

## Chapter 2

# Traumatic Structural Dissociation and Its Cultural Dimensions

### 2.1 Why Dissociation?

Dissociation is a term used to describe a failure of integration of different psychic functions (mind-body; cognition-emotion; self-parts; mental functions etc.). There is debate as to whether the term should be used to describe normal experience, such as automatic driving and absorptive experiences, and whether pathological dissociation is qualitatively different from such normative dissociative-like states (Kirmayer 1994 and 2011; Nijenhuis and van der Hart 2011; van der Hart et al. 2004). The frequency and qualitative dimensions of dissociative experience also varies cross-culturally (Lewis-Fernández et al. 2007), as can be seen when comparing Western countries with non-Western settings where practice of trance and belief in spirit possession are more widespread. For anthropological purposes the use of term appears useful, since at a basic level it can be used initially for purely descriptive purposes, with theoretical models and assumptions put temporarily on hold. But as Seligman and Kirmayer (2008) note, when it comes to theorising, anthropological accounts of dissociative phenomena, while rich in attendance to context and social meaning, have remained disjointed from psychological and neurobiological understandings<sup>1</sup>; something which their own work seeks to partly address, and upon which we have built.

In this work we have drawn on specific models and contemporary research from multiple arenas, including cognitive and experimental psychology, psychoanalysis, neurobiology and anthropology, but hold that characterisations of dissociated states of mind are found both historically and cross-culturally (e.g. possession states), and have, in Rorty's (1989) words, been variously *redescribed* and represented in the

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<sup>1</sup>Itself a further example of the epistemological tension between agentic and deterministic accounts of experience (see Sect. 1.7.2).

overlapping terminologies of many schools of Western psychology.<sup>2</sup> While acknowledging that the experience and concept of self-assumed within the Western psychological canon on dissociation may differ significantly from non-Western experience and constructs, the anthropological literature, including in relation to spirit-possession, can be read as supporting this broad definition of dissociation, with the proviso that lack of integration and externalised *experience* and attribution may be normative and not necessarily pathological (Seligman and Kirmayer 2008). Additionally important and efficacious cultural-work may *require* that such dissociated parts remain *unacknowledged* as *self*-parts (see Sects. 4.1.2—Footnote 2 and 5.2.1) and aspects of traumatic intrusions, might even be fruitfully understood, ontogenetically, as non-self (see Sects. 3.2 and 5.2.1—Footnote 14). Of course, the implicit theoretical assumptions, and subcultural understandings, embedded in different terminology, may itself shape both experience and outcome, through “social-looping” (see Sect. 1.7.2; Hacking 1999) and cultural scripting (see Sect. 5.2.5). Nonetheless, whatever the various bottom-up and top-down forces involved, it is pertinent to note that dynamic brain imaging of changes in dissociable and discrete self-states supports their *subjective experiential* veracity (Littlewood 1996).

While the boundary between dissociative and everyday experience is obviously not always clearly defined, dissociative phenomena are accepted to be more common in non-Western settings. Certainly this was our experience in Timor-Leste where abrupt and apparently discontinuous changes in mental state, suggestive of dissociative shifts (albeit potentially culturally normative and adaptive ones) were commonly observed in many day-to-day encounters. These included culturally sanctioned contexts such as funerary and mourning rites (see Sect. 3.2), but also our research interviews (which sometimes appeared to precipitate a dissociative shift, unveiling previously masked distress, but sometimes facilitate a *sealing-over* of distress depending on the individual—see Sect. 1.4.3, Footnote 11). In both cultural and interview contexts, the abrupt shifts described were often precipitated by social cues although further cues later appeared to reconnect the individual with their earlier mental state, thereby restoring the continuity that appeared to have been lost.

Within the narrower research cohort of brief-remitting-relapsing (BRR) and acute-on-chronic (AOC) exacerbations of psychotic-like states under focus, and while not specific markers in themselves, there were also a number of features, suggestive of dissociative processes at work. These will be subsequently examined more extensively (see also Sect. 1.5) but in summary included:

1. Stereotyped descriptions/manifestations of psychotic symptoms with little variation between subjects. These included extreme states of agitation and aggression that appear to have rarely led to significant physical violence, suggesting such behaviour may have been partly “culturally scripted” (see Sect. 4.2.2).
2. Rapid onset in response to social stress or *symbolic triggers*, that sometimes included *dramatic* precursors or precipitants of onset and recurrence, such as

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<sup>2</sup>Examples include a self “fragmented into a set of modules, subsystems, ego-states or part-selves, depending on the vocabulary chosen” (Ross 2008, Sect. 20.1.1).

episodes of collapse preceding an episode (see Sect. 2.3.4—Case BP5 and Table 2.1). While such precursors and triggers were often emotive, taken in isolation the subsequent response would appear unexpected and disproportionate. Resolution of symptoms was often equally rapid, often after a matter of hours or days, with occasional longer episodes.

3. Disavowal or genuine amnesia of disturbed behaviour (see Sect. 1.4.2—Table 1.3)
4. Some degree of *secondary gain*, in addition to the *primary gain* of temporarily sealing off distress from awareness, is often apparent to the impartial observer. This may include unobvious gains such as exemption from certain family, social and occupational expectations, or more complex dynamics of *social redress* (see Sect. 4.2.2).
5. Disturbed behaviours were reported by families to respond to very small, doses of antipsychotic medication that may not be simply attributable to drug-naivety or racial pharmacogenomics (cf. Ninnemann 2012), but rather the “symbolic” power of Western medical treatment facilitating a sealing-over of distress (cf. van der Geest and Whyte 1989) although attitudes towards Western medicine and its interface with wider cultural dynamics are complex.<sup>3</sup>

We will also argue that there were many aspects of the psychosocial and cultural context at the time of our study in Timor-Leste that may have served to increase the likelihood of such dissociative phenomena. Dissociative states are often assumed to be *culturally pathoplastic* phenomena (Spiegel et al. 2011; see also Sect. 1.5), thereby explaining the fit between local factors and illness presentation, but once again how and why pathoplasticity come about is poorly understood and is an area we will attempt to conceptually develop. Finally dissociation may provide a useful model for at least *some psychotic states* (see Sect. 2.2.1), both being predicated on ideas of *failed psychic integration* (see Sect. 5.1). While there is burgeoning interest in this connection within the critical psychology field (e.g. Morrison et al. 2003; Moskowitz et al. 2008a, b) there are few modern studies that explore this link in non-Western settings. Guinness’s (1992) and Castillo’s (1994) work are notable exceptions but remain in need of updating.

The dissociative formulation outlined in this work commences with an exploration of trauma-informed linear models of dissociative phenomena, and how they can contribute to an explanation of psychotic or psychotic-like mental states and behaviour, but further considers how traumatic events may become symbolically encoded and re-triggered, in the context of Timorese practice and belief. We will also go on to consider how unconscious motivation, conflict and phantasy, further shape dissociative-psychotic responses (Chap. 3) and how the recursive interaction of cultural factors further interact with this process (Chap. 4)—factors arguably critical to the unique patterns of dissociative phenomena in different parts of the world.

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<sup>3</sup>Several individuals and families articulated a degree of faith in Western medicine, although there was also disappointment (see Sect. 5.2.4) and ambivalence and such faith is moving in the opposing direction to forces promoting cultural revitalisation (Sect. 4.2.3). We also need to be aware of how our positioning as doctors may have influenced responses (Csordas et al. 2010; Sect. 1.7.1).

## 2.2 The Model of Traumatic (Structural) Dissociation

The clearest *linear model* of dissociative experience is the trauma model. Also known as the model of structural dissociation, it designates dissociative states as pathological, albeit perhaps understandable and even partially adaptive, responses to trauma (van der Hart et al. 2004). Rehabilitating and refining the observations and theorising of Pierre Janet,<sup>4</sup> trauma theorists, van der Hart et al. (2004) have argued that a breakdown of integration between different parts of the psyche, on account of predisposing vulnerability and later trauma induced cognitive and affective overload, to result in the splitting or fragmentation of self-experience, into psychobiological subsystems, along pre-existing fault lines dictated by evolutionary psychobiology. For example, in elaborating on Myers' observations from World War I, they argue a split might emerge, along the most basic fault lines, between subsystems underpinning *rational-thought* and *feeling*; or between *approach* and *retreat* (van der Hart et al. 2004).<sup>5</sup> Additional trauma may then further fragment these defensive or goal-directed self-subsystems; for example defensive subsystems may become further divided to include *freeze*, *flight* and *hypervigilance* (van der Hart et al. 2004).

