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Indonesia's Mental Health Services: Availability and Current Challenges

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Capstone Project

Indonesia's Mental Health Services: Availability and Current Challenges

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APS 650 – 02: MAPS Capstone Seminar

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Image 1: Scott Typaldos, *A Boy Chained to a Wall in One of Indonesia's "Insane Asylums"*, 2016, *Prospekt Photo*, 2016, <http://www.prospektphoto.net/hub/scott-typaldos/>.

Abstract

The deep deficits in Indonesia's mental health care system seem to currently lack explanation. While Indonesia's economic growth may outstrip even that of its neighbors, the country still appears to significantly lack parity in provided mental health resources. Due to the paucity in available information and studies on the topic, this paper seeks to inspect the issue directly through the use of direct interviews supplemented by available literature. Through the interviews of Indonesian self-identified patients, non-patients, and mental health care providers, it appears that the apparent weak state of Indonesia's mental health care system stems from widely held cultural beliefs. More specifically, the intersection of social expectations, religion, and cultural superstitions impede both the willingness and ability of individuals to seek professional psycho-social support. Ultimately, these interactions appear to render a population that direly desires improved psycho-social support resources unable to articulate demands, leading to a slow development of available resources.

Keywords: Indonesia, mental health, *pasung*, health care infrastructure

An Equal Lack of Access

Jane, whose name has been changed for the sake of her anonymity is a 23-year-old Indo-Chinese Jakarta native. As is the goal of most others, she does everything in her power to live a normal, fulfilling life. She works a prestigious, well-paid job at an international accounting firm, lives in Senayan, one of the wealthiest districts of Jakarta, and was fortunate enough to receive her diploma from an American university in Seattle. In many ways, she lives a relatively glamorous life that most Indonesians, who on average make around three-hundred dollars a month could only dream of. Yet, Jane suffers from chronic destructive episodes of hypomania as well as painful depression. She confides in me that although she likely suffers from bipolar disorder, she has been unable to find adequate treatment beyond a basic diagnosis. As she quiets her voice to a near whisper, she admits that she has turned to self-medicating because of her inability to find a doctor who can treat her effectively. Alongside with alcohol, she often takes the highly addictive and dangerous class of anti-anxiety drugs known as benzodiazepines to “level” herself out. She explains that these serve to smooth out the highs and lows of her depressive and hypomanic episodes. At just twenty-three she already identifies as an alcoholic and has been arrested for illegal possession of benzodiazepines.

Visible in the background of our Facetime call, the multiple expansive black marble corridors and koi pond of Jane’s home raise a key question: with a seeming overabundance of monetary resources, how is it that Jane is unable to find adequate care for her mental health diagnosis in one of the largest economies on Earth?¹ Having traveled to Indonesia on several occasions and made dozens of friends during my stay, this question is one considered deeply personal to me. During the course of just several limited stays, the sheer lack of any mental

¹ Jane, interview by Alexander Gronowski, online, February 12, 2020.

health resources for all members of society became quickly apparent to me. While anecdotal, I have traveled to many countries in and around Asia, never having encountered a country with such an apparent lack of mental health infrastructure.

While Jane has a general understanding of her illness and managed to skirt prison time with a “payment” of nearly \$30,000 USD (the equivalent of around eight years of the average Indonesian salary), the vast majority isn’t so privileged. For those suffering from mental illness in Indonesia, Jane’s story is perhaps one of the “happier” ones afforded only to the extremely wealthy. For many, those with severe mental health disorders are perhaps better left to their own devices than seek help in what exists of Indonesia’s mental health care system. It is not uncommon to see those who are placed in whatever semblance of care facilities are available subjected to a non-evidence-based practice known as *pasung*. Often reserved for those suffering more severe mental health disorders, those forced to undergo *pasung* face imprisonment in small cages and chains, garnering allegations of human rights abuses.^{2 3} What has occurred in Indonesia to cause such a paucity of mental health resources not just for the poor, but also the rich?

