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Opening the paths to healing: developing an integrated approach to health in Timor Leste

Lisa Palmer[a], Susana Barnes[a] and Ritsuko Kakuma[b]

[a]School of Geography, The University of Melbourne, Carlton, Australia; [b]Global and Cultural Mental Health Unit, Centre for Mental Health, Melbourne School of Population and Global Health, The University of Melbourne, Carlton, Australia

ABSTRACT

In Timor Leste, customary healing practices are deeply embedded in the inter-relationships between people, the ancestors and the environment. Meanwhile being 'modern' has long meant being both educated and Christian, ushering in ongoing shifts in moral worlds. These seemingly contradictory forms of sociality, relationality and subjectivity are, we argue, uniquely woven together through a deeply political meshwork of performative practices. Drawing on the experience of our collaborative research into mental health systems in Timor-Leste, we ask what this means for attempts to engage with diverse approaches to healing through an integrated approach to the nation's public health programmes and policies.

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Introduction

Transcultural health studies have long shown that culture matters for how an illness is experienced and for the explanatory model influencing diagnosis.[1] Most illnesses in Timor Leste are attributed by sufferers to specific supernatural causes and people (more so in rural areas) prioritise treatment by customary healers, usually those associated with, or known to, their own ancestral origin houses. In more urban contexts, approaches to health and healing have been shaped by the influence of Christianity and in particular charismatic (and universalising) faith-healing practices common to both the Catholic and Protestant traditions. Both customary and more 'modern' religious healing practices are used inter-changeably with biomedical health systems. We therefore aim to investigate how these diverse health seeking behaviours might be woven together in order to improve equitable access to culturally and context-appropriate health services.

The paper draws on our experiences as researchers of a project which, focusing on mental health, sought to improve understanding Timor Leste's diverse customary health and healing practices and explore the potential of integrating these practices with modern psychological and biomedical approaches. Studies in other low- and middle-income countries have consistently shown that individuals with mental disorders typically seek traditional and religious healers before going to a doctor or mental health specialist and the consequent delays in

CONTACT Lisa Palmer lrpalmer@unimelb.edu.au

seeking appropriate mental health care can have significant detrimental effects on the mentally ill individual. From a global mental health perspective it is argued that better linkages and referral mechanisms are therefore necessary to ensure that a person's mental health care needs are met appropriately and in a timely manner.[2] This requires an effective collaborative mechanism between the customary healers and mental health professionals. Yet evidence has also consistently shown poor relationships between customary healers and mental health professionals due to a variety of reasons including deeply embedded conceptualisations about mental disorders and its causes which conflict with biomedical models, and mutual lack of trust, respect, consideration and understanding. To overcome these challenges and make effective system change, strategies that foster respectful and considerate dialogue to better understand divergent perspectives and put the patient's well-being first are necessary.[3]

But this raises the question of what exactly a concern for the patient's well-being should entail and how this idea of well-being might best be formulated and measured. It also raises questions about power. What are the implications of highly differential power relations for the development of integrative models of care that aim to bring together diverse healing practices? How can dialogue be initiated between those in the formal health system and those people (and their practices) who normally have no formally recognised therapeutic role in it? In this paper we argue that in Timor Leste, customary and other faith-based religious ritual healing[4] practices need to be taken seriously as performances that 'bring forth, define, and empower social relationships'.[5] At the same time, we argue that the limits of this inclusive approach must be carefully fleshed out in each relevant context. This requires close attention to the particular circumstances and spatio-temporal domains of power in which these practices find 'voice', are treated as 'background noise' or simply dismissed.[6]

Reflecting on these questions and issues through the lens of our own research into Timor Leste's mental health systems, we are in this paper primarily interested in the drivers of change in social systems of care. In order to ground and enable our analysis we first provide some background to mental health services in Timor Leste and the research setting. Next we present the case example of Bere to demonstrate the complex individual, collective and societal factors influencing health and health seeking behaviours in Timor Leste. Finally, we discuss the challenges of pursuing integrated models of care in the light of differential and complex power relations between a range of actors. In considering the varied responses to the notion of developing an integrated model of care, and to examine the ambiguity of 'healing' in the context of Timor Leste, we draw on insights from the transcultural psychiatry, regional anthropology, global and public mental health, and the social studies of science literature. Hence while our analysis is particular to Timor Leste, the issues which arise are also pertinent to other contexts.