While some aspects of semantic, episodic and procedural memory may be shared by different self-subsystems, others may become tied to a specific domain of the psyche (Castillo 1994)—particularly highly emotive, traumatic events that become encoded when the field of consciousness is adaptively narrowed to deal with the threatening event or injury, which lacking wider contextual links requires the recreation of the same intense emotional state, or specific triggers to *activate* them (cf. Kirmayer 1994 on state-dependent learning). Poor recall *across* different parts of self would therefore be predicted. Amnesia, following the brief-psychotic states described, might be expected, if they are indeed dissociative in origin, as such experience would be rapidly *walled-off* following the removal of key triggers.

However implicit in the model of structural dissociation model is the recognition that dissociative responses are imperfect in sealing-over distress, and become problematic for the individual, and those close to them, even when “successful” (Seligman and Kirmayer 2008; van der Hart et al. 2004). *Positive* and painful dissociative phenomena may emerge when embodied experiences and memories from one self-subsystem intrude into consciousness, yet, when successfully sealed-over, a sense of deficit or loss may be *felt* or apparent to others, due to the removal of significant self-experience and affective range from the dominant

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<sup>4</sup>Janet (1869–1947) is described as the French founding father of the “new dynamic psychiatry” before Freud (Ellenberger 1981).

<sup>5</sup>Van der Hart et al. (2004, 907), following Myers, have divided the healthy and traumatised parts of the self into the “apparently normal part of the personality” and “the emotional part of the personality” respectively, although we have not followed this cultural convention here.

self-domain (van der Hart et al. 2004).<sup>6</sup> Greater difficulties in effectively walling-off experience may also become apparent as the initial narrow range of trigger stimuli become widened due to the subsequent pairing of conditionally emergent, imperfectly sealed, affective experiences with new contexts, thereby providing the material for new conditioned cues (van der Hart et al. 2004).

### 2.2.1 Traumatic Dissociation: From PTSD to Psychosis

A range of PTSD symptoms—not limited to the ones thought of as classically dissociative—can then be conceptualised via this model. As such *positive*, or intrusive, dissociative experiences may entail *psychoform-phenomena* from both the *re-experiencing* (intrusive thoughts, flashbacks, nightmares, emotional reliving) and *hyperarousal* (anger, hypervigilance, hyperstartle) dimensions of PTSD<sup>7</sup> (van der Hart et al. 2004). The more commonly understood dissociative symptoms of PTSD (complete or partial amnesia, and a sense of detachment) then become understandable as the *negative* (or deficit) correlates of these positive dissociative phenomena, that can be expanded to include other symptoms, such as *restricted range of affect* (van der Hart et al. 2004).

In clinical contexts, traumatised individuals may have a predominantly *intrusive-hypervigilant*, or a predominantly *emotional overmodulation-numbing* clustering of symptoms (Lanius et al. 2010). While peritraumatic dissociation has been shown to be a significant risk-factor for the development of PTSD symptoms, it seems likely that it may also give rise to a symptom profile more dominated by emotional numbing and less objective physiological arousal (Griffin et al. 1997) as the initial traumatic experience remains at least partially sealed-off, except when triggered or brought to the fore by other factors. In contrast the absence of peritraumatic dissociation, might be predicted to lead to a PTSD profile more dominated by re-experiencing and hyperarousal symptoms (cf. Lanius et al. 2010). This model also predicts *fluctuation* between intrusive dissociative experience and deficit states, in response to changes in the perceived level of stress or threat, in addition to other factors (see Sect. 5.3—Fig. 5.1), and such fluctuation between “intrusions into and withdrawals from the executive self” has been well described in clinical work with dissociative conditions (Ross 2008, Sect. 1.4; cf. Lanius et al. 2010) and indeed are described by Ross (2008, Sect. 1.3) as “the predominant cause of a symptoms in a structurally dissociated psyche.”

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<sup>6</sup>Relational psychoanalysts may speak of sensing the missing emotion in the counter-transference (Wallin 2007).

<sup>7</sup>Most factor analytic studies exploring PTSD symptom-clusters have confirmed the basis for separating out *re-experiencing*, *hyperarousal* and *avoidance* symptom dimensions, but have also pointed to the need to separate out a further dimension of emotional numbing (Pietrzak and Southwick 2009).

Additionally it is now understood that dissociative experiences can include *somatoform phenomena* (van der Hart et al. 2000). Intrusive somatoform phenomena may include pain or other somatic sensations, that may represent unprocessed and poorly integrated embodied memories of painful experience, or even ongoing physiological pain, split off, or repressed, from active awareness (van der Hart et al. 2000). Negative correlates of somatoform symptoms would then include, experiences of non-organic sensory loss (including blindness or deafness) and paralysis (van der Hart et al. 2000) and need not resort to “symbolic” Freudian explanations of intrapsychic conflict and conversion (although need not be mutually exclusive of such explanations—see Sect. 3.1.4).

In this light, the difference between flashbacks and hallucinations may not be as clear as descriptive psychopathologists would like. Rather flashbacks might be defined as intrusive perceptual phenomena in which the insight and awareness that one is re-experiencing events from the past is at least partially retained, or only very briefly lost. In some instances, “hallucinations” may then represent perceptually and aetiologically similar processes but in which this awareness or memory of the begetting trauma is lost (Read et al. 2005). For example due to the narrowing of attention, or peritraumatic dissociation, affecting encoding during the traumatic experience; different sensory aspects of the traumatic memory may be subsequently recalled in a piecemeal manner, or may be fully recalled but lack the contextual mnemonic embedding that allow their identification with the past, rather than the present (Read et al. 2005). Additionally “hallucinations” might also represent *variations* on a traumatic-theme, or *symbolic*-representations, of earlier trauma (Hardy et al. 2005), further complicating awareness and insight into their origin.

Since trauma is often re-lived in multiple sensory modalities, the proposed shared ontogenetic basis of “flashbacks” and certain hallucinatory experiences, may provide an alternative explanation as to why visual and tactile “hallucinations” (conventionally often seen as a marker of organic brain disturbance) are not uncommonly represented, alongside more traditional “auditory hallucinations,” in psychotic symptomatology partly attributed to trauma, and was consistent with our own recording of such symptoms in the BRR group (see Sect. 1.4.2—Table 1.3).

Similarly *hypervigilance* secondary to traumatic experience may become generalised and de-contextualised, manifesting as paranoid ideation, or misattributed and misdirected leading to the development of more specific persecutory delusions (Moskowitz et al. 2009; Read et al. 2005). If hallucinations are sometimes a form of de-contextualised flashback, the inaccessibility to memory of the historical cause may then trigger a different set of secondary attributions that appear delusional. Additionally any associated de-contextualised emotional experiences may further contribute to misattribution or be associated with a particular phenomenology such as the genesis of “delusional atmosphere” (Moskowitz et al. 2008a, b; Read et al. 2005).

Several researchers have also commented on the similarity between the so called *negative symptoms* of schizophrenia and the cognitive and emotional deficits seen in chronic and/or dissociative subtypes of PTSD (Morrison et al. 2003; Read et al. 2005; Stampfer 1990) in which charged-emotional states may be largely sealed-off.

The intrusion–withdrawal model, also provides a basis for considering *passivity phenomena* such as thought insertion/withdrawal and “made emotions” or “made actions” that are included amongst so called First Rank Symptoms (FRS) of schizophrenia (Ross 2008).

