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# Cultural Idioms of Distress as an Example of the Social Distribution of Health – The Case of Javanese *Ngamuk*

The aim of this article is to look at the phenomenon of the social distribution of health in terms of differences in the relative perception of diseases, including their symptoms. The author presents this phenomenon using the example of *ngamuk* illness. It is considered to be characteristic of Javanese culture, similar to *amok*, characterised by extreme physical aggression (including homicide). The empirical basis for this article is the results of an ethnographic field study conducted in the grounded theory strand in Yogyakarta, Indonesia, in 2019–2020. The data come from 31 individual in-depth, semi-structured interviews on the cultural image of mental illnesses. Western medical practitioners, traditional healers and students participated in the interviews. What emerges from the Indonesians' statements is the social image of largely the mentally ill person as one who displays aggressive behaviour towards others, including murder. The results indicate that although none of the interviewees used the word *ngamuk* when describing mental illness, the symptoms cited were close to the symptomatology of the disorder. Juxtaposing the results with other studies in the field of cultural perceptions of illness, the author concludes that the social perception of mental illnesses is strongly culturally-relativised. This also means that the view of illnesses is socially distributed, as exemplified by *ngamuk*.

**Keywords:** mental illness, *ngamuk*, Indonesia

## Introduction

The social distribution of health is sometimes viewed as a phenomenon of inequalities related to morbidity, the course of illness or the presentation of symptoms. This phenomenon can also be considered in a different way – as disparities in the relative perception of illness. Differences in identifying and talking about symptoms of mental illness are the subject of this article. In the study, I analyse

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which symptoms of mental illness are talked about by Indonesian Javanese people and to what extent one can talk about the perceived prevalence of *ngamuk* in this cultural circle. The text looks at Indonesian society and outlines the symptomatology of mental illness in other cultures, in particular the phenomenon of culturally determined illness. I consider how the results of my empirical study can be related to previous reports of *ngamuk* morbidity in Java. I provide some examples of the different symptomatology of mental disorders across cultures, discuss and debate the concept of cultural idioms of distress, and present the results of my own research conducted in Indonesia, considering how they relate to the phenomenon of the social distribution of health. I show to what extent culture matters in perceiving, assessing and describing health and illness.

## An anthropological view of health

The study of the social distribution of health is closely linked to anthropology, as this discipline recognises health and illness as culturally-relativised phenomena. Medicine is a system of symbolic meanings embedded in the conditions of social institutions and patterns of interaction. Not only patients, but also physicians and healers are entangled in a system of cultural meanings and placed in specific configurations (Kleinman 1980). According to Kleinman, the health care system is formed by collective beliefs and shared practices operating at the local level. This system is perceived and used differently by individual social groups, families and individuals (Kleinman 1980). The beliefs and behaviours that constitute symbolic activities within the health care system are influenced by social institutions (e.g., hospitals, trade unions), social roles (e.g., physician), economic and political constraints as well as other factors, in particular available treatments and the type of illness (Kleinman 1980). The phenomenon of illness perception is aptly summarised by Fabrega: “Beliefs about illness are thus examined in terms of the cultural themes and organised behaviours of the group. An underlying assumption of course, is that the group does not share the prevailing Western biomedical view of disease and medical care” (Fabrega 1974: 4). The perception of diseases is thus closely linked to the beliefs found in the community (Twaddle 1973: 753).

Even between groups within the same society, different perceptions of mental illness can be observed (Brodniak 2000). These differences become even more apparent when comparing Western cultures to more distant ones. Non-Western cultures are characterised by greater collectivism, which is also reflected in the perception of the mentally ill by those around them. A study in China showed that conditions that are described as mild mental problems in Western psychiatry are not classified as mental health-related as long as they do not impact relationships with family,

neighbours or friends. They have often been seen as stemming from difficulties functioning in a collective culture – for example, being unintegrated into society or not having friends (Kolstad, Gjesvik 2014). Various researchers have also highlighted that the clear division between physical and mental illness found in the West, is not so obvious in non-Western cultures (e.g., White, Marsella 2012: 17). Cultural conceptions of mental illness or mental health refer to "*common sense* knowledge which is used to interpret social and medical experience, and which plays an important role in shaping both professional and *everyday* views of mental disorder" (White, Marsella 2012: 3).

