond and continued to look confused," explained the police officer.

To his social workers surprise, a week into his stay in Camp Assessment, Rizal was already communicative and able to recall where his family was. He was very responsive to anti-psychotic medication. Rizal was in his thirties and after a week of medications was deemed as

“eks-psikotik.” Rizal did not want to undergo rehabilitation and wanted to return home to his sister and her two children. Without much hesitation, his social worker arranged for Rizal to be sent back home.

I asked Rizal, his sister, and his social workers if I could follow his return and visit their house. “Please, come. Our house is near Sheraton hotel. But I am sorry...I cannot prepare food. My hands are swollen,” said Tuminah, Rizal’s sister over the phone.

“Don’t worry. I will bring food and check your hands,” I replied.

Rizal was shy and did not want to talk much while he was in Camp Assessment. In the week he was staying in Camp Assessment, he did, however, go with me on walks around the compound. During these walks he would tell me that he loved his sister and needed to be there for her. He shared that he loved going on nightly excursions. He needed to walk around the area in the night to clear his mind. “I like walking at night. Sometimes I sleep in the roads, sometimes in the field. I walk to clear my mind,” said Rizal. However, even after my probes, he would not reveal to me what it was that needed clearing.

It was a blisteringly hot afternoon. I had planned with Rizal’s social worker to participate in his reintegration back to his family. She arranged a car and, after buying lunch for Rizal’s family, we were headed to his house. We drove past the large complex of the Sheraton hotel and just adjacent to the expansive garden that surrounded the hotel, there was a road leading away from the city. The road, barely fitting the size of our car took us up towards the north of the city. As we passed the large complex of the Sheraton hotel, we found ourselves surrounded by fields. Rizal stared out the window and shared, “I like to walk in these fields, in the night the sound of the frogs and the breeze is really calming. I unpack myself and sometimes sleep in the fields.

Sometimes I walk all the way to the hotel and hear the sound of cars. I like to just sit by the road and see cars passing.”

After about ten minutes, we arrived at an old statue of a woman holding her infant. Inscribed underneath the woman were the words “two children are enough.” 20 years after the fall of the authoritarian New Order regime, its presence was looming in the village. Beyond the point of the statue, the road did not fit a car. We decided to walk from that point. We walked down the fields and entered an area concentrated with houses. As we were walking, neighbors would greet us. One said, “Rizal! You really made your sister worried.” Another said, “Rizal! Did you go out on an excursion again?” Rizal would not respond any of his neighbor’s greetings.

We walked to the most unkempt area of the cluster of houses. An old small house with cracked walls stood out from the other freshly colored houses. We walked up to the house and knocked at the door. Tuminah answered, “I’m coming.” We waited outside for about five minutes while she walked to the door. With every step we could hear her moan in pain. A thin frail woman with severe deformities in her hands and feet walked out. Tuminah had severe rheumatoid arthritis.

We let ourselves in and sat down in the main hall of the place. That was the only room in the house. Rizal, Tuminah and her two boys slept in the floor of the hall. As we settled down, Tuminah said, “I’m sorry the house is dirty. Because of my condition I cannot clean the house. I also cannot make food for you.”

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Tuminah previously enjoyed stable income in Jakarta where her husband worked in a factory. Three years after her second son was born, however, her husband died in a tragic incident in

his factory. Tuminah was left caring for her two children by herself. After receiving some compensation from the factory, she decided to move back to her native village and live with her father and brother. At the same time, she was also progressively getting weaker and having pain in her hands and legs. She did not have the energy to work or help in the house. As her disease progressed, the pain became increasingly intense. Tuminah tried several things to relieve her pain. She went to a traditional massage therapist and several general practitioners. It was not until her condition made her unable to walk properly that she went to a specialist. She was diagnosed with rheumatoid arthritis and underwent long term care. She used all her savings for her treatment.

Rizal, according to his neighbors and sister, was always shy and quiet. He did have some friends when he was growing up, but things began to change when he had a falling out with his girlfriend when he was nineteen. After the falling out, Rizal would not socialize with his friends and would remain in his room all day. He would only speak and eat with his family. Around the same time, his mother's health deteriorated to the point that she was bedridden. While Rizal's father was working and Tuminah was in Jakarta, he was the one who took care of his mother. They discovered that Rizal's mother had breast cancer that has spread all over her body. She was offered palliative treatment in the hospital but refused and wanted to die on her own terms at home. Rizal feed, bath and took care of his mother. She died a few months after she was diagnosed. After her death, Rizal withdrew himself from activities. He did not eat much and lost a lot of weight. He also started going on late night excursions.

