Dutch colonial psychiatry towards order and social responsibility: The making of asylums for the "insane" in the former Dutch East Indies, 1866- 1920

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Introduction

In an article in the academic journal *Psychiatrische en neurologische bladen* from 1905, psychiatrist dr. Hulshoff-Pol claimed the 'Inlander'[1] in the Indonesian archipelago was "soft hearted, indolent, fatalistic, and similar to other "people from nature": hospitable and helpful to their equals."[2] According to Hulshoff-Pol, these characteristics evidently resonated in the treatment of insanity in the setting of the *desa*.[3] Whenever a person was labelled as insane, it's kin and the rest of the community would leave the person roam free as long as this individual caused no nuisance or harm to others. In the case an insane member of the community posed a danger to the rest of the *desa*, out of self-preservation, he or she would be locked up in a bamboo cage or placed in a construction to scotch their legs. Remarkably, Hulshoff-Pol preferred this form of confinement, which he thought was bestial nevertheless, over the incarceration of patients in asylum-cells in Europe, often for periods of months. What helped to make the fate of the local insane more sufferable, Hulshoff-Pol continued, was their assumed relation with the supernatural world. To demonstrate the consequences of their mythical status, Hulshoff-Pol narrated the story of Madlapi, a patient of the Buitenzorg asylum:

"On a certain day, after being already insane for 4 years, Madlapi would heal the sick child of a fellow inhabitant of the desa. Having said the child needs to be first murdered before it can be healed, Madlapi, in the company of his own wife and the parents of the child, took the child, threw it twice in the air, grapped it by the legs and hit the child with its head against the doorpost. After cleansing the body of the child in the river, and removing the flesh of its bone, (arguing that the child had become half human-half goat) members of the *desa*, who saw Madlapi perform this act, warned the police."[4]

When the parents were asked why they allowed Madlapi to murder the child, their answer was that they believed him when he had said he was able to bring the child back alive after first murdering it. This gruesome account is delivered to the reader by Hulshoff-Pol to demonstrate the social and cultural position of insanity in the worldview of the local population. Moreover, the example of Madlapi - immediately followed by an elaboration of care in state asylums - is provided to argue for the institutionalization of people defined as insane who were argued to

[1] Inlander: Dutch pejorative for "native" inhabitant of the Indonesian archipelago.
[2] Dr. Hulshoff-Pol, "Verpleging van krankzinnige Inlanders in onze O.-I. bezittingen" Psychiatrische en neurologische bladen, Vol 9 (Amsterdam: van Rossum, 1905): 436.
[3] A rural community of several hamlets or villages
[4] Hulshoff-Pol, "Verpleging", 438.

pose a threat to their family and the rest of society.

The majority of the psychiatrists who were in charge of the colonial asylums in the Dutch East Indies, between the establishment of the first asylum in Buitenzorg in 1882 and the start of a more repressive colonial politics from the 1920s onwards, practiced psychiatry based on the idea of "mental isomorphism". They argued that the human psyche was a universal entity, with the Western and "native mind" essentially alike.[5] Any differences between the ethnic groups of Dutch colonial society were explained by exterior factors such as culture, climate and economic conditions. Although the sameness of people was the theoretical premise maintained by most psychiatrists, differences between the Dutch and local (in)sane were fitted in a scheme of civilizational progress. This meant that even though they were esteemed to be on a lower step of the civilizational ladder, progressive colonial governance could potentially undo the negative effects of exterior factors such as religious superstition and a climate that induced laziness.

Termed the "excuse of colonialism" by Waltraud Ernst, the practice of European medicine was presented to the European population as a noble institute of the civilizing mission and an expression of pure humanitarianism.[6] Fulfilling the task of ideological legitimation, advocates of modern psychiatry characterized the development of the medical field as a reflection of civilization. In a report that lay the blueprint for asylum care in the Dutch East Indies, its authors cited John Conolly (the English psychiatrist who introduced the principle of non-restraint in the treatment of asylum patients), who said that "nothing is more difficult to explain than states, who call themselves civilized, that neglect the unhappy – those who are suffering from the worst of all illnesses."[7] Echoing the words of Conolly, dr. Bauer and dr. Smit articulated in the same report the need to set up a network of asylums in the Dutch East Indies based on the modern principles of psychiatric care they encountered during a study trip in Europe in 1866.

According to Claire Edington, historian of colonial psychiatry in French Indochina, the colonial asylum was a unique colonial institution that functioned as both hospital and prison.[8]

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[5] Hans Pols, *Nurturing Indonesia: medicine and decolonisation in the Dutch East Indies* (Cambridge: Cambridge university press, 2018), 121.

[6] Waltraud Ernst, "Idioms of madness and colonial boundaries: The case of the European and "native" mentally ill in Early Nineteenth-century British India," *Comparative studies in society and history* 39, no. 1 (Cambridge: Cambridge university press, 1997): 168.

[7] F.H. Bauer & W.M. Smit. *Verslag van het onderzoek naar den tegenwoordigen toestand van het krankzinnigenwezen in het algemeen en van de gestichten en verblijven der krankzinnigen in Nederlandsch-Indië in het bijzonder* (Batavia: Landsdrukkerij, 1868), 73.

[8] Claire Edington, *Beyond the asylum: mental illness in French colonial Vietnam* (Ithaca: Cornell university press, 2019), 4.

Bringing together positivistic explanations about human nature and illness on the one hand, and castigations of unwanted social behavior on the other, the asylum has largely figured in the historiography of colonial medicine as a site of colonial violence. As the point of assembly for medical science and colonial power, research on the colonial asylum often departs from the intention to identify the repressive character of colonialism. Since the late 1990s, historians of colonial psychiatry have unsettled the idea of asylums as sites of a Foucaldian 'great confinement', where the socially undesirable were removed from mainstream society on a large scale.[9] With regards to psychiatry in British India, Waltraud Ernst identified how superintendents lacked unbridled authority to implement psychiatry after a European model and were forced to concoct 'colonial variations.'[10] The differences between the European metropole and colonial society in terms of state organization and race relations, inaugurated a number of problems for colonial asylums regarding financial resources, hiring staff and cultural misunderstandings. Despite the mapping of the limits of psychiatric authority, the (postcolonial) histories of colonial asylums are dominantly narrated through a confrontation between colonial psychiatry – which pursued hegemony through medical diagnosis and authority over treatment – and resistance of the colonized, who tested the limits of colonial authority.

According to Hans Pols, historian of medicine in Indonesia, the practices of institutionalization and social control were less important to the colonial context compared to the articulation of ideas of the "native" mind in colonial discourse.[11] Pols therefore, limits the scope of his research agenda to the monologues of psychiatric experts on the inferiority of the local population, and its instrumentality to the repressive and racialized colonial governance that was shaped in the 1920s and 1930s following economic turmoil and the rise of different Indonesian nationalist movements.[12] Pols narrates the discursive formation of ideas about the "native" mind as a confrontation between Dutch psychiatrists and Indonesian medical students who opposed the colonial construct of the "inferior native" (Dr. van Loon stigmatized and reduced the 'normal' Malay mind as "lazy, emotional, childish and suggestible" based on research of insane patients). Hence, he bypasses the 'conversation' between psychiatry and indigenous forms of knowledge, the relation between colonialism and asylum practice, and the construction of the "native insane" as a social category, embodied in the history of the

[9] Manuella Meyer, "Madness and psychiatry in Latin America's long nineteenth century," in The Routledge history of madness and mental health, edited by Greg Eghigian (New York: Routledge, 2017), 193.
[10] Waltraud Ernst, "Idioms".
[11] Hans Pols, "Psychological knowledge in a colonial context: theories on the nature of the "native mind" in the former Dutch East Indies," *History of psychology* 10, no. 2 (2007): 127.
[12] See footnotes 4 and 6. In addition: Hans Pols, "The development of psychiatry in Indonesia: From colonial to modern times," *International review of psychiatry* 18, no. 4 (August 2006): 363-370.

institutionalization of psychiatry. The work of historians like Hans Pols and Meghan Vaughan on psychiatric conceptions of the "native mind" and their relation to colonial discourse is an important field of research because it uncovers the intricate relationship between psychiatry (and other scientific disciplines), political discourses and the sustenance of colonial hierarchies of power.[13]

However, to narrate the history of colonial psychiatry through the different social actors and bodies of knowledge that shaped it, I foreground the social histories of the state asylums in Buitenzorg and Lawang (the only two central psychiatric institutions in the archipelago until a third asylum was opened in Magelang in 1923). Following Claire Edington, I argue that historians of colonial psychiatry – identifying the limits of psychiatric authority in colonial settings – have failed to question what the limits of expert authority can reveal about the history of colonial psychiatry and "the making of the asylum."[14] The story of Madlapi, and its interpretation by Hulshoff-Pol, exemplify how local ideas of insanity – ascribed to "exterior" differences such as culture and climate – were employed to argue for institutionalization while simultaneously prompting a reflection on the psychiatric discipline. In the existing literature on colonial psychiatry in the Dutch East Indies, the institutionalization of insanity in asylums is rendered marginal to the influence of psychiatric expert discourse on colonialism as an ideology. Remarkably, however, a social history of the mental asylums and their place within colonial society is absent from historiography.

Going beyond a research frame that emphasizes the instrumentality of psychiatry to colonial hegemony, a history of the making of the asylum brings into scope the institutionalization of insanity in a society dominated by colonial hierarchies. In addition, it sheds light on how insanity, as a social category, was produced during the era of institutionalization based on the need for colonial hierarchies and the incommensurability between local worldviews and a static scientific discipline. By rejecting universal notions of insanity, I will continuously interpret insanity and people deemed insane as products of social categorizations shaped by colonialism. Moreover, the production of an asylum system required the participation of different (local) social actors, who impacted psychiatric ideas and practices in a seemingly European sphere of control.

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[13] Meghan Vaughan, *Curing their ills: colonial power and African illness* (Stanford: Stanford university press, 1991).

[14] Claire Edington, "Beyond," 3. In addition: Claire Edington, "Going and getting out of the colonial asylum: families and psychiatric care in French Indochina," *Comparative studies in society and history* 55, no. 2 (2013): 727.

As such, this thesis pivots around the following intertwined questions: How was the institutionalization of asylum care given shape over the period 1882-1920, and how did local actors influence the making of psychiatric practices and ideas of madness in the colonial asylums of Buitenzorg and Lawang?

Set against the stage of a society with strict colonial hierarchies based on categories of race and class, mapping the role of local actors in the making of colonial psychiatry suggests towards an alternative characterization of colonial hegemony, and the relationship between colonizer and colonized therein. Different from the studies on the range of colonial hegemony and the instrumentality of psychiatry, I argue that a focus on the production of living conditions and care practices within the asylum, reveals how local psychiatrists, nurses, *mandurs*, patients and family members shaped colonial psychiatry. Nevertheless, the history of the mental asylums in Buitenzorg and Lawang, between the establishment of the former in 1882 and the rise of a more repressive asylum practice from the 1920s onwards, is first and foremost a history of the institutionalization of insanity. First articulated by Bauer and Smit in their report in 1868, the inauguration of state asylums was informed by the civilizing mission on the one hand, and the need to protect the public against dangerous individuals on the other:

"With the significant reforms of that branch of medicine in Europe, mainly brought to life at the beginning of this century, the desire to consider the overseas possession arose, and to better the miserable fate of those unhappy, those incurable insane who have a rightful claim to deepfelt compassion"[15]

"We bring back to memory, in accordance with the intentions of the Dutch government, with regards to locals, that only those are considered insane, who are a danger to public safety."[16]

This dual motivation for the transplant of psychiatry to the Dutch East Indies manifested in 1865 in a government decree ruling the construction of two state asylums on Java. The first asylum, erected in Buitenzorg in 1882, was modelled after the state-of-the-art Meerenberg institute in Bloemendaal. The second asylum, only to be constructed after the construction of the asylum in Buitenzorg was finished, was located in Lawang (residency of Pasoeroean), in a hilly region with a cool climate. A novel terrain of medicine in the colonial setting of the Dutch East Indies, superintendents operating in the early days of Dutch colonial psychiatry were fundamentally embedded in the tradition of modern psychiatry as practiced in Europe. The

[15] Bauer and Smit, 32.
[16] Idem, 35.

study trip of Bauer and Smit in 1866 through Europe before coming to Java, and the mistakes made with regards to the construction of Buitenzorg (the central asylum was entirely made up out of expensive stone materials to house local patients that were uncomfortable and unadjusted to a European environment), suggest towards the intention to transplant modern psychiatry to the colonial context. On paper, superintendents wielded wide jurisdiction ranging from decision-making concerning confinement and release to shaping patient-labor. In addition, the asylums were entrusted with a significant share of the budget of the public health service residing under the department of education, religious affairs and industry. In practice, however, the power of superintendents, and colonial hegemony in "the making of the asylum", were curtailed by 1) a lack of financial resources that forced the incorporation of 'colonial variations' of asylum care and 2) the need to bridge and accommodate exterior differences, between the psychiatric discipline and its local subject, within institutionalized asylum care. These two concerns – which often materialized at one and the same instance – informed the process of institutionalization in which local actors were able to negotiate asylum care.