## The social distribution of mental illnesses – research to date

In the case of mental illnesses, as with all other illnesses, we can speak of their social distribution, understood as their unequal prevalence in society and, moreover, their different symptomatology and perception. The phenomenon of the social distribution of health can be considered both within one society and at a cross-cultural level. What may be considered a symptom of illness in one culture may not necessarily be defined as such in another. Loss of appetite is an example of this. Among people in the upper social class in the United States, 75% of people recognise loss of appetite as a symptom of illness, in the middle – 50%, and in the lower social class only 20% (Kobierzycki 2011: 158). Emilia Jaroszewska, on the other hand, notes that in non-Western cultures "depression is more often reduced to psychosomatic symptoms such as fatigue, anorexia and decreased libido", while schizophrenia in developing countries has a much milder course (Jaroszewska 2013: 74).

Researchers and scholars have been demonstrating for years that non-Western societies construct concepts of mental illnesses quite differently from Western ones. According to Adebayo Olabisi Odejide et al., Yorubas in Nigeria indicate the following symptoms of disorders that would be diagnosed as depression in Western medicine: "crawling, heat, peppery sensations, numbness, and vague aches and pains all over the body" (Odejide et al. 1989: 711). The Gandas of central Uganda, on the other hand, distinguish a number of types of mental illnesses, which, according to Vikram Patel, overlap to some extent with those distinguished by Western researchers (Patel 1995). Theodore T. Bartholomew studied popular conceptions about mental illnesses among members of the Ovambo tribe in Namibia. When asked about the symptoms of mental illnesses, his interviewees mentioned: inappropriate behaviour, aggression of people with mental disorders towards others, insulting other people, hearing non-existent sounds and seeing non-existent people, running quickly from place to place, thinking too much, talking all day or saying things that do not make sense, isolating oneself, talking to oneself, abusing alcohol, looking for food in rubbish bins (Bartholomew 2017: 428). Many other researchers

have described how mental illnesses are experienced in non-Western societies and how much this experiencing is culturally-relativised (e.g., Patel et al. 1995; Opare-Henaku, Utsey 2017; Ventevogel et al. 2013).

## Culture-bound syndromes and cultural idioms of distress

The social distribution of mental health can manifest itself not only in the different course of illnesses depending on culture, but even in the occurrence of certain illnesses exclusively in particular societies (e.g., Jakubik 2003; Krzyżowski 2002; Yap 1962). Such mental illnesses are most often referred to as "culture-bound syndromes" (Jakubik 2003: 139). According to Yap's definition, culture-bound syndromes have unique symptoms that are determined by cultural factors (Yap 1962). Wen-Shing Tseng characterises culture-bound syndromes as follows: "mental conditions or psychiatric syndromes whose occurrence or manifestation are closely related to cultural factors and which thus warrant understanding and management from a cultural perspective" (Tseng 2006: 554). Among such conditions, *koro* and *susto* are often mentioned (Krzyżowski 2002: 55).

Culture-bound syndromes are included in the DSM-IV (Diagnostic and Statistical Manual of Mental Disorders) wherein they are characterised as follows: "The term culture-bound syndrome denotes recurrent, locality-specific patterns of aberrant behaviour and troubling experience that may or may not be linked to a particular DSM-IV diagnostic category" (American Psychiatric Association 2000: 898). However, in the DSM-5, culture-bound syndromes have been withdrawn and replaced by: *cultural syndrome*, i.e., "a cluster or group of co-occurring, relatively invariant symptoms found in a specific cultural group, community, or context" (DSM-5: 14); *cultural idiom of distress* – "a linguistic term, phrase, or way of talking about suffering among individuals of a cultural group (e.g., similar ethnicity and religion) referring to shared concepts of pathology and ways of expressing, communicating, or naming essential features of distress" (American Psychiatric Association 2013: 14); and *cultural explanation or perceived cause*, which the DSM-5 contributors define as: "a label, attribution, or feature of an explanatory model that provides a culturally conceived etiology or cause for symptoms, illness, or distress" (American Psychiatric Association 2013: 14). Importantly, the authors emphasise that all illnesses included in the DSM-5 have a cultural component, and even conditions such as depression or schizophrenia can be experienced differently depending on the culture.

In fact, from the moment Yap presented the concept of culture-bound syndromes, it was questioned. The arguments of critics have focused on the fact that it is impossible to attribute a syndrome to a particular culture and that the incidence