It is important to note that, following Ross (2008, Sect. 20.1), we also view the model of psychotic-dissociation described here as “entirely consistent with the structural model of dissociation” but advocate an extension and broadening of its logical implications. We acknowledge with Ross that this goes beyond what is intended by the pioneers of this model who continue to assert that the concept of dissociation should be limited to instances involving a “division of an individual’s personality” such that each “dissociative part of the personality, minimally includes its own at least rudimentary first-person perspective” (Nijenhuis and van der Hart 2011, 418). In response Ross (2014, 285) rightly raises this as a threshold question, and asks “how rudimentary can...personality...be and still qualify as structural dissociation?” More specifically in the context of dissociative model of psychosis he quotes Bleuler’s assertion, from his seminal *Dementia Praecox or the Group of Schizophrenias* (Ross 2008, Sect. 20.0) that “even emotionally charged ideas or drives attain a degree of autonomy so that the personality falls to pieces” suggesting the possibility of dissociative fragments of the psyche, at a much more rudimentary level than that captured by the concept of personality is possible (see also Sect. 3.2). As such this is consistent with theories and observations of both personality preservation (Johannessen et al. 2007) and “personality disintegration” (Chung 2007, 2) in persons diagnosed with psychosis and may reflect the success or otherwise respectively of sealing-over intrusive symptom. Preservation of the personality has been particularly noted in brief-psychotic states (McCabe and Strömngren 1975) and in Chaps. 4 and 5 (for summary diagram see Sect. 5.3—Fig. 5.1) we will explore an array of sociocultural processes that may mitigate against disintegrative forces, fostering a degree of integration, or at least psychic-organisation. Where genuine integration occurs, *constructive* and lasting personality change would be predicted.

### **Evidence for the Trauma-Psychosis Model**

In recent years there has been a convergence of evidence linking trauma, both in childhood and as an adult, to an increased risk of psychosis. This holds both at a general level but also to specific symptoms. Studies have now moved well beyond evidence of simple association, and can be argued to provide strong corroboration of causal models according to Bradford Hill’s (1965) well-established criteria of strength and consistency of association, dose-response gradient (through stratification of trauma exposure) and directionality (through prospective studies) (for comprehensive reviews see Morrison et al. 2003; Read et al. 2005, 2008). These obviously need to be considered alongside the interrelated criteria of psycho-biological plausibility, analogy, and scientific coherence, which we have partly addressed above, and will return to in the final chapter (see Sect. 5.1).

Studies using dose-response stratification of trauma-exposure are also illustrative for our purposes, and while mainly conducted in high-income, industrial Western

countries, also highlight the impact of cumulative trauma and adversity, characteristic of the population studied in Timor-Leste.<sup>8</sup> For example, large scale epidemiological studies quantifying retrospective-trauma exposure and using validated structured diagnostic interviews, in the United States measuring *childhood* trauma, and in the United Kingdom measuring trauma in *adult* life, generated an adjusted psychosis-prediction odds-ratio (OR) of 7.4 and 18 respectively for those who had experienced 3 different trauma-types, and an exponential increase to an OR of 30.2 and 193 respectively, for those who had experienced the maximum of 5 trauma-types<sup>9</sup> (Shevlin et al. 2008). A smaller scale, but well-designed study in the Netherlands (Janssen et al. 2004, 41), also retrospectively stratified trauma-exposure and severity in childhood, but prospectively explored development of psychotic illness using a structured diagnostic interview, and similarly reported that:

subjects who reported abuse in the highest frequency category had an estimated 30 times greater chance to develop a needs-based diagnosis of psychosis compared to those not exposed to childhood abuse. Less frequent abuse was associated with an estimated five times greater risk to develop a need-based diagnosis of psychosis compared to those without any exposure to childhood abuse.

In examining the impact on individual symptoms, the evidence is strongest for positive-symptoms, in particular for hallucinations, but less consistent for delusions.<sup>10</sup> However again in larger studies and those stratifying levels of cumulative trauma and adversity, dose-response and arguably causal associations are also found for paranoid ideation (Bentall et al. 2012) and delusions (Scott et al. 2007), comparable with risk levels for hallucinations. For example, Bentall et al. (2012)

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<sup>8</sup>Supporting our explanation of traumatic origins it appears noteworthy that the average lifetime experience of traumatic event in the BRR psychotic cohort in Timor-Leste were higher (mean 7.8, s.d. 3.1) than the screened population as a whole (mean 4.2, s.d., 2.6) although lower than those who were identified with a diagnosis of PTSD (mean 15.3, s.d. 6.4). This latter finding however is unsurprising given that by definition those with simple PTSD are likely to be ruminating about traumatic experiences and experiencing intrusive recollections of such experiences, whereas (according to our argument) BRR psychotic symptoms may *seal-over* day-to-day memories and acknowledgement of trauma and associated emotional distress, through a culturally shaped dissociative process, potentially affecting questionnaire responses relating to such events.

<sup>9</sup>Although we might expect greater psychosis-risk to be associated with childhood trauma, a higher risk in this analysis was associated with the British study measuring trauma in *adult* life (Shevlin et al. 2008). However this latter British study did not concurrently measure predisposing childhood-trauma in victimised adults and since childhood trauma predisposes to later adult victimisation (Widom et al. 2008), an association that holds in sufferers of psychosis (Bebbington et al. 2011), it seems likely that the study of adult trauma would have concurrently subsumed many histories of childhood trauma. This is consistent with epidemiological risk models of psychosis, which report high rates of both childhood and adult trauma in psychotic persons (P.E. Bebbington et al. 2004).

<sup>10</sup>However, since delusions are often modelled as arising from misinterpretations of anomalous experience such as hallucinations, and such models predict that not all those who experience hallucinations will develop a delusional explanation, it is not surprising that the association between trauma and delusions is slightly less robust than for hallucinations (according to Bradford-Hill's consistency-replicability across studies).

measured and stratified retrospectively recalled childhood-trauma against paranoid-ideation and voice-hearing experiences quantified by the Psychosis Screening Questionnaire. While a single reported childhood adverse event was associated with an adjusted OR of paranoid ideation and auditory-hallucinations of 3.3 and 2.3 respectively, risk increased exponentially to 17.5 and 14.8 respectively, in the presence of 4 or more reported adversities. A similar recent study (Muenzenmaier et al. 2015) measuring and stratifying both retrospective trauma alongside aspects of the wider family environment (which may be protective or lack protective influence perhaps partly analogous with a conflict-torn environment like Timor-Leste) and utilising structured diagnostic interviews in place of screening tools, found a similar, although more modest, dose-response ratio for both delusional experiences and hallucinations.

In further support and illustration of our hypothesis a large-scale Australian study (Scott et al. 2007) retrospectively stratifying trauma-exposure and using structured diagnostic interviews, found evidence of delusional experiences associated with trauma, could be in the presence or absence of concurrent symptoms of PTSD (the latter perhaps representing a state of more effective *sealing-over* of intrusive trauma symptoms; see also Sect. 1.6, Footnote 22). Particularly relevant to our own work in Timor-Leste, some of the strongest predictors of concurrent delusions (all with a relative-risk (RR) > 7) included: being physically attacked, threatened with a weapon or tortured; involvement in combat; or witnessing someone close to you harmed or killed. Again an exponential increase in risk of endorsement of delusional experience was documented from a RR of 2.5 in those reporting 1–2 trauma types, to 9.5 in those reporting 5 or more trauma-types.

There is less direct evidence of an association with trauma in *negative-symptoms* of psychosis, although such subjects may be difficult to recruit in sufficient numbers as lack of volition and motivation may represent important aspects of the clinical picture. Additionally negative-symptoms often develop later in the disorder's trajectory, often in the context of multiple relapses, in which case the recollection of trauma may be more tenuous, confounded with the trauma of recurrent admissions and a subsuming illness-narrative. Finally presentations dominated by negative symptoms, may represent a deficit-dissociative state, in which active memories and emotions of trauma are dissociative sealed-off, or defended against, and therefore not available for recall.

Finally there is little research looking into associations between trauma and *passivity phenomena*, except to note that studies have in fact found higher rates of first-rank symptoms (FRS) in dissociative identity disorder (DID), with its more explicit traumatic aetiology, than in schizophrenia<sup>11</sup> (Laddis and Dell 2012; Ross et al. 1990). These were not elicited in our subjects, but would have required subject openness and recall, alongside translator linguistic dexterity, so neither could we

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<sup>11</sup>For schizophrenia such FRS were once considered pathognomonic and retain some diagnostic weighting in DSM-IV-TR and ICD-10 (although have been downgraded in significance with the publication of DSM-5; APA 2013, 810).

confidently say that they were absent (for discussion on the cultural dimension on such phenomena however see Sect. 5.2.1).

