

Besesandigon, Melangun, and Ritual Healing among the Suku Anak Dalam: A Marcelian Interpretation of Relational Health during COVID-19

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Abstract

Purpose: This study examines how Suku Anak Dalam (SAD) customary leaders classify illness, implement *besesandigon* and *melangun* in response to perceived epidemic threats, and integrate spiritual rituals with plant-based healing. It also interprets the relational logic connecting these practices through Gabriel Marcel's philosophy of intersubjectivity. **Methods:** The study employed a qualitative mini-ethnographic case study conducted from September to November 2020 in the Air Hitam and Kejasung SAD communities, located near Bukit Duabelas National Park in Jambi, Indonesia. Data were obtained from seven key customary leaders and three supplementary participants through participant observation, unstructured and joint interviews, group conversations, and contemporaneous field notes. The data were analyzed manually using open and focused thematic coding. **Findings:** Three interconnected dimensions were identified. First, SAD diagnosis combined bodily symptoms with customary conduct, contact with outsiders, ecological signs, and spiritual relations. Second, *besesandigon* regulated localized risks through distancing, temporary separation, indirect communication, and customary authorization, whereas *melangun* involved broader residential relocation associated with death, misfortune, or communal danger. Third, medicinal plants were embedded within *basale/bedeki*, guidance from Badewo, observance of *pantangaon*, family participation, and access to *Tanah Gedong Obat*. These findings indicate that diagnosis, prevention, and healing were organized through a relational rather than individually centered logic. **Research implications:** Health engagement with SAD communities should involve recognized customary authorities and respect community protocols governing access, ritual knowledge, and ecological resources. The findings are ethnographic and do not establish botanical, clinical, or epidemiological effectiveness. **Originality/value:** This study integrates SAD disease cosmology, epidemic-response practices, and ritual-herbal healing within a single analytical framework. Marcel's concept of *esse est co-esse* is used to clarify their relational coherence without equating SAD cosmology with Western philosophical categories.

Keywords: *besesandigon*; Gabriel Marcel; Indigenous health; medical anthropology; *melangun*; ritual healing; Suku Anak Dalam.

Introduction

The COVID-19 pandemic renewed scholarly attention to community-based health practices that organize prevention, care, and collective responsibility beyond formal biomedical institutions. Among Indigenous communities, responses to infectious disease often draw on established systems of customary authority, environmental knowledge, spiritual obligations, and social regulation rather than on isolated individual behavior alone (Amentie et al., 2022; Bahagia, Hudayana, Wibowo, & Anna, 2020). The Suku Anak Dalam (SAD) communities living around Bukit Duabelas National Park, Jambi,

provide an important case. Their responses to illness include *besesandigon*, which regulates distance and interaction around individuals considered ill or exposed, and *melangun*, which involves household or communal relocation when threats are associated with death, misfortune, or broader danger. During COVID-19, these practices were adapted to reduce contact with outsiders and reorganize residential space, although their epidemiological effectiveness has not been independently established (Ridwan & Sari, 2020). These practices form part of a wider health system in which bodily symptoms, customary prohibitions, environmental relations, spiritual signs, ritual mediation, and plant-based healing are understood as interconnected.

Existing scholarship has documented several components of SAD knowledge and social life. Ethnographic studies describe customary prohibitions, forest-based cosmology, relationships with spiritual entities, and the role of customary leaders in regulating community conduct and access to SAD settlements (Ginting, Wongta, Ounjaijean, & Hongsibsong, 2025; Najib, 2020; Prastio et al., 2023; Sandbukt, 1988). Ethnobotanical research has recorded medicinal plants used by SAD communities and has drawn attention to forest areas associated with medicinal knowledge, including *Tanah Gedong Obat* (Andhika, Hariyadi, & Saudagar, 2015; Indriati, 2014; Sapina, Arfan, Halim, Mubarak, & Kailani, 2022). Other studies have examined the effects of ecological change and oil-palm expansion on SAD livelihoods and customary territories, as well as the role of *melangun* as an adaptive response to death, displacement, and communal disturbance (Pahmi, Gunawan, Iskandar, & Soemarwoto, 2023; Prasetijo, 2017). Research conducted during the COVID-19 period has also highlighted customary distancing and forest withdrawal as responses to perceived infection risks (Ridwan & Sari, 2020).