As time passed, the excursions became more frequent and his weight reduced significantly. His community and family characterized his withdrawal from daily activities as "trauma." "He was traumatized. We have to give space and allow him to go on excursions," explained his

neighbor. They tried asking a local religious leader to talk to him, but it did not change his behavior. Rizal was brought to a general practitioner several times, but they would just give him vitamins.

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Tuminah's pain intensified and she could not bear it. I went with her several times to see a specialist, but she would not want me to buy her medication. She took pride in her enduring without the need for other's help. That day however was unusual, she texted that she wanted to speak to me. I arrived at her home a few hours after she texted. It was Sunday and I had never visited them on weekends because Tuminah would be busy with her kids. Her children went to an Islamic boarding school and would only be home on the weekends. It was very unusual of her to ask me to come that day. The sun was at its peak, and as soon as I arrived to the house I noticed something unusual. Despite experiencing severe pain, she always made sure her house was somehow clean and prepared tea for visitors. This time, the house was unkempt with clothes lying in the floor. Mattresses sat on the floor unfolded and unfinished food laid in the kitchen sink.

"Sorry, Sandeep, I did not clean my house and prepare food for you," she said.

"It's fine, Tuminah, I hope everything is okay with you," I replied.

"No...I just wanted to talk with you in private. Is that okay? Should we go outside?"

"Sure, but aren't you in pain? Can you step out?" I replied.

"No, I can bear this. I need to speak to you," she said.

Tuminah was in distress. She just had an argument with her son. Her son wanted new shoes so that he could play soccer with his friends and Tuminah had no money for it. She spent the month's savings for Rizal's treatment and her own medical care. "Why doesn't he understand? We are all suffering. I need his support. I cannot afford to buy shoes. It's very expensive.

I still love him. But I cannot do it,” said Tuminah. Her son was in an Islamic boarding school and playing soccer was a major part of their extracurricular activities. Tuminah could barely pay their school fees, and the school gave their family tuition waivers.

Tuminah felt isolated and alone. “Everyone hates me. Rizal has his own problems and never talks to me. I never know what is going on in his mind. My sons hate me because I can’t provide them with what they want,” she explained. Tuminah felt a deep sense of failure. She felt that she could not provide for her children. She was also extremely worried about Rizal. “He will not talk to me. He will not tell me what is bothering him. Whenever he is stressed he would just go out on excursions. I wish he could tell me what was troubling him,” she said. Tuminah felt that meeting the responsibilities of maintaining relationships in the household was extremely difficult. Her children grew hostile and distanced as she was unable to meet their demands. Her older son was particularly affected by his inability to be like his peers. He would get into arguments with Tuminah.

“He likes to shout at me all the time. Everyone can hear it. I feel ashamed. Everyone knows that I am a bad mother. That our family has conflicts, that we are not harmonious,” she said.

“Tuminah, you really need to think about your health. We should get your assistance from the state,” I replied

“No, Sandeep. I cannot ask help from anyone. It’s my responsibility,” she said.

“Tuminah, getting health is your right. Even I have the insurance. Allow me to arrange something to help you.”

“You know, Sandeep, the pain in my joints is nothing compared to the disappointment in my heart. I feel so much pressure. I feel alone in this. I just have God. I have to be patient. God will help us. Thank you for hearing my complaints” she said.

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After Tuminah moved back to Jogja, she worked for a short while selling cakes in the local market. Rizal never worked. He would rarely go out of the house. He spent his time working cleaning the house and the neighborhood. Rizal’s main social activities would often only be village cleaning gatherings where members of the village would clean public areas together.

Tuminah’s small business was flourishing for the first few years; however, as her physical condition worsened, she was unable to meet the need to cook more cakes to sustain the business financially. She decided that she would invest in making a food stall. She hired her an assistant and was able to quickly get some return on her investment. However, just as she was able to muster enough money to get proper specialist treatment, the economy fell into a recession. The 2008 global economic recession hit her business, and in the next year Tuminah was forced to close down her food stall.

Fortunately, the setback in Tuminah’s business did not push her family into poverty. Her father had a stable job as a driver in a hotel and continued to support the household. As time passed, however, her father developed diabetes. Unfortunately, he developed a diabetic foot ulcer before he knew he had a disease. He was unable to continue working as a driver. Rizal’s family survived based on savings and retirement compensation from his father’s work place. Within a year of his diagnosis, Rizal’s father’s physical condition deteriorated and two years before I met Rizal in Camp Assessment, his father died.

With the death of their father, Rizal and Tuminah were left with no source of income to sustain the household. They resorted in borrowing from neighbors to survive. Rizal had deep desires to support the family and work but would always say he needed to work through something in his head.

“This head of mine needs to straighten out. I need to help my family,” said Rizal.

“What do you mean? Do you hear voices?”

“No, I don’t hear voices. But I have to fix my head. I need to work with my brain. My brain goes everywhere,” he replied.