of some diseases is not as culturally limited as the concept assumes (Isaac 2013: 357; Ellenberger 2020: 143). Tseng notes that international disease classifications were created in the Anglo-Saxon system and based on the experience of diseases by Western societies. Any conditions that ran differently were seen as "peculiar" or "exotic" (Tseng 2006: 556). In addition, the prevalence of some diseases that were judged to be culturally relativised is extended by globalisation and the influence of the media. Anorexia is a case in point (Kaiser, Weaver 2019: 590). The process of globalisation also makes the boundaries between different cultures blur, so that it becomes increasingly difficult to attribute a particular condition to a particular culture (Ventriglio et al. 2016: 4). Reporting on the debate, Janusz Krzyżowski writes that representatives of critical voices believe that it is not always possible to speak of a specific, relativised syndrome of a disease – sometimes only single symptoms occur and certain symptoms may present in many different cultures, just not in those in the Western world (Krzyżowski 2002: 56). Furthermore, as Tseng points out, sometimes behaviours that should not be classified in this way at all, such as *latah*, are considered as diseases (Tseng 2006: 559). It should also be noted that, from a diagnostic point of view, it is crucial to distinguish between culturally relative symptoms and the illnesses as a whole, that are limited by their incidence to a particular culture (Tseng 2006: 566). In the debate on the relativity of illnesses, there are also claims that what to date have been called culture-bound syndromes by some are actually just culturally relativised symptoms of universal illnesses (Ellenberger 2020: 144).

## *Ngamuk* as a culture-bound syndrome?

To illustrate the phenomenon of the social distribution of mental health in Indonesia, I use the example of Javanese *ngamuk*. *Ngamuk* is a syndrome similar to *amok*, found in the people of Java. According to Andrzej Jakubik, *amok* is "a short-lasting state of acute excitement, constriction of consciousness, physical aggression (up to and including homicide), usually ending in sleep or stupor with amnesia of the disturbed period" (Jakubik 2003: 143). *Amok* can be triggered by a state of extreme embarrassment (Tanra, Roosdy 2017: 187). According to Jilek and Jilek-Aall, this state can also occur in people who do not suffer from mental problems, when the level of emotion is sufficiently high – then sudden and unfounded attacks of aggression occur (Jilek, Jilek-Aall 2001: 234). Martin Manuel Saint distinguishes between two types of this disorder: *beramok*, which involves experiencing a loss and is preceded by a period of depressive mood, and *amok*, which involves more of a state of rage, preceded by a desire for revenge or retribution for an insult. *Beramok* has thus been associated with depressive or mood

disorders, while *amok* has been associated with psychosis, personality disorders or delusions (Saint 1999: 67).

According to the DSM-IV classification, *amok* is a culture-bound syndrome. However, this categorisation is disputed by other researchers, firstly because it has been shown that it is not specific to Java – similar symptoms can also be found in countries of other cultural backgrounds (Saint 1999: 66; Jilek, Jilek-Aall 2001: 235), secondly, because some researchers consider it to be a set of symptoms, a symptom of an illness, rather than an illness in itself. According to Martin, *amok* should therefore no longer be classified as a culture-bound syndrome, because the only thing that is different about it is how it manifests itself (just as all other mental illnesses manifest differently) (Saint 1999: 67). Similarly, Ellenberger believes that disease symptoms similar to *amok* can be found in many different societies and over many centuries (Ellenberger 2020: 143). Moreover, *amok* was not always described as a condition associated with a mental health illness. It was initially associated with the behaviour of exceptionally bold men (Murphy 1972: 32). It was not until the Dutch colonised Indonesia that *amok* was recognised – by the Dutch – as an illness. They considered it a form of insanity caused by the opium they imported into Java. Descriptions by British colonisers in the early 19$^{th}$ century indicate that *amok* was considered a form of mental illness (Murphy 1972: 32).

*Ngamuk*, like *amok*, is associated with aggressive behaviour, but is described somewhat differently. According to Krzyżowski, *ngamuk* "is characterised by fears of mental illness and is often associated with a previously strong repression of emotions in the patient, sometimes preceded by conflict with the environment" (Krzyżowski 2002: 72). Kevin Browne believes that *ngamuk* is a way of manifesting an ailment rather than an illness. According to him, it is an idiom used to describe the vague categories of aggressive, threatening behaviour and mental illness. It is thus a set of emotional and cultural concerns and practices (Browne 2021: 148). It is also a way of framing incomprehensible, aggressive behaviour in terms of a familiar cultural form of mental illness (Browne 2021: 154). A similar view is shared by Manuel Saint Martin, who believes that *amok* is simply a description of aggressive behaviour that is a symptom of depression, psychotic illnesses or a severe personality disorder (Martin 1999: 67). Research by Good and Subandi shows that Javanese use the word *mengamuk* – "to run amok" – to describe outbursts of anger and violence (Good, Subandi 2003: 186). According to Browne in Yogyakarta, the word *ngamuk* refers to a wide range of behaviours that are associated with danger – in particular loud, threatening or aggressive behaviour. The term is used both within and outside professional circles (Browne 2021: 151). *Ngamuk* was cited by Javanese as a symptom that prompted families to bring their loved ones to psychiatric hospitals (Browne 2021: 153), and was also characterised as the most common symptom of mental illness (Browne 2021: 157).