A Country Far Behind Its Neighbors

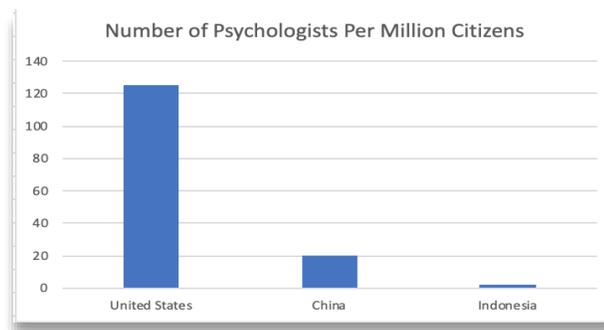
Indonesia has experienced significant economic growth in the past fifty years while simultaneously undergoing little apparent change in the availability of mental health services. Curiously, while the archipelagic nation has experienced some of the greatest economic development in all of southeast Asia, these services often even lag behind those of the country’s

² Nash Jenkins, “Thousands of Mentally Ill Indonesians Are Imprisoned in Shackles, Report Says,” *Time*, March 21, 2016, <https://time.com/4265623/indonesia-mental-illness-chains-pasung-hrw/>.

³ Saeed Kamali Dehgan, “Indonesia Takes Steps to Improve Protection of Mental Health Patients,” *Guardian*, September 13, 2019, <https://www.theguardian.com/global-development/2019/sep/13/indonesia-takes-steps-to-improve-protection-of-mental-health-patients>.

neighbors.⁴ As of 2018, the country reported a shockingly low total of 773 psychiatrists and 451 clinical psychologists for the entire country's population of over 240,000,000.⁵ In comparison, Indonesia has approximately one psychologist for every 530,000 citizens, China has approximately one trained psychologist for every 50,000 citizens and the U.S. one for every 8,000.⁶ Below is graph created in order to best illustrate this disparity.

Figure 1:



It should go without saying that varying levels of economic development between countries must be taken into account, yet this alone cannot possibly account for the incredible disparity on display. While Indonesia's GDP per capita is nearly half of that of China's, the country boasts less than 1/10th the number of psychologists per capita. Even when compared to the less economically developed Philippines, Indonesia's pattern of mental health care services paucity continues. The Philippines maintains significantly more psychiatrists per capita with nearly one psychiatrist per 190,000 citizens, in comparison to Indonesia's one per 310,000.⁷

⁴ I Irmansyah, Ya Prasetyo, and H Minas, "Human Rights of Persons with Mental Illness in Indonesia: More than Legislation Is Needed," *International Journal of Mental Health Systems* 3, no. 1 (2009): 14, <https://doi.org/10.1186/1752-4458-3-14>.

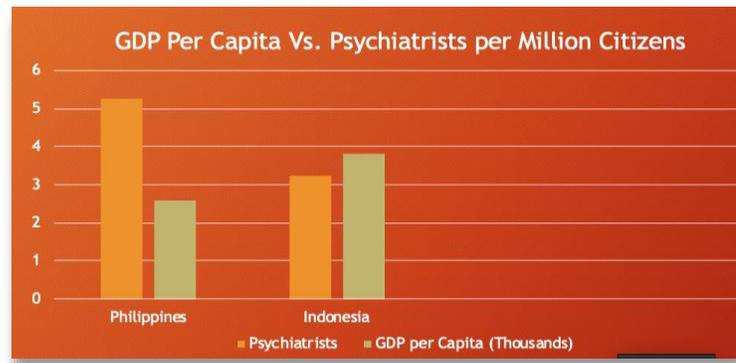
⁵ Susy K. Sebayang, Marty Mawarpury, and Rizanna Rosemary, "Less than 1,000 Psychiatrists for 260 Million Indonesians," *Jakarta Post*, November 6, 2018, <https://www.thejakartapost.com/academia/2018/11/06/less-than-1000-psychiatrists-for-260-million-indonesians.html>

⁶ Rebecca A. Clay, "Psychotherapy in China," *American Psychological Association*, October 1, 2019, <https://www.apa.org/monitor/2019/10/psychotherapy-china>.

⁷ John Lally, John Tully, and Rene Samaniego, "Mental Health Services in the Philippines," *BJPsych International* 16, no. 03 (2019): 62-64, <https://doi.org/10.1192/bji.2018.34>.