Mental health services in Timor Leste

Mental health services in Timor Leste are relatively new. Prior to independence (2002) there were no state-sponsored mental health services available in the country. Although considerable effort has been made towards the provision of community-based services that are integrated into the mainstream health sector, the mental health care system faces numerous challenges. While there is one national hospital located in Dili at which the only psychiatrist in the country is based, one large regional hospital and four smaller hospitals, no public

inpatient mental health care is available in the country. The only inpatient mental health care facility in the country is delivered by a non-governmental organisation (NGO) – the Centro São João de Deus run by the order of Brothers Hospitallers (A Ordem Hospitaleira de S. João de Deus).

Each district has an allocated mental health worker with basic training in mental health and a background in nursing or public health. Primary health care doctors and nurses are authorised to prescribe and/or renew prescriptions for some psychotherapeutic medicines. Primary health care nurses with mental health training are also authorised to diagnose or treat mental disorders. Referrals for initial assessment can be made to counsellors working with one of two NGOs providing specific mental health services (PRADET (Psychosocial Recovery and Development in East Timor) based in Dili and the Centro São João de Deus in Laclubar). Priests and nuns in the Catholic Church also provide informal care through a range of pastoral services. In terms of training, the majority of primary health care doctors have not received official in-service training on mental health within the last five years.

Consistent with other countries, family and community bear the greatest responsibility for care of the mentally ill[7] and at this level, customary health and healing practices often operate as complementary care to formal health services.[8] However there have been few systematic attempts to document them in Timor-Leste.

The research setting

Between 2013 and 2015, we initiated an interdisciplinary scoping study that aimed to improve understanding of Timor Leste's diverse customary health and healing practices and explore the potential of integrating these practices with modern psychological and biomedical approaches. While two of us (author a and b) have each carried out long-term ethnographic research in diverse locations across Timor Leste, research for this particular study was conducted in three main locations, the capital Dili, the regional town of Baucau and the rural community of Venilale in the municipality of Baucau. Study participants, however, were drawn from 12 municipalities of Timor Leste representing a variety of socio-cultural and linguistic groups.[9] In-depth interviews and focus group discussions were conducted with key stakeholders: policy-makers, mental health workers, patients and their family caregivers as well as customary and other religious healers. Further data were collected through participant observation at a national level forum in 2015 that brought together over 60 Timorese participants representing government, international agencies, academic and community stakeholders from across the country to present the preliminary findings of our scoping study and stimulate dialogue on mental health policy and practice in Timor Leste. This forum also included the re-enactment of a 'healing ritual' by three customary healers from the Venilale sub-district on how health issues may be addressed collaboratively. Forum participants were asked to consider how inter-sectoral partnerships might best be realised to build an integrated system of care.

During the course of the scoping study we identified a range of different types of informal healer and healing practices, including customary approaches to healing that are associated with ancestral origin houses (*uma lulik*) and nature spirits and other religious healing practices common to both the Catholic and Protestant traditions, as well as syncretic indigenous derivatives thereof such as *oratorio* (see below and note 20). All were informed by different epistemologies and involved different diagnostic techniques and treatments. We also

identified that in Timor Leste both patients and health care providers across many sectors understand the practices of customary healers as essential to 'opening the pathway' to healing of all kinds and to ignore/neglect this would impede effective diagnosis and treatment and therefore recovery. Different diagnostic techniques were linked to specific healers' practice and these included watching the patient, listening to their life history, divination, augury and prayer. Among customary and other religious healers interviewed, we found a complex vocabulary for describing illness, symptoms and causes, different therapies or treatment based on diagnosis (including prayer; laying of hands; animal sacrifice; candles, herbal medication; and a focus on repairing relations and repaying debts to ancestors, family, house and affines, particularly through animal offerings and sacrifice). There was no necessary distinction made between a diagnosis of physical or mental illness[10] in either customary and other religious healing practices, insofar as neither type of illness nor symptoms more generally were considered characteristic of a particular (spiritual) cause.[11]

While formal links between the church institutions and the state-run health system exist, we found no formal connection between customary healers and the mainstream health sector.[12] However it became apparent that some healers refer patients to health workers in the clinics if their intervention is not effective and/or receive those who have not been 'cured' through formal health services. It was also apparent that while they may charge a fee for services, this is not always the case. It was recognised by customary healers themselves that there are (perhaps increasingly) many charlatan healers and a range of different stakeholders reported both positive and negative aspects of customary healers and healing practices. Nevertheless, many recognised that there may be benefits to working together. Not surprisingly, most health workers and bureaucrats maintain their traditional beliefs and also continue to seek help from customary healers and/or religious healers.