Despite these contributions, the existing literature tends to examine disease beliefs, customary prohibitions, epidemic responses, ritual healing, and medicinal plants as separate domains. Limited attention has been given to how SAD customary leaders connect causal explanations of illness with diagnostic indicators and treatment decisions; how physical distancing, communication, customary authorization, and relocation operate at different levels of perceived threat; and how ritual mediation and medicinal plants are integrated within a single healing process. The analytical problem is therefore not simply the absence of documentation but the absence of an integrated explanation of the relational logic connecting these practices. When Indigenous health systems are divided into isolated categories such as belief, ritual, environmental knowledge, or medicinal technique, their internal coherence can be obscured and their spiritual dimensions can be treated as secondary to material practices (Cox, 2016; Kleinman, 1980; Smith, 2021). A more appropriate analysis must examine SAD categories on their own terms without automatically translating them into biomedical equivalents.

Gabriel Marcel's philosophy of intersubjectivity provides an interpretive framework for examining this relational structure. Marcel's concept of *esse est co-esse*—being is being-with—understands existence as constituted through participation, presence, fidelity, and relations with others rather than as the property of an isolated individual (Marcel, 1950, 1965b, 1965a, 1998). This perspective is relevant to the SAD case because illness and healing are not described solely in terms of physiological dysfunction or the material properties of remedies. Informants connected illness to relations among individuals, customary conduct, outsiders, the forest, signs interpreted as *petako*, spiritual entities, and Badewo. Likewise, healing involved the patient, family members, ritual practitioners, medicinal plants, *pantangaon*, and *basale/bedeki*. Marcel's framework is therefore used here not to equate SAD cosmology with Western existential philosophy,

but to interpret how relational participation organizes diagnosis, prevention, and healing within the empirical accounts.

Based on the field findings, the relational structure of the SAD health system can be examined through three interconnected dimensions. The first is relational diagnosis, in which bodily symptoms are considered together with recent conduct, violations of *pantangaon*, contact with outsiders, dreams, bird vocalizations, and possible disturbances involving forest or spiritual entities. The second is tiered communal prevention, in which *besesandigon* regulates localized interaction through distance, temporary separation, indirect communication, and customary authorization, while *melangun* reorganizes household or communal residence when a threat is perceived as broader or associated with death. The third is integrative healing, in which medicinal plants are not treated as independent remedies but are used within ritual processes involving customary practitioners, family participation, spiritual guidance, and continued access to *Tanah Gedong Obat*. These dimensions emerged from the empirical themes and are subsequently interpreted through Marcel's relational philosophy rather than imposed as fixed biomedical or philosophical categories during initial data description.

Accordingly, this study addresses three questions. First, how do SAD customary leaders classify the causes of illness and combine bodily, social, ecological, and spiritual indicators in diagnostic practice? Second, how were *besesandigon* and *melangun* implemented as localized and broader customary responses to illness threats during the COVID-19 pandemic? Third, how were *basale/bedeki*, Badewo, *pantangaon*, ritual authority, and medicinal plants integrated within SAD healing practices? The study aims to: (1) analyze SAD disease cosmology, causal classification, and diagnostic processes; (2) examine the implementation and differing social-spatial scales of *besesandigon* and *melangun* during COVID-19; and (3) explain the integration of spiritual rituals and plant-based healing and interpret its relational logic through Marcel's framework of intersubjectivity.

Methods

This study employed a qualitative mini-ethnographic case study design to examine how Suku Anak Dalam (SAD) communities understood illness, implemented customary responses to epidemic threats, and integrated ritual mediation with plant-based healing during the COVID-19 pandemic. The unit of analysis was not the individual informant in isolation but the system of explanations, practices, and customary relations through which illness was diagnosed, prevented, and treated. The inquiry focused on three interrelated domains: SAD disease cosmology and classification; the implementation of *besesandigon* and *melangun*; and the integration of *basale/bedeki*, spiritual guidance, and medicinal plants. A mini-ethnographic design was selected because the fieldwork was conducted over a three-month period and because *larong*, or customary restrictions, limited direct access to sacred ritual performances (Dobbins et al., 2021; Fusch et al., 2017).