## Methodology

The results presented here are part of a study on cultural conceptions of mental illness in Java that I conducted for my Master's thesis at the Department of Sociology, University of Warsaw. I posed three research questions: 1) what are the causes, 2) symptoms and 3) reactions to mental illness according to the inhabitants of Java. The results presented here only concern the part relating to the perception of symptoms of mental illness.

I conducted 31 individual in-depth, semi-structured interviews between October 2019 and March 2020. Ultimately, I included 30 out of 31 interviews in the analysis (Table 1).

Table 1. A brief overview of the interviewees

| Interviewee identification | Group | Gender | Faith | Description |
|---|---|---|---|---|
| Z1 | a representative of western medicine | Male | Islam | doctor of psychology |
| Z2 | a representative of western medicine | Female | Islam | psychologist from a private practice |
| Z3 | a representative of western medicine | Female | Islam | puskesmas psychologist |
| Z4 | a representative of western medicine | Female | Islam | hospital psychologist |
| Z5 | a representative of western medicine | Female | Islam | hospital psychiatrist |
| Z6 | a representative of western medicine | Female | Christianity | social worker |
| Z7 | a representative of western medicine | Female | Islam | social worker |
| T1 | traditional healer | Male | Islam | ustad |
| T2 | traditional healer | Female | Islam | ustad |
| T3 | traditional healer | Male | kayewen | Javanese healer |
| T4 | traditional healer | Male | kayewen | dukun |
| T5 | traditional healer | Male | Islam | ustad |
| T6 | traditional healer | Male | Islam | priest |
| S1 | student | Male | Christianity | |
| S2 | student | Male | Christianity | |
| S3 | student | Female | Christianity | |
| S4 | student | Female | Christianity | |
| S5 | student | Female | Christianity | |

| S6 | student | Female | Christianity | |
|---|---|---|---|---|
| **Interviewee identification** | **Group** | **Gender** | **Faith** | **Description** |
| S7 | student | Female | Christianity | |
| S8 | student | Male | Christianity | |
| S9 | student | Female | Islam | |
| S10 | student | Male | Islam | |
| S11 | student | Male | Islam | |
| S12 | student | Male | Islam | |
| S13 | student | Male | Islam | |
| S14 | student | Male | Islam | |
| S15 | student | Male | Islam | |
| S16 | student | Male | Islam | |
| S17 | student | Female | Islam | |

Source: own study.

Importantly, none of these individuals suffered from a mental illness. Therefore, the results are primarily concerned with the perception and identification of symptoms of mental illness, rather than the actual presence of mental illness.

I selected the sample based on my own knowledge of the study population and the aims of the research, opting for purposive sampling (Babbie 2004: 204). I felt that it would be important to include three social categories of interviewees to deepen our knowledge of the cultural definition of mental illness in Java: professionals associated with Western medicine such as psychologists or psychiatrists, traditional healers, and students. I conducted the study in a grounded theory approach. I entered the field without pre-conceptualising ideas or theories. When conducting the interviews, I used emic terms – those used by my interviewees. I constructed the dispositions for the interviews gradually, based on the information I collected.

I conducted the interviews in Indonesian and English languages. The vast majority of interviews with Western medicine practitioners and traditional healers were conducted in Indonesian (including one in Javanese), while I conducted all interviews with students in English. Apart from one conducted in Jakarta and one online, all interviews were conducted in Yogyakarta or close to the city.

I performed the main part of the analysis in Maxqda. The unit of analysis was usually a single sentence or a few-sentence statement. I coded the answers only, without the questions, unless including a question in the coding was necessary to understand the statement. Codes were created on the basis of emic categories rather than external categories imposed by myself (Hammersley, Atkinson 2000: 60).

Ultimately, most codes took an "in-vivo" form – they were words used by the interviewees themselves (Miles, Huberman 2000: 64). I looked for regularities and patterns in the responses, focusing less on individual interviews and more on connecting the material as a whole. I also made use of other tools offered by the Maxqda programme to conduct the analysis, such as the document portrait, the interactive citation matrix, the code matrix viewer, and the code dependency viewer. These were ancillary tools that allowed me to better understand the coded material. The interviewees' statements quoted in the text are selected to reflect, as much as possible, the thoughts that most people expressed. It also shows the clearest and most intriguing quotes.

The study dealt with the sensitive issue of mental health and its social perception. It was also for this reason that I decided not to carry out the study on a group of people with mental illnesses who could be described as vulnerable. Instead, I felt that talking to non-mentally ill people could yield valuable findings, especially as this group of people has not been widely studied to date in terms of cultural conceptions of mental illness. Participants were responsive to all questions, despite the difficult topic, although at times the embarrassment of the topic could be perceived. When respondents talked about *pasung* – the practice of incarcerating mentally ill people – they tended to lower their voices and emphasised that they were ashamed that this practice was used in their country. Overall, however, the interviews proceeded in a very good atmosphere.