It was also clear that patients and families were more likely to have greater faith in and trust customary and other religious healers. In approaching these healers, they are taking responsibility for themselves and seek diagnosis/treatment and in doing so they are also more likely to address stressors from problematic relations within the family and with others that may influence their health. While in our discussions with patients, health workers and bureaucrats nobody openly criticised religious healers, some concerns were raised regarding the effectiveness of customary healers and healing practices e.g. that they provided short-term fixes but not long-term treatment or solutions. In a country where health care is provided for free, customary care was reported to have a higher financial cost to the family and its unregulated nature was perceived to be more vulnerable to harmful practices and abuse. It was also felt that dissatisfaction with the customary sector delayed engagement with the formal health service, resulting in their conditions being more severe when they arrive to the formal sector. While these concerns may be valid, similar concerns can be raised about the current state of the formal mental and broader health care system.[13]

Navigating multi-named conditions: customary healing, house-based societies and the case of Bere

Despite considerable socio-cultural and linguistic diversity, all customary health and healing practices across Timor Leste are deeply embedded in the inter-relationships between people, the ancestors and the environment.[14] Families of particular lineages are organised around origin groups linked to particular ancestral origin house (Tetun: *uma lulik*) and local spirit

ecologies which embed these families in intimate, intergenerational social, political and economic relationships with their extended consanguinal and affinal kin from other sacred houses. Links between these lineages and with the surrounding environment are embedded in a lifeworld of obligation and reciprocity built around socio-cosmic dualisms such as male/female, fertility-giver/fertility-taker, younger sibling/older sibling, indigene/newcomer, political authority/ritual authority, as well as a suite of botanical metaphors such as trunk/tips – the harmonious (or conflictual) relations between which ensure the 'flow of life'.[15]

In the case of house-based marriage relations, the *lia na'in* ('custodians of the words') of particular 'houses' will negotiate, often over a long period of time, the substance of the exchange of gifts and counter gifts (glossed in Tetum as *barlake*) between the families of the couple. These gifts will then be exchanged (and re-exchanged outwards) through a series of life cycle events (betrothal or 'path clearing', marriages and deaths) relating to both the couple and their closely associated kin. Such exchanges may extend over a period of many generations and the alliances formed include the obligation of members of each 'house' to perform particular ritual duties at each other's life and death-based ceremonies (Tetum: *lia moris* and *lia mate*). At the societal level these exchanges function to reach out politically and jurally to engage with, demonstrate respect for, and create mutual support between an ever extending web of kin-based relations based on the principles of *fetosaa* and *umane* (terms which we gloss here as 'fertility-takers' and 'fertility-givers'[16]). These exchanges form the basis of local customary economies and familial well-being.[17]

Within this meshwork of relations, customary healers may be *lia na'in* of particular houses, who take on as a matter of course the responsibility for the spiritual care and protection of their kin, or they may be more specialist healers. Without kin relations to the patient, these specialist healers are auspiced by their cultivated spiritual powers drawn from either their own 'house', 'nature' or the powers of divinity. The healing gifts of these 'specialists' may be received as a hereditary gift, through dreams or acquired through life experience and practice. It is also common for those who have been said to be afflicted by an adverse spirit possession to become healers if they are able to overcome and control the cause of their affliction.[18] In Timor Leste the continuum between such positive healing and negative affliction or intent (often glossed in the literature as witchcraft and sorcery) is delineated by who holds the locus of power: either people who are skilful enough to contain and control the power of the spirit they are exposed to or those that succumb to its power and come under its control.

To understand the complexity of these lifeworlds and understandings of health and healing, we present the case of Bere whose personal circumstances initially motivated the inter-disciplinary scoping study. The presentation of this case is not one of thick ethnography, rather through its narration we aim to provide an example of what are, in our ethnographic and public health experience, broadly commensurable community-based approaches to health and healing across the country.

In 2013, a 16-year-old boy called Bere died from what appeared to be a complex medical and psychiatric condition that led to self-starvation. Bere's mother came from a region where lineages are predominantly matrilineal and matri-local while his father was from a region which is largely comprised of patrilineal and patrilocal lineages. His parents' marriage was the cause of some concern and unease on both sides of the family requiring over many decades lengthy negotiations regarding expectations and outcomes related to the marriage such as place of residence, access to land, and the mutual exchange of goods and labour.

Despite different places of origin, both families were relatively well-educated 'town' people and Tetum dominated as lingua franca at home.

Bere's condition first manifested itself a year prior to his death. At the time he was living with his maternal uncles away from his natal home in Dili. There he was admitted to the national hospital for about a month. His maternal uncles, who were feuding between themselves over property, then sent him to his maternal grandmother's home in his natal town in one of the districts. There his condition worsened and he was eventually taken to live with his father in a town in a different district.