Fieldwork was conducted from September to November 2020 in two SAD communities located within the ecological zone of Bukit Duabelas National Park, Jambi Province, Indonesia. The first site was the Air Hitam community in Sarolangun Regency, while the second was the Kejasung community in Batanghari Regency. The sites were purposively selected because they provided access to different customary authorities and complementary accounts of disease classification, interactions with outsiders, epidemic responses, and ritual-based healing. The field researchers conducted the fieldwork at both

sites and documented the observed events, interview accounts, and accessible ritual preparations in contemporaneous field notes.

Participants were purposively selected for their customary authority, knowledge of SAD health practices, and involvement in community decision-making. The core informant group consisted of seven customary leaders: Jenang Jalal and six Tumenggung—Melayar Tuah, Bepayung, Meladang, Melimun, Ngerip, and Jelitai. Their accounts addressed disease causation, diagnostic indicators, customary prohibitions, community access, epidemic protocols, and ritual healing. Supplementary accounts were obtained from three additional participants identified in the field records as Nguyup, Nyuntut, and Tarib. Nguyup and Nyuntut provided information concerning community withdrawal into forest areas and responses during COVID-19, while Tarib contributed to the account of changes in *Tanah Gedong Obat*. Thus, the empirical material used in the Results was derived from seven key customary leaders and three supplementary participants. The customary positions and community affiliations of the supplementary participants should be reported if they are recorded in the original field documentation.

Data were collected through participant observation, unstructured interviews, joint interviews, and group conversations. Individual and joint interview sessions generally lasted between 45 and 90 minutes. Unstructured conversational interviewing was used because rigid question-and-answer formats did not consistently produce detailed accounts of customary and sacred practices. Participant observation included negotiating access during a visit to Sungai Kejasung and preparations for accessibility associated with *basale/bedeki*. The field researchers directly observed the staged approach to the settlement, communication from a distance, and the mediation performed by a Tumenggung. By contrast, the field researchers did not directly observe the implementation of *melangun* or the central performance of *basale/bedeki*. Descriptions of these practices were therefore based on informant accounts and on interviews conducted before and after ritual activities.

Interview and observational data were recorded in written field notes with participants' permission. Audio recording was not used in deference to community protocols. Statements presented as direct quotations were retained only when their wording had been documented contemporaneously and sufficiently precisely in the field notes; accounts that were not recorded verbatim were presented as paraphrases. The manuscript distinguished direct observation from reported practice through formulations such as "the field researchers observed" and "informants explained." The language or languages used during the interviews and the procedure used to translate participants' statements into English should also be specified from the original field records before publication.

Several forms of information were treated as participant estimates or recollections rather than independently verified measurements. The reported distance of approximately 50–100 meters for *besesandingon* was based on informant estimates and approximate field observation; the field researchers did not conduct systematic distance measurements. The reported decline in *Tanah Gedong Obat* from approximately 140 to 128 species was based on the recollections of Jelitai and Tarib. The study did not include a botanical inventory, voucher-specimen collection, or expert taxonomic examination. Similarly, community reports of no known COVID-19 transmission among relocated families were not verified through systematic testing or independent epidemiological records. These accounts were analyzed as community-reported knowledge and experience rather than as evidence of botanical, clinical, or epidemiological effectiveness.

Data were analyzed manually through thematic coding informed by Saldaña's

(2021) coding procedures. During the first cycle, open coding was used to identify recurring categories in the field notes, including bodily symptoms, violations of *pantangaon*, contact with outsiders, *petako*, dreams, spatial separation, customary authorization, relocation, ritual mediation, spiritual protection, and medicinal plants. During the second cycle, focused coding organized these categories into three empirical themes: (1) disease cosmology, causal classification, and diagnostic practice; (2) tiered customary responses through *besesandigon* and *melangun*; and (3) the integration of ritual authority and plant-based healing. These themes structured the three Results subsections. Gabriel Marcel's conceptual categories were subsequently used during the interpretive stage presented in the Discussion rather than imposed on the initial descriptive coding.