Unfortunately, our vision on the social history of the asylums in Buitenzorg and Lawang relies heavily on the colonial archive, including all the pitfalls of colonial reporting. Moreover, while sources from the perspective of the colonized implicated in institutional affairs are scarce, accounts by local patients suffering from a mental illness are almost completely absent. Therefore, the majority of sources used for this research are institutional sources: annual reports of the asylums in Buitenzorg and Lawang, publications by superintendents in academic journals, reports from advisory boards and newspaper articles. Relying heavily on these colonial sources brings up a difficult question that troubles most colonial historians: how can we write a history of marginalized groups and individuals when we use biased sources that only speak *about* these people? To make it concrete: How can we do justice to the experience of asylum patients, their families and local staff by reading colonial sources in which they are narrated instead of narrators? As Remco Raben has argued, "The archives offer the frames for classifying society, and they produce silences and absences that obfuscate certain fundamental dynamics in society."[17]

Within this limitation, historians like Ann Laura Stoler and Talal Asad have turned their critical gaze towards imperial mindsets to untangle the formation of colonial discourses.[18] To

[17] Remco Raben, "Ethnic disorder in VOC Asia: A plea for eccentric reading," *BMGN – Low countries historical review Volume* 134, no. 2 (2019): 116 (115-128)

[18] Talal Asad, "Afterword: From the history of colonial anthropology to the anthropology of Western hegemony," in *Colonial situations: essays on the contextualization of ethnographic knowledge,* ed. George W. Stocking (Madison, Wisconsin: University of Wisconsin press, 1991).

complicate the idea of colonial psychiatry as a product of positivist science and rational governance, I will read institutional sources as sites of knowledge production instead of knowledge retrieval. As such, Stoler's method of "reading along the archival grain" will be deployed to shed light on sources that convey the motivations and reasoning behind colonial psychiatry.[19] Performing a reading along the grain is wielded to identify the embeddedness of superintendents in what Stoler termed the 'colonial common sense'. Narrating the supervision over the asylums through the colonial tenets of rational governance, universal science and psychiatry as a form of humanitarianism, the superintendents – who produced the majority of sources on colonial psychiatry – obscured the epistemic anxieties inherent to Dutch colonial rule.

Even though Stoler conceptualized the reading method with regards to the production of the colonial administration's archive, I consider "reading along the grain" relevant and applicable to the analysis of life in the asylum through the lens of the colonizer. Asylum politics – decisions on confinement and release, management of staff, increasing the yields of patient-labour - required the monitoring of sentiments, which potentially destabilized the authority of superintendents within the walls of the asylums, or lowered the credibility of psychiatry as a crucial hallmark of colonial medicine. Concerned with potential obstacles with regards to the management of the colony's insane population, colonial officials and asylum-psychiatrists had to adjust, consolidate, or cancel out asylum care. These efforts disclosed 'epistemic anxieties' about what superintendents, and other colonial officials, could know, how they could know it, and how to act on it. In the words of Stoler, these epistemic anxieties – far from rational governance – shaped a form of colonial rule in which:

"Grids of intelligibility were fashioned from uncertain knowledge; disquiet and anxieties registered the uncommon sense of events and things; epistemic uncertainties repeatedly unsettled the imperial conceit that all was in order"[20]

By following the thread of these epistemic anxieties, lingering in colonial sources, the impact of local actors on the making of the asylum can be brought to surface. At the intersection of anxieties about the continuity of colonial hierarchies of class and race, and the pressure on officials to adopt 'colonial variations" of asylum care, local personnel and patients were able to make a mark on asylum politics.

[19] Ann Laura Stoler, *Along the archival grain: epistemic anxieties and colonial common* sense (Princeton: Princeton university press).
[20] Ann Laura Stoler, *Along the archival grain: epistemic anxieties and colonial common* sense (Princeton: Princeton university press), 57.

To identify the role of local actors in the making of asylum politics and psychiatric knowledge beyond the reading of colonial sources along the archival grain, I will make use of the articles written by *dokter djawas* (local doctors) in the scientific journal *tijdschrift voor Inlandse geneeskundigen* (TVIG). While the 'official' academic medical journal for medicine in the Dutch East Indies – *Geneeskundig tijdschrift voor Nederlands-Indie* – was considered more prestigious by *dokter djawas*, getting published was hard because of discrimination against the less educated local doctors who had attended the *Stovia*[21] in Batavia.[22] Founded in 1893, the TVIG was created by Dutch doctors teaching at the *Stovia* to answer the needs of European doctors to know indigenous medicine, and to guarantee and monitor the quality of indigenous doctors. Brought to life to facilitate the practice of Dutch medics, the TVIG articulated the need of the Dutch health service to acquire indigenous knowledge through intermediaries. Moreover, according to Liesbeth Hesselink, author of the book *Healers on the colonial market*, the intermediary role of *dokter djawas* allowed them to fulfil a bridging role between Western medicine and a hesitant public.[23]

I argue, however, that publications of *dokter djawas* in TVIG reflect the impact of local doctors on asylum politics and the production of psychiatric knowledge beyond the role of intermediary between asylum and the local population. One example comes from *dokter djawa* Raden Soemeroe, who stated that he was needed in the asylum because other than translating, he understood that the Javanese mentality of his patients was incommensurable to European psychiatrists. Therefore, the different meaning of terms such as good and evil, stupid and clever, needed to be incorporated in psychiatric ideas of the human mind.[24]

To sketch a social history of the mental asylums in the Dutch East Indies, the chapters in this thesis follow a chronological order. Starting from the different conceptions of, and solutions to insanity at the arrival of psychiatry on Java, the first chapter maps how the arrival of institutionalized psychiatry related to the self-perception of Dutch colonialism (with regards to the status of state care of insanity) and existing forms of care in community settings. Moreover, I discuss in the first chapter how the establishment of the asylum in Buitenzorg inaugurated new epistemic anxieties concerning expansion amidst the creation of a social-legal category for those deemed insane.

[21] School tot opleiding van Inlandse artsen (school for the training of native physicians).
[22] Suri Yani, "Indonesian authors in Geneeskundige tijdschrift voor Nederlands Indie as constructors of medical science," *Lembaran Sejarah* 16, no. 2 (October 2020): 125.
[23] Liesbeth Hesselink, *Healers on the colonial market: native doctors and midwives in the Dutch East Indies* (Leiden: KITLV press, 2011), 197.
[24] Raden Soemeroe, "Eenige psychiatrische mededeelingen over imbeciliteit," *Tijdschrift voor Inlandsche geneeskundigen* (1898).

The second chapter revolves around the development of the agricultural colony, taking definitive shape from 1900 onwards, as a solution to the need for expansion. Representing a new phase in the institutionalization of colonial asylum care, the agricultural colony figured as an answer to epistemic anxieties concerning the social responsibility of asylums for a population of people defined as insane who proved more complex to categorize than anticipated. Unfolding within the realization of the agricultural colony were debates about the nature of the local (in)sane mind and the limits of cost-effective expansion. Presented as a 'colonial variation' of unconfined care that was developed in Europe, the agricultural colony in the Dutch East Indies inaugurated a new type of asylum care that upheld the pretense of civilized care adapted to local conditions.

In the last chapter I will argue how a complex amalgam of epistemic anxieties concerning expansion, reverberations of the civilizing mission and the ethical policy, and a more visible manifestation of local asylum staff resulted in an increased presence of the latter in the continuous "making of the asylum".

Confronting "insanity", a Dutch exploration of colonial mental illness

In 1868, the Dutch government received recommendations of two Dutch physicians to drastically expand and intensify the *krankzinnigenwezen* (psychiatric system) in the Dutch East Indies. Assigned by the Dutch government to first inquire on the latest trends in psychiatric care in modern European hospitals before setting sail to Java, F.H. Bauer and W.M. Smit took several months to investigate the status of care for the insane in the European metropole and the colonies before postulating their expert advice. Remarkably inexperienced, both Bauer and Smit did not possess – individually - a complete grasp of both psychiatry and the operation of colonial medicine in the Dutch East Indies. Bauer had been third-ranked psychiatrist at the Meerenberg asylum in Bloemendaal. Smit, on the other hand, was a general physician in the colonial health service. Combining their knowledge of psychiatry and health care in the colony, the two authors of the report formulated a number of recommendations that served as the blueprint for colonial psychiatry in the Dutch East Indies.

Not the first exploration of a reform of psychiatric care in the Dutch East Indies, *Het verslag van het onderzoek naar de tegenwoordigen toestand van het krankzinnigenwezen in het algemeen en van de gestichten en verblijven der krankzinngen in Nederlandsch Indie in het bijzonder* build on a number of government decrees and investigations preceding the studytrip by Bauer and Smit through Europe and Java. Dr. G. Wassink, chief of the military medical service in the Dutch East Indies, held an investigation into the number of insane based on the number of patients in the Chinsese hospital in Batavia (the Chinese hospital was a regular hospital with a number of rooms for patient suffering from mental illness) and estimations received from the 22 residents of Java.[25] In 1862, Wassink concluded that it would be sufficient if the colonial administration interfered with regards to the care for dangerous insane, whose number he estimated at 586 (later corrected to 800 taking the territories outside of Java into consideration). It would be impractical and "unnecessarily harsh" to confine patients who were relatively harmless to their surroundings and public order.[26] Later reiterated by Hulshoff-Pol, Wassink argued that the population of the *desa* was relatively tolerant towards individuals suffering from insanity, and only dangerous and badly treated insane had to be hospitalized by the state.[27]

The report by Wassink received criticism from the council of inspectors of Dutch

[25] Bauer and Smit, *Verslag*, 36.
[26] Ibidem.
[27] Idem, 39.

asylums because of the flawed statistical research, the absence of psychiatric expertise and the lack of proposed modern innovations.[28] Requesting further research into the number of insane and a new set of recommendations based on (modern) European psychiatric practices, the Dutch government send out Bauer and Smit to make a design for colonial psychiatry based on an elaborate study trip in Europe and on Java. In the meantime, indicating their intentions for reform, the Dutch government had already decreed in December 1865 that two new central asylums for insane patients had to be erected on Java. Following this kickstart from the Dutch government, the task of Bauer and Smit was to investigate where the first of two asylums had to be built, how it should be designed, and how it had to operate.

Before elaborating on the recommendations made by Bauer and Smit, it is important to stipulate what the two physicians-cum-investigators encountered on Java with regards to the existing institutionalized and communal forms of care. Building on the research agenda of postcolonial scholarship scholars, I explore how structures of colonial repression and subsequential ideological justification, formulated as ethical concerns, resonated in the early phase of constructing an asylum system. Central to this first chapter are the relation of institutionalization to preexisting practices and the obstacles encountered during the first decades of state asylum care: To what extent was institutionalization explained as an ethical project? How did the asylum figure as an institute for monitoring and policing the local population? What epistemic anxieties resonated in the production of an asylum system? How were these epistemic anxieties guided by perceived differences between colonizer and colonized, and the need for colonial hierarchies? And how did asylum practice produce a social-legal category of "the insane"? The elaboration on these questions in the rest of the chapter are a first explanation of what the history of the asylums can uncover about colonial medicine beyond its role of ideological legitimation.

According to Waltraud Ernst, a crucial question in the history of colonial medicine is the question raised by historian Roy Porter: "what is exactly colonial about colonial medicine?"[29] Within the field of post-colonial historiography, the work of Frantz Fanon has made a lasting impact on the answers formulated to this question. Ernst argues however, that studies within the Fanonian tradition have produced overly generalizing accounts in which the colonizer and colonized are rendered as binary homogenous group. In these accounts, the hegemonic colonizer is placed vis-à-vis the Fanonian trope of the subversive-submissive

[28] Bauer and Smit, *Verslag*, 39.
[29] Waltraud Ernst, "Beyond East and West. From the history of colonial medicine to a social history of medicine(s) in South Asia Social history of Medicine," 20, no. 3 (2007): 508.

colonial subject. This problematic tendency of postcolonial theory to postulate universal theories of social groups and subject positions obfuscates complexities on both side of the binary scheme. In contrast with the idea that historical accounts objectify and diminish the lived experience of marginalized colonial populations, a social history of psychiatric asylums can reveal the diversity of subject positions and forms of agency. Despite the urge to complicate postcolonial theory concerning colonial medicine, it is vital to not lose sight of the working of power in favor of foregrounding local actorship. Borrowing from Foucault, many historians of colonial medicine have engaged with power to critique colonialism through the lens of medicine. A social history of colonial asylums is inadequate when it is reduced to explain the one-dimensional context of Dutch colonialism and local resistance. Hence, it is vital to identify both historical threads that square with postcolonial theory concerning medicine and the production of colonial hierarchies, and those accounts of local actors who despite being subjected to colonialism enacted their agency and impacted the making of the asylum.

A disgrace to the colonial project

From the outset of the report, Bauer and Smit and later commentators juxtaposed the existing state facilities in the Dutch East Indies with the modern asylums seen in the Netherlands and other European countries. Richard Keller, historian of French colonial psychiatry in North Africa, has argued how the history of colonial psychiatry is incongruous with the idea of the colony as a 'laboratory for modernity'.[30] According to much of the work studying the relation between different scientific disciplines and empire, colonial territories served as sites to test and craft medical theories and social policies before they were implemented in the European metropole.[31] Hence, modern science followed a circular path instead of a trajectory of global expansion. In the case of colonial psychiatry, Keller argues, the idea of "productive cores and stultified peripheries" has proven rather resilient.[32] In the report by Bauer and Smit, this

[30] Richard Keller, *Colonial madness: psychiatry in French North Africa* (Chicago: The university press of Chicago, 2007), 7.
[31] Roy Macleod, "On visiting the 'moving metropolis': reflections on the architecture of imperial science," in *Scientific colonialism*: A cross-cultural comparison, ed. Nathan Reingold and Marc Rothenberg (Washington D.C.: Smithsonian, 1987).
[32] Keller, *Colonial madness, 6.*

conception of a global transfer from center to periphery is echoed in their comparison of state facilities in the Indies and the Netherlands. In their critique, the authors focus their attention on the Chinese hospital in Batavia, which in accordance with a government resolution from February 1824, was founded to "except for sufferers of incurable ailments, nurse insane belonging to the Chinese, Javanese and other unchristian nations."[33] The wing of the hospital designated to the care of insane, with a maximum capacity of 100 patients, was according to the report, highly unsuitable because of a number of reasons. Faulty ventilation, the non-existent separation between calm and restless patients, and insufficient separation between the sexes were only a few of the infrastructural shortcomings of the care for the insane in the Chinese hospital. Missing "straight chairs, tubes or what the new age has invented for this" the nature of care in the Chinese hospital was characterized by Bauer and Smit as non-medical, limited to somatic treatment, and "a prison for the insane."[34] Therefore, they concluded that care for the insane in the Chinese hospital, including its infrastructure, was unfit for proper treatment corresponding with the requirements of medical science. Similar to the Chinese hospital in Batavia, hospitals in Semarang and Surabaya housed a limited number of insane patients in conditions unworthy to the progress made in the psychiatric discipline in Europe.