All participants in the study gave verbal, informed consent to participate in the study, to record the interviews and to use the results in the thesis and for subsequent research work. All participants were also assured of the confidentiality of the information provided.

## Cultural features of Java and Yogyakarta

Yogyakarta is one of three special regions (Dareah Istimewa) in Indonesia. It is one of two sultanates in Indonesia (the other being Surakarta), but is the only centre where the Sultan still exercises real power – in Surakarta he has a purely representative function. The Yogyakarta region has a population of over 3 million people (the city alone has around 630,000) (Good et al. 2019). The city is considered a unique place. People believe that Kraton – the Sultan's palace – is the mystical centre of Indonesia and the centre of Javanese culture (Woodwark 2011: 13). It is situated halfway between two other important sites – the Merapi volcano and Parangritis Beach (Subandi et al. 2021). Yogyakarta is a city of many identities. It is known as a city of culture, tourism and students (Subandi et al. 2021: 4). It is considered one of the most important centres of "authentic" Javanese culture. It is also a centre for arts

such as batik, a technique for dyeing fabric, and *wayang*, a puppet theatre. It has important tourist sites, such as Kraton, Taman Sari, and the temples of Borobudur and Prambanan. It is the second most-visited destination in Indonesia, the most-visited being Bali. Thousands of students from different parts of Indonesia and abroad come to Yogyakarta (Subandi et al. 2021: 4–5).

Yogyakarta is also specific because of the relationship between culture and religion and between Indonesian nationalism and Yogyakarta nationalism (Woodwark 2011: 3). Few people believe that Yogyakarta should be independent, but many think of Yogyakarta as a nation within a nation. For many Yogyakarta residents, democracy means the right to be ruled by the Sultan (Woodwark 2011: 8). The people of Yogyakarta speak the local language, Javanese, on a daily basis. However, few people can write and read in the Javanese alphabet (which is different from the Latin alphabet) – most people use it only for oral communication.

The overwhelming majority of Yogyakarta's population adhere to Islam, but as in other parts of the country, religion also becomes fused with local beliefs. 86% of the population is Muslim, 10% Christian and the rest form small Hindu and Buddhist communities (Good et al. 2019). However, local beliefs are still practised (although their adherents are most often formally Muslim), with the *Kayewen* religion at the forefront (Woodwark 2011: 81). The Javanese world is one filled with spirits and supernatural powers (Good et al. 2019).

The Javanese have a unique approach to emotions and interpersonal relationships compared to the rest of Indonesia. "In Java social relations are structured in terms of concepts of hierarchy, obligation and mutual assistance. The social as well as mystical ideal is the 'union of servant and lord' and a free flow of aid among equals (*gotong royong*)" (Woodwark 2011: 85). For Javanese, family is central to their lives. This is reflected in the proverb "even if there is no food, being together is the most important thing" – "mangan ora mangan waton kumpul". Even today, with many young Javanese leaving for work or education, family remains extremely important – Javanese try as much as possible to maintain emotional closeness with their family members (Subandi 2011: 333). According to researchers in Java, the boundary between self, family and community is often blurred. Parents remain involved in their adult children's lives, particularly in their marriage (Subandi 2011: 341). The Javanese family also teaches the children not to show intense emotions and to minimise conflict within the family (Subandi 2011: 334). Consequently, any loss of control over one's own behaviour is seen as a symptom of emotional disturbance and problems (Subandi 2011: 337). Javanese try to maintain peaceful relationships (or at least the appearance of such) to avoid conflict. Experiencing frustration, stress or showing feelings of being shocked can disrupt peace of mind (Subandi et al. 2021). Mothers argue that the child should have calm

thoughts at all times and that parents should protect the child from emotional and psychological shock (Subandi et al. 2021: 10).

In Javanese culture, a sense of shame is also important for interpersonal relationships (Subandi, Good 2018). It is felt at both the individual and collective level. The sense of shame is important for proper functioning in society. Feeling shame, for example, is necessary for the maintenance of hierarchy, which is extremely important in Java (Collins, Bahar 2000). Children learn emotional control by recognising shame and controlling it. This process is called *ngerti isisn* – knowing shame. Shame is seen as a necessary cultural aspect. Feeling shame is a necessary part of being normal, healthy, moral and mature. It is linked to behavioural control (Subandi, Good 2018; Collins, Bahar 2000). According to Glen Pettigrove and Nigel Parsons, shame is also an important part of experiencing *amok*. Based on their research, they believe that the experience of shame can be a factor in experiencing *amok*. This is especially true for men, as it is accepted in Indonesian culture that the response to men experiencing shame is to behave aggressively (Pettigrove, Parsons 2012).