This is especially shocking considering Indonesia's purchasing power parity is nearly 33% higher than that of the Philippines.⁸ Below is a graph created for the sake of comparison.

Figure 2:



Interestingly, the apparent gap in mental health services between Indonesia and its Asian neighbors, as it exists separately of economic development, is rarely explored if even acknowledged. As with many of its Eastern and South Eastern Asian neighbors, hundreds of studies exploring the current state, most often quantitatively, exist. While these studies describe the current lacking nature of Indonesia's mental health care system, few of these, if any, seek to explore why exactly it is that Indonesia lags behind virtually all of its neighbors in the levels of access the average citizen has when compared to similarly developed economies.

It is likely that the answer to this question lies in the cultural traditions and attitudes many of the ethnic groups comprising Indonesia hold toward professional psychosocial interventions. These interventions have historically been met with varying attitudes and levels of stigmatization, and as a result, Javanese and Indo-Chinese attitudes towards such concepts should be specifically explored.⁹

⁸ "GDP Per Capita, PPP," *The World Bank*, 2020, <https://data.worldbank.org/indicator/NY.GDP.PCAP.PP.CD>

⁹ Matthias C. Angermeyer et al., "Public Attitudes towards Psychiatry and Psychiatric Treatment at the Beginning of the 21st Century: Systematic Review and Meta-Analysis of Population Surveys," *World Psychiatry* 16, no. 1 (2017): 50-61, <https://doi.org/10.1002/wps.20383>.

Many local attitudes and beliefs in Indonesia have created specific and varied methods of dealing with mental health that differ greatly from their Western counterparts.¹⁰ Because of this, this paper seeks to explore in further detail exactly how local, namely Javanese and Indo-Chinese beliefs have interacted with Western conceptions of medicine, hindering the rollout of readily available pharmacological and psychotherapeutic treatments.¹¹

The Javanese, Indonesia's majority ethnic group comprising nearly 1/3 of the population hold attitudes and traditions that are illustrative of a distrust of both the mentally ill and the systems that exist to help them. In regions that are primarily occupied by Javanese, mainly the central Islands, a "treatment" for the mentally ill known as *pasung* has arisen. In this practice, those dealing with severe mental illness are chained in small cages, subjected to worse-than-prison conditions. Of those diagnosed with any mental health disorder in any part of the country, over 28% are subjugated to this practice and locked in shackles.¹⁰

Additionally, while instances of *pasung* are more common in the rural areas of Java, access to hospitals and other medical services does not decrease the occurrence of the treatment as drastically as would be expected. The practice maintains relevancy in Indonesia's most developed and Westernized city, Jakarta.¹² This seems to further suggest that Indonesia's comparative lack of services is not due to a lack of economic resources, but due to cultural beliefs that stigmatize the mentally ill and their treatments.

¹⁰ Nenden Hikmah Laila, Renti Mahkota, and Tri Krianto, "Perceptions about Pasung (Physical Restraint and Confinement) of Schizophrenia Patients: a Qualitative Study among Family Members and Other Key Stakeholders in Bogor Regency, West Java Province, Indonesia 2017," *International Journal of Mental Health Systems* 12, no. 35 (2018): <https://doi.org/https://doi.org/10.1186/s13033-018-0216-0>.

¹¹ Nathan Porath, "The Naturalization of Psychiatry in Indonesia and Its Interaction with Indigenous Therapeutics," *Bijdragen Tot De Taal-, Land- En Volkenkunde / Journal of the Humanities and Social Sciences of Southeast Asia* 164, no. 4 (2008): 500-528, <https://doi.org/10.1163/22134379-90003653>.

¹² Stanley Widiyanto, "Some Indonesians Are Shackling and Imprisoning the Mentally Ill in Sheds," *Vice*, April 14, 2016, https://www.vice.com/en_us/article/nknx8/pasung-indonesian-shackling-imprisoning-suffering-mental-illness-schizophrenia.