Beyond the deplorable facilities, Bauer and Smit lamented the working conditions of doctors in the colony who were underpaid and therefore forced to practice private care in addition to their activities for the state. As a consequence of their dual practice, doctors in the medical service had no time to acquaint themselves with the latest developments in the field of psychiatry. Bauer and Smit concluded that the psychiatric care for insane in the existing state facilities fall terribly short with the "norms of science" and the level of civilization achieved in the West.[35]

Perceptions of the other

According to the report, the fault for the shortcomings of state asylum care could not be attributed to the Dutch government because it had demonstrated its interest in reform already

[33] Bauer and Smit, *Verslag*, 34.
[34] Idem, 35.
[35] Idem, 48.

several years before Bauer and Smits investigation. The failure of reforms, Bauer and Smit continued, had to be attributed to the local conditions of the Dutch East Indies:

" It is an irrefutable fact, that from the natural riches of the land, the simple way of life, the little needs in connection to the tropical climate, a situation ensues that creates fewer need for charitable public institutions compared to Europe, where the needs are far greater, and the struggles more urgent."[36]

In addition to the more favorable geographical conditions of the archipelago, the authors pointed to a number of social-cultural reasons that had obstructed reform: the simple diet, the communal willingness to help each other - "whether from a sense of humanity or because of religious customs" – created enough grounds to belief that the local population would never turn to the Dutch administration to take care of their insane unless they were dangerous to their surroundings.[37] Echoing the story of Madlapi discussed in the introduction, Bauer and Smit noted that similar to the other "more developed Eastern people who are Muslim", the majority of inhabitants in the archipelago respected the insane as illuminated individuals send by God.[38]

Even though the climatic and cultural differences informed a different interpretation and way of dealing with madness among the local population, Dutch psychiatrists stressed the need to implement mental asylums that embodied European notions of insanity. Combining the notions of humanitarianism and the protection of public order, Bauer, Smit and their successors argued to transfer the most pressing cases of local insane from community settings to the environment of the state asylum. Throughout the decades after erecting the Buitenzorg asylum, these men legitimated the existence and continued need for asylum reforms by addressing the horrendous conditions local insane suffered among their equals. Dr. J.W. Hofmann, superintendent in Surabaya and later in Lawang, published an article in the public liberal journal *De Indische gids*, in which he gave several accounts of residents who had witnessed the worst cases of maltreatment in *kampung* (village) settings. To strengthen the argument that "these cases prove sufficiently the questionable nature of the local care for insane" he added a case of which he himself had been an eyewitness of while working as 2nd ranked psychiatrist in Buitenzorg:

"Riding on horse a certain morning through the land Dramaga (in the immediate vicinity of Buitenzorg) my ear was struck by persistent wailing. Approaching this noise, I encountered

[36] Bauer and Smit, *Verslag*, 32.
[37] Idem, 33.
[38] Idem, 33.

there, in the kampung, an insane, locked up and pinned down in a bamboo cage; I inquired the assistant-resident, who put an end to this situation."[39]

Hofmann concluded with a condemnation of local care and reiterated the words of the Dutch psychiatrist and earliest reformer of asylum care in the Netherlands, Professor Jacobus Schroeder van der Kolk, who said in 1837 that "instead of incarcerating the unfortunate in cells and treating them with indignity, we need to open accommodations for them, fitted to sooth their misery and provide them with the necessary support."[40]

Reformers and (later) superintendents such as Bauer, Hofmann and Hulshoff-Pol continuously staged the care for insanity in *desa*-settings to argue for the introduction and expansion of asylum care. While, in the case of Bauer and Hulshoff-Pol, they engaged with the different social-cultural interpretation of insanity, respectively Islam and belief in the supernatural, they contrasted these accounts vis-à-vis psychiatric asylums as bastions of civilization where the living conditions were humane and treatment scientifically sound. Somewhat paradoxical, investigators and especially superintendents who soon familiarized with the day-to-day operation of the asylum, realized that institutionalization had to, somehow, adapt to the nature of the local patient. This is already articulated by Bauer and Smit in their comparison of the conditions in Europe and the Dutch East Indies:

"Our conviction is, that with the application of the same principles, adapted to the nature, customs and development, also from the normal local, the same result will be acquired as in Europe. How little civilized and developed men may be, everywhere he is receptable to good treatment and sensitive to humanitarian care and kind speech."[41]

The adjustment to these *differences* in the organization of asylums was a continuous struggle for Dutch investigators and superintendents during the early phase of state asylum care. Based on the principles of isomorphism, these men explained the differences of both the mind of insane locals, and the way their surroundings dealt with them, through civilizational inferiority and the task to uplift the poor sufferers out of their miserable conditions. In the early stage of colonial psychiatry in the Dutch East Indies we thus see an intertwined explanation, characteristic for the colonial politics at the turn of the 20th century[42], of (in)sane local patients and patient-communities: On the one hand, the local was the same but different, and its

[39] J.W. Hofmann, "Krankzinnigenverpleging in Nederlandsch-Indie" *Indische gids* 16, no.2 (1994): 988.
[40] Idem, 103.
[41] Bauer and Smit, *Verslag*, 1.
[42] Frances Gouda, *Dutch culture overseas, colonial practice in the Netherlands Indies, 1900*-1942 (Amsterdam: Amsterdam university press).

differences from the colonizer explained its inferiority and the need for colonial hierarchies. On the other hand, the local is different but the same and therefore equally sensible to psychiatric care embodied by the asylum. This innate incongruity of colonial psychiatry embodied the desire of the Dutch colonial project – during the years of the ethical policy - to civilize the local to a European intellect and standard of living while paternalistically sustaining colonial hierarchies based on the inferior differentness of the local. In the next chapters, I will argue how the limited authority and resources of superintendents and the colonial administration, forced a reinterpretation of the differentness of the local and its role in the making of the asylum. First, I will inquire how the ideas about the state of institutionalized and community care informed the early phase of institutionalization in state asylums.

Epistemic anxieties, debates and the creation of Buitenzorg

Similar to Wassink and other predecessors, Bauer and Smit struggled to determine the number of insane in need of care in the East Indies (Europeans were supposed be able to always get a place, whether voluntarily are because of a decision from one of the councils of justice). Unable to acquire a better estimation based on statistical research, the investigators remained critical of the reports by colonial officials who lacked psychiatric expertise and were therefore likely to make judgement errors regarding the threat an insane individual posed to its surroundings. Moreover, the authors warned the tendency of many psychiatrists to suggest that the people of the "hot climate zones" were less inclined to transgress into insanity. This reasoning, according to Bauer and Smit, was logical presuming that: "the lesser excitement of the native psyche, its lower stage of civilization, the simple and little needs, and societal condition, keep many causes of insanity removed from him."[43] According to Bauer and Smit, however, this theory had no raison d'être because of the many physical origins of insanity, which the local shared with the "Caucasian tribes". Moreover, passions such as love, revenge, bigotry and zealotry, Bauer and Smit noted, played an important role in the life of the local, and could lead to mental alienation the same way it did among "the more civilized nations".

For that reason, the report recommended the Dutch government, and the governor-general in the Dutch East Indies, to make no decisions about the quantitative need for facilities

[43] Bauer and Smit, *Verslag*, 53.

based on existing investigations into the number of (dangerous) insane locals. In their critical discussion of the quantitative need for institutionalized care and the subsequential recommendation by Bauer and Smit, resonated the first of many epistemic anxieties on the side of the Dutch colonizer regarding what they knew about insanity in the archipelago. Rejecting untested theories about the lesser prevalence of insanity among locals, and the absence of expertise among residents in their reporting, Bauer and Smit feared the potential consequences of "miscalculations" for future asylum care. Considering both the theory on climate zones and the unverified reporting by residents presumed the presence of relatively little insanity among locals, a negative reverberation of the epistemic uncertainty would be a shortage of places for European and dangerous local insane. Hence, the epistemic anxiety articulated by Bauer and Smit concerned the potential threat of (local) insane to public order and its racial hierarchies of power.

Therefore, to avoid a miscalculation based on numbers, Bauer and Smit advised the Dutch government and the governor-general of the Dutch East Indies to acquire large parcels of land around the institute in Buitenzorg, and later Lawang, to build agricultural colonies for patients who were no longer dangerous but still needed care.[44] According to Bauer and Smit, in the face of lacking statistical data, the expansion through agricultural colonies would safeguard state care for insane locals from overcrowding for decades to come.[45] Despite having their eyes on the future, Bauer and Smit were criticized for the design of Buitenzorg and its significant costs. Construction of the asylum in Buitenzorg had begun in 1875 and the asylum was taken into use on the first of June 1882. The construction process, however, proceeded with numerous setbacks and public debates. The first half of the asylum, designated for men, was finished in 1879 and costed a massive 1,095,000 guilders. The expenditure of the second half, designated for women, was estimated at 725,000 guilders. The Dutch government decided to put a hold on the construction of the second half, and resort to a temporary solution using acute care hospitals in Surabaya and Semarang, each able to accommodate around 100 patients.[46] With Buitenzorg being able to house 212 patients, the three facilities in different parts of Java were able to house a total of roughly 430 patients. This number, and the makeshift solution after ceasing the further construction of Buitenzorg, matched a government decree from May 14th 1867 determining that Buitenzorg and the second yet to be build asylum both had to have place for 400 patients. In an

[44] Bauer and Smit, *Verslag*, 67.
[45] Ibidem.
[46] Dr. D. Schoutz, *Occidental therapeutics in the Netherlands East Indies during three centuries of Netherlands settlement 1600-1900* (Batavia: Mededeelingen van den dienst der volksgezondheid in Nederlands-Indië, 1937), 167.

article published in *Psychiatrische en neurologische bladen* in 1905, Hulshoff-Pol commented that Bauer, the man behind the design of Buitenzorg, would have been surprised by the fact that half of the Buitenzorg asylum in 1905 was constructed out of semi-permanent materials (wood, bamboo thatch), considering the fact that in 1882 all the buildings were constructed out of stone.[47] This somewhat ironic comment by Hulshoff-Pol tied in to a debate waged towards the commissioning of the asylum in Buitenzorg. Ranging in the extremity of their ideas, a share of the Dutch and *Indische* public in the colony was opposed to the cost of Buitenzorg and it's use for care for the insane. Even though the asylum was designed to harbor all the European patients of the archipelago in the first place, there were criticasters that attacked the idea of locals hospitalized in state-of-the-art facilities. This was articulated by an anonymous contributor writing under the name A. in the *Bataviaasch Handelsblad* on the 30th of December 1882. The unknown author argued that the facilities in Buitenzorg should be designated towards the care of wounded soldiers:

"It should be called aggravating, that the ill soldiers of our Indies army are housed in poor bamboo constructions on damp clay soil, while less than an hour away, there is an idyllic, monumental hospital that can compete with the best in the world, that is used wrongly as an asylum for stupid, dazed and therefore insane locals: good-for-nothings, loafers, in any case beings that would be happier if they could have stayed in the *kampungs*."[48]

The critique of the anonymous contributor responded to the purpose of the institute and the way it was designed. The appointment of Bauer to design Buitenzorg and become its first superintendent meant that many of the recommendations articulated in the report were incorporated in the asylum. Explicitly inspired by the Meerenberg institute in Bloemendaal, the asylum in Buitenzorg was constructed 2 km from the town bearing the same name. Bordering Semplak village, the Tjidani river and the Kampung Tjikemeuh, the asylum grounds comprised a large terrain with agricultural lands and leisure areas (Coffee gardens, Sawahs, a garden and even a pool). In accordance with the conventional architectural style of the colonies, the psychiatric asylum comprised several smaller buildings rather than a large central structure. The pavilion structure embodied the separation of patients based on class, gender and the expression of their illness (often reduced to calm and restless) by housing them in separate buildings, scattered out over the terrain of the asylum. Connected by paths through gardens and

[47] Hulshoff-Pol, "verpleging", 441.
[48] Anonymous, "De verandering van het krankzinnigengesticht te Buitenzorg in een centraal militair hospitaal," *Bataviaasch Handelsblad*, 30 December 1881.

open spaces, the pavilion structure allowed local patients to be kept away from European patients, and patients defined as restless from those deemed calm. Moreover, the smaller separated buildings were encircled by corridors enabling patients to be outside in the shade. In addition, it provided supervising staff with a view on the inside and outside of the wards.[49] While the wards were located inside a walled terrain, the asylum perimeter was designed to have significant space for gardens, orchards, and both inside and outside leisure facilities such for *wayang* performances.as a billiard room for European patients and a *pendoppo*[50] for *wayang* performances.

Figure 1: "Het krankzinnigengesticht te Buitenzorg", Circa 1890, KITLV Leiden 50N8.

Inspired by the European non-restraint model, each ward had two "single rooms" or solitary cells to prevent the use of continuous physical correction and restraint. In practice, the single rooms had a broader use of isolation. Dr. Ledeboer, superintendent in Buitenzorg, for example wrote in the annual report over 1882-1892 of patient N. 704, a youthful Javanese who had to

[49] L.B.E. Ledeboer, *Verslag omtrent het krankzinnigengesticht te Buitenzorg over het jaar 1892* (Batavia: Landsdrukkerij, 1894), 11.