We will return to a review of neuropsychological evidence linking trauma, dissociation and psychosis (see Sect. 5.1) in which we also go on to consider the relationship between brief and chronic psychosis (see Sect. 5.2).

## 2.3 Trauma and Symbol

### 2.3.1 *Trauma Can Arise from Bodily and/or Symbolic Threat or Injury*

Whereas conventionally trauma is defined as arising from events involving actual threat to bodily integrity (of self or others), “symbolic trauma” might be defined as involving threats to the integrity of important individual and communal beliefs and systems of meaning, critical to the individual’s and group’s concepts of life and selfhood. Both types of trauma are of course intensely real to the sufferers and may commonly co-exist, or represent overlapping dimensions of a single act/violation—as in military rape (Littlewood 1997).

A particularly well documented example of symbolic trauma (although undisputedly co-existing with gross bodily and material human rights violations) is that experienced by Tibetan citizens and refugees resulting from the systematic destruction and confiscation of public and private Tibetan Buddhist symbols (including temples, monasteries and monuments, together with private texts, flags, prayer wheels and photos), alongside the total prohibition of the outward expression of Tibetan Buddhist practices and sentiments, through which their cultural identity and sense of self was articulated and constituted (Janes 1995). While a study investigating the cross-cultural applicability and relevance of Western concepts of traumatic-experience concluded that such concepts were meaningful for Tibetan refugees exiled in India, and who were believed to have undergone only minimal Western acculturation, the researchers identified a critical need, for this group, to expand notions of traumatic experience to include the impact of the kind of symbolic traumas described above (Terheggen et al. 2001). Indeed when eleven independent Tibetan assessors were asked to rank traumatic experience according to likely impact and distress, “destruction of religious signs”, “leaving home for political reasons”, and “being forbidden to live according to one’s own religion” were consistently rated first, second and third, ahead of “feeling one’s life is in danger” which was ranked fourth (Terheggen et al. 2001, 397).

Despite little take-up of Christian Catholicism during the period of Portuguese administration, the majority of East-Timorese subsequently overwhelmingly identified with, and converted to, the Roman Catholic church, which had become a symbol and bastion of the resistance movement, and a public thorn in the side of the Indonesian regime (Kohen 2001) notwithstanding very visible attempts at

appeasement of the church by Indonesian authorities.<sup>12</sup> During the independence struggle the attempted incrimination of Catholic leaders, including the iconic resistance leader Bishop Belo, and the desecration of religious buildings, for example through their appropriation into houses of torture, might be seen as another aspect of symbolic trauma (Aditjondro 2000), not dissimilar to the religious oppression described in Tibet. Traube (2007) further describes the extensive destruction of traditionally sacred sites (mythically enshrined “origin villages”) by pro-independence militia, in her work with Mambai people in the mountainous district of Aileu, 40 kilometres south of the Dili.

In Timor, the killing or loss of animals was also described by the ex-patriate service director of Timor’s fledgling mental health service, *Saude Mental*, as eliciting a greater and more protracted degree of distress than might be expected from their loss of their material value alone (pers. comm.). Perhaps because, as observed by Hicks (2004) in his ethnography of the Tetum in the 1970s, certain animals—in particular buffalo, but also pigs—are associated with a high degree of social prestige, and form key components of important ritual transactions such as bridal wealth and ritual sacrifices (where the spilling of animal blood provides an important conduit between the living and ancestral dead). The spilling of animal blood by the enemy appears then as an affront and aberration of this symbolism. This was particularly perversely illustrated by the case of a young woman we interviewed from the wider non-psychotic cohort, meeting ongoing criteria for severe PTSD. *She described witnessing a wide range of atrocities, including the slaughter and consumption of 20 family pigs and goat. Furthermore she reported she herself was then made to drink the blood of the animals which militia had dipped with the Indonesian flag.*

The understanding of symbolic trauma we have developed here overlaps with what Litz et al. (2009) have termed “moral injury.” They define this as “not merely a state of cognitive dissonance, but a state of loss of trust in previously deeply held beliefs about one’s own or others’ ability to keep our shared moral covenant” (Nash and Litz 2013, 368). Sakti’s (2013, 441) ethnographic fieldwork in the Western Baiqueno speaking enclave of Oecussi illustrated just such a broken covenant—alongside broken kinship networks of exchange and ritual obligation earlier described (Sect. 1.6)—when interviewing a father whose son had been killed by local Indonesian sponsored militia in a brutal post-Independence ballot massacre, the father lamented: ““Our *brothers* from our *brothering* village took our *children* and *fathers* away from us”” [italics in original].

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<sup>12</sup>This included the erection, at considerable expense and technical difficulty, of an enormous, 27 meter high, effigy of Christ the King (Portuguese Cristo Rei), high on a hilltop overlooking Dili’s harbour (similar to that overlooking Lisbon, and the Cristo Redentor, overlooking Rio de Janeiro.). Unveiled by Indonesian President Suharto himself in 1996, the statue was envisioned as a gift to the Timorese people, to commemorate twenty years of Indonesian “integration” (Aditjondro 2000).

As with symbolic trauma, it clearly co-exists alongside physical trauma and threat to life, and appears to be associated with intrusive symptoms,<sup>13</sup> including *traumatic re-experiencing* (Litz et al. 2009) that based on the model developed here might include hallucinatory-like content.

### 2.3.2 *Belief Itself Can Be Traumatic*

In cultures, where threats from unseen but presumed potent “symbolic realities” are ever present, one can argue for causation of mental illness, and perhaps even death, from simply the belief alone that one has become a victim of sorcery (or of allied sources of harm; Hahn and Kleinman 1983). Anthropological studies have convincingly demonstrated a link between such imprecations, accusations, counter-measures, and the community’s response; and the wider psychosocial dynamics of material inequality, jealousy, trauma and loss common to all societies (Evans-Pritchard 1976; Niehaus et al. 2001) which was a view supported by aspersions of sorcery in our study. In all we interviewed eight persons in which sorcery/witchcraft was mentioned, predominantly as culturally validated cause of misfortune or distress, and sometimes but not necessarily crossing severity thresholds associated with mental health diagnosis. Significantly sorcery was not described as a cause of psychosis except in one person who cited it half-heartedly, amongst a number of other possible causes (see Sect. 2.3.3—Case BP3 below). Although in one interview the subject identified his mother as a witch, accused of harming others (but not the son himself), this was arguably a symptom of psychosis not shared or validated by other family or community members (but nonetheless with implications reflecting a shared cultural logic; see Sect. 2.3.4—Case BP4). In two persons fear of sorcery was reinforced by the transmogrified appearance of a sorcerer in dreams (which relates to the night-time when they are thought to attack their victims while asleep—again see Sect. 2.3.4).

Accusations were not directed at specific others in our presence which may have been because direct aspersions of such would have serious implications for both victim and the accused in accordance with traditional systems of justice.<sup>14</sup> Notions of witchcraft and sorcery may however be tacitly subsumed in wider beliefs in

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<sup>13</sup>Whether symbolic trauma or moral injury on its own would lead to intrusive rather than simply ruminative experience is unclear—studies of moral injury, generally involving military veterans, generally include trauma that has a concurrent dimension of physical threat, injury or loss (whether as victim or perpetrator). The model predicts that where physical and moral injuries co-occur, symptoms and/or impairment will be more severe. As we shall go onto explore (see Chap. 4) it may be that the loss of containing meaning rendered by moral injury, leads to an uncoupling of the memory and affect associated with physical trauma, now untethered and subject to recurrent intrusion into daily experience.