Bere and his family believed that the 'black spirit' being who once enabled the healing powers of his long-deceased mother had invaded her son's body and taken retribution on the family. In her lifetime, Bere's mother had healed people through prayer and candle flame – an indigenous form of healing practice influenced by the Catholic tradition that draws power from the 'light' rather than the 'dark' world of ancestral spirits.[19] Bere's family believed that to treat his condition they had to draw on the same practices from the world of light known in Tetum as *oratorio*.[20] Others murmured that the original source of Bere's mother's power must have also come from the darkness and this needed to be acknowledged. It was considered that should Bere pull through he would more than likely inherit his mother's healing power – harnessing the 'black spirit' under his control, rather than submitting to it. The question was could the spirit be brought under control or was its rage such that it could no longer be placated?

Bere continued to refuse food and his father took him to the regional hospital on several occasions. The medical staff at the hospital examined him and took x-rays of his stomach, but he was discharged and prescribed vitamins. According to Bere's father, the medical staff could find nothing physically wrong with him and this was because the 'black spirit' was preventing the X-ray machine from detecting what was wrong. From this perspective, Bere had to be exorcised before a proper diagnosis and/or treatment could begin.

Despite the visitations of *oratorios* – who would sit with the boy and his father and siblings to negotiate the spirits exit before carrying out further rituals and prayers – within two months Bere was distressingly emaciated. He could still walk and talk but most often this was when he was channelling his mother. One day her presence and rage grew stronger and Bere was increasingly agitated. As she spoke, she told the listening family that she could wait no longer and would take Bere 'across' to be with her in the next few days.

Immediately a non-East Timorese doctor from the regional hospital was called to the house. He had not seen the boy before. He agreed to take him on as a patient diagnosing Bere as severely depressed. He told Bere's father that if it was still necessary he should complete any customary healing practices and then agree to hand Bere over to his sole care. After three more days consulting the *oratorio*, Bere was admitted into emergency. Unfortunately, this was too late. Admitted into the doctor's care and placed on tubal nose feeding, it soon became clear that his intestinal system had been badly affected and within three weeks he died.

Immediately after his death, the question was not so much about why he died but where the boy should be buried and with which side of the family (maternal or paternal). Later, some family members reflected on the calamity, it was suggested that ceremonies at the maternal line's sacred origin house had never been carried out to appease the 'black spirit': this neglect had caused the mother's death (from cancer) and that of her son 14 years later, as well as ongoing conflict and illness in the family.

Because Bere's own person was so embedded in the historical contingencies and present circumstances of his extended kin relations, it was difficult, if not impossible, for his relatives and caregivers to relate to him as an individual, and to see his distress as an individual experience.[21] Bere was a boy of parts – his mother, the being who gave her healing power, her sacred house, and his wider maternal (and matrilocal) and paternal (and patrilocal) families and the unresolved tension between what pathway the marriage of his parents had, or indeed, would take (matrilineal or patrilineal). Hence a diverse network of people had a direct stake in the well-being of Bere and that of his many siblings, nieces and nephews.

Across the country, similar explanatory models for illness are also bound up in the familial tensions and histories which imbue life in these house and inter-house arrangements (there are just as many tensions to negotiate within houses (*maun/alin* = older sibling/younger sibling) as between houses (*fetosaa/umane* = fertility givers/fertility takers)). In all of these arrangements the well-being of present and future family members and their livelihoods is dependent on ensuring that relations with the ancestral and spirit realm have been sufficiently and correctly attended to. Any actions or circumstances which cause ancestral displeasure will result in the illness, misfortune or death of the living (and potentially affect future generations).

The critical issue for Bere was that these parts (the relations between the living and as a result the living and the dead, the human and the 'more than human') were not in harmony, rather they were playing out in conflict through and around his body, with ultimately devastating consequences. This high stakes ontology involved spirit powers, those potentially tamed and under human control (Tetum: *maus*) and those which are wild and outside of human control (Tetum: *fuik*), from the worlds of both lightness and darkness. In this case, it was the power of the dark world, of wildness (and fury) which prevailed and maintained the locus of power. After Bere's death, from the perspective of the origin houses involved, it became clear that this angered force from the darkness was causing particular kinds of blockages that had to be cleared to enable the wider flow of life.[22] They eventually consulted specialist healers of the darkness searching for a diagnosis of the cause of the blockage. Yet even while Bere was alive, as they discussed ways to overcome the unwanted spiritual presences, they were also trying desperately to find other ways of explaining the affliction writ large on the body of Bere himself. While Bere was not taken to be healed via any local Catholic or Charismatic institutions, his family, as we saw above, did take him to the hospital hoping there for some certainty, some diagnosis which would provide the pathway to a cure. Yet the biomedical system, in which they temporarily placed their hopes for answers, also failed them. From the family's perspective this was understandable, inevitable even. Modern medicine was being outsmarted, succumbing to the whims and obscurant effects of a more powerful being. The problem from the family's perspective was not the loss or absence of the ability of Bere to thrive (as a result of depression or self-starvation), but one of presence, the presence of a powerful and enraged being who it seemed could not be placated.