[50] A roofed shelter that is open on all sides and provides shelter from sun and rain. They were commonly used as common spaces for ceremonies (Wajang) and receiving guests.

be nursed in a single room because of a "tendency towards pederasty".[51] To regulate the operation of the asylum, the government published a regulation titled *Instruction for the superintendent of the insane asylum in Buitenzorg* on the 29th of June 1882. This legislative document stated that the "superintendent is the head of the asylum and is charged with the care and supervision for- and on everything, belonging to the service of the asylum."[52] The superintendent, however, was subordinated to the director of the department of education, industry and religious affairs, who initially considered requests for placement and assigned patients to a class corresponding with their social status in colonial society.

The construction of Buitenzorg according to what Bauer and Smit called the "demands of science and the deepest sense of humanity" was the reports most important recommendation and answer to the insufficient state facilities and local structures of care. After laying the infrastructural foundation of state care for the mentally ill, the anxieties of those involved in the creation of state asylum care, however, shifted towards issues concerning expansion. After Buitenzorg and the assisting institutes in Semarang and Surabaya started operating, the demand for institutionalized care soon outdid the combined capacity of 400 beds. Both requests from patients' families and the verdicts of judicial councils (*landraad*) stirred the superintendents to envision and argue for the construction of more facilities.

Pleas for expansion and the production of the social-legal "insane"

Since all known Europeans deemed insane were hospitalized in Buitenzorg, the urge to expend was directed towards the care for local patients, who were significantly more numerous. The pressure on the asylum in Buitenzorg, and the time needed to construct Lawang, informed superintendent Bauer and the colonial administration to act. Soon after care for the insane in Buitenzorg commenced, the asylum was expended with an agricultural colony. Intended for patients of all classes diagnosed as relatively tranquil, though mainly housing locals of the third and fourth class, the agricultural colony started operating in the vicinity of the enwalled asylum from 1884 onwards. The two pavilions were built on land designated for agricultural activities

[51] L.B.E. Ledeboer, *Verslag*, 96.
[52] Idem, 20.

and were described by Hulshoff-Pol as "simple and resembling farms."[53] In 1889, two more pavilions were added, enabling the care for a total of 80 patients in the four pavilions made up out of bamboo walls, cement floors and tiled roofs (In 1889 the atap roofs were replaced by tiles because of the many leakages). In addition to the expansion of the agricultural colonies, the second half of the central asylum in Buitenzorg, was finally ready in 1897. This second set of stone structures, the section intended for women, brought the total capacity of the asylum in Buitenzorg to 800. Despite the completion of the central asylum in Buitenzorg and the expansion of the agricultural colony, a call for expansion prevailed among the Dutch psychiatrist in charge of the asylums in Buitenzorg, Semarang and Surabaya. Therefore, the Dutch government decided in 1898 to give way to the construction of a second central asylum in Lawang, designed to house 500 patients, with the possibility to upscale this number to 1000.

The anxieties among superintendents over the shortage of facilities was intertwined with the creation of a legal arrangement of state care. While psychiatrists did not immediately criticize this legal arrangement, this legislative document codified aspects of state care that articulated the motivations of asylum-psychiatrists' to call on the government for expansion. In congruence with the absence of sufficient structures of care provided by the state before 1882, Bauer and Smit observed in 1868 that the legal provisions concerning asylum care had to be subjected to equal reform to meet "the demands of time and science." Since it was already part of their assignment to study the legal provisions in other European countries during their study trip, Bauer and Smit thought it would be best if the government commissioned them, together with a legal administrator, to draft a law for state asylum care in the colonies. It was, however, on the 4th of February 1897, 29 years after Bauer and Smits recommendation, and long after their retirement, that a regulation concerning the care for the insane in the Dutch East Indies (*reglement op het krankzinnigenwezen in Nederlandsch-Indie)* was realized.[54] In contrast with French Indochina, where regulations were drafted before the establishment of the first asylum for the mentally ill, the Dutch East Indies introduced regulations fifteen years after institutionalized care commenced in Buitenzorg.[55]

The superintendents mostly lamented the temporary confinement of patients before their admittance, regulated in Art. 6 Chapter I[56], and the judicial procedure preceding placement in

[53] Hulshoff-Pol, "verpleging", 445.
[54] Staatsblad van Nederlandsch-Indië No. 54, *Reglement op het krankzinnigenwezen in Nederlandsch-Indië* (1997).
[55] Edington, *Beyond*, 46.
[56] Art. 6: *Plaatsen tot voorlopige opneming van krankzinnigen zijn voor Europeanen de militaire hospitalen, voor Inlanders de voor hen bestemde ziekeninrichtingen, en wanneer de laatstbedoelde inrichtingen niet in eene afdeeling aanwezig zijn, insgelijks de militaire hospitalen. Ontbreken zoowel militaire hospitalen als voor*

one of the central asylums (chapter III). Due to a persistent shortage in the asylums in Buitenzorg and the assisting hospitals in Semarang and Surabaya, many of the patients who were already sentenced or assigned to asylum care had to wait for placement in provisional facilities. The 'places of provisional admission', as article 6 named them, were different for the Europeans and locals. For European patients, military hospitals were the first resort before being assigned a place in Buitenzorg, Surabaya or Semarang. For local patients, the first option were the hospitals for locals, followed by the military hospitals. For both categories of patients, prison was the last possible location where they could be accommodated awaiting placement in the asylums. In the annual report of Lawang over the years between its opening in 1902 and 1905, Dr. Siek Lykles, addressed the shortcomings of the "provisional facilities" that prevailed before the existence of Lawang. According to Lykles, out of the 554 mentally ill patients cared for in the military hospitals, hospitals for locals and prisons between 1890 and 1895, 69 (12%) died.[57] He commented that especially the patients who stayed a month or longer in these facilities suffered "highly unfavorable health consequences." Based on these numbers and the accounts by the doctors in charge of these institutions, Lykles came to the conclusion that "the prisons and local hospitals, where the care has not yet reached a significant level of civilization, the unfortunate mental sufferers are more maltreated than treated."[58]

The account of Lykles demonstrates how the critique of asylum-psychiatrists involved in asylum care shifted between the report by Bauer and Smit and the creation of the *Pasaroean* asylum in Lawang. Satisfied with the efforts by the Dutch government and the administration in the Dutch Indies to have built an asylum in Buitenzorg on a par with European institutions and scientific demands, the anxieties of asylum-psychiatrists in the Indies were transplanted to questions concerning the expansion of facilities and the sustainment of qualitive care. The present reality of shortages and maltreatment in provisional care was in immediate contradiction with the self-perception of the psychiatric discipline, embodied by the expensive asylum in Buitenzorg, as the pride of colonial medicine in the colony.

Parallel to the frustrations and seemingly humanitarian anxieties of asylum-psychiatrists, the asylums maintained and upscaled their policing task. The construction of

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Inlanders bestemde ziekeninrichtingen, of bieden deze geen voldoende ruimte aan, en bestaat in de afdeeling geen andere gelegenheid tot verpleging, dan worden de gevangenissen als plaatsen tot voorlopige opneming gebezigd. In deze plaatsen worden de krankzinnigen zoveel mogelijk van de overige daarin opgenomen personen afgezonderd. De bestuurders houden een register aan overeenkomstig het model door den directeur van onderwijs, eeredienst en nijverheid vastgesteld.

[57] Dr. S. Lykles, *Verslag omtrent het krankzinnigengesticht te Lawang (residentie Pasoeroean) vanaf de opening op 23 juni 1902 tot ultimo 1905* (Batavia: Landsdrukkerij, 1906), 8.

[58] Ibidem.

Buitenzorg and the codification of the 1897 regulations enforced the image of colonial state asylums as an institute for incarceration. From 1882 onwards, newspapers in the East Indies increasingly explained violent acts by locals as acts of insanity. In these short news bulletins, the authors reiterated the new role of the asylum by stating that alleged perpetrators had to be send to Buitenzorg. On the 30th of June 1886, the *Bataviaasch nieuwsblad* described the account of a local who "suddenly turned insane" and tried to harm one of his peers with a knife.[59] Prevented from doing harm by bystanders, "a swift dispatch to Buitenzorg was a pressing matter."

In the same year, a unanimous author in the *Bataviaasch handelsblad*, who claimed to speak on behalf of a group of people who had worked in asylum care in the Netherlands, stated that psychiatry was a science in the making that lacked the instruments to heal people.[60] Until scientific research had developed medical solutions for insanity, asylum staff had the responsibility to render the patient harmless to themselves and others. The task of protecting patient and society, the unanimous author continued, gave asylums a policing character: "Carrying in its nature an element of force, the asylum rules over its patients and decisions concerning stay and release based on the police laws in the *Inlandsch reglement"* (legislation concerning the rights and duties of locals in which regulations concerning insane patients were codified before 1897). While Buitenzorg offered plenty of places to European patients, the asylum system was primarily conceived for locals, the majority of the population of the archipelago. The idea that "everywhere there are persons living in freedom who are insane and need surveillance before they commit crimes", articulated in the *Soerabaijsch dagblad* in March 1888, reflected public sentiments on the task of the asylum to confine dangerous insane who threatened colonial order.

The cohesive articulation of public opinion on the duty of asylums to hospitalize local insane who were dangerous to public safety resonated in the creation of the legislation for insanity. The process of a local individual becoming legally insane started when the individual in question, his or her kin, or the (local) officer of justice filed a request for placement to the *Landraad* (judicial council existing of a jurist and two important members of the local community). The officer of justice was legally obliged to make a case to the *Landraad* when he considered "the placement of the insane under strained supervision in the interest of public order or to prevent accidents" a necessary action. Thereafter, the *Landraad* would host a sitting where the filed request was consulted, and eyewitnesses or even the person deemed insane were

[59] Anonymous, *Bataviaasch nieuwsblad*, June 30, 1886, 2.
[60] H. "Krankzinnigenverpleging te Soerabaja," *Bataviaasch Handelsblad*, May 13, 1886, 2.

heard to provide information. The *landraad* consulted a licensed physician to assess the case report - which consisted of the conditions that led to the request and the testimonies of kin and other witnesses - and provide a written evaluation that accounted whether the person in question suffered from a mental illness. When the *Landraad* thereafter ruled the person on trial to be insane, this status would remain legal for the maximum of one year. This legal status could be ended before the expire date of one year, or extended with one year, based on the recommendation of the superintendent of the respective asylum. The new legal status of asylum care meant that superintendents bore responsibility over their patients, both with regards to their care and the protection of public order.

However, given the colonial context of racial hierarchies and subjugation of the local population, it is important to question what was considered dangerous insanity? and what people ended up in state asylums? The annual reports of Buitenzorg and Lawang contain some patient histories of "sufferers" that left the asylum because they were considered "recovered", "sufficiently improved" or "unrecovered but no longer dangerous." Even though the reports contain little reference to the legal procedure of "becoming insane", they can help trace the motivations behind hospitalization.

Beyond detailed descriptions of character, mental deviations, and anxieties over heredity and the duration of illness, the superintendents often identified direct and indirect reasons that required hospitalization. Patient No. 696, an Indo-European of 53 years old, was hospitalized in the military hospital in Weltevreden in July 1890 before coming to Buitenzorg because "his residency at home had become impossible because he walked after his wife with a knife." The notion of a dangerous crime that immediately required hospitalization is contingent and lacking context. Hence, the assessment of patient No. 696 as a dangerous insane individual was informed by additional bits and pieces of information. According to Ledeboer, the superintendent in question, the patient had recently been "highly irritable, quarrelling with his wife who he accused of abortion and adultery, and demonstrating erotic tendencies towards his 18-year-old daughter in law. Making the removal of the latter inevitable." In another case, Ledeboer narrates the hospitalization of patient No. 735, a Sumatran of roughly 30 years old. According to the "state of intelligence" this patient was insane for over a year and transgressed into insanity two times before. Despite him being categorized as "not yet directly dangerous for himself or others" his excessive behavior (fencing against an imaginary opponent, "walking around at night", interest in arson, petty theft and following people who "attract" him) was deemed enough reason to place him in the asylum in Buitenzorg. Remarkably, he was discharged after six months because the asylum-psychiatrist had not identified any indications

of insanity. These two examples demonstrate how the process of determining whether a patient was a "dangerous insane" was ambiguous and far from bound to strict procedures. Beyond direct acts that justified categorizing a patient as dangerous, the detailed descriptions of problematic behavior, also in the private sphere, suggest towards a more complex process of diagnosing insanity. Despite the diversity of the asylum population in terms of ethnicity, class, gender and age, it seems that the categorization of insanity, beyond notions of danger, was constituted by colonial ideas of socially desirable behavior.

In addition to the argument of maltreatment, Lykles and other superintendents criticized the impact of the long periods between the transgression of a patient into insanity, the judicial verdict of placement, and the actual placement in the asylum, on recovery. In the annual report over the period 1902-1905, Lykles argued that the chance of recovery significantly decreased because of the long waiting lists and the many people that, aware of the waiting lists, did not file for the hospitalization of their kin.[61] Echoing Bauer and Smit, who had stated that a patient was categorized "uncurable" after a year of prolonged insanity, Lykles noted that in 1893, the department had 50 unsolved requests for hospitalization. The fact that many of the patients spend significant amounts of time in provisional facilities or remained in community settings before admission, where the risk of maltreatment existed, placed an impediment on the chances of curing patients. Instead of receiving patients soon after their mental illness manifested, many patients entered the asylum after months of being ill. According to Lykles:

"As a general rule, we can assume that chances of recovery from insanity are inversely proportionate to the duration of the illness. Most recoveries take place in first months of the illness, in the second half year the chances have already significantly decreased, and in the second year only 2 to 5%. After two years, recovery is extremely rare."[62]

Hence, because of the significant time between becoming ill and entering the asylum system, the asylum in Buitenzorg and the assisting hospitals in Semarang and Surabaya struggled to become care facilities where temporary treatment was provided before sending patients, recovered or significantly improved, back to their families. In 1892, for example, the asylum in Buitenzorg admitted a total of 106 new patients. 93 of these new patients belonged to the "4th class", the category for local insane that were not able to make any financial contribution to the

[61] Lykles, Verslag, 7.
[62] Idem, 7-8.

care provided to them.[63] Of these patients, both men and women, 38 were suffering from their mental illness for longer than a year, 5 already since their early childhood, and of 19 patients the duration was unknown. The number of patients that entered the asylums after suffering from their mental illness for a year or longer, as a share of the total number of new patients admitted to the asylum in 1892, suggests how the long duration of the observed mental problems led to a wavering asylum system with few recovering patients and many individuals waiting for hospitalization. Dr. J.W. Hofmann, superintendent in Surabaya between 1887 and 1891, argued in *De Indische gids* in 1894 that the asylums were overcrowded with uncurable patients, who made it impossible to admit more people with recent symptoms of insanity.[64] He concluded that "under these conditions, the noble avocation of the asylum-psychiatrist is close to being reduced to the officialese duty of a warder."[65] In congruence with article 21 (chapter III) of the 1897 regulation, stating that legal custodianship over an insane patient had to be renewed or terminated after a year, superintendents had to endlessly reassess the cases of numerous uncurable patients who would remain in the asylum for the rest of their lives.