<sup>14</sup>For example amongst the Tetum-speaking community, described by Hicks (2004, 88) in the eastern district of Viqueque, *historically* “death was the traditional punishment for ... sorcery” and no doubt required “proof” with consequences for false-allegations.

particular the *fulan lotuk* (see Sect. 2.3.4) or projected onto *rai nain* rather than the human world. Beyond sorcery, the belief in unseen spirits appeared widespread—throughout different strata of society and across different parts of the country, including the capital—and has formed an important focus of much historical and contemporary ethnography (e.g. Bovensiepen 2011; Hicks 2004). Once distressing experiences have been attributed to a specific cultural cause, such as *rai nain* or the *fulan lotuk*, by the individual and those around him/her, the meaning and implicit cultural prognosis may create a social-looping process confirming the individuals fate (see Sect. 1.7.2; Seligman and Kirmayer 2008; cf. Hacking 1999), or necessitating counter-measures which if followed may bring about recovery (Kapferer 1979).

### **Case BP2**

*Such was the case with Ricardo, a 60 year old man, who believed, with his wife, that he was under the spell of the “fulan lotuk.” Back in his late thirties for three years he had experienced intermittent visual hallucinations. This first began when he was on his way home late one evening and, having lost his way, entered a coconut farm. When he left the farm he felt drunk, despite having consumed no alcohol, and he felt the place he was in was very different from the material world. He heard a rustling sound and states he then saw a large fluctuating white and red non-human creature as “big as a house”. It followed him home although he states he was not scared—as although he did not know what it was, he thought it might have been from God and he knew it not to be evil. Subsequently it would appear to him about once or twice a week when he was walking, including when his family was present, although they could not see it. He thinks it may have occurred because he did something wrong while walking through the coconut farm, and he didn’t say sorry. He recalled that five small rocks were thrown to him at this time. He kept them and for two years he acted as a healer (killing chickens and divining by looking at their hearts). He would tell people whether they would die, or the cause of their pregnancy loss (such as jealousy by other people). He also performed some ceremonies for spirits. After two years, another healer took the stones, telling him that they would make him crazy and he has not been a healer since.*

The stones “found” by Ricardo and their linkage to his encounter with the non-human entity have a strong resonance to Hicks’ (2004) description of men encountering stones believed to harbour *rai nain*, powerful nature spirits, who subsequently appear to the finder in dreams in order to establish a relationship and covenant with it. *Rai nain* were described by Hicks’ informants of being capable of bestowing significant power of the finder, but also great misfortune, including illness and death, should the covenant be broken, and Hicks describes an elaborate ritual protocol to be followed in such situations. Although Ricardo was still affected by the *fulan lotuk* his current symptoms consisted mainly of feeling a “bit drunk”, sleeping an hour or two less a night, and being angry and argumentative with his wife and grown-up children for two to three days each month, during which he often takes himself off into the fields. Although there may be links with trauma (see Table 2.1), his age, gender and social position, and wider local and national context; *at the level*

*of belief* it may be that the healers actions in removing the stones had delimited the spirits influence in the mutually influencing eyes of Ricardo, his family and surrounding community, and mitigating any potentially malignant social looping process. According to one cultural consultant, it is recognised that people who have recovered from a state of *bulak* may still be influenced by the *fulan lotuk* but in a less dramatic manner, consistent with Ricardo's story.

### 2.3.3 Trauma Can Be Encoded Symbolically

That is to say that an individual's experience or witnessing of physical threat, injury or loss may be ascribed symbolic significance and processed in these terms. Salient personal and cultural meanings may therefore be closely linked to the actual events influencing how such events are encoded and subsequently recalled, retrieved or involuntary elicited from memory stores. For example in Timor-Leste, illness or misfortune might be interpreted in terms of violation of sacred (*lulik*) codes, or taboos in relation to the ancestors or local spirits (*rai-nain*). Even where death was ascribed as secondary to natural causes, or as the result of armed conflict, as both Hicks (2004) and Traube (1986) confirm, the passage of the deceased person's soul to the secure and desired realm of the ancestors is fraught with danger. Deviations from proscribed ritual practices, participated in at fixed points for a fixed period following a death, and designed to ensure the smooth transition of the deceased's soul to the ancestral realm—alongside death believed to have occurred in the first place due to *lulik* violations—may therefore leave the soul in an indeterminate and unhappy state, free to "haunt" remaining kin in the land of the living to remind them of their dereliction of duty (Hicks 2004). Such beliefs and practices remained evident in present day Timor-Leste, across social strata.

#### Case BP3

*The relevance of this was clearly illustrated by Does, a 24 year old who was tormented by recurrent and distressing visual and tactile hallucinations, of soldiers in uniform coming into her room every night, sometimes touching her. In response she would often shout, indicating a desire to be left alone ("get away from me" or "I don't want to go with you, go home its cold"), but sometimes responses that were harder to make sense of (for example, "its raining, I am going to climb the mountain with many people"). She also claimed to see the spirits of the dead, including her own grandparents.*

*Does lived in one of a cluster of small building occupied by extended kin and other families. Family members and co-residents described her as "bulak" and her distress was also stated to be worse during the "fulan lotuk." While she had initially endorsed the items of "involvement in a combat situation during Indonesian times" and having "witnessed the murder of strangers around the time of the 1999 vote" on the HTQ, on later interview she denied experiencing significant trauma, and her family appeared sceptical, although she indicated a desire*

talk in private “to give us the whole story.” What was clear was that her own father had been killed in 1984 by the Indonesian military, when she was still very young.

While there were some features of her presentation that suggest a possible organic contribution, including previous malaria in the year it began, alongside drowsiness and somatic symptoms that predictably prefigured her nightly “hallucinatory” symptoms; her fevers had long since resolved, and she had apparently seen medical practitioners on three occasions with no physical cause for her experiences identified (although procedures such as EEG and brain imaging were not available in this setting). There were potential complex social and family tensions that may be relevant to understanding her symptoms, and she was unusual in being treated with little sympathy, sometimes even mockingly, by some family members and co-residents. Outside of home however she appeared to show a relatively high level of functioning and social adjustment. She was actively pursuing higher education, which she reported enjoying although feeling stressed by, but reported she was coping with the workload, and had many friends.

As well as doctors, she had seen a traditional healer on several occasions about her symptoms. While various explanations were offered by Dores and family members, Dores appeared to accept (at least publically) the idea that she had this problem primarily because Indonesian soldiers killed her father but his body was not properly buried. The healers needed to perform another rite to appease the spirit of her dead father, having apparently done this once before, after which she said she had improved a little.

### 2.3.4 *The Symbol Itself May Be Sufficient to Trigger Distress*

Symbols through which memories of trauma and loss have become encoded and entwined, may themselves be sufficient to evoke involuntary recollection of these events, together with their associated meanings and emotions. Such symbols may be identical to those implicated in encoding (see Table 2.1—trauma and *lulik* factors), or related through association. They may be configured in time, or in place, or both. The clearest example of such a temporally configured symbol in the current cohort is the reoccurring periodicity of the *fulan lotuk*, which was the most common trigger of brief-psychotic recurrence or exacerbation (in 7/10 of the BRR cohort and 4/4 of the AOC cohort respectively). It was unclear whether, and under what conditions, the *fulan lotuk* was considered causal in relation to *initial* presentations of mental distress; although on direct probing it was sometimes ambivalently cited as such. It appeared however to represent a common *aggravator of pre-existing vulnerabilities* associated with other *lulik* factors, perhaps linked by principles of association (see Sect. 3.1.2).

Other important symbols configured in both time and space included both public and private *lulik* rituals and ceremonies. A commanding example of a significant

public ceremony was the *mate bien* (lit. good death). This was a traditional public festival celebrating the ancestors that in Catholic times had become amalgamated with All Soul's Day. In more recent years it had become a contemporary memorial day to those who lost their lives in the Independence struggle. The most important private ceremonies also pertained to the deceased and involved a series of ritual celebrations at prescribed times over a fixed period (the duration and frequency of which may vary according to ethnolinguistic group) at which point, if successful, the departed soul would finally arrive home in the safe and benevolent realm of the ancestors (Hicks 2004; Traube 1986). No longer could it torment the living, and in it was invested a power for good (and fecundity), so long as the correct taboos and appropriations continued to be observed (Hicks 2004).