## Symptoms of mental illness in Indonesia – a review of the literature

The symptoms of mental illness as perceived by Indonesians are strongly linked to cultural factors. In the aforementioned studies by Byron Good and M.A. Subandi, one of the symptoms of mental illness described by their interviewees was the sufferer's obsession with religion, or the feeling that certain things like clothes, food and even neighbours are *haram* – unclean, forbidden (Good, Subandi 2003: 186). As Good and Subandi note, in Java, symptoms such as feeling like having an unclean body, being sinful, letting god down or losing his grace are common symptoms of depression (Good, Subandi 2003: 187). Another symptom reported by the sufferer was that in psychotic states he perceives his mother as an enemy (Good, Subandi 2003: 188). In another study conducted by Subandi, his interviewee, who is a mentally ill person, when describing the symptoms of his illness mentioned: lack of control over his own behaviour, being aggressive, feeling tense, being nervous, and having somatic sensations such as a burning sensation in the heart or sweating profusely, as well as visual and auditory hallucinations and thoughts of being followed. The interviewee also made a suicide attempt (Subandi 2015: 600). Good et al. also mention symptoms related to experiencing supernatural forces (Good et al. 2019: 514).

Another cultural symptom of mental illness, in the Javanese view, is the loss of a capacity for shame (Subandi, Good 2018: 34). Shame in this context refers primarily to the loss of eating habits and good manners. The appropriate way of eating was a factor that, in the eyes of the Javanese, distinguished the mentally ill from the healthy (Subandi, Good 2018: 35). Harald Broch, on the other

hand, indicates that mentally ill people in Indonesia exhibit deviant behaviour (Broch 2001: 278). Broch also lists such symptoms of mental illness as lack of orientation in time and space, inability to function on a daily basis (e.g., by losing the ability to communicate properly), being aggressive, obsession with religion, and lack of manners (Broch 2001). According to Broch, what characterises the thinking about mental illness among the people of Christian Toraja, where he conducted his research, is aggressive behaviour and the inability to adapt to the cultural norms of society – living in a different world. Other salient characteristics of a mentally ill person include: talking to oneself, shouting, getting angry easily, undressing in public, complaining about the quality of food, and severe and prolonged sleep difficulties (Broch 2001: 297). Andi Tanra and Ireine Roosdy note differences in the symptoms of schizophrenia between patients from the UK and those from Indonesia. Indonesian patients showed mainly hyperactivity, while fewer symptoms related to delusions, persecutions, visual hallucinations or depressive states could be observed in them (Tanra, Roosdy 2017: 190).

## Results of own research

Although none of my interviewees used the word *ngamuk* to describe the symptoms of mental illnesses, they extremely often talked about aggressive behaviour as a symptom of mental illnesses – i.e., the main symptom and actually the determinant of *ngamuk*. As my study was conducted in the grounded theory strand, I did not inquire about the prevalence of *ngamuk* when none of the interviewees raised this topic. However, it is possible that because most of the interviews were conducted in English, the interviewees did not want to use the word. It is also possible that they assumed that, as a person from another country, I would not understand the term. However, it is, of course, also possible that the word *ngamuk* has fallen out of use, but that symptoms associated with it are still being reported. This would be indicated by the fact that, after the interview stage was over, I asked some of my interviewees about the word – they indicated that it simply meant anger, but in no way linked it to mental illness.

Other symptoms of illnesses mentioned included: behaviours inconsistent with good habits, difficulties in controlling behaviour and emotions, difficulties in maintaining contact with other people, and psychotic and somatic symptoms. I do not consider the symptoms of individual mental illnesses but, like my interviewees, generalise them. Although some interviewees, especially Western medics, mentioned various mental illnesses, when asked about their symptoms, they were able to point to generalisations. Two interviewees did not mention any symptoms of mental illness. Therefore, this part of the analysis refers to 28 rather than 30 interviews.

Displays of aggressive behaviour by people with mental illnesses were by far the most frequently mentioned symptom of mental illness by my interviewees. According to a doctor of psychology, mentally ill people get angry easily, hurt people and destroy everything (Z1). One psychologist described mentally ill people in a similar way and believes that people with mental illnesses can hurt others (Z2). Another psychologist working in a hospital says: *maybe the person* [with mental illness – AS] *has destructive behaviour, they hurt people, they hurt the environment* (Z4). A psychiatrist, on the other hand, stated the belief that aggressive behaviour is characteristic of psychotic states (Z5). For a community outreach worker, the most difficult patients are those who become enraged (Z7). The woman cites the story of one patient: *he was defending himself inside the house with the weapon, he was prodding every person that was trying to go there* (Z7).