Different from the indigenous Javanese, Jane, who is Indo-Chinese, a group of Indonesians who can trace their ethnic roots to China, holds beliefs mental illness that vary wildly from what appear to be the Javanese norm. While not fully knowledgeable about the complications and medications necessary for her condition, she and her family have long been able to recognize when she needed help from a mental health professional. Unfortunately, as it stands there is little more data available on the attitudes of Indo-Chinese or other non-Javanese ethnic groups towards mental health services.

The nature of the relationship between the beliefs of the largest ethnic group, the Javanese and mainstream Indonesian society is full of contradictions and highly complex. How exactly these stigmas interact with the rollout and use of mental health services as well as the level of general knowledge about mental health must be further explored. Based on existing research, it is difficult to tell how the stigmas held by the largest ethnic group in Indonesia shape the beliefs of Indonesia as a whole. Because of this, deeper exploration into the variances in ethnic beliefs will likely prove fruitful.

An Unrecognized Dire Need for Psycho-Social Support

In order to explore the question of why Indonesia's mental health care is the way it is, it is key to first look at both the concept and practice of *pasung*. As explained earlier, *pasung*, in plain English, is the practice of imprisoning those suffering from mental health disorders. In image two, a woman who is victim to this type of imprisonment can be seen. The conditions of those subjugated to *pasung* are widely considered abuses of basic human rights, affording little freedom through cramped prison-like conditions.³ It is not uncommon for the spaces in which the mentally ill are imprisoned to allow no movement whatsoever.



Image 2: Andrea Star Reese, *A Woman Bound to Her Bed in Central Java's Bina Listari Healing Center after Experiencing Severe Depression*, 2015, *Andrea Star Reese I Disorder*, 2015, <http://www.andreastarreese.com/disorder>.

As might be expected, the prevalence of the practice is significantly greater in Indonesia's less developed rural areas where education is scarce. Moreover, *pasung* and its underlying, driving ideology exist pervasively throughout Indonesia as a whole. It is estimated by Human Rights Watch that the number of those imprisoned in abysmal number in the tens of thousands throughout the country. Among these tens of thousands of imprisoned individuals are, not uncommonly but perhaps surprisingly, those with university degrees and access to some degree of academic resources.¹³

Perhaps equally worrying to its abuses of human rights, the practice is indicative of a much deeper, pervasive issue in Indonesian society. While the current number of people subjugated to *pasung* may seem low relative to a country of nearly 250 million people, the

¹³ Ibid, para 4.

widespread perception of the practice is most worrying. In 2017 the *International Journal of Mental Health Systems* published a qualitative study exploring the perceptions of *pasung* amongst residents of West Java. A common thread amongst these interviews was the perception that *pasung*, while a practice that is uncomfortable to undergo, is a process that is necessary for the safety of the community and those seeking illness treatment.¹⁴ It is a necessity derived, as the interviewees explain, from a lack of financial resources, lack of available mental health care resources, and lack of education surrounding mental health. The discomfort of the Javanese in using *pasung* to ensure the safety of both the individual and community is illustrative of a demand for a form of additional help. While low information may lead to a lack of direct demand for science-based support, the desire for help in some form or another is extant in modern Indonesia.

Additionally, the application of *pasung* is more prevalent than even the relatively intimidating number of 50,000 cases may suggest. According to a 2013 survey by the Indonesian health research center, Riskesdas, 14% of all Indonesians with a severe mental health disorder in urban areas and 18% in rural areas have at some point been imprisoned with the practice of *pasung*.¹⁴ This statistic paints a much more accurate picture of the scope of the problem the Indonesian health care system faces. Nearly one in every five people with severe mental illness in rural areas has been imprisoned in conditions that appear to violate their human rights.

Most sobering of all are the downright disturbingly bleak statistics shared by the *Jakarta Post* in a 2019 article. The article, sharing statistics from a survey conducted by data company YouGov, explains that 27% of Indonesians have experienced suicidal thoughts “frequently” and

¹⁴ Ibid, para 8.

45% of the country's under-eighteen population has engaged in some form of self-inflicted physical harm.¹⁵ While these statistics are perhaps beginning to turn in the right direction, the full nature of Indonesia's mental health crisis doesn't end here.