Such occasions, whether private or public, remained, according to our Timorese cultural consultants, a time of intense reflection and self-searching in relation to the cause of death, in which individuals may privately and repeatedly question themselves as to whether some ritual abnegation on their part was somehow responsible. In such instances the symbolic and more concrete reminders of the loss/trauma often appeared to sit side-by-side. This was well illustrated by a young man from the BRR psychotic cohort:

#### **Case BP4**

*Emilio, a 24 year old single male, was identified by the community as “hanoin barak” and experienced the onset of his first psychotic state during the traditional final mortuary rite, one year after the death of a cousin with whom he was emotionally very close. Although his first two episodes lasted about five days each, significantly his third, most recent episode, had lasted thirty days and was also related to a bereavement—occurring one day after the death of a younger cousin from an unidentified illness.*

*At the onset of the first episode Emilio had been found holding a machete to his own throat, and when questioned said that people at the mourning celebration had been talking about him and plotting to harm him, despite no one else observing this. Apparently, while he often felt aggressive towards others, the only person (beside himself) he had attempted to harm was his mother who he said he had believed to be a “buang” [approx. trans. “witch”—from Austronesian-Buli—see below] implicated in the death of his cousin, although no one else in the family held such views. During his last episode he had thrown stones and glass at his mother before the family called the police, following which he was held in a cell for three days. For the remainder of this episode he had appeared very frightened and locked himself in the house, apparently fearful of the police.*

*To protect him from harm to himself and others, the family acknowledged they had tied him up on more than one occasion as they described him being extremely physically strong in this state needing “eight men to restrain him.” In this state he was described as restless and easily distracted, and he would wander around in an agitated state, frequently destroying property in and around the house for no apparent reason. He reportedly slept a great deal less (perhaps three or four hours a night).*

*Building on this description with the SCID-interview, he was described as talking a lot more and a lot quicker than usual, and sometimes in a nonsensical manner, with no obvious connections between sentences and poorly grounded in reality although his sentences themselves were properly formed and understandable (“you are bad...I am going to have you cut up...I will report you to the police...I am going to fly!”). He also described many physical symptoms associated with the disturbance such as feelings of tension and excitability, alongside the sensation of his heart racing, while he was observed by others, at times, to have “wide frightened eyes” and an observable tremor. When the episode eventually subsided he would reportedly sleep for a good deal of time and on waking reported little memory of the said events. Despite some obvious potential sources of psychological trauma (see Table 2.1—Emilio) no symptoms of PTSD or inter-episodic depression could be elicited, and he asserted that none of the potentially traumatizing events described had caused him significant distress.*

*His family asserted that in between these episodes he was reasonably normal except that he was easily angered or upset, sometimes causing him to become vocally aggressive but not physically violent—particularly if asked too many questions or if surrounded by a crowd of people. Indeed during our second interview he had appeared tearful when talking about his young deceased cousin and excused himself from the rest of the interview. During a follow-up visit to discuss treatment with a worker from the new local mental health team, he was home alone and appeared mildly perplexed and suspicious of our presence, although no further evidence of residual psychotic symptoms was evident. He asserted to us that “as far as I know I am normal.” His family contended that the cause of his sickness was a “rai nain.”*

While Emilio was one of only three within the BRR cohort in whom the *fulan lotuk* was not described as a trigger for recurrence, his presentation is consistent with our overall model of symbolically entwined grief and trauma and subsequent ritually-evoked psychotic-presentations, and appears clearly connected with the wider BRR cohort by virtue of *family resemblance* (see Sect. 5.4). Interpreting his inter-episodic perplexity and suspicion towards us is difficult. On the one hand we might see evidence of residual, unsealed dissociative-psychotic symptomatology; on the other this may have been an understandable response to the unsolicited appearance of a *malae* (foreign) doctor asking about a problem he remembers little about.

In relation to his beliefs about this mother, we later read an account of witchcraft from the fellow Austronesian Eastern Indonesian island of Halmahera that the term *buang* (from the Buli language) refers to the living human “carcass” left behind by a parasitic cannibal-witch spirit [Buli: *gua*]. However in doing so the carcass becomes similarly identified as a *human witch*. Local “custom has it that if one fills the abandoned and sleeping body (*buang*) with sharp stones, shards of glass, or broken seashells, the human witch will die” (Bubandt 2014, Chap. 5: The Body of the Witch) along with the parasitic *gua* spirit. The subtleties of this may have been lost in the linguistic and cultural translation of our interview, but it seems likely that a similar belief-system was shared by some in Timor-Leste (either on account of

acculturation, diffusion or their shared Austronesian origins—see Sect. 1.3 and also below) and if so, while not necessarily challenging the view that Emilio was psychotic (since his beliefs about his mother were not shared by others), it nonetheless confers an internal logic on his actions that is otherwise not apparent.

Such feelings of intense persecution appear common to brief psychotic presentations in non-industrialised countries (e.g. Jilek and Jilek-Aall 1970) and although common in psychotic presentations in the industrialised world, may play out differently along cultural lines, as we will further explore for Emilio's case, through a psychoanalytic lens, in the following chapter (Sect. 3.1.1, incl. Footnote 4 and 3.1.3).

### **The Cultural Significance of the *Fulan Lotuk* (New Moon)**

While we did not undertake an ethnographic study sufficient to elicit a complete or coherent set of such associations, a lack of a systematic and consistent set of cosmological associations within the Tetum communities in which he participated was previously remarked on by Hicks (2004) leading him to propose that the power of ritual resided within the “realm of performance rather than in that of hermeneutics” (p. 23). Similarly Traube (1986) reflects on her own struggle to piece together mythic narrative fragments in her own efforts to achieve semantic coherence in her understanding of Mambai ritual performance, in which non-verbal elements were seen to be as important as words. Our own evidence suggests that these observations may be at least partly applicable to local understanding and manifestations of mental illness or distress in Timor-Leste and we would agree with Traube (2011) that to propose some overarching semantic logic or framework would likely be more reflective of our own need to create such a coherent cultural world than that of the Timorese-community with whom we worked (cf. Kirmayer et al. 2003; see Sect. 4.2.1)

In line with this it was often difficult to draw out a particular logic of meaning concerning *why* the *fulan lotuk* appeared to be a common and recurrent trigger of psychotic-behaviour in vulnerable individuals—it was simply acknowledged to be part of the natural order of things, although this may also have a reflected a reluctance to share such *lulik* related knowledge. Nonetheless one key cultural consultant, a Timorese mental health worker, with a degree in Philosophy, asserted the significance of this time is less to do with the moon itself, as it is to do with the consequent darkness, left by its absence. Such nocturnal variation in natural light is hard to appreciate in the developed urban setting where many of us now dwell, but in Timor it was striking in both rural areas and urban areas since even in the capital Dili, street lighting was poor and the power supply was not operational during the night. According to this consultant the night/darkness was associated with witchcraft and sorcery. He said at this time the soul of the sorcerer would leave his/her body through an orifice (usually the mouth) and enter that of another, while the potential victim is sleeping and unprotected. The victim may come to know of this through their dreams. The sorcerer's soul is also said to travel and metamorphose—for example into an animal—unseen under the cover of darkness.

Whether our consultant's relatively detailed explanatory model is representative of widely held Timorese beliefs, across different ethnolinguistic groups, is uncertain but would make an important focus of future ethnography. Certainly however there was a striking resonance between our consultant's descriptions and the ethnographic portrayal of witchcraft described above from the regional fellow Austronesian-speaking island of Halmahera,<sup>15</sup> which seemed to confer some logic to Emilio's behaviours. For similar reasons in Timor-Leste, the absolute darkness of the *fulan lotuk* was identified by our consultant as a time ripe for sorcery and witchcraft.

Our model is not reliant on this interpretation, and other symbols and understandings, can as easily be incorporated, although with potential implications for form and content of mental distress. Certainly however we had some further support for the idea of *darkness*, rather than the moon itself, being the key explanatory variable. As one relative of an afflicted individual put it (borrowed for the book's epigraph), "Perhaps because the sky becomes dark, so too people's minds become dark." The suffering of Dores earlier described (see Case BP3), while amplified during the *fulan lotuk*, takes this to the extreme, with symptoms occurring every night fall, and whose content strongly suggest both traumatic and *lulik* dimensions.