Meanwhile, Tuminah’s children was struggling with the financial conditions of the household. Her older son found it hard to deal with the new reality. He felt that what happened with him was unfair. He was angry at the conditions he was in, unable to meet the demands of consumption. “I hate that we have to be like this. God is punishing us. I hate my life. I just want to finish school and run away.”

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Rizal would not give clear accounts of what was troubling him. He insisted that he had to work through the troubles in his head, and that required remaining in the house. “My mind is filled with bad thoughts. I need to work through it. I need to be with myself,” he explained. I asked many times if there was a voice haunting him or if I could help him work through what was going on in his mind, but he would just say that “his mind needed straightening.” In Camp Assessment, Rizal consulted with a psychiatrist for the first time and was diagnosed as having major mental illness. “The medicine makes me think clearer. It helps me. But I cannot get the medication at home,” he remarked.

Before his time in Camp Assessment, he did not know that he had major mental illness. “It was just my mind. I thought it was because I did not have enough vitamin for the brain. I did not think it was broken. The doctor in the clinic told me that that my brain has a disease. I can fix it with medicine,” explained Rizal. The medical naming of his condition changed Rizal’s outlook of his future. “The doctor said that with that the medicine will help me work through my problems in the head. I did not think that was possible. I thought the problem will stick with me.”

I probed Rizal several times to tell me what was bothering him. He would just respond by saying that the thoughts in the head were bothering him. Rizal was given medications for one month after discharge from Camp Assessment. After the month, Rizal was expected to get his medications from his local primary health center. Rizal was very disciplined with his medication. “I am not even one minute late, I take the medication every day.” Despite his “compliance” to medications, he would still voice out the problem in his head and he would still go on excursions. I did not get some sense of the problems in his head until he asked me to join him on one of his excursion.

The rain had just subsided, and the roads were filled with pot-holes covered by water. I had visited Rizal and Tuminah to check up on them. When I arrived, I noticed Rizal looking visibly distressed. He was rubbing his thighs and hitting his chest.

“See, Sandeep, he is stressed but will not tell me what is bothering him,” said Tuminah.

“Hi, Rizal. What’s wrong? Is there anything I can do?” I said.

“I want to go out,” said Rizal.

“Why don’t you want tell me what is going on, Rizal? It really hurts me,” said Tuminah.

“Rizal, do you want me to go with you? We can speak about what’s bothering you,” I said.

“Yes, Sandeep, go with him. Help me find out what is troubling him,” said Tuminah while wiping away her tears.

“Okay,” said Rizal.

Rizal and I went for a walk. He guided the way through padi fields and roads. We walked about one kilometer into the depths of the fields. Rizal guided me along a narrow path by the bushes and said, “I made this path myself. It leads to a space I created for myself.” We walked for about 500 meters into the bushes and found a space Rizal had carved out for himself. Rizal had several scraps of wood lying in the space. He had also collected bottles he found from the street and put them in the corner of the space. He had cut some bottles up in half, filled it with water and put cigarette buds in them.

“I keep the cigarettes you buy for me here,” he said, showing the packets of cigarettes lying on the grass.

“Is the space where you do the thinking?” I asked.

“Sometimes,” he answered.

Rizal revealed to me that he comes to this space whenever he thought about his mother. “I miss my mother...I wish I could have done more,” he said, while staring at the empty fields adjacent to us. Rizal came to the space whenever he needed some respite. “I come here, and I sing...I cry...I smoke cigarettes,” he explained. Rizal’s thoughts were occupied by his mother and he would go to this space to remember her. He pointed out pieces of cloth stained with dirt in a corner of the space, “My mother wears red just like this. I cut this from a banner. I wish she accepted her.”

Rizal talks about this woman who was not accepted by his mother, but up to that point I did not know who she was. I probed him several times to find out who this woman was, but he

would not reveal the answer. He would instead just emphasize the fact that his mother never accepted her.

It was not until I shared with him my personal story of the loss of my own mother, that he shared who this woman was. “My mother never liked Ani. She was the woman I loved but my mother never liked that. She never forgave me for loving Ani. My mother hates me for that.” Rizal never allowed me to bring this topic up to his sister. He would also not reveal any details about Ani. Rizal felt the presence of his mother. “I feel her [Rizal’s mother] anger...It’s right here [pointing at his chest]...Oh, not there...But here [pointing at his head].”

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The medical naming of Rizal’s condition increased the responsibility of Tuminah. She initially thought that Rizal’s condition was a consequence of “trauma” from their mother’s loss. Rizal was always shy, and she thought he had not “moved on” from their mother’s loss. However, with the information that Rizal had some form of major mental illness, Tuminah had to arrange care for him. Rizal wanted medication and medical treatment. “The doctor in Camp Assessment gave me hope. She said I can work through the thing that is in my head if I had medication,” said Rizal.