Moreover, the legal custody over uncurable patients was hard to reconcile with the idea, articulated by Bauer and Smit, that only those who were a danger to the public order were considered insane. Hulshoff-Pol, observed that the asylums housed many "forensic cases of whom it is hard to decide what to do with them".[66] These patients, often having committed severe crimes, seemed recovered and were ridden of clear psychological malfunctions. The superintendents, however, were hesitant to release these patients because they were not sure of complete recovery, or feared the recovery was of a temporary nature. Hulshoff-Pol, observing that this problem equally troubled psychiatrists in the Netherlands, stated that the issue was extremely difficult to Dutch psychiatrists in the Dutch East Indies because:

"We Europeans know so little about what moves the native, making it very difficult to ascertain whether an insane who seems recovered, really is free of his ailments. Moreover, conditional discharge of patients, where the patient remains under supervision of the police, is unknown to these regions."[67]

This dilemma led Hulshoff-Pol to self-reflectively ask: "I don't dare to release them, and I don't want to keep them within the institute among all the other insane, what else to do? The question

[63] Ledeboer, *Verslag*, 82.
[64] Dr J.W. Hofmann, "Krankzinnigenverpleging in Nederlandsch-Indië" Vol 17, No. 2 (1894): 984.
[65] Idem, 986.
[66] Hulshoff-Pol, "Verpleging," 453.
[67] Hulshoff-Pol, "Verpleging," 453.

posited by Hulshoff-Pol, and the feeling of impotence that came along with it demonstrates how the social-legal category of mentally ill became a burden to the colonial state during the first two decades of state asylum care. Similar to what Claire Edington identified in French Indochina, state engagement with mental illness in the Dutch East Indies evolved from merely being a concern for social order, to a problem of social responsibility.[68] Hence, the complaints of asylum-psychiatrists over the maltreatment in provisional facilities and the growing number of uncurable patients remaining in the asylums, echoed the former's epistemic anxiety concerning the ability of the asylum to render dangerous insane harmless.

Willingly or not, the creation of the insane as a legal category, combined with the slow process of admission and the rising number of uncurable and dormant dangerous patients, inaugurated continuous pressure on the asylum network. In the next chapter we will see that this question, critical to the social history of the asylums in Buitenzorg and Lawang, intertwined the anxieties of asylum-psychiatrists with the creation of 'colonial variations' of state asylums.

[68] Edington, *Beyond*, 54.

Envisioning the agricultural colony

In the previous chapter, I have argued how the concerns of psychiatrists in the Dutch East Indies shifted towards the expansion of the asylum system to accommodate the growing demand for hospitalization of local insane. Unanimous in their verdict on the provisional facilities and the consequence of overcrowding on acute care and recovery chances, asylum-psychiatrists sought for a method to expand asylum care to answer their newly acquired social responsibility for people deemed insane by social-legal categorizations. This new responsibility, however, was accompanied by debates concerning the realization of expansion, and the nature of the local insane.

The expansion of state facilities for local insane remained interwoven with a multitude of epistemic anxieties concerning: the number of insane in the archipelago, the most suitable form of asylum care for local patients and the frightening realization that modern psychiatry knew so little about the local mind.[69] Underneath these interlinkages between state asylum care and the colonial desire to "know and represent the natural world and society of the Indies as a series of fact that could be governed"[70], lay a continuous financial struggle. This financial strain resonated in the realization and subsequential operation of the agricultural colonies in Buitenzorg and Lawang. In this chapter I will therefore explore the following questions: How did the need for expansion, considering the financial problems, result in a 'colonial variation' of asylum care? How did debates over the nature of the indigenous insane figure in the realization of expansion? And to what extent was the expansion of the asylum system inspired by practices in Europe (Similar to the original institute in Buitenzorg)?

Expert debates on the nature of insanity and the need for cost-effective expansion

In 1894, J.W. Hofmann argued in *De Indische gids* that all local patients, including the restless, had to be removed from the permanent stone structures in Buitenzorg to make place for the 50

[69] Van Brero on this matter in GTVN: "Statistical data concerning the prevalence of the difference forms of insanity among the population of the East Indies archipelago, numbers that are crucial to the construction of an asylum, are absent because nobody has witnessed a sufficient number of acute psychoses."
[70] Cohn, Colonialism and its forms of knowledge: the British in India (Princeton: Princeton university press, 2003), 4.

European patients on waiting lists. Inspired by his comparative study with asylum care in British India, Hofmann proposed to repatriate European patients to the Netherlands after British example.[71] The heat, homesickness and anemia were just a few reasons to assume that conditions in the metropole were significantly better for recovery. Hofmann believed the costly asylum in Buitenzorg was contradictive with the nature and living conditions of the local. In addition, it did not serve the purpose of state care for the local population. The money spend on the cathedral of Dutch colonial medicine could have facilitated a simple, yet organized and non-impoverished asylum system for local patients. Therefore, he argued for a new system of "unconfined care" in the setting of the agricultural colonies with patients housing in bamboo structures, their "natural home".[72]

Unambiguous about the role of the asylum psychiatrist, Hofmann argued that it was the obligation "of us, pioneers of civilization and humanity, to aid the hundreds of unfortunates in accordance with the law and science."[73] To finally reform the asylum system and walk "the royal road instead of a side path" implied the transplantation of local patients out of the monumental structures of Buitenzorg into the agricultural colony where "the Javanese is granted a view on his blue mountains, nature has a pleasant effect on the insane mind, the pathological fantasies of the harmed consciousness are distracted, bodily strength is hardened and anti-hygienic influences are reduced."[74] Hofmann therefore advised the government to construct an agricultural colony in central or East-Java with place for 600 local patients - and the opportunity to expand to 1200 - existing of semi-permanent wooden and bamboo structures and one stone building with isolation cells. He concluded his request stating that he did not ask for a treasure trove of costly measures in the spirit of the "minotaur of Buitenzorg."[75] Rather, his exposition of the agricultural colony as both hospital and nursing home (for the significant number of chronic cases) was a plea for a cheap and practical reform of the present lamentable local asylum care.

The polemic observations by Hofmann in a public journal, which stood in stark contrast with the report by Bauer and Smit and the operation in Buitenzorg, were soon refuted by Ledeboer, who argued that state asylum care for the local insane was well-developed, including agricultural colony and patient-labor. Ledeboer, superintendent in Buitenzorg, confuted Hofmanns observation concerning excited local patients in the *Geneeskundig tijdschrift voor*

[71] Hofmann, "Krankzinnigen-verpleging", 994.
[72] Idem, 992.
[73] Idem, 995.
[74] Idem, 996.
[75] Idem, 1003.

Nederlandsch-Indie.[76] Hofmann had contended that locals should be housed in bamboo buildings because their neurological excitement, paired with episodes of anger, occured rarely in comparison to European patients. In stark contrast with the claim of Hofmann, Ledeboer stated that all the asylum-psychiatrist in the Dutch East Indies, who at some point had worked in Buitenzorg, believed that locals needed a walled asylum.[77] Continuing his counterargument, Ledeboer maintained that episodes of violent excitement occurred more often, and with a longer duration, among local and Chinese patients. Even the regular construction of the asylum walls could at times not withstand the violence of local and Chinese patients, exemplified by two cases where the cells had to be reinforced, with Portland-cement and jointed wood panels respectively. Therefore, he concluded, a colonial variation of the agricultural colony was not suitable for restless or potential harmful patients.

In early 1895, Hofmann stirred the polemic one more time in *de Indische gids* after what he considered to be "general inaccuracies and personal contentions by the doctor Dr. L.B.E Ledeboer."[78] He stated once more that the asylum in Buitenzorg, including the costs of construction, were not in congruence with the needs of local patients. This opinion, he continued, was at the time of construction shared by the general public in the East Indies and several high-ranked officials in the Netherlands. Hofmann discredited Ledeboer because he had failed to argue how the prevailing system with the central asylums (including Surabaya and Semarang) and the small agricultural colonies bettered the fate of local patients in asylums, and the many insane in need of treatment in the near future.[79] Moreover, Ledeboer had referred to the division between patients cared for in the central asylum and the agricultural colony in the German Alt-Sherbitz institute (48.75% to 51.25%) to argue that agricultural colonies were used in Europe, however not to the extent that Hofmann envisioned for the colony. According to Hofmann the European context was incomparable to the problem at hand in the East Indies. Deciding whether a patient was apt for care in the setting of the agricultural colony depended on former living conditions and occupation. A significant share of the patients in Alt-Sherbitz had never wielded a spade or knew anything of construction and plowing.[80] Hence, Hofmann continued, it would be objectionable to nurse them in the setting of rural life. In the Dutch East

[76] L.B.E Ledeboer, "Krankzinnigenverpleging in Nederlandsch-Indië," *Geneeskundig tijdschrift voor Nederlandsch-Indie* 34 (1894): 662.
[77] Idem, 674.
[78] Dr J.W. Hofmann, "Krankzinnigen-verpleging in Neerl.-Indië," *De Indische gids* 17, no. 2 (1895).
[79] Idem, 529. Hofmann on Ledeboers argument: "We hadden een licht verwacht, stralend als de morgenfakkel onzer tropen, maar staan voor de weinig grootsche vertooning, die een Hollandsch zonnetje maakt, wanneer het met inspanning door de nevelen van een mistigen November-dag tracht heen te breken."
[80] Idem, 533.

Indies on the other hand, asylum psychiatrists were dealing almost solely with former residents of the *kampungs* and *desas* who had worked the fields all their lives. To prevent resurgences of memories of suffrage experienced in imprisonment, and take away the feeling of lost freedom, the agricultural colony was of utmost use. In addition, Hofmann untangled the argument made by Ledeboer concerning the higher percentage of excited and violent local patients by making use of Ledeboers own statistical schemata. Adding up the excited and isolated European patients, and doing the same for the local patients, Hofmann concluded that the percentages were identical (respectively 17.9% and 18%). Therefore, nothing stood in the way of a reform of the asylum system based on a colonial variation of a European inspired phenomenon, the agricultural colony.

Both asylum-psychiatrists were guided in their own right by epistemic anxieties regarding the reform of the asylum system for local patients. Ledeboer, protégé of Bauer (founding father of Buitenzorg), and the present superintendent of Buitenzorg, wanted to justify the continued existence of the grand central asylum. Declaring the nature of local and Chinese insane as more excited and violent, he legitimated the care for this group of patients in the central institute. Hofmann, on the other hand, seemed to further the argument of civilizational duty[81] combined with the idea that differences of culture and living conditions had to inform the making of the asylum. His argumentation in favor of the agricultural colony, however, articulated a concern for the problems encountered by asylum-psychiatrists in the 1880s and 1890s described in the previous chapter. Fearful of the negative impact of maltreatment and postponed treatment on patients in the asylum and those outside its walls in need of it, Hofmanns' quest for further reform was a first effort to articulate a plan that answered the epistemic anxieties concerning the scale and nature of insanity in the colony.

Entangled with ideas about reforms based on presumptions of the "native mind", and the creation of a cost-effective asylum system, was the relentless preoccupation with statistical data on the number of insane. Informing the need for expansion, the risk of dangerous patients becoming chronic dangerous patients without acute care, and the civilizational responsibility for the unfortunate, knowing and not-knowing stood at the basis for any argument concerning the scope or form of care in state asylums. Taking the number of insane per thousand inhabitants in Europe (Ledeboer, 2.0 per 1000) and per thousand European inhabitants in the East Indies

[81] Hofmann, "Krankzinnigen-verpleging," 538. "Voor onze inlandsche lijders, voor de meest ongelukkigen onder dat volk, waaraan wij, Nederlanders, heerschers over hun „Gordel van Smaragd," zooveel verschuldigd zijn, moge uit den strijd de waarheid geboren worden, en laten wij intusschen met Griesinger blijven gelooven „dass die Zukunft Mittel und Wege finden wird, das Problem der Irren-Colonien, und damit erst auch das der gänzlichen Irren-Versorgung, zu lösen."

(Hofmann, 3.0 per 1000), the psychiatrists came to the respective numbers of 60.000 and 90.000 insane inhabitants in the archipelago. Both men, however, appealed to the unverified medical premise that insanity was far less prevalent among locals. Similar to Bauer and Smit who had searched for a statistical study of insanity in the tropics, Ledeboer and Hofmann wielded this argument based on a preconceived idea of the inferiority of the local mind. Moreover, Ledeboer contended that a large number of insane was cared for at home, while Hofmann presumed that only 1 out of 3 insane individuals fell under the description of art. 230 of the "native regulation."[82] In the end, they both came to a number of 3000 to 3200 individuals who needed asylum care provided by the Dutch colonial government.