Methods: Interview-Focused Data Collection

Admittedly, available data on the mental health care system in Indonesia is sparse, but not barren. In both the urban and especially rural areas of Indonesia, data on available services and the use of such services is sometimes available. A small number of studies additionally outline some ethnically specific attitudes towards mental health services and provide general quantitative data on the prevalence and use of such services. In order to supplement the lack of available data on the attitudes of Indonesians, individual qualitative interviews with both Javanese and Indo-Chinese, rural and urban must be obtained. Because of the personal connections of the author with both Indonesian mental health service providers as well as patients, these interviews will provide insight into the current landscape of attitudes towards mental health services, supplementing the lack of available information.

Interviews conducted for the purposes of this paper surveyed interviewees who broadly fall into one of three categories: 1) mental health care providers; 2) those seeking mental health treatment actively; 3) those who are Indonesian but don't identify as having experienced mental illness. All interviewees, with the exception of Jane, with whom I have a personal connection, were asked the following series of questions depending on which category they identified as. A full list of interview questions can be found in the appendix. Additionally, analysis of the organizational fliers as well as promotional YouTube videos of several Indonesian non-

¹⁵ "More than One in Four Indonesians Experienced Suicidal Thoughts: Survey," *Jakarta Post*, June 23, 2019, <https://www.thejakartapost.com/life/2019/06/23/more-than-one-in-four-indonesians-experienced-suicidal-thoughts-survey.html>.

governmental organizations is provided in order to more fully assess the current state of Indonesia's mental health care infrastructure.

***Pasung*: Draconic Practices and Misinformed Attitudes**

Pasung's pervasiveness throughout a multitude of different socio-economic groups within Indonesian society owes itself to a set of cultural beliefs surrounding the mentally ill and those with psychosocial disability. While Indonesia is itself comprised of a multitude of ethnic groups with varying religious and spiritual beliefs, a common thread does exist throughout the most highly populated regions of the country comprised of Java and its northern provincial neighbor provinces. Often those who face mental illness, of varying severity from minor depression to psychotic schizophrenia are viewed as having interacted in some way with "evil spirits." This interaction is believed to take a multitude of different forms ranging from demonic possession, "lack of faith," and "displaying immoral behavior."¹⁶

Dr. Addi Chandra is one of Indonesia's only 450 clinical psychologists. His practice, located in Jakarta, is at the forefront of Indonesia's evidence-based Western mental health care system. He holds regular meetings in which he attempts to discourage traditional cultural beliefs and superstitions around professional psycho-social support as well as mental health disorders. During our interview, he explains that an often-common thread throughout these pervasive cultural superstitions and beliefs is that the psycho-social disabilities "remove people from their identities in the eyes of other Indonesians." "Education is low [*sic*] about what mental illness is...I encounter some (students, patients) that [*sic*] believe their illness is from curses or magic." Although he explains that the majority of his patients have some understanding of the true nature

¹⁶ Kriti Sharma, "Living in Hell: Abuses against People with Psychosocial Disabilities in Indonesia," *Human Rights Watch*, July 12, 2017, https://www.hrw.org/report/2016/03/20/living-hell/abuses-against-people-psychosocial-disabilities-indonesia#_ftn28.

of whatever mental illness they may be experiencing, Dr. Chandra is quick to note that this is only because those who believe their illness comes from external sources tend to not seek any help. Dr. Chandra also notes that the practice of *pasung* most commonly occurs in those with little understanding of mental illness.

The belief that psychological maladies are the incursion of external spiritual forces is a huge detriment to Indonesians' desire to seek evidence-based help, and Dr. Chandra is trying to change this. He is founder of what he terms "Catharsis Class." As shown below in a poster for Dr. Chandra's class, for a fee starting at 125,000 rupiah, or about \$8 USD, students and adults alike are able to express themselves in groups and begin to learn the geography and terminology of navigating their own mental health. As Dr. Chandra puts it: the class is an "introduction to caring for yourself...it is a steppingstone."



Image 3: Addi Chandra, A Flyer Advertising Dr. Chandra's Most Recent Session, Heart of People (Heart of People Organization, March 2020), <https://www.heartofpeople.org>.