Given this complexity of approaches to both understanding and treating Bere's illness, how we might ask could the outcome for Bere have been different? Is it simply a matter of creating better linkages and referral mechanisms and establishing an effective collaborative mechanism between the customary healers and health professionals, or is there something more fundamental at play, something which goes beyond a technical or managerial solution? Law and Singleton (2004) characterise such multi-named conditions as 'fire objects' which spread unevenly across the realms of body, mind, society and in this case spirit. The

particularities of these multi-named conditions, they write, do not in all cases find presence only absent-presences as 'each is made differently' constituting 'an object, that jumps, creatively, destructively and more or less unpredictably from location to location'.[23]

Drawing on our ethnographic experience and extrapolating the familial approach taken in Bere's case to similar approaches to such multi-named illnesses across the country, we argue here that by drawing on Law and Singleton and understanding such illnesses as 'fire objects' helps explain why they are so notoriously hard to pin down and to find a coherent narrative from which to respond. Such objects write Law and Singleton are created by 'a pattern of presences and absences', through which 'realities, messy or otherwise, are [not given] but enacted into being'.[24] By hospitalising Bere his treatment began with the withdrawal (absence) of his wider network of carers, while 'absent' from the hospital's approach was the fact of a boy possessed. In the ensuing organisational distinction between his networks of formal hospital-based and informal community-based care we can trace the ways in which the 'generative links between presences and absences … are both brought, and cannot conceivably be brought together'.[25] While there are of course many tacit connections, as Law and Singleton write, such 'objects cannot be narrated smoothly from a single location … [rather] it subsists in, and participates in the enactment of, entirely different, spatial logics or realities, and those spatial realities have complex relations with one another … [making it] a spatially complex object.[26] Understanding such illnesses in this way, as (abstract) objects of discontinuity which fluctuate between presence and absence in often incommensurable ways, we can also see how such illnesses resist all technical, managerial and even varied epistemological attempts to overcome them. It is quite simply, too slippery to bring into presence, such objects live 'in and through the juxtaposition of uncontrollable and generative othernesses'.[27] As a result its 'otherness in one form or another always escapes method. It cannot be domesticated … [and] we cannot know it by insisting that it is clear'.[28]

Below we explore the challenges of designing a health systems response to these complex scenarios. We move on from the case of Bere and draw on the insights of others, who have studied similar customary healing approaches, before examining the broader politics of 'doing' health in Timor Leste. Our point of departure for this exercise is our collaborative research into mental health systems and the intersection and juxtaposition of the customary, religious and biomedical spatio-temporal networks we became aware of through this research. We take as our example the aforementioned national level forum that brought together over 60 Timorese participants representing government, international agencies, academic and community stakeholders from across the country, and included the re-enactment of a 'healing ritual' by three customary healers from the Venilale sub-district.

Towards an integrated model of care: the ambiguity of healing

In relation to customary healing practices, Hoskins (1996) examines the social role of ritual healing performances among the Kodi in neighbouring Sumba and concluded that illness (of any kind) may be incidental or a pretext for sorting out other long-standing issues. She identifies a range of practices around approaches to diseases and noted that the classification of all illnesses and injury is based on causes not symptoms. Diagnosis, she notes, refers to the affliction (caused by which particular spirit or event) not the ailment itself. When the diagnosis is one of spiritual intervention, the required healing performances are often the catalyst for group therapy which leads to the restoration of pathways of relations and

exchange. As a result, she argues, there is in such contexts a need to de-centre the modern medical focus on patient and symptoms and focus instead on the importance of social factors such as repairing social relations and healing the group before the 'cure' of the patient can be enabled or addressed by whatever means.

Similarly Sakti (2013) writing about post-conflict trauma in Timor Leste analyses the frequently referred to affliction of '*hanoin barak*' or 'thinking too much' (associated with trauma or mental illness). She writes that this condition refers not so much to a particular traumatic event or violence, but to the ongoing trauma or blockage (especially in family relations) manifest as a result of this event. The person is literally 'thinking too much' about the consequences of the social ramifications/obligations which cannot be met.