The agricultural colony, a victory of civilization

According to Dr. Hulshoff-Pol, the debate between Hofmann and Ledeboer (and the rest of the asylum-psychiatrist) remained unresolved till 1899 when a first test was performed with the female population in Buitenzorg.[83] A significant reason for the changed willingness of Ledeboer and the lower-ranked psychiatrist to experiment with the transplantation of excited patients to the agricultural colony was the success of bedrest as a new form of treatment. From the 1830s onwards, the psychiatric discipline had moved towards what were considered more humane forms of treatment. Inspired by men like Pinel, Tusk and Conolly, modern asylum practice radically changed with the introduction of non-restraint policies regarding the forced restraint of patients by machinery such as straightjackets and leather bed-streps.[84]

Illustrating the relationship between Europe and the colony, and the flow of psychiatric practices and conceptions of civilized treatment from the former to the latter, psychiatrists in the Dutch East Indies after Bauer and Smit boasted about their role in introducing non-restraint

[82] 230. (1) (St. 1897 no. 54, ten tweede, III.) De Landraad is bevoegd om, op verzoek van naastbestaanden, of ook van den Hoofddjaksa of Djaksa, tot behoud van goede orde of tot voorkoming van ongelukken, zoodanige personen, die wegens een dóórgaand slecht en buitensporig gedrag, ongeschikt zijn om aan zich zelven overgelaten te blijven, of wel voor de veiligheid van anderen gevaarlijk zijn, na behoorlijk onderzoek, in daartoe bestemdé gestichten, ziekenhuizen of andere geschikte plaatsen in verzekerde bewaring te doen stellen, en hen daarin te doen houden, zoolang 164 door die personen geene merkbare teekenen van beterschap worden gegeven. (I. R. 225v., 232; Ov. 11; B. W. 456; Bb. 775, 1072, 1148, 1630, 2143; R. O. 134v.).

[83] Hulshoff-Pol, "verpleging," 444.

[84] Leslie Topp, "Single rooms, seclusion and the non-restraint movement in British asylums, 1838-1844," *Social history of medicine* 31, No. 4 (2018): 754.

treatment in the Dutch colony. This feature, which was instrumentalized to legitimize colonial medicine and place it on the pedestal of Western civilization, resonated distinctively in the annual reports. In the 1892 annual report of Buitenzorg, Ledeboer mentions that the straitjacket was used once over the entire year. The "single rooms" or isolation cells on the other hand, were used frequently and for lengthy periods, especially for local and Chinese patients. Ten years later in 1901, Hofmann, the new superintendent of Buitenzorg after Ledeboer, wrote below the section titled 'instruments of coercion': "Those are not wielded here and are banned from the institute."[85] Progressing steadily since the 1890s, discussions over the use of the isolation cell had moved towards its complete dismissal. According to P.C.J van Brero, the isolation cell was not an instrument of immediate physical restraint. However, it caused similar if not even more damage because isolation and the "sober an lurid cells worsen the rage of the maniac and the fears of the melancholic."[86]

Bedrest applied in wards for the excited, in contrast, rendered isolation redundant and made asylums "little different from normal hospitals where order and peace rule and humane treatment is found."[87] Bedrest was used for both new patients who had to be controlled for observation and diagnosis and acute cases of insanity who needed physical rest to combat weight loss and other ailments. The residing of the patient in his or her bed was achieved by "inexhaustible patience, perseverance, soft handling and kind speech."

[85] J.W. Hofmann, *Bericht uber die landesirrenanstalt in Buitenzorg von 1894 bis anfang juli 1901* (Batavia: Landsdruckerei, 1902). Original in German: "Kommen hier nicht zur anwendung und sind aus der Anstalt verbannt worden".
[86] P.C.J. van Brero, "De betekenis der bedrust in de behandeling van krankzinnigen en die der waakzalen in de bouw van tropische gestichten," *Geneeskundig tijdschrift voor Nederlandsch-Indie* 37 (1998): 8.
[87] Idem, 9.

WAAKZAAL VOOR INLANDSCHE MANNEN OP WEG VAN HERSTEL, BEZIG GEHOUDEN MET KLAPPERDOPPLUIZEN.

Figure 2: "Dorm for local men on their way to recovery," Lawang, year unknown. 2e verslag omtrent het gouvernements krankzinnigengesticht te Lawang (residentie Pasaroean) over de jaren 1906 tot en met 1912

In practice, Brero admitted, nursing staff persuaded their patients with fruits or the occasional cigar. According to van Brero, most patients, who were physically exhausted themselves, accepted the rest voluntarily and with gratitude. For those who remained excited, mostly paralyzed and epileptic patients, there were secondary treatments such as hydrotherapy (being enwrapped in wet sheets or lengthy warm baths). With the introduction of bedrest, newly received and relapsed patients could be easily monitored and nursed in a relatively small central institute surrounded by the agricultural colony. It enabled asylum staff to move patients, who suffered from intercurrent aggravations of their mental illness, swiftly between a significantly smaller central institute and the colony where patients lived in freer and more rural conditions.

These conditions in the agricultural colony, also known as "vrije verpleging" or unconfined care, were widely implemented in Buitenzorg after the successful experiment in 1899 and the arrival of Hofmann as Buitenzorg's superintendent in 1901. The same principle stood at the foundation of the newly build institute in Lawang. In 1905, Hulshoff-Pol painted the reader of his article in *Psychiatrische en neurologische bladen* a picture of the rural idyll that was the agricultural colony:

"Imagine a plain, existing of fields and gardens with fruit trees, set amidst of this, a very small village, made up half of houses with gardens around it, inhabited by the nursing staff, and the other half made up out of eight pavilions, together harboring two hundred insane. The cows,

chicken, geese and ducks are walking everywhere, it is the native insane placed in the environment where he belongs."[88]

Dr. Lykles, the first superintendent of Lawang argued in the first annual report that the construction of Lawang in the spirit of an agricultural colony was of importance because compared to the closed institutions (Buitenzorg) it furthered freedom, patient-labor and humane treatment in general.[89] With subtle surveillance by supervising staff, patients roamed relatively free in the pavilions, gardens and leisure areas. According to Lykles it was these conditions and the setting of the colony that stimulated patients to reconcile with their desire to be home and prepared them for a possible return in mainstream society. Lykles claimed it was a fact, confirmed through his observations in Lawang, that the uncurable are less dazed and demonstrate fewer transgression of the mind compared to patients in closed asylums. Most patients, sensitive to stimuli from their environment, it was believed by Lykles, became more calm and pleasant for their surroundings because of the experience of freedom. Hulshoff-Pol added that one needed to see how calm the insane move in their leisure time, unhindered by the "pinching straps" of rooms and walls though always under unnoticed supervision, to be able to grasp the importance of unconfined treatment.

As their name suggest, a considerable aspect of the asylum colonies developed from 1899 onwards was the performance of agricultural labor. Beyond the creation of an asylum setting that resembled the *kampung*, asylum-psychiatrists hoped to construct an elaborate system of patient-labor. With the varied agricultural and artisanal activities of the asylum-colony, superintendents believed to better the prospects for recovery. Already in 1893, Ledeboer argued that labor resisted weariness and functioned as an important tool for recovery because physical effort slowed down the transgression of the insane mind.[90] The different activities ranging from working rice fields, tending the gardens, constructing roads and keeping up the buildings belonging to the asylum, however, served ulterior motives as well.

[88] Hulshoff-Pol, "Verpleging," 446.
[89] S. Lykles, *Verslag*, 21.
[90] Ledeboer, *Verslag*, 29.

WEG NAAR DE BESMETTELIJKE ZAAL, DOOR PATIËNTEN IN ROTSACHTIGEN GROND UITGEHOUWEN EN AANGELEGD

Figure 3:"road to the contagious ward, carved and paved by patients out of rocky ground", Lawang, around 1912. *2e verslag omtrent het gouvernements krankzinnigengesticht te Lawang (residentie Pasaroean) over de jaren 1906 tot en met 1912*.

PATIËNTEN BIJ DEN SAWAH - ARBEID. MANNEN EN VROUWEN.

Figure 4: "Patients at the Sawah - labor. Men and women. Agricultural colony Lawang, year unknown. *2e verslag omtrent het gouvernements krankzinnigengesticht te Lawang (residentie Pasaroean) over de jaren 1906 tot en met 1912*.

According to Lykles, another indisputable benefit of the agricultural colony was the financial gain. In addition to the fact that the asylum constructed of mainly semi-permanent buildings had costed a pittance compared to Buitenzorg, the labor performed by patients gained a financial component. Ernst has argued with regards to British asylum care in India how the asylum system, and colonial medicine in general, performed the role of a Habermasian socially integrative task (social welfare, public healthcare, legal regulation) to tie the local population to colonial regimes of emergent capitalist states.[91] A more insidious interpretation of the agricultural colony as a colonial variation of the asylum thus holds that patient-labor was advanced to further economic output. According to this perspective on the intertwinement of the asylum and capitalism in the colonial setting, the asylum system took on colonial subjects who were a "nuisance" to the authorities and returned them as recovered men and women ready to be once again incorporated in exploitative workforces under colonial rule.

While this interpretation requires an independent comparative study of patient-labor in asylums in the Netherlands and the Dutch East Indies, it is evident that the medical purpose of patient-labor was clouded by financial motives. Asylum-psychiatrists such as Lykles attributed considerably more value and attention to raising productivity (in 1905 90.1% of local male patients performed labor) and financial gain in their discussions of patient-labor in the annual reports. With the wide range of activities, the asylum became more self-sufficient (regarding the nutrition of patients and the upkeep of the asylum and its terrain) and generated an income through the sales of agricultural products to the government, companies and private persons.[92] Yet, it changed the position of the local patient from a helpless insane who had become a social responsibility of the state to a laborer that was essential to the continuity of the asylum system: "By making the available forces among patients productive, the fruits of this labor can be immediately benefitted to the asylum."[93] Due to a lack of ego documents by patients it is unclear to what extent labor was forced upon them. What is evident, however, is that a division existed between European and local patients. Ledeboer observed in 1892 how the work ethic of European patients, from few exceptions, is close to non-existent. Hence, patient-labor, as a reflection of colonial society, was arranged according to racial hierarchies that condemned the local to perform the role of subordinate working for the colonial master.

[91] Waltraud ernst, "Idioms of madness and colonial boundaries: The case of the European and local mentally ill in Early Nineteenth-century British India" Comparative studies in society and history Vol 39 No. 1 (Cambridge: Cambridge university press, 1997): 169.
[92] Lykles, Verslag, 118.
[93] Idem, 23.

Against doubts and castigations: the rise of local staff

"For such research is required of the physician that he immediately after the amokmaker is rendered harmless, starts the investigation because every minute has its value, and it is at that time that most kin and acquaintances are present to provide with the necessary intelligence. In this regard, but also for the knowledge of psychiatry in the East Indies territories in general, psychiatric schooled doctor djawas would be of utmost use."

P.C.J. van Brero, "Een en ander of de psychosen onder de bevolking van den Indischen archipel" *Geneeskundig tijdschrift voor Nederlandsch-Indie* (1898): 29.

In 1922, Soeprarto, *dokter djawa* in Merauke (New-Guinea), wrote an article in the *Tijdschrift voor inlandse geneeskunde* on two cases of alleged dementia paralytica[94] among his local patients.[95] Referring to the experience of European psychiatrists working in the colony, Soeprarto observed how this type of illness was very uncommon among local patients compared to its prevalence in European asylums. Investigating the two women diagnosed with dementia paralytica, he suggested that the cause of their illness might be connected to the cohabitation of the two women with Europeans, and the paired consumption of alcohol. While Soeprarto was unable to formulate any scientifically sound answers to his own premise, his article gives a glimpse of how local physicians contributed to the psychiatric discipline and the exploration of mental illness among the population of the archipelago. Unfortunately, ego-documents by local psychiatrists are scarce. Moreover, apart from the independent publications in TVIG and GTNI, the presence and voices of local psychiatrists in the asylums are mostly silenced in colonial sources. Nonetheless, from the development of the agricultural colonies onwards, most care for local patients was provided by local psychiatrists, nurses and *mandurs*. Therefore, I will explore in this third and last chapter the increased importance of local staff in the making of the asylum. Obliged to rely heavily on the colonial sources for the role of local nurses and psychiatrists in the asylums, I will shed light on their presence by exploring the following questions: How did the local staff of the asylums gain more responsibility in the period between 1900 and 1920? How was their new role tied to colonial epistemic anxieties over expansion on the one hand, and doubts by superintendents about the abilities of local personnel on the other hand? And to what extent can we identify increased agency by local psychiatrists in acquiring responsibilities and producing psychiatric knowledge?

[94] A neurological disorder caused by advanced syphilis.
[95] Soeprarto, "Dementia paraltica bij Inlanders" Tijdschrift voor Inlandse geneeskunde 30, no. 1 (1922): 50.

Hulshoff-Pol observed in 1905 how the ratio of local nurses to local patients was 1:10.[96] Every unit of local nurses that ran a section or a combination of pavilions was accompanied by a number of European male nurses, and one female European head nurse who came from a better social position. Her superior social status was presumed to make her less inclined to cooperate with male nurses if they wanted to keep something hidden from the superintendent. Even though a training program was called to life in 1903 to develop a body of educated nurses, most European male nurses were military veterans who proved difficult to supervise and instruct. Over the years they gained a reputation of authoritarian display and short temper.[97] Despite this reality, Hulshoff-Pol argued, reiterating the racial hierarchies among personnel and the mistrust towards local staff, locals were not allowed to participate in the training program because "we Europeans knew too little about their language and we need to exercise control."[98] Superintendents often complained about local staff and their inability to perform hard tasks that required strong character and soft guidance. Moreover, superintendents lamented their tendency to run off after several weeks which they ascribed to their lack of the necessary zeal and sense of duty.[99]

Increased autonomy and crumbling colonial superiority

Despite these castigations by asylum-psychiatrists, the care for local patients was increasingly trusted into the hands of local psychiatrists and nurses. According to Lykles, who stated that the Lawang asylum employed several dozes of zealous local nurses with a sensible kindness, the appointment of this category of personnel was deemed logical because they were a cheaper labor-force. And, he continued, "it is not more than reasonable because also in the asylum more and more good occupations can be fulfilled by the children of this country."[100] Hulshoff-Pol boasted in 1905 that unconfined care in the agricultural colony was performed with little

[96] Hulshoff-Pol, "Verpleging," 448.
[97] Lykles, *Verslag*, 44. Lykles on veterans among the male European nurse: "The mutations among this group was not unimportant: often they did not like their job, others suffered from the "drinking devil" who interferes with their good intentions, and a last group was fired because they had a less gentle interaction with patients"
[98] Hulshoff-Pol, "Verpleging," 448.
[99] Lykles, *Verslag*, 44.
[100] Idem, 45. Demonstrating the role of local personnel in the operation of the asylum system Lykles reserved some space in the annual report of 1906 to show his appreciation for Nassio, a local *mandur* who had been first employed by the assisting asylum in Surabaya since 1877, even before the reforms instigated by Bauer and Smit. He was awarded the bronze star of loyalty and merit by the governor-general.