Yet, while Doctor Chandra seeks to make education on mental health more accessible, the English of his organization's poster hints at a slightly different story. He admits that successfully reaching those who need it the very most is a serious challenge. Those whose families have forced them into *pasung* and hold deep-seated, generational superstitions about the cause of mental illness not only have no desire to seek evidence-based help but are insulated from exposure through economic means. While rp 125k to rp 200k (\$8-16 USD) may not seem like much to most Western readers, the median Indonesian salary of \$320 USD equivalent puts the price of the sessions far out of reach for those who already see little value in the education.¹⁷ Dr. Chandra explains that the choice to use English in the poster alienates the large portion of less educated Indonesians who can't speak English, and instead targets a more urban, educated, upper-middle class crowd who, as he puts it "are challenged by the same lack of education."¹⁸

"Challenged by the Same Lack of Education": Jane's Story Continued

We can see this disturbing parity in lack of education in Jane's own story. Jane, who exists as a member of not Indonesia's upper-middle class, but upper-class has struggled with finding help because of the beliefs of her family members. Jane, who identifies as a member of Indonesia's Indo-Chinese Christian minority explains that her family viewed her substance use disorder and likely bipolar as the manifestation of an "evil spirit haunting." She explains that after confronting her mother for help, her mother attempted to identify Jane's problems as the result of late aunt's spirit provoking her maladies. Jane's psychological issues are seen as she puts it, "evil," and viewed as deeply shameful. Because of this, in combination with a culture of saving face, a practice in which one attempts to avoid embarrassment and maintain social

¹⁷ "Average Income around the World," *World Data*, 2020, <https://www.worlddata.info/average-income.php>.

¹⁸ Dr. Addi Chandra, interview by Alexander Gronowski, online, March 17, 2020.

standing, it is easier for her family to blame such “shameful” issues on an external force. As a result, rather than seek evidence based professional psycho-social support, her mother brought her to a priest instead.

Interestingly, Jane appears to have a comparatively high level of mental health literacy, identifying her issues as depression, hypomania, and addiction. She is additionally aware of her coping mechanisms: drugs, food, and alcohol. She believes that this literacy is likely the result of her time in the West. Yet, while she is able to identify her problems, the problematic views of her family preclude her from seeking consistent, professional help. With Indonesia’s culture of “saving face,” alongside cultural superstitions, she has little drive to shame her parents by admitting the true nature of her ailments and seeking increased support.¹⁹

Not Just Christians or Indo-Chinese: Yujiro’s Interview

In line with Dr. Chandra’s explanation, the cultural view that mental illness is both shameful and the result of supernatural phenomena is pervasive amongst many of the regions, religions, and ethnicities of Indonesia. Yujiro, a thirty-year-old Muslim, Japanese Indonesian who resides in Jakarta explains to me that not only does his mother hold cultural superstitions similar to that of Jane’s, so does he. Yujiro, is a member of Indonesia’s middle to upper-middle class because of his travel abroad explains to me that he has some evidence-based understanding of mental health disorders, but still holds some sentiment that supernatural phenomena influence these maladies. While he admittedly appears reluctant to admit his supernatural superstitions, adding prefaces of uncertainty to each explanation such as “maybe,” it is apparent that this uncertainty is likely because he believes that, I, from my position as a Westerner, “won’t understand” such superstitions. His acknowledgment that he understands, or at least has been

¹⁹ Ibid

exposed to in some degree, Western, evidence-based conceptions of mental health care while simultaneously holding cultural superstitions is intriguing. He explains to me in simple terms that its “easier” to view mental health this way, that since his mother holds similar beliefs, it is more comforting to him.