Darkness of course, appears to represent, a universal time of increased fear, observed most clearly in children but also in the minds of many adults, as we lack the reassurance and knowledge normally continually bestowed by our eyes. As Harrison (2004) notes, the relationship between darkness and states of mental anguish has been observed throughout history and across cultures and the imagery of darkness is also often used to evoke (and appears to often invoke) dysphoric states of mind. Historically, in the Western cultural tradition, this has a lineage at least as far back as the classical medical theories of Galen (see also Sect. 3.1.2), as Harrison (2004, 594) expounds:

Melancholy was understood throughout the Middle Ages and Renaissance as being contrary to light and was strongly associated with night, twilight, and darkness... Galen (131-201 AD), wrote of melancholy as not only produced by external darkness, but as also involving an *internal darkening of the mind itself*, giving rise to the fear and sadness [emphasis added].

But darkness however may have brought fear and frightening memories for other reasons too: for even into the post-conflict period at the time of our research, the cover of darkness had been used to strike terror and instability into communities such as Becora, by so called ninjas, groups of youths skilled in martial arts and believed by those we spoke with to be disgruntled in the wake of Timor's independence (cf. Aditjondro 2000). While our local consultant disagreed with this explanation, reasonably asserting that politics and magic were separate realms of explanation, from the perspective of our current framework it seemed possible that

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<sup>15</sup>In Halmahera, the cannibalistic witch-spirits are similar described as transforming themselves (including similarly into animals) and attacking others at night while they are sleeping (Bubandt 2014).

the connotations of darkness may simultaneously agitate both the symbolic and more concrete associations of terror and trauma.<sup>16</sup>

The question of course is how is this then linked, beyond melancholy, anxiety and dysphoric states, to brief psychotic states of mind? The model of structural dissociation deals with this neatly. An increase in overall emotional distress weakens the effectiveness of dissociative sealing-over—through cognitive and emotional resonance with previous trauma and loss—such that fragmented traumatic memories, emotions and sensations may more easily break through<sup>17</sup> (see Sect. 2.2.1). Such traumatic-resonance may include with culturally connoted, wilfully malign activities (imagined or real) associated with external darkness, feared by some (of witchcraft or “ninja” activity). Such a model becomes more complex when we consider the impact of unconscious agency (see Chap. 3), and sociocultural processes (see Chaps. 4 and 5), but the basic idea of a change in the effectiveness of internal barriers holds (see Sect. 5.3—Fig. 5.1c) and remains compatible with the cultural constructivist position, that such cultural expectations create a context for “acting into” (cf. Pearce 2007; see Sect. 1.7.1).

It is also curious that while beliefs regarding power of unseen forces and spirits such as *rai nain* were well documented by Hicks (2004) and Traube (1986), including as causes of illness and madness, in their ethnographies of Timor-Leste undertaken during the mid to late 1960s, it appears striking that the cyclical phenomena of the *fulan lotuk*, reported so frequently to us, was absent from their accounts of the unforeseen forces impinging on East Timorese daily life. While this might be simply because the anthropology of mental illness lay outside of their focus, Littlewood (1990) points us towards wider ethnographic evidence suggesting that the erosion of traditional ritual practices in some societies is associated with a rise of associated individual symbolic expressions of distress which can be construed as individual unconscious attempts to reproduce the kind of symbolic resolution of intrapsychic and interpersonal tensions previously facilitated through ritual. While we have no evidence or knowledge of the kind of ritual that may have preceded it, given the competing forms of acculturation to which Timor-Leste had been exposed, in particular since Indonesian annexation in 1975 and beyond into

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<sup>16</sup>Although culturally, amongst the Mambai at least, the magical and the political, while now considered separate domains, were mythologically understood to have been a unity, and only later subject to division (Traube 2011); we understand that in taking a different position to that of a local cultural consultant we inevitably commit a degree of “interpretive violence” (Bibeau and Corin 1995; cf. Keesing 1995, 220). Nonetheless we understand that the separation of the magic/sacred and political poles makes fundamental cultural sense, and is indeed required. In fact we might be said to do the same through our epistemological division of *deterministic* and *agentic* modes of understanding (Sect. 1.7.1), and in conceptualising sites of intervention—the latter point we will return to in the final section (Sect. 5.5).

<sup>17</sup>Similar ideas were in fact well developed in the models of psychogenic psychosis expounded by Wimmer and other Scandinavian psychiatrists although the intellectual milieu of psychiatry in the remainder of Europe—including Britain and also later in the United States—which had aligned itself with the ideology of biological determinism, prevented ideas of psychogenesis being given due serious consideration (Castagnini 2010; Sass 1992).

the post-Independence period (see Sect. 4.2.3), it seems possible that the phenomenon of transient or exacerbated madness during *fulan lotuk* was either a recent development (arising de novo) or—perhaps more likely—a phenomenon rapidly increasing in frequency and visibility, partly also in the context of widespread trauma. Certainly there has been a shift in Timor-Leste from traditionally bestowed ritual authority to charismatically self-asserted authority (Traube 2007).

### Hidden Trauma and Loss

The extent of human rights violations inflicted on the East Timorese under Indonesian rule, and in the wake of the 1999 independence vote, was on such a scale, that on the basis of existing research in post-conflict setting, it would be easy to concur with predictions and observations that a significant proportion of the population would experience substantial mental health burdens associated with post-traumatic reactions (Steel et al. 2009). While our own work indicated that crude questionnaire estimates are likely to significantly overrate (by up to two thirds) the prevalence of genuine PTSD in such a population (Silove et al. 2008) and that many people suffering with PTSD-spectrum symptoms may spontaneously improve with the emergence of law and order and consequent greater confidence in personal security (Silove and Steel 2006), others have critiqued the assumptions of Western traumatologists pertaining to the assumed consequences of such violations, in communities in which the meaning and response to such events may markedly differ from our own (Last 2000; Summerfield 1999).

In highlighting *hidden trauma and loss*, in addition to symbolic antecedents and consequences, our intention is neither to minimise the impact of such experience, nor to, a priori, grant it undue weight. The linking of such experiences to the brief psychotic-like reactions described, within the above framework, does, however appear to bring a certain theoretical and pragmatic coherence, although given the almost ubiquitous prevalence of traumatic experiences with the general population, the question as to why some people are more vulnerable to its effects, and why this appears to manifest in different ways in different subjects, remains important to consider. Returning to the concept of hidden trauma then, it was notable how often the experience of any kind of traumatic event was denied, downplayed or simply not associated with (literally *dis-associated* from) the presenting problem. Lack of privacy during interviews, alongside a desire to conform (at least publically) with conventional cultural forms of self-narration, was no doubt an influence here, but might also potentially feed into theorised psychological mechanisms of traumatic amnesia and dissociation—although these may be partly contingent on cultural proscriptions of what can be talked, or even “thought,” about.

### Case BP5

*Marina, a 40 year old female, with a young family, was described by her daughters as “a little ‘bulak’” and “pontu.” Both she and her daughters described her problems as starting following the death of her paternal uncle and subsequent viewing of his body following which she had “cried all day”. The following day she dramatically collapsed on the floor, reportedly hitting her head, and was reported to be unconscious (Tetum: “mate kik”—lit. “little death”) for several hours. On*

wakening she was described as “acting ‘bulak’ for a whole month” and especially if disturbed by others. At this time she recalled a continuous crawling-like sensation on her face. Subsequently she improved and was able to contribute to subsistence farming, albeit often with little enthusiasm or interest. Additionally her daughters reported outbursts, sometimes two to three times a day, manifesting (according to the SCID) not just as verbally abusive speech but as “disordered speech” (sentences out of context and not meaningfully following one another) and destructive “disordered behaviour” (throwing stones, breaking things). These were in response to various triggers including family disagreement and being left on her own by her daughters, and were notable at the time of the “fulan lotuk.”