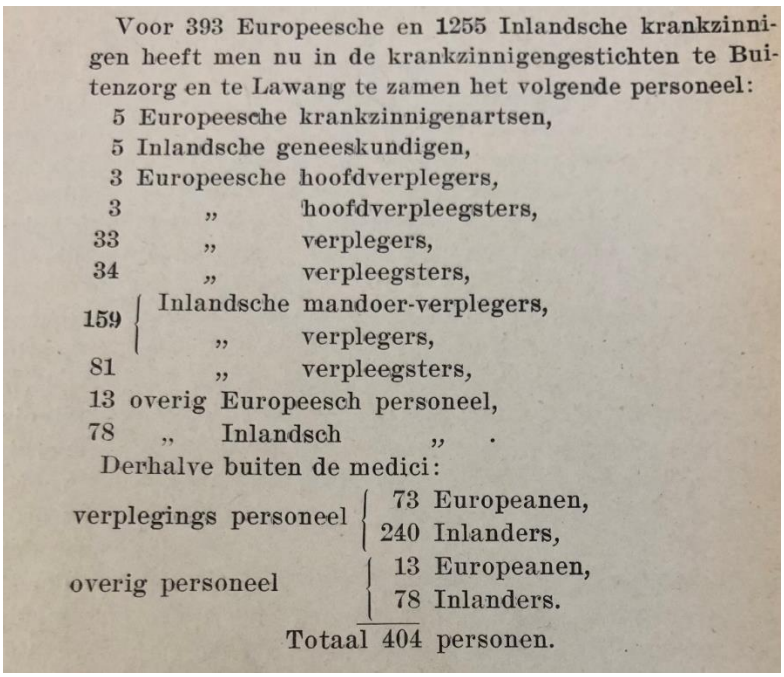
physical separation between local patients and staff. Separated merely by a green hedge, the proximity of the bamboo houses for local staff and the pavilions for patients was considered the epitome of unconfined care. The morphing of the agricultural colony and the residential complex of local employees had facilitated friendships between patients and the families of nurses and other local staff.[101] This development, which initially caused anxieties among superintendents (Hulshoff-Pol hasted to assure the reader that all staff was married), set the stage for family care. This form of care was the answer to the question asked by Hulshoff-Pol regarding forensic cases who seemed recovered but had high risks of potentially violent relapses.[102] Patients were trusted into the hands of their own families or befriended families of staff members. He or she was allowed to live in the family setting in the vicinity of the asylum. Provided with an income large enough to take care of their family, the patients remained in employment of the institute. This last aspect of family care suggests towards the hypothesis that state asylums were tasked with the production of a mentally hygienic workforce apt for labor under colonialism. What is evident, however, is that family care transferred a significant amount of responsibility to local staff and the families of patients. Despite being informed by epistemic anxieties over the level of recovery of forensic cases, this development was one of many that increased the presence of local actors in the making of the asylum.

Already since the 1880s, *dokter djawas* were used in the operation of state asylums as assisting physicians. Mainly treating somatic problems, *dokter djawas* were initially considered inapt to diagnose mental illnesses based on the study of symptom development because they had not received any education in the field of psychiatry at the STOVIA. *Dokter djawa* Raden Soemeroe argued in 1898 that according to article 102[103] of the code of law *dokter djawas* had the same responsibility to be able to investigate the sanity of alleged felons.[104] The opportunity to gain knowledge about psychiatry was however unavailable to students of the STOVIA. Therefore, Raden Soemeroe was grateful to Dr. L.A. Demmers, second ranked asylum-psychiatrist in Buitenzorg, for guiding him during his employment in Buitenzorg. Besides the treatment of somatic diseases, local psychiatrist acted as 'intermediaries' to translate between the Dutch psychiatrist and their patients. Beyond linguistic translation, the intermediary role asked of local psychiatrist to make the character of the locals, and their customs and cultural

[101] Hulshoff-Pol, "Verpleging", 453.
[102] "I don't dare to release them, and I don't want to keep them within the institute among all the other insane, what else to do?"
[103] "Aan een ieder, die de geneeskunde uitoefent, kan de verplichting worden opgelegd, een onderzoek in te stellen naar den zielstoestand van iemand, die eenig misdrijf heeft gepleegd en daaromtrent schriftelijk verslag uit te brengen."
[104] Raden Soemeroe, "Eenige mededelingen," 40.

meaning of insanity insightful to their superiors. The struggles of *dokter djawas* to embed themselves in the psychiatric discipline changed, however, because of two reasons.

Primarily, the realization that continuous expansion was needed, even after the institute in Lawang reached its peak capacity with 1300 patients in 1909, obliged the public health service and superintendents to rethink the role of local psychiatrist. In the *rapport der commissie tot voorbereiding eener reorganisatie van den burgerlijke geneeskundige dienst*, published in 1908, a commission for the reform of the public health service argued that the ratio between European and local asylum-psychiatrists and nurses was financially unsustainable considering the pressure to expand.[105]



Voor 393 Europeesche en 1255 Inlandsche krankzinnigen heeft men nu in de krankzinnigengestichten te Buitenzorg en te Lawang te zamen het volgende personeel:

5 Europeesche krankzinnigenartsen,
5 Inlandsche geneeskundigen,
3 Europeesche hoofdverplegers,
3 „ hoofdverpleegsters,
33 „ verplegers,
34 „ verpleegsters,
159 Inlandsche mandoer-verplegers,
„ verplegers,
81 „ verpleegsters,
13 overig Europeesch personeel,
78 „ Inlandsch „ .

Derhalve buiten de medici:

verplegings personeel { 73 Europeanen, 240 Inlanders,
overig personeel { 13 Europeanen, 78 Inlanders.

Totaal 404 personen.

Figure 5: Overview of the combined European and local staff in Buitenzorg and Lawang, *rapport van de commissie tot voorbereiding eener reorganisatie van den burgerlijke geneeskundige dienst.*

According to the commission, the organization of the asylums had to be swiftly rearranged because the demand for expansion was dire: "If they have the slightest idea they can risk it, asylum-psychiatrist rather send the patients they see for observation back to the *desa* than to set in motion the lengthy process leading to hospitalization."[106] Hence, the most important reason

[105] Commissie tot voorbereiding eener reorganisatie van den burgerlijken geneeskundige dienst, *rapport der commissie tot voorbereiding eener reorganisatie van den geneeskundige dienst* (Batavia: Landsdrukkerij, 1908), 131.

[106] Commisie tot voorbereiding eener reorganisatie van den burgerlijken geneeskundige dienst, *Rapport*, 131. Entire quote: *Geneesheren zenden, als zij het maar enigszins durven wagen, de menschen, die zij ter observatie krijgen, maar liever naar hun dessa terug dan het langdurige proces, dat tot opname in het gesticht moet voeren, door te maken. Het zou ons niet verwonderen als plaatsgebrek ook invloed heeft op het getal van hen, die uit de gestichten als hersteld worden ontslagen, en van wie later blijkt dat zij het niet waren. En daarom*

for the colonial government to incorporate *dokter djawas* in the operation of state asylums was the failure of the former to provide sufficient care for local insane. Grown from epistemic anxieties over the management of local insanity, the self-imposed burden of social order and social responsibility thus led to a more important position for local physicians within colonial psychiatry.

Second, asylum-psychiatrists started to acknowledge that cultural and linguistic differences rendered the mind of the local (in)sane largely incommensurable to them. According to Hulshoff-Pol, superintendent of Lawang since March 1909, the care for local patients by Europeans could never be satisfactory. Similar to the creation of living conditions in the agricultural colony that were true to life in the *desa*, the interaction with local doctors would make patients happier and more inclined to give expression to their thoughts and feelings.[107] Moreover, Hulshoff-Pol continued, "Similar to an Asian not being able to understand a European, neither will a European be able to identify with the passions of a native. Even more because he has a closed-off nature." The reasons why local psychiatrists were initially commissioned with merely subordinate tasks such as somatic treatment was ascribed to their "hesitant and little resolute character", and the introduction of bedrest. The latter, he argued, required the asylum-psychiatrist to be in complete control of his staff. Even when it was decided to educate a select group of local physicians in asylum psychiatry, it remained hard to assess if they had the energy to cope with the small and large sorrows that were part of managing an asylum. Therefore, it was justified to wonder whether the local physician could be trusted with the responsibility of running a section of the asylum. The ever-growing demand for placement and the need for cost-effective expansion, the superintendent of Lawang concluded, gave significant weight to this question.

Before elaborating on the ground gained by local psychiatrist it is important to further identify the reservations on the side of the colonial government. An answer to the question posed by Hulshoff-Pol remains opaque because of the ambiguous relationship between the public health service and *doctor djawas* educated at the STOVIA. Characteristic for the ethical policy that took sway over colonial politics from the late 1990s onwards, the decision to grant more responsibility to local physicians echoed a paradoxical desire to uplift the local population on the one hand, and a disparagement of the same people based on civilizational explanations

durven wij te beweren dat er veel meer Inlandsche krankzinnigen in de dessa zijn, voor wij opname in een gesticht bepaald noodzakelijk is, dan men denkt.

[107] Hulshoff-Pol, "De organisatie van het krankzinnigen-wezen in Nederlandsch-Indie," *Psychiatrische en Neurologische bladen* 17, no.1 (1913): 107.

of competence on the other hand. The manifold degradations and deprivations of native physicians based on their ethnicity suggests towards the idea that the new responsibilities had little to do with the recognition of their achievements. Rather, it seems that the new role of local psychiatrists was perceived as a solution for the colonial anxieties over social order and social responsibility.

In the report, the commissioners argued in a orientalist and racist fashion that the nature of the local was hard to reconcile with scientific occupations. With their "good sentience, strong imagination, feeling for colour and form, and happy outlook on life, the nature of the native *inboorlingen* was more predisposed towards the arts."[108] Lacking the same respect for the truth as Europeans[109], locals had not yet shown their value in scientific inquiry. In addition, the education received by Dutch physicians at Dutch universities was incomparable to the *Stovia*. The knowledge transmitted by actual professors in the Netherlands, the command of the Dutch language (which seems a sophism considering that a language barrier was exactly what obstructed Dutch psychiatrists in their treatment of local patients), and the duration of their education led the commission to conclude that the education of local physicians was superficial from a scientific point of view.[110] Therefore, local physicians were expected to not occupy themselves with research and theoretical science. According to the report, the most peculiar property of science was doubt. Except for he whose mind was synchronized with the spirit of science and gained an unwavering faith in it, the doubts raised by science impacted the competence to act. In consequence, half-hearted scientific endeavors by local physicians would always be haunted by insecurity and doubt. It was therefore deemed best if the local physician was only instructed with theory that was undisputable and instrumental to their task: the practical treatment of the most common diseases and injuries.

[108] Commissie, *Rapport*, 70.
[109] Commissie, Rapport, 70. "Dit is een vingerwijzing: men kan geen wetenschappelijke padvinder worden, zolang men niet de waarheid als het hoogste ideaal erkent".
[110] Idem, 72.

Gained or granted? The visibility of local psychiatrist in asylum care and scientific debates

The members of the commission remarked that from a solely scientific perspective it was indeed the best decision to only employ European psychiatrist in the expanding state asylums. This, however, overlooked the fact that "the study of psychiatry to further the cause of science cannot be the purpose of the medical labor in the asylums here."[111] In contrast, what was important were the practical demands of day-to-day care. The idea that colonial psychiatry served a practical purpose before the production of scientific knowledge reverberates Kellers observation on the discipline's static circulation of knowledge between Europe and the Dutch East Indies. Although there was evidential interaction between European psychiatrists and the asylums in Buitenzorg and Lawang (the leading psychiatrist Emil Kraepelin visited Buitenzorg in 1906 for research on etiology)[112] the focus on developing colonial variations of asylum care stood in stark contrast with the idea of a colonial laboratory for modernity.

After the reforms proposed by the commission were implemented, each asylum had to limit its number of European asylum-psychiatrists to two.[113] One superintendent and one deputy director were assigned with the supervision and general management of the entire institute. On the level of psychiatric practice their responsibility was reduced to the admission of new patients and the writing of forensic-medical advises in accordance with the 1897 regulations. The remaining tasks, including the treatment of the intercurrent patients who moved between the "watch room" for excited patients and the agricultural colony, were supposed to be fulfilled by local psychiatrists. In practice, however, the Dutch asylum-psychiatrist kept a tight grip on treatment. In 1913, Hulshoff-Pol wrote in the annual report of Lawang that "the treatment of excited, dangerous, observation and other ill patients that require a lot of psychiatric knowledge can not be trusted to local psychiatrists."[114]

[111] Commissie, *Rapport*, 132.
[112] Holger Steinberg, "Emil Kraepelin's ideas on transcultural psychiatry," *Australasian psychiatry: bulletin of the royal Australian and New Zealand college of psychiatrists*, 23, no. 5 (2015).
[113] Commissie, Rapport, 133.
[114] Hulshoff-Pol, "De organisatie van het krankzinnigen-wezen in Nederlandsch-Indie," *Psychiatrische en Neurologische bladen* 17, no.1 (1913): 113.