As a result of such ethnographic insights, in their study of the cultural shaping of recurring but temporary psychosis in post-conflict Timor Leste, Rodger and Steel argue that even from a biomedical perspective, this idea of 'externalizing' the source of an affliction (bringing it to presence as a blockage in relations or a spirit possession rather than an individual health issue) can have positive effects. They write that in Timor Leste such externalising acts to reduce the stigma of mental illness for an individual and also enables and encourages a collective response to resolving the individual's circumstance.[29] Healers, in these instances, act as an external locus of control, people who take on and confront the external cause head on.[30] It is a process they argue which can allow the self to separate from the traumatic event and thereby help recovery by averting chronic or life-threatening situations.[31]

How can the formal health care system reconcile these insights with calls for more integrated models of care? To answer this question here we reflect on the discussions at the 2015 national forum that was held under the auspice of the Timor Leste Ministry of Health, the Office of the President and the World Health Organisation. The participation of the customary healers was due to the fact that the Venilale sub-district mental and other health workers involved in the forum had a long association of informally working together with these healers in the treatment of patients (a relationship, which as we might expect, is facilitated though their own familial networks with each other). As such it was intended to both reflect the reality of diverse health practices, particularly in areas outside the capital, and to be an example of the possibilities for integrating these practices, encouraging an open dialogue and more relational approaches to building an integrative model of care. Yet among the audience of predominantly Timorese health workers present that day there were complex reactions to the dramatised re-enactment of a customary healing practice. For a great many there was a palpable and welcoming excitement that this form of knowledge and practice was being performed on this very public health stage. While for most present this is a world they are at least privately participants in, there was at the time also a quiet sense of embarrassment that this 'dark' (and by association 'primitive' or 'backward') world was so daringly being brought into a setting usually reserved for the practices of the 'light'. For a vocal minority of young Catholic charismatic healers present however, there was immediate and public outrage expressed at the fact that what they called the work of the 'devil' (something to be exorcised) should have been allowed a legitimising space at all. While this was certainly not a sentiment shared by the majority, when these concerns were voiced the majority remained publically silent.

These varied responses (and in particular the silence of the majority) need to be understood in the context that being modern in Timor Leste is the default aspiration of most of those employed in the government and associated sectors.[32] Being modern has long meant

being both educated and Christian, while maintaining on the whole a generally parallel or syncretic, if private, approach to more customary Timorese traditions. Yet increasingly prevalent in the capital (the seat of the government, the bureaucracy and the locus of formal health systems) are a range of institutionalised Catholic and Protestant charismatic movements. Drawing usually on the charisma of visiting foreign teachers, these traditions often express disdain or outright objection to engagement with customary healing practices.[33] They seek instead a break from ancestral religions and associated customary practices, radically refashioning newer traditions based on individualism and a direct spiritual relationship with a Christian God.

By openly rejecting their responsibilities to their networked customary social and cultural relations, members of these congregations argue instead for a radical reshaping and codification of an increasingly individualised habitus.[34] On the one hand, as we saw in the example of the forum, this gives the illusion at least of aligning these practices with the more individuated 'modern' and biomedical focus on a patient's well-being. On the other hand, and as we became aware of through the research process, while referring to the 'dark world' of 'stone worship' and animal sacrifice as the devil's work, these charismatic Christians are simultaneously focused in their prayer-based healing practices on the need to extract foreign or spirit substances from those afflicted with illness (nails, pigs and crocodiles are some of the things said to be commonly in need of extraction).

Hence it is also important to note that, as we saw in the case of the forum, while there is a clear tension between these customary and institutionalised charismatic healing practices, it is also clear that the difference between these practices is not so much ontological as epistemological. In other words, which practices and pathways to healing are chosen and legitimised depends on an ongoing dialogue between people and between people and the 'more than human' world, including whether (and when) people place their faith in the ways of the light, the dark or both.[35] Across Timor the default Catholic and customary position has traditionally been one of mutual accommodation (enabling both to varied extents). For this reason many people will engage strategically with the worlds of dark and light carrying out in considered succession various customary and Catholic healing practices including highly syncretic indigenous derivatives such as *oratorio*. Yet increasingly in the nation's capital these diverse practices are being challenged by those whose 'new'[36] individuated and institutionalised faith in an exclusive Christian God increasingly closes them off to the possibilities of others. The fact that these institutionalised movements can on the surface approximate a 'modern' biomedical focus on the well-being of individuals makes them doubly powerful.[37]