Credibility was strengthened through triangulation across individual interviews, joint conversations, participant observation, and field notes from the two research sites. Accounts were compared across customary leaders and supplementary participants to identify recurring descriptions and differences in the reported implementation of practices. Claims not supported consistently across the available records—such as standardized durations, precise relocation distances, exact botanical counts, or direct epidemiological effects—were reported as uncertain, variable, or based on participant recollection. Secondary ethnographic and ethnobotanical literature was used for contextualization and comparison in the Discussion, but it was not treated as primary evidence in the revised Results.

Results

1. SAD Disease Cosmology and Classification

Interviews with customary leaders indicated that illness was understood not merely as a physical condition but as a disturbance involving bodily weakness, social conduct, environmental relations, and spiritual forces. Informants explained that the identification of illness extended beyond visible symptoms to include recent interactions with outsiders, possible violations of *pantangaon*, changes in the surrounding environment, and signs interpreted as spiritual warnings. Illness was therefore understood as a condition that could arise from disturbed relations among individuals, the community, the forest, and spiritual entities rather than solely from physiological dysfunction.

Interview data identified three principal and potentially overlapping categories through which SAD customary leaders explained the causes of illness: violations of *pantangaon*, contamination associated with outsiders, and spiritual or ecological disharmony. Tumenggung Jelitai stated, “Diseases originate from three sources: violation of prohibitions (*pantangaon*), contamination from outsiders, and disharmony with forest spirits. Each requires different healing approaches” (personal communication, November 26, 2020). His account indicates that illness was not interpreted through a single causal framework. Instead, customary leaders considered whether an individual had violated a prohibition, had recently interacted with outsiders or potentially contaminating substances, or had experienced a disruption in relations with forest and spiritual entities.

Field accounts indicated that violations of *pantangaon* encompassed actions believed to disrupt customary, ecological, and spiritual order. In a joint interview, Tumenggung Ngerip and Tumenggung Meladang stated, “We and Badewo share and protect each other. Through *bedeki* mediation, we ask Badewo to protect us from epidemics, and in return, we protect Badewo by obeying its commandments” (personal

communication, November 26, 2020). They identified prohibitions against consuming livestock, passing by the dwellings of deceased persons, using soap, toothpaste, or other chemical substances in ways believed to contaminate rivers, cutting ritually significant trees such as *tenggeris* and *setubung*, and photographing *basale/bedeki* houses or women. In the informants' accounts, violations of *pantangaon* were therefore understood not merely as individual misconduct but as disturbances affecting relations among community members, the forest environment, and spiritual entities.

Illness attributed to external contamination was associated with recent interactions with outsiders, whom informants perceived as possible sources of disease entering the community. By contrast, spiritual or ecological disharmony was identified through unusual bird vocalizations, dreams, and other indications interpreted as *petako*. These categories were not necessarily mutually exclusive. For example, a violation of *pantangaon* could simultaneously be understood as an individual transgression, an ecological disturbance, and a disruption of relations with spiritual entities.

The diagnostic process drew on several interconnected indicators rather than a single fixed procedure. Tumenggung Ngerip explained that the assessment of illness began with attention to visible physical symptoms but also extended to socially, environmentally, and spiritually interpreted signs. He stated, "When someone falls ill, we first listen to bird calls; certain vocalizations indicate *petako*. We observe the patient's dreams and examine their recent activities for prohibition violations" (personal communication, September 10, 2020). Bird vocalizations and dreams were thus treated as interpretive signs, while the patient's recent conduct was examined to determine whether a violation of *pantangaon* might have contributed to the illness.

When external contamination was suspected, the assessment also considered the patient's recent interactions with outsiders. Diagnosis, therefore, involved a combination of physical observation, interpretation of *petako*, examination of dreams, review of the patient's activities, identification of possible violations of *pantangaon*, and investigation of recent social contacts. These indicators were not necessarily applied in a fixed sequence; rather, customary leaders considered them in light of the symptoms and circumstances of each case. Table 1 summarizes the principal causal categories, diagnostic indicators, and treatment responses identified in the interviews.