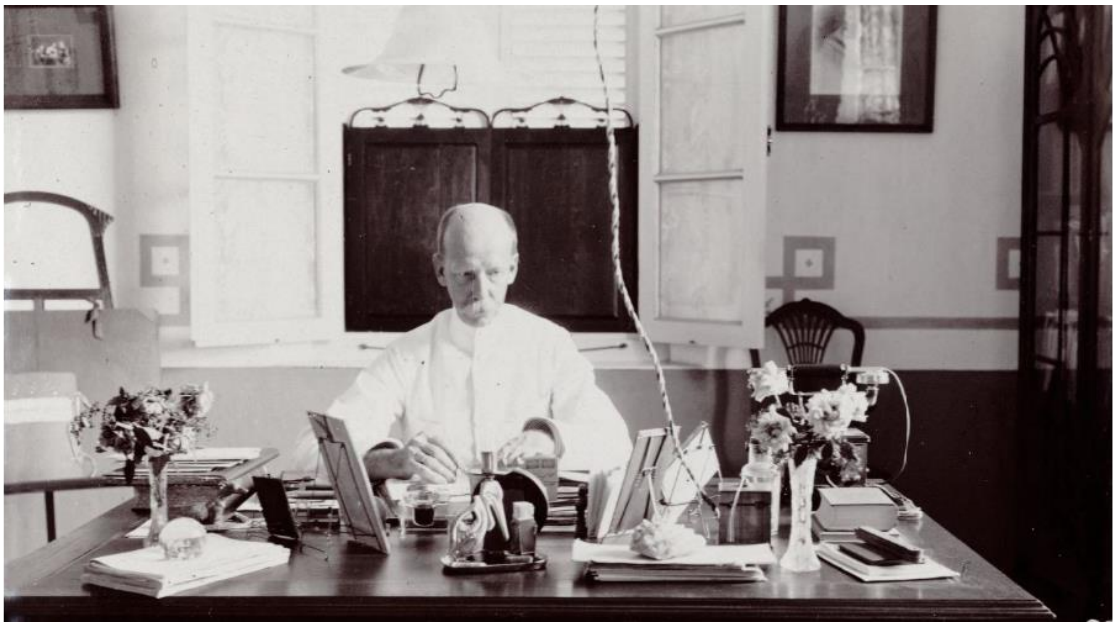


Figure 6: "D.J. Hulshoff Pol, geneesheer-directeur van het krankzinnigengesticht te Lawang, in zijn kantoor te Lawang ten noorden van Malang", 1912, KITLV A172.

The tension between the inability or unwillingness to give this responsibility out of hands, and the need to develop a cost-effective asylum system, resulted in a model developed by Hulshoff-Pol in consultation with the public health service. According to this three-stage scheme, *doctor djawas* who finished the Stovia were first employed by one of the two central asylums to be educated by Dutch psychiatrists. In this first stage, the physician did not yet officially belong to the special medical service of asylums and thus remained a *doctor djawa*. After earning his merits, the local physician would be placed at the newly build annex-asylum where he was trusted with greater responsibilities and expected to demonstrate the knowledge gained during his education. Once the *doctor djawa* in question proved capable of taking leadership at the annex-asylum he would be elevated to the ranks of the asylum service (1st class local physician) and considered ready to be completely in charge of a new type of asylum: an institute completely ran by local personnel in the territories outside of Java. From the 1920s onwards we see that the last step of this model becomes a reality with a large asylum on Pulau Weh (Sabang institute, Aceh, Sumatra) ran by Dr. Latumeten, a local psychiatrist.

In 1913, at the time Hulshoff-Pol wrote this model, the first annex-asylum near Lawang was finished. Mostly independent, the supervision over the local psychiatrist in charge was reduced to a minimum. In addition to the preservation of authority over local psychiatrists, the Soeko annex-asylum was preferred over newly constructed institutes because it was cost-effective. Logistically connected to the central asylum in Lawang, Soeko was sans expensive stone constructions such as warehouses and administration offices. In the annex-asylum resided

400 calm local men and women who were diagnosed with dementia. Although primarily motivated by the need for cost-effective expansion, the newly acquired position by *doctor djawas* who had worked themselves up to the rank of (local) psychiatrist demonstrates how this group of actors fulfilled an increasingly important role in the system of state asylum care. Unfortunately, there are no ego-documents or accounts of local psychiatrists in the annual reports of the asylums in Buitenzorg and Lawang.

Beyond their increased responsibility for patient populations in the Soeko annex-asylum and the central institutes in Buitenzorg and Lawang, the local psychiatrists in fact made contributions to the production of scientific knowledge. Different from the commission's verdict on the task of psychiatrists, many of them, including local psychiatrists, published articles in scientific journals such as the *Geneeskundig tijdschrift voor Nederlands-Indie* and *Tijdschrift voor inlandse geneeskundige*. In 1912, for example, Abdul Irsan, psychiatrist among the ranks of "inlandse" geneeskundige in the Lawang asylum, published an article in the TVIG to enlighten his peers from the Stovia on different variations and symptoms of insanity.[115] While the article is not remarkable from the perspective of scientific innovation, it is important because it is the first instance where a local psychiatrist attempts to make psychiatric knowledge available to Stovia students who are psychiatric "laymen". In accordance with the troubles of the asylum system, Irsan informs his reader of the difficulty to diagnose mental illnesses with patients who suffer from intercurrent symptoms. Therefore, Irsan accounts of the four different types of mental disturbances (perception, thought, passions and will or action) that a psychiatrist could identify in a patient. Attempting to enlighten his junior peers, Irsan demonstrates his psychiatric knowledge of diagnostic practices.

Two years earlier, in 1910, a local psychiatrist made a more "scientific" contribution to the psychiatric discipline in the Dutch East Indies. Mas Malikin (the title Mas, similar to Raden, indicated title in the ranks of Javanese nobility), working at the Lawang asylum, wrote an article in the GTNI on malaria as a cause of insanity.[116] At the time, the relation between malaria and mental illness was little explored by medical scientists. Moreover, colonial asylums in tropical climates, where malaria was common, were unable to detect malaria as a direct cause of mental illness beyond temporary psychosis. Often, the cause of insanity was attributed to the general designative term "fevers" (At the time of publishing Lawang counted 105 out of 949 patients whose mental illness was attributed to "fevers"). Explicitly building on the research of Wilhelm

[115] Abdul Irsan, "Iets over verschijnselen van krankzinnigheid," *Tijdschrift voor Inlandse geneeskundigen* (1912).
[116] Mas Malikin, "Malaria als oorzaak van krankzinnigheid," *Geneeskundig tijdschrift voor Nederlands-Indië* (1911).

Griesinger and Emil Kraepelin, two renowned medical scientists in the field of neurology and psychiatry, Malikin contributed to this relatively new field of research by sharing the account of some sufferers of malaria induced amentia. The articles by Irsan and Malakin demonstrate how the role of local psychiatrists expanded beyond their newly acquired responsibility in the asylum system. By sharing and producing psychiatric knowledge, Irsan and Malikin represented the incorporation of local psychiatrists in a scientific network where knowledge circulated through publications in journals. Ignited by the more significant position of local psychiatrists in the asylum system since 1900, the contributions of second and third generation local psychiatrists in scientific journals started to increase from the 1920s onwards.

Conclusion

In the preceding chapters, I have argued how the social history of psychiatry in the Dutch East Indies between 1868 and 1920, formulated as "the making of the asylum", was first and foremost characterized by the institutionalization of insanity in the central state asylums in Buitenzorg and Lawang. Different from the work and argumentation of Hans Pols on colonial psychiatry in the Dutch East Indies, I foregrounded the history of asylums, and the production of power and knowledge at these sites, to demonstrate what the history of colonial psychiatry in the Dutch East Indies reveals about the relation between colonialism and medical science. In contrast with perspectives on the ideological bond between the two phenomena, a history of the making of the asylums in Buitenzorg and Lawang brings alive how colonial psychiatry was shaped between ethical incentives and structures of colonial domination on the one hand, and the dependency on different social groups of the local population that defined the need, purpose and character of asylum care.

To answer what characterized the making of the asylums, and its relation to nature of colonial medicine, I repostulate the question formulated by colonial historian Roy Porter: what is exactly colonial about colonial medicine? Or: what is exactly colonial about colonial psychiatry? In the early phase of institutionalization, defined by the investigation and recommendations by Bauer and Smit, and the construction of the first state asylum in Buitenzorg, colonial officials and psychiatrists narrated the introduction of modern psychiatric asylums as an answer, and much needed change, to the existing structures of institutional and communal care. In particular the inhumane care for insane individuals in the *desas* of Java, and the risks of dangerous insane locals roaming free, functioned as ideological justifications for the construction of a large asylum in Buitenzorg. As a triumph over the inferior interpretations of insanity by the local population of the Dutch East Indies, Buitenzorg was presented as the uplifting of insane care to the standards of European civilization, defined by its sense of humanity and advanced medical science.

However, beyond the discursive presentation of asylum care as a civilizational hallmark of Dutch colonialism, the making of the asylums in Buitenzorg and Lawang was "colonial" because of the (epistemic) anxieties over the sustenance of domination on the one hand, and the forced adaptation to the local population on the other hand. Against the backdrop of limited financial resources and faltering knowledge about the scale and characteristics of insanity in the colony, asylums were under continuous pressure to expand. The anxieties and frustrations

over maltreatment in provisional care facilities and the many new patients that were labeled uncurable (because of the duration of their mental illness before admittance), forced asylum-psychiatrists to campaign for expansion. Moreover, the creation of the social-legal category of the insane in 1897 codified the problems of placement and the social responsibility of asylums for "dangerous" patients. In practice, the diagnosis of dangerous insanity proved complex and hard to reconcile with the codified process of hospitalization. Beyond the diagnosis of immediate danger, the patient-histories demonstrate how the categorization of insanity was based on explanations of behavior that was considered socially undesirable, or a threat to colonial order. The campaign for expansion, and the social problems of maltreatment and lack of places echoed both humanitarian concerns and anxieties over the wavering task to define, monitor and confine an insane population of unknown size.

To answer the epistemic anxieties concerning the asylum's ability to provide care for a growing population of uncurable patients and potential curable patients, the institutionalization of colonial psychiatry materialized in the expansion of asylum facilities. From the mid-1890s onwards, the planned expansion was interwoven with continuous epistemic anxieties concerning the nature of the "native mind" and the most appropriate to house and treat patients legally categorized as dangerous. Informed by limited financial resources and insufficient scientifically verifiable knowledge on the scope and character of "native insanity", a debate between J.W. Hofmann and L.B.E Ledeboer, gave direction to the character of expansion. In contrast with the central asylum in Buitenzorg, the newly build asylum in Lawang was designed as a colonial variation of the agricultural colony that was developed by European psychiatry. Following the argumentation of Hofmann, housing and living conditions corresponding with life in the *desa* were considered more favorable for the recovery and mental tranquility of local patients. Siek Lykles and other superintendents, argued that the conditions and treatment in the agricultural colony furthered the patient's sense of freedom, enabled patient-labor and its medical benefits, and gave way to more humane forms of treatment. Unconfined care, and the application of the non-restraint model were particularly laureated by superintendents as evidence of the civilized care for locals that prevailed in the colonial asylums in Buitenzorg and Lawang. Moreover, the agricultural colony could be cost-effectively managed and expanded because of the cheaper housing and the deployment of patient-labor. The latter, however, justified by asylum-psychiatrists as being beneficial for the physical and mental recovery of patients, was additionally instrumentalized to increase the economic productivity of the patient population. The institutionalization of colonial psychiatry through the development of the agricultural colony was thus colonial because its design and practice were 'colonial variations',

shaped by the forced adaptation to the needs of local patients and the epistemic anxieties concerning the threat insane individuals posed to the social order of colonial society. Despite the dominance of Dutch colonial officials and asylum-psychiatrists in the making of colonial psychiatry, the 'colonial variations' of the living conditions, diagnosis and treatment were a result of limited authority and knowledge.

In addition to reading the colonial sources "along the grain" to untangle the motivations and anxieties of asylum-psychiatrists and the Dutch colonial government, I have argued that the making of the asylum needs a foregrounding of local actors. Subjugated to the social hierarchies of colonialism in asylum practice, and marginalized and opaqued from institutional sources, local nurses, *mandurs*, psychiatrists, and even patients, nevertheless impacted the social history of colonial psychiatry in a profound way. Beyond being the object of colonial epistemic anxieties, local actors produced the asylum with ranging levels of coercion. Local patients, the most subordinated group in the asylum, constructed many of the facilities and infrastructural planning in the agricultural colony. Due to their silencing in the colonial sources, it is hard to determine the level of agency enacted by patients in the process.

More evident, however, is the contribution of local staff in the making of the asylum. In contrast with historical perspectives inspired by Fanonian scholarship, I have tried to map the agency of local actors in colonial psychiatry past the sole category of resistance. While suffering from subordination and castigations based on the racist ideology of colonialism, local personnel acquired more responsibility, and thus increased authority, over the management of life and the execution of treatment in the asylum. Admittely, the increased presence and responsibility of local personnel was significantly informed by the epistemic anxieties over insane and the need to develop cost-effective solutions. Within this vacuum, however, local nurses and psychiatrists had manifested themselves as crucial links because they were able to bridge the cultural gap between psychiatry and the lived experience of patients. Local nurses took on the responsibility of accommodating and tranquilizing patients in the setting of unconfined and family care. Local psychiatrists, in addition to gaining authority over the management and treatment in sections of the agricultural colony and the annex-asylum, made psychiatric knowledge available to their peers from the Stovia by publishing in TVIG. Moreover, psychiatrists such as Irsan and Malikin contributed to the development of psychiatric knowledge through their articles in scientific journals.

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