Conclusion

As we have outlined, biomedical and public health approaches to mental health frameworks have increasingly embraced and promulgated the hope and expectations of co-ordinating a technical approach to systems change and an integrative models of care. This research has found that in the context of Timorese customary healing practices, such hopes and expectations are underpinned by a commitment to a network of inter-generational kinship relations which are as much about the dead as the living, as much about nature as culture (and in this way they embrace the lightness and the dark). While the mainstream Catholic church is also known in Timor Leste for its embrace or appropriation of customary symbols, for

'newer' traditions of charismatic church-based healers these hopes and expectations of healing are channelled through a commitment made exclusively to God and other members of the same church (for them the darkness (and associated nature spirits) is the place (and work) of the devil). Through the case of Bere and the 2015 national forum, we have seen two different contexts through which these processes play out. These have been presented to demonstrate the challenging and diverse array of deeply political ritualised healing practices which must be taken into account in any attempt to achieve an integrated systems approach to mental health and well-being.

In agreement with Law and Singleton's (2004) notion of the generative (and potentially destructive) power of multi-named conditions and approaches to treating these conditions, Mol (2002) argues that disease (and illness) are both embodied and 'continuously becoming'. She writes that shared practices and the telling of stories 'is a form of public coordination…a part of our we govern ourselves and each other'.[38] This is a collective and socio-political rather than individual and technical way of doing health. From our initial research, it appears that patients, their families, health workers and bureaucrats in Timor Leste already understand that customary, religious, psychological and biomedical approaches are all valid (and even interconnected) pathways to healing (addressing illness) and that all may be tried, just in case they provide a 'cure'. This sense of 'cure' is not necessarily specific to an illness and, at least for the customary system, it involves the search for a pathway to healing through the reparation of broken or weak (and very often 'more than human') social relations.

By negotiating carefully across these approaches it is possible that the range of actors involved can get better at sharing practices and integrating perspectives. Yet this will require a long-term commitment to working through dynamic, highly nuanced, deeply political, polymorphous understandings of ways to ensure communal and individual well-being. It will also need to involve an openness to criss-crossing boundaries,[39] working through and with difference, whilst recognising the deep politics at work in any performance.

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Notes on contributors

Lisa Palmer is a human geographer in the School of Geography at The University of Melbourne where she teaches and researches on socio-natures and indigenous approaches to environmental and social governance. Her research is focused on South-East Asia and Indigenous Australia. Since 2004 she has conducted fieldwork in East Timor where she has researched issues surrounding the ongoing importance of customary land, resource management and healing practices and the influence of these processes on nation building and development. She has published widely on these issues in geography, anthropology and cognate areas. She is the author of *Water Politics and Spiritual Ecology: Custom, Environmental Governance and Developmen*t (Routledge Explorations in Environmental Studies 2015).

Susana Barnes is a research associate in the School of Geography at the University of Melbourne. Her research interests are East Timorese ethnography, social organisation, customary land and natural

resource governance, ritual and religion, and customary health and healing practices. She has published a number of journal articles on these topics and is the co-author of *Property and social resilience in times of conflict: land, custom and law in East Timor* (Ashgate 2012).

Ritsuko Kakuma is a senior researcher in the Global and Cultural Mental Health Unit, Centre for Mental Health, Melbourne School of Population & Global Health, The University of Melbourne. She has a background in epidemiology and biostatistics, public health and mental health systems and policy research. Her research and development activities are primarily based in low- and middle-income settings and include: mental health policy and system strengthening, health system evaluation, mental health workforce development, mental health stigma and discrimination research, health policy analysis, policy and community engagement, and health research capacity development. She has extensive experience in conducting both quantitative and qualitative research, partnering with governments for research and policy development, consulting with stakeholders to develop community-based mental health services, supporting governments in drafting mental health policies and legislations, developing and delivering training programmes on mental health system development. She and the other co-authors have contributed to the recent development of the National Mental Health Strategy 2017–2021 in Timor Leste.