Sarah’s Story: Evidence-Based Understanding with Social Stigma

Sarah, who hails from a Christian family and doesn’t identify as any specific ethnicity explains that both she and her family don’t hold any specific superstitions and recognize that mental illness is “real.” She explains that both her parents spent portions of their youth in the United States and brought her to a psychologist when she was young. “My parents saw my slow speech as a child as possibly being autism,” she explains. When asked why her parents differed in the nature of their beliefs surrounding mental illness, she explains her parents were “brought up differently from others...they had friends that informed them of the symptoms (of autism).” She further explains that while her family seems to hold no superstitious beliefs surrounding mental illness, any disorder is viewed as potentially deeply shameful. “My mom half believes in ghosts...my dad doesn’t completely.” She explains that her family and many others understand to some degree the “true” nature of mental illness, but often choose to attribute the symptoms to supernatural phenomena instead. This is due to the deeply shameful nature of such illnesses and the “saving face culture of Indonesia.”²⁰

The Intersection of Saving Face and Cultural Superstition

Strikingly, the very visible and strong common thread through all of the interviews conducted suggests that some Indonesians, particularly those of the upper and upper-middle classes in urbanized areas may have some basic understanding of the nature of mental health

²⁰ Sarah M, interview by Alexander Gronowski, online, April 3, 2020.

disorders. Yet, notably, this understanding appears to end right where Indonesia's culture of "saving-face" begins. All those interviewed mention the almost universal view that any mental health disorder is deeply shameful. Interestingly, because it is easier to explain the illness as an external, rather than internal phenomena, the shame of such maladies is shifted towards into a more socially acceptable avenue. That is to say that, while many Indonesians appear to not necessarily fully believe in the supernatural originations of such disorders and illnesses, many choose to as social status preservation method.

It appears likely that just as Jane who has both the knowledge and resources to seek out a psychologist or psychiatrist yet chooses not to, this social preservation method has drastically reduced the *actual* demand for professional psycho-social support. While there is demand for better interventions, specifically beyond that of *pasung*²¹, there is no willingness to subject oneself to the shame of actually undergoing other professional psycho-pharmacological interventions. It appears that the number of psychologists and psychiatrists in Indonesia is so few because there is so little actual demand for their services.

On the Forefront of Change

If Indonesia's paucity of mental health care resources is in fact due to the underlying stigma of such maladies hindering demand, then the first place to start in further developing Indonesia's mental health care infrastructure is the erasure of such stigmas. Thankfully, an increasing number of programs and NGOs appear to be heading the call to battle.²² One such organization is Griya Schizofren, which devotes itself to the de-stigmatization of those with

²¹ Ade Prastyani, "Mental Health Care in Indonesia: Short on Supply, Short on Demand," *New Mandala*, July 26, 2019, para 17, <https://www.newmandala.org/mental-health-in-indonesia-short-on-supply-short-on-demand/>.

²² Marcel Thee, "'You're Not Religious Enough': Pain of Indonesia's Mentally Ill and the Online Group Bringing Sufferers and Carers Together," *South China Morning Post*, November 6, 2019, <https://www.scmp.com/lifestyle/health-wellness/article/3036343/youre-not-religious-enough-pain-indonesias-mentally-ill>.

schizophrenia, those most commonly subjugated to *pasung*. Through open invitations to the public to spend time with those suffering from the pernicious illness, this NGO seeks to attack *pasung* at its root cause.²³ The flyer shown below reads: “Coloring and drawing with people with mental illnesses, physical exercise with people with mental illness, sharing a meal with people with mental illnesses, storytelling with the mentally ill.” The organization hopes that through such shared activities, those with mental illness who are used to hiding away behind lock and key won’t need to be hidden.²⁴ Hopefully by removing the stigma of mental illness, Indonesians will begin to both seek and demand professional psycho-social support when necessary, ultimately leading to a development of the countries meager mental health system resources.



Image 4: A Flier from Griya Schizofren That Reads: "Draw with People with Mental Illness", Instagram (Griya Schizofren, March 19, 2019), <https://www.instagram.com/griyashizofren/?hl=en>.