Traditional healers also believe that a mentally ill person is characterised by aggression. One ustad – an Islamic healer – tells the story of a man addicted to drugs who he believed was mentally ill.

> *So the case is the addictive person when he did, like, hurting things to other people because he wants to get the drugs but he cannot so he is, like, reflecting to others. In this case the husband is beating the wife because the wife is trying to stop of using the drugs. So he used to do beat the wife for, like, almost one hour* (T2).

Another case of a husband beating his wife is told by a traditional Javanese healer. His patient was shouting at his wife, hurting her. He behaved this way because of the action of the *jinn* – an evil spirit, in Islamic belief – because an evil spirit makes people very emotional (T3). It is the *jinn*, according to the healer, that forces people to be evil (T3). Mentally ill people not only shout at and beat others but also throw things at other people (T4). In addition, "lunatics", according to another traditional healer, are angry and do not remember what they have done – once the aggressive behaviour has stopped they *do not remember anything* (T5).

The view of aggressive behaviour as a symptom of mental illness is also shared by students. One of them says that there are different types of mental illness, among them there is one in which people attack others (S1). The aggressive behaviour of people with mental illness can, according to one student, be very intense, up to the point of committing murder. When asked for an example of a mentally ill person, she cites a story from the media in which a 15-year-old girl killed a five-year-old girl by *pushing her head under the water until she is dead* (S4). Furthermore, the girl responsible for the murder said that she was happy with what she had done (S4). The same student emphasises that because of the aggression of mentally ill people, Indonesians are afraid of them and are not eager to help such people (S4). This is not the only case where my interviewees told of a murder committed

by a mentally ill person – one student said *she wrote and then she did it. She killed one girl* (S12). Another student talking about mentally ill people said: *Because it* [mental illness – AS] *is very dangerous, like you don't know what is happening in their mind and they can commit suicide or be violent for themselves or for someone else, for, yeah* (S6). For another interviewee, a mentally ill person is one who does *not-normal things*. An example of such an activity is carrying a knife everywhere with them and scaring people with it (S7). According to one interviewee, people with disorders hit everything and make trouble for their neighbours. In addition, they bully children. She calls mentally ill people criminals (S9). Another interviewee says: *maybe it is sometimes dangerous for me if they become aggressive. Because sometimes it is uncontrolled, so maybe they will do something like aggressive action or become wild, or something like that. And that is dangerous for me* (S15). Also another student was afraid as a child of a certain "madman" who *is standing in the middle of the road and shouting really loud and sometimes trying to catch us* (S11). Students emphasise that mentally ill people are capable of hurting others (S16, S17). There is also a more emphatic voice: *some of crazy people always hurting somebody* (S13).

Aggressive behaviour as a symptom of mental illness is mentioned by representatives of all the social categories I analysed. I did not notice any differences in the frequency with which this aspect was indicated either between people from different social categories or between followers of different religions. There were, however, differences in identifying the causes of aggressive behaviour. Western medical practitioners linked it to illness, most often to a psychotic state. Traditional healers, on the other hand, indicated that the cause was the presence of a *jinn*. Meanwhile, students very often made the following distinction: *orang dengan ganguan jiwa* – a person with a mental illness (literally a person with a soul disorder) versus *orang gila* – a madman, a lunatic. Aggression was more often linked to *orang gila* behaviour than *orang dengan ganguan jiwa*.

The terms used for the mentally ill were a differentiating element for my interviewees. Western medical practitioners always used the term *orang dengan ganguan jiwa*, only when asked about *orang gila*, they said that most Indonesians still use this term. Traditional healers, on the other hand, overwhelmingly referred to mentally ill people as *orang gila*. Students varied in this aspect, with some using one and some using the other of these terms. Some, as I pointed out, made a distinction between *orang gila* and *orang dengan ganguan jiwa*.

## Conclusions

Although none of my interviewees used the word *ngamuk* when talking about symptoms of mental illness, I believe that thinking about such disorders is close

to what characterises the disorder. When I asked several of my interviewees after the interviews if they knew what *ngamuk* meant, they said it was simply being very angry, but they did not link it to a medical condition. In contrast, what they said about symptoms of mental illness fit the definition of *ngamuk* as a state of aggressive, threatening behaviour (Browne 2021; Saint 1999). Based on what my interviewees said, *ngamuk* could therefore be a way of manifesting mental illness rather than an illness in itself.