The experience of a highly traumatic incident emerged, almost incidentally, through the more directive focus of the SCID, in which Marina described witnessing her brother accidentally shoot himself dead while playing with a gun, many years previously. This was an event she “tried not to think about”, but was not related either by her or her family in any way to her current presentation. She had some prominent symptoms of both depression and PTSD but these were just sub-threshold for a DSM-IV diagnosis although it seems likely that the threshold for one or other would have previously been met. However evaluation of both her psychotic-like symptoms alongside her more non-specific and overlapping symptoms of depression and PTSD (insomnia, irritability, poor concentration etc.) was complicated by the possible history of head-injury, which may have been sustained after the episode of collapse, even if the collapse itself was of “psychological” origin.

The above case history illustrates the not infrequently experienced difficulty of obtaining a detailed timeline of events and symptom progression/resolution from past to present, as well as inherent nosological issues with operationalised diagnostic criteria in relation to co-morbidity and diagnostic boundaries (Kendell and Jablensky 2003). In terms of the model developed here, it also highlights both the minimisation of trauma and its consequent entwining in cultural symbols. Cultural proscriptions on what can be talked about, alongside any avoidant disposition or coping style—that might arise or be reinforced by trauma (the avoidant dimension of PTSD, including *overmodulation-numbing* emotional responses (Lanius et al. 2010)—see Sect. 2.2)—would be predicted to be risk-factors for a dissociative response.

Invoking a useful comparison, Kirmayer (1996, 140) draws our attention to the frequency of *susto* or “fright illness” in Central and South America, in which symptoms are often attributed by patients and family members to a “sudden startle, shock or fright”. Such dramatic presentations of sudden onset are suggestive of a dissociative aetiology (Steinberg et al. 1994) and indeed “falling-out or blacking out” are linked with dissociative presentations in certain cultural groups, within the DSM-IV-TR Glossary of Culture Bound Syndromes (APA 2000, 900).

In Marina’s case both she and her daughter asserted it was the *shock* of seeing her uncle’s dead body that gave rise to Marina’s subsequent problems. However as Kirmayer (1996, 140) points out “such attributional schemas may complicate efforts to identify traumatic precursors of distress,” although of course in Marina’s case it might be argued that the emotional and symbolic resonance of seeing her

grandfather’s dead body connected with her earlier traumatic grief. Our understanding of Marina also supports Csordas et al. (2010) findings that the dual discourses emerging from the SCID and more ethnographic-based interviews, have the potential to complement each other, in furthering our understanding about a particular persons situation and response (see Sect. 1.7.1).

In identifying such trauma as potentially significant we advocate caution, however, so not to give our perspective and explanation privileged status over the family or community. It may be that the family view of her presentation, circumscribes and effectively delimits, the effects of such experience, in an equally or more effective way than Western *psychological* understanding or intervention, better adapted to local culture and context, and about which an individual’s distress may often also be read as a commentary (cf. Janes 1995; Skultans 2003). We shall discuss these points further in relation to the *fulan lotuk*. Yet neither should we let our awareness of the differential meanings and responses to such events become an extreme form of cultural relativism, in which we minimise the impact of loss and violation on different communities. Our recent work on “explosive anger as a response to human rights violations in post-conflict Timor-Leste” is a clear indicator of understandable but highly distressing responses to such trauma (Silove et al. 2009), although of course this does not assume the need for interpretation or intervention though a clinical lens.

Table 2.1 highlights the potentially hidden histories of trauma and loss in our index subjects, from within both the BRR and the AOC exacerbation psychotic cohorts combined. It also highlights the symbolic (*lulik*) antecedents of onset and triggers of recurrence, which we have argued to become cognitively and emotionally entwined with the original experience, as well as acting as sources of fear and anxiety in their own right.

**Table 2.1** Traumatic and “*lulik*” triggers of onset and recurrence

ID	History of trauma and loss as triggers for onset and/or recurrence	<i>Lulik</i> factors as triggers for onset and/or recurrence
BP1 Adriano	Experienced displacement. Endorsed other items on HTQ later denied or minimised. No reporting of loss—but lives with extended family-? parents dead	Family believe strongly in <i>rai nain</i> as cause. Recurrence due to <i>fulan lotuk</i>
BP2 Ricardo	Fought in Portuguese army against Indonesian invaders. Denies witnessing violence then or subsequently. 2 close family members killed at time of Indonesian invasion (not witnessed)	Visual encounter with <i>rai nain</i> but believes broke “contract.” Dramatic loss of consciousness while on patrol 1975. Recurrence due to <i>fulan lotuk</i>
BP3 Dores	Father killed by Indonesian army in 1984 (not witnessed). Initially described multiple traumas on HTQ but later denied. Nightly hallucinations of soldiers suggestive	Father killed 1984 by military and not “properly” buried and believes she is a possible victim of sorcery. However florid onset of problems not until

(continued)

**Table 2.1** (continued)

ID	History of trauma and loss as triggers for onset and/or recurrence	<i>Lulik</i> factors as triggers for onset and/or recurrence
	of trauma and linked to fear of darkness? Mother attributes to “broken heart” ( <i>laran kanik</i> )	2003. Fear of darkness linked with <i>lulik factors</i> ?
BP4 Emilio	Experienced displacement, separation and “crowds fleeing” but significance downplayed although large crowds may trigger distress. One year post-mortuary rite for close cousin precipitated sudden onset. Subsequent death of another cousin preceded third prolonged episode	Mortuary rite also strongly associated with <i>lulik</i> attributions (first episode during this ceremony), and subsequent death of another cousin (preceding third episode) may also have had <i>lulik</i> connotations. Family believe <i>rai nain</i> implicated
BP5 Marina	1975 witnessed brother accidentally shoot himself dead but subclinical symptoms of PTSD only (unclear if ever met full criteria). Current problems started in 2000 after viewing body of dead uncle. Recurrent distress triggered by being left on own and family arguments	First episode started after viewing of uncle’s body (precipitating dramatic collapse)—apparent <i>lulik</i> dimension. Believed due to <i>lulik</i> problem and recurrence due to <i>fulan lotuk</i>
BP6 Julinha	Husband killed by Indonesian military 1975. Problems started after subsequent death of her 2 children in 1997	Recurrence due to <i>fulan lotuk</i>
BP7 Luciano	Beaten by militia in 1999 but this was after onset of mental health difficulties	Married but said a <i>rai nain</i> made him have sexual relations with another woman 1987 and get her pregnant. Recurrence due to <i>fulan lotuk</i>
BP8 Ronaldo	Many symptoms began in 1999 but no history volunteered	Recurrence due to <i>fulan lotuk</i> . Claims to be a healer
BP9 Carla	Family report father may have caused it. Recurrence can be precipitated by anger, and becomes angry if does not get own way	One healer suggested cause due to her breaking taboo by touching traditional medicine
BP10 Renata	Lived in jungle as part of female resistance movement but no explicit history given	Encounter with a water spirit ( <i>bai nain</i> ) 1975 when living in jungle—believed to be initial cause. Recurrence due to <i>fulan lotuk</i>
CP1 Christiano	Political beating in 1975 but problems started before this. Divorced and possible prior social humiliation may have led to social exclusion and rumination	Unwell for many years. Historically reports seeing a <i>rai nain</i> in the form of a snake. Chronic symptoms exacerbated by <i>fulan lotuk</i> but also seen as contributing to initial onset
CP2 Fernanda	Temporarily displaced in 1975. Death of 3 children (of 12) but long before onset of problems	Speculation about various possible causes including breaking of <i>lulik</i> taboo, and sorcery. Chronic symptoms exacerbated by <i>fulan lotuk</i> but also seen as contributing to initial onset

(continued)

**Table 2.1** (continued)

ID	History of trauma and loss as triggers for onset and/or recurrence	<i>Lulik</i> factors as triggers for onset and/or recurrence
CP3 Eduardo	Family experienced displacement in 1975 due to invasion. Wife and 2 children died while displaced due to sickness	Speculation that onset caused by <i>rai nain</i> . Chronic symptoms exacerbated by <i>fulan lotuk</i> but also seen as contributing to initial onset
CP4 Lorena	Widowed 1983. Problems attributed to severe head injury 1989—dementia	Obvious physical cause but chronic symptoms exacerbated by <i>fulan lotuk</i>

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