Table 1 SAD Disease Categories, Diagnostic Indicators, and Treatment Responses

Causal Category	Locally Recognized Conditions	Diagnostic Indicators	Reported Treatment Response
Violation of <i>pantangaon</i>	Illness believed to be associated with the violation of customary prohibitions	Physical symptoms, the patient's recent activities, and indications of possible violations of <i>pantangaon</i>	Customary and ritual treatment adjusted to the type of prohibition believed to have been violated, often accompanied by herbal preparations

Causal Category	Locally Recognized Conditions	Diagnostic Indicators	Reported Treatment Response
External contamination	Illness believed to occur following contact with outsiders or exposure to external sources of contamination	Physical symptoms, recent contact with outsiders, and the circumstances surrounding possible exposure	Restriction of contact through <i>besesandington</i> , temporary separation, and other customary protective measures
Spiritual or ecological disharmony	Illness associated with disturbed relations involving forest, environmental, or spiritual entities	Physical symptoms, bird vocalizations interpreted as <i>petako</i> , particular dreams, and signs of disturbed relations with spiritual or forest entities	<i>Basale/bedeki</i> rituals combined with herbal preparations and requests for guidance or healing from Badewo

Note. The categories and treatment responses are based on interviews conducted during the 2020 fieldwork. They represent informants' interpretations of illness and customary healing practices rather than biomedical diagnoses or evidence of clinical effectiveness.

As shown in Table 1, the perceived cause of illness shaped the response considered appropriate by SAD customary leaders. Physical symptoms were important but were not treated as the sole basis for diagnosis. Informants also considered the patient's recent conduct, possible violations of *pantangaon*, contact with outsiders, dreams, bird vocalizations interpreted as *petako*, and indications of disturbed relations with forest or spiritual entities. Diagnosis therefore incorporated bodily, social, ecological, and spiritual dimensions.

The reported responses likewise varied according to the presumed source of illness. Conditions associated with violations of *pantangaon* were addressed through customary or ritual practices, often together with herbal preparations. Illness attributed to external contamination prompted restrictions on contact, including *besesandington* and temporary separation. Conditions associated with spiritual or ecological disharmony were treated through *basale/bedeki* rituals, herbal preparations, and requests for guidance from Badewo. These findings indicate that SAD disease classification connected causal explanation, diagnosis, and treatment. Responses to illness were selected not solely according to physical symptoms but also according to the type of relationship believed to have been disturbed.

2. Implementation of *Besesandington* and *Melangun* during COVID-19

Field interviews and observations identified *besesandington* and *melangun* as two

related but distinct customary responses to perceived threats of illness. *Besesandongon* was activated when an individual or household was considered ill, exposed, or at risk of transmitting disease. It was implemented by limiting direct contact, regulating communication, and creating temporary separation between those considered healthy and those considered ill or exposed. By contrast, *melangun* was undertaken when the threat was understood as broader, particularly when it was associated with death, epidemic danger, or risks affecting an entire household or community group. The two practices therefore operated at different levels: *besesandongon* addressed localized risks involving individuals or households, whereas *melangun* reorganized residence and mobility in response to a wider perceived threat.

Tumenggung Jelitai explained, “When someone shows signs of illness, healthy people must maintain a distance of 50 to 100 meters. This has been our way since ancestral times” (personal communication, September 10, 2020). Informants estimated the separation distance at approximately 50–100 meters. These figures represented customary estimates; the field researchers did not systematically measure the distances during fieldwork. The practice separated those considered healthy from those considered ill and reduced direct physical interaction until the perceived threat was considered to have passed.

Interview and field accounts indicated that a separated individual could stay in a *sesudung*, a small temporary shelter located away from the main residential area. Communication was conducted indirectly or from a distance, while food and other necessities were provided in ways intended to minimize close contact. *Besesandongon* therefore involved more than the maintenance of physical space. It also regulated movement, communication, the provision of necessities, and the temporary use of residential areas. The available interview records did not establish a uniform duration because the period of separation varied according to the circumstances of illness and customary assessment.