In my opinion, the fact that aggression was mentioned by far the most frequently as a symptom of mental illness is not without significance. This fact, however, does not necessarily indicate a relativistic perception of such disorders. Indeed, it appears that in many cultures, a mentally ill person is seen as dangerous and unable to control themselves (Todor 2013). What seems instead relatable are the various factors that accompany aggression, which in my opinion can be linked to *ngamuk* symptoms. Some interviewees (e.g., Z7) spoke not only of aggression, but even of *rampage patients*. This would therefore indicate exceptionally strong bouts of aggression that fit the definitions of *ngamuk* that I have cited. Aggressive behaviour has also sometimes been linked to the action of supernatural forces, most notably that of the *jinn* – an evil spirit, as understood in Islam. This is also an element that points to the relativism of the views expressed. The response that could most prove the occurrence of *ngamuk*-related syndromes in Java is the words of one traditional healer, who speaks of people with mental illnesses forgetting their violent acts (T5). Jakubik (2003: 143) argues that it is the "amnesia of the illness period" that is characteristic of *amok*, and which is akin to *ngamuk*. Similarly, the example of a homicide committed by a person whom one student (S4) assessed as mentally ill would indicate that the syndromes of these disorders are perceived similarly to the symptoms of *ngamuk* and *amok*. In contrast, a different perception of aggression would be indicated by interviewee S1's statement that aggression is characteristic of one disorder (not all) – one in which individuals harm others. This would indicate the existence, in his view, of a different illness entity, of which aggression would be a determinant.

The dominant role of aggression in talking about symptoms of mental illness can, in my view, be linked to the ethos of controlling one's own behaviour and emotions in Java (Subandi 2011: 337). In this light, it is possible that the hypothesis advanced by Pettigrove and Parsons (2012) and Tanra and Roosdy (2017) that *amok* is a response to shaming is correct. I feel that the Javanese culture, which heavily proscribes the showing of emotion, may mean that at some point these emotions have to resurface and this happens in the form of aggression. As this was a study of perceptions of the symptoms of mental illnesses and not the illnesses themselves, strictly speaking, cultural norms seem to play a dominant role. I conclude that interviewees indicated symptoms that are most closely

associated with behaviours that break the norms defined by Javanese culture, including aggression. My findings show that perceptions of illnesses can be as culturally relativised as the illnesses themselves. I postulate that when dealing with illnesses (both mental and physical), the cultural aspect should be taken into account, regardless of the researchers' field of study.

In the light of my research, it is impossible to prove the existence of *ngamuk*. Instead, I believe that my results certainly prove that illnesses are culturally relativised, and in particular the perception of them is relativised. Thus, it shows that they are socially distributed across cultures. Research by other authors shows that mental illness is perceived differently in Western cultures than in non-Western ones. The research I have already mentioned (Kolstald, Gjesvik 2014) proved that behaviours that were identified as mental illness in the West were not perceived in this way in Chinese culture. Giosan, Glovski and Hasam (2001) conducted a study in which participants from Brazil, the United States and Romania were asked to rate which of the listed behaviours indicated the presence of mental illness. The behaviours and symptoms included those listed in the DSM-IV, as well as conditions that in Western culture can be associated more with behaviour that breaks social norms or is regarded as deviant behaviour. The difference became most apparent between Americans and Brazilians. The former were much more likely to point to symptoms included in the DSM-IV as symptoms of mental illness, while the latter pointed mainly to deviant and norm-breaking behaviours (that in Western cultures are not considered symptoms of mental illness per se).

While it is true that also in Western cultures mental illness is sometimes associated with aggressive behaviour, this association is, in my opinion, much rarer than in Indonesia. Moreover, not all illnesses are perceived in this way. The example of Angermeyer and Matshinger's (2003) research on the social perception of schizophrenia and depression in the United States seems to be evidence of this. Aggression was much more frequently linked to schizophrenia than to depression. Aggression was associated with mental illness by 35.7% of respondents who identified it with schizophrenia and 20.7% of the people who identified it with depression. In my opinion, based on the qualitative research I conducted, if an analogous quantitative survey was conducted in Indonesia, these percentages would be much higher.

It would certainly be valuable to explore differences in perceptions of mental illness between Polish and Indonesian cultures. A study constructed in a manner analogous to the one I conducted in Indonesia, done on Polish grounds, could confirm my hypothesis about the unusual importance of aggression in the commentary on mental illness by the people of Java. It would also be valuable to explore differences in social perception of illness within Indonesia itself. This is because it is an extremely diverse country with many distinct cultures. This would be particularly

valuable for research on *ngamuk*, which other researchers have argued is confined to Javanese culture.

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