Notes

1. Kleinman et al., "Culture, Illness, and Care"; Kleinman, "Depression, Somatization and the "new cross-cultural psychiatry.""
2. Sorsdahl et al., "Traditional Healer Attitudes and Beliefs."
3. Kakuma et al., "Towards an Integrated and Accessible."
4. In this paper, we refer mainly to Catholic or Protestant faith-based healers.
5. Lansing, *Priests and Programmers*: *Technologies*, 15.
6. Dikeç, "Space, Politics, and the Political."
7. Silove et al., "Estimating Clinically Relevant Mental."
8. McWilliam, "Fataluku Healing and Cultural"; While mentally ill people in Timor Leste are generally cared for in and by family and community, there is stigma attached to certain behaviours associated with mental illness and fear of (spiritual) contagion and very often physical violence. In the absence of viable care alternatives, some people are shackled or otherwise restrained.
9. For logistical reasons no participants from the Special Economic Zone of Oecusse were able to take part in the study.
10. While local interpretations of illness seldom differentiate between mind and body, in this paper we focus on interactions with the newly introduced mental health care system. The term mental illness used here is drawn from the traditions of Western medicine, while acknowledging the inter-dependent relationship between the two, nevertheless distinguishes mental and physical health/illness.
11. cf. Hoskins, "From Diagnosis to Performance: Medical."
12. Within the National Hospital in Dili, religious sisters perform pastoral visits on a regular basis as do visiting priests. All private health care providers, including those run by the Catholic Church or Protestant churches are regulated by law (Decree Law 18/2004). Informal links also exist between church-based healers and the formal health system. For example, the only practicing psychiatrist in the country is a member of a Charismatic church and member of their healing community. He told the authors he frequently refers patients to church healers when all possible avenues have been pursued within the formal health system. Informal linkages between the church and customary healers abound. One of the customary healers who participated in the enactment of customary healing practices in the 2015 national forum was also a charismatic healer associated with his local Protestant church.
13. Price et al., ""I Go I Die, I Stay I Die"; Zwi et al., *Timor-Leste: Health Care*.
14. cf. McWilliam, "Fataluku Healing and Cultural Resilience"; Sakti, "'Thinking Too Much': Tracing"; Zwi et al., *Timor-Leste: Health Care*.
15. Fox, "The Flow of Life: Essays."

16. While the *fetosaa* and *umane* alliances systems vary in their detail and terminology across the country, partilineal systems are usually glossed by anthropologists in English as wife-taker and wife-giver alliances. Wife givers/takers do not reflect the meaning of Indigenous terms which speak more to the transferral of generative power and house affiliation. In these systems the local language terms refer, in general, to the relationship formed between the marriage house of a man's sister (and her children) and the house of the man's patriline (and his children). Once the *barlake* process is completed, children belong to the house of their father (who are in effect fertility-takers from the wife's natal house). While in matrilineal systems (and indeed, in certain circumstances, in many of the systems which are nominally patrilineal), men marry into their wife's natal house, in which case the children of the union belong to the mother's house (who are in effect fertility-takers from the husband's natal house).
17. Palmer, *Water Politics and Spiritual Ecology*.
18. cf. Hatala et al., "Narrative Structures of Maya Mental," 479; Rodger et al., *Between Trauma and the Sacred*.
19. The cyclical movement (but also spatio-temporal co-existence) between darkness and light, day and night, the world of the dead and the world of the living is the core principle of local cosmologies and spirit ecologies among various socio-cultural and linguistic groups in Timor Leste (see Traube (1986) for Mambai; Palmer (2015) for Makassae and Waima'a; Barnes (2017) for Naueti).
20. The Tetun term *oratorio* is derived from the Portuguese word meaning 'oratory', place of prayer. While *oratorios* draw on certain Catholic rites and saints, they are in fact appropriating (drawing in) their symbolic powers and attributing new meaning to them (see also Fidalgo Castro (2012)).
21. cf. Strathern, *The gender of the gift*; Bialecki and Daswani, "What is an Individual?."
22. cf. Sakti, "'Thinking Too Much': Tracing."
23. Law and Singleton, "Object Lessons," 16.
24. Ibid., 12–3.
25. Ibid., 17.
26. Ibid., 17.
27. Ibid., 16.
28. Ibid., 19.
29. Rodger and Steel, *Between Trauma and the Sacred*, 139–40.
30. Ibid.
31. Ibid.
32. It is also the case that Timorese customary cosmologies recognise the spirit world as having both benevolent and malevolent features. Within this dualism, the threat and need to placate various 'devil'-like or angry spirits is a constant force which must be negotiated and attended to. However, this acceptance is different to asserting that customary practices themselves are promulgating 'the work of the devil' and are therefore illegitimate.
33. Wiyono, "Timor Revival: A Historical."
34. cf. Strathern and Stewart, *The Python's Back*.
35. cf. Schram, "A Society Divided: Death"; Chua, "Horizontal and Vertical Relations."
36. See Wiyono (2001) for an historical account of the periodic emergence of these charismatic traditions in the region.
37. In addition to fact of the inadequate services and access issues in the 'free' formal health system, it is also the case that people engage with such charismatic faith healing practices because of its enchantment (as opposed to secular health services) and associated inter-group sociality and support systems (a sociality circumscribed by the valorization of collective individualism).
38. Mol, *The Logic of Care*, 89.
39. Ibid., 91.

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