I insisted that we help the family get registered into the national insurance program (Ministry of Health, 2014), but Tuminah was adamant that she did not want to burden me with that responsibility. I then tried to at least get Rizal some care from the primary health center. However, it turned out the doctor at the primary health center asked us to do a host of lab tests in a city laboratory. Although the drugs from his primary care would have been free, we had to pay out of pocket for the lab test, as Rizal did not have health insurance.

Tuminah and I were able to muster up enough money to get the lab tests done. The lab test revealed that Rizal had slightly high liver enzymes and the general practitioner at the primary health center was afraid to prescribe antipsychotics and suggested we consult a specialist at the district hospital. Rizal was very disappointed that he did not get his drugs from the primary health center. “They won’t give me the drugs. I won’t be able to fix my head. I don’t know what to do. Should I go back to Camp Assessment?” he remarked. Because the primary health center denied him the drugs he wanted, he went on excursions more frequently. He had lost the hope the doctor in Camp Assessment instilled in him. “I don’t think I can ever get away from this crazy mind. This thinking will persist forever,” he said.

Meanwhile, Tuminah’s pain was intensifying. She could barely get up and walk. She laid in her bed all day. Fortunately, neighbors knew that Tuminah’s pain intensified, and brought food daily. Everyone in her community knew that Tuminah and her family were in dire need of social support. The head of the village had written the letter to the district social welfare office but did not hear back. To help Tuminah’s family, the village community decided to share the welfare rice support the community received from the state. Officially, only households listed as being impoverished are given rice assistance. The community decided however that they would pool all the rice together so that Tuminah would get a portion.

Tuminah was aware that her community went out of the way to help her. She did not like this special attention, but could not deny the assistance.

“Everyone is going out of the way to help me and my family. I don’t feel nice,” she said.

“You deserve direct services from the state. Everyone knows that. Somehow you are not in the state’s list that is why you don’t get it. Everyone is just attempting to give you what you deserve, Tuminah,” I said.

“Is there a way for me to be in the list and get it officially?” she asked.

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Nobody in the village knew why Tuminah’s family was not registered as a social welfare recipient. If she were on the list, not only would she get social assistance, medical care for both Rizal and Tuminah would be covered. The head of the village tried several times to certify Tuminah’s household as poor, but despite that, the household was not registered. “Rizal was by classmate in school. We really care about his family. I have tried many times, but I am always unsuccessful in putting the family into the list,” explained the head of the village.

Technically, the village leader is responsible for identifying households that need social assistance (Ministry of Social Affairs, 2008). Despite several letters issued by the head of the village certifying that Tuminah’s household was eligible for social assistance, she was unable to access it. It took a bit of detective work on my part to find out what was happening. After some investigation that included visiting the district department of social affairs and the civil registration office, I got some sense of the issue.

Poverty data in the district were updated yearly and required a cumbersome process of verification. Social workers from the sub-district offices had to physically verify whether the household met the requirements of social assistance. There had been no coordination between village leaders, social workers at the sub-district level in charge of maintaining data, and district social welfare office that was in charge of distributing the assistance. Tuminah’s paperwork had been lost for two years in communication between these stakeholders.

I brought these stakeholders together digitally via text message. In no time, Tuminah’s paperwork was arranged and she was registered into the system. Because the systems updated

itself yearly, Tuminah would get her social assistance only in the next year. Meanwhile, she endured through the help of her neighbors. Being registered as receiving social assistance meant that health care was also covered by the state. Rizal and Tuminah had to wait until the next year to access some care.

The ethnographic fragments I have woven together in this conclusion highlight the enormous struggles that one is put through to contain madness in the household. Conditions make containing madness—even if the symptoms were not as dramatic as the others I have described—extremely difficult. However, I hope these fragments also show that there are opportunities that we can work on to help families contain madness. Throughout the thesis, I have demonstrated how state institutions outsource the labor for the containment of madness to families. Yet Rizal’s case shows that within the households, families have to struggle to get access to resources that could help them contain madness.

Families and communities bear the biggest burden for caring for people with major mental illness. While state officials downplay the immense difficulties of containing madness within the household, the resources that communities and families can draw on remain minimal. Although families still draw on support and resources from their neighbors and communities, containing madness still remains a struggle. Without resources—whether medical care, social support, or community-based recovery programs—communities are not able to bear the burden of containing madness. The available discourses in which rehabilitation is anchored perpetuates the difficulties and reproduces shame to families that cannot contain madness within the household. And yet, even with this immense responsibility, families still scavenge to contain madness. Help-

ing families and communities by creating community-based programs that leverage all the available resources and help families coordinate care could do so much in helping families contain madness.

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