Looking Forward and Limitations of Research

Indonesian identity encompasses populations as ethnically and religiously diverse as they are geographically disparate. Due to the nature of the nation and the way in which the

²³ “Bali’s Miracle Worker” (SBS Australia, March 7, 2010)

²⁴ Ibid

unprecedented COVID-19 crisis has limited access to less developed regions of the nation, it is difficult to draw precise and nuanced descriptions of why Indonesia's mental health system lags behind economies with similar levels of development. It is very likely that significant regional disparities in provided mental health services exist to varying degrees amongst these populations. The interviews and literature reviewed here expresses a strong bias towards English speaking, moderately affluent, Jakarta natives. Ethnicities such as Balinese, Sundanese, and other must further be explored in order to represent a picture of Indonesia's attitude towards professional psycho-social support that isn't overly simplistic or skewed towards certain socioeconomic and geographic groups. While this paper provides a starting point in exploration of the issues of Indonesia's professional psycho-social support systems, a more clear picture likely will require intensive, region-specific research.

Appendix

Interview Questions:

Health care Providers:

1. How are you related to the health care infrastructure in Indonesia?
 - a. Do you have a specialization?
 - b. Where do you practice?
 - c. Do you think where you practice influences the way you practice?
2. What are the demographics of your patients?
 - a. What are the socio-economic demographics of your patients?
 - b. What the ethnic demographics of your patients?
 - c. What are the geographic demographics of your patients?
3. What would you say, if any, are the most common issues faced by persons seeking your help?
4. Are you familiar in any way with the mental health care infrastructure in countries outside of Indonesia?
 - a. Are their significant differences apparent to you between these infrastructures? How would you characterize these differences?
5. How readily available is mental health treatment in Indonesia?
 - a. How common is it that those with serious, debilitating illnesses are able to find treatment or go untreated?
 - b. What are the areas in which Indonesian health care is most lacking?
 - c. Do you see specific areas in which the Indonesian mental health care system fully meets the needs of patients?
 - d. In your experience, how available is psycho-therapeutic support?
 - e. In your experience, how available is psychiatric support?
6. What is the practice of *pasung*?
 - a. Do you have any personal experiences with the practice?
 - b. Why do you believe this practice exists solely in Indonesia?
 - c. Is *pasung* harmful to those suffering from mental illness?
 - d. Do you believe the practice of *pasung* could be the result of lacking infrastructure?
 - i. Could it be that the values and beliefs influencing *pasung* hinder the rollout of mental health care services?
7. What is the general attitude Indonesians have towards mental health as well as forms of psycho-social support? (i.e. Psychiatric medicines, psychotherapy)
 - a. Have you noticed any differences in attitudes amongst geographical locations?
 - b. Have you noticed any differences in attitudes amongst ethnic lines?
 - c. Have you noticed any differences in attitudes amongst socioeconomic lines?
8. How well-informed would you say the average Indonesian is about mental health?
 - i. Does the level of education in this area vary with other factors? (Ethnicity, socioeconomic status, etc.)

Self-identified patients:

1. What is your personal experience with the Indonesian mental health care system?
 - b. In your experience, how available is psycho-therapeutic support?
 - c. In your experience, how available is psychiatric support?
 - d. Has the Indonesian mental health care system been able to meet your needs?
2. What would you say is the general attitude Indonesians have towards mental health as well as forms of psycho-social support? (ie. Psychiatric medicines, psychotherapy)
 - a. Have you noticed any differences in attitudes amongst geographical locations?
 - b. Have you noticed any differences in attitudes amongst ethnic lines?
 - c. Have you noticed any differences in attitudes amongst socioeconomic lines?
 - d. How well-informed would you say the average Indonesian is about mental health?
 - i. Does the level of education in this area vary with other factors? (Ethnicity, socioeconomic status, etc.)
3. Have you had any personal experience with *pasung*?
 - a. How do you view the practice?
 - b. Why do you think the practice exists? What beliefs underlie the practice?
4. How affordable are psycho-therapeutic services in Indonesia?
5. Do you see any areas in which the Indonesian mental health care system is lacking?
 - a. Do you see any areas in which the system excels?
6. How are those who seek out professional psycho-social support viewed?
 - a. How are those who require professional psycho-social support (ie. those who struggle with their mental health) viewed?

Non-patients:

1. What is the general attitude Indonesians have towards mental health and other forms of psycho-social support?
 - a. Have you noticed any differences in attitudes amongst geographical locations?
 - b. Have you noticed any differences in attitudes amongst ethnic lines?
 - c. Have you noticed any differences in attitudes amongst socioeconomic lines?

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