During a field visit to Sungai Kejasung, the field researchers observed that entry into the settlement was negotiated from a distance. The accompanying Tumenggung called to community members from about 50 meters away. A community member then emerged and remained partially concealed in the surrounding vegetation at an estimated distance of approximately 20 meters. From that position, the Tumenggung explained the visitors’ identity and purpose in the SAD language. The field researchers was permitted to approach only after the community member had acknowledged the explanation and granted access. The receiving community member subsequently called the elders and other residents to meet the visitors.

This observation indicates that interaction with outsiders followed a gradual and regulated process rather than immediate face-to-face contact. Distancing was embedded in an established protocol involving recognition of the visitors, communication of their purpose, customary authorization, and controlled approach. The accompanying Tumenggung acted as an intermediary, whereas the receiving community member retained the authority to permit or refuse closer access. The protocol thus combined spatial separation, indirect communication, and customary approval to regulate contact between community members and outsiders.

Informants located the overarching authority for such interactions in the Jenang. Tumenggung Ngerip, Tumenggung Melimun, and Tumenggung Melayar Tuah explained, “The Jenang serves as our tongue, feet, and hands, both internally and externally, preventing us from dispersing and losing our way across regions, like chickens with their mother hen, and like lemongrass, our community stands strong when the Jenang is

present” (personal communication, September 10, 2020). Their account presents the Jenang as the community’s representative, communicator, and guarantor of customary order in relations with outsiders.

Permission to enter or approach the settlement was therefore mediated through recognized customary authority rather than obtained through direct access. Visitors were required to communicate their identity and purpose from a distance, after which an authorized representative conveyed the request and sought approval from the receiving community. In the observed visit, the Tumenggung performed this intermediary role before the researchers was permitted to approach. The data therefore indicate that the protocol regulated not only physical distance but also the authority through which access was negotiated. The Jenang held overarching customary authority, while Tumenggung or other authorized representatives could mediate particular encounters.

Melangun was described by informants as a customary response associated with death, misfortune, and the perceived risk of disease transmission. Nyuntut explained, “*Melangun* is imperative for us. It serves to alleviate grief over the loss of family members. We also believe that *melangun* dispels misfortune and prevents the transmission of diseases suffered by the deceased” (personal communication, November 26, 2020). This account indicates that *melangun* combined emotional, spiritual, and preventive functions. It enabled bereaved family members to distance themselves from the place of death while avoiding locations believed to remain affected by misfortune or illness.

According to the interview accounts, bereaved family members relocated together to another forest location rather than remaining near their former residence. The new location was selected away from the previous settlement and routes commonly used by outsiders or surrounding populations. Informants also associated the relocation with *genah pasaron*, the burial place prepared for the deceased. After the burial site had been established, the surrounding area was treated as restricted, and the family moved away as part of the *melangun* process. The practice therefore involved both separation of the living from the burial site and temporary reorganization of household residence.

The implementation of *melangun* was reported by informants and was not directly observed by the field researchers during the fieldwork period. The available interview records supported the relocation of bereaved families and the selection of a more distant forest location but did not provide consistent measurements of relocation distance or duration. Consequently, the field data establish the occurrence and general form of relocation but do not support a standardized distance or period of residence.

During the COVID-19 pandemic, informants reported that SAD community members moved farther into forest areas and reduced contact with outsiders. Nguyup and Nyuntut stated, “Since COVID-19, SAD community members have retreated to the forest to avoid infectious diseases. We follow Badewo’s command to implement *besesandigon*, as the world is no longer safe from infectious diseases” (personal communication, September 10, 2020). Their account indicates that the pandemic response combined restrictions on interpersonal contact with withdrawal from locations where encounters with outsiders were considered more likely. In this context, *besesandigon* regulated distance and communication, while movement farther into the forest extended separation to the household or community level.

Community leaders reported no known transmission among the families who relocated during the period discussed. This account was not supported by systematic testing or independent epidemiological records and should therefore be understood as a community-reported observation rather than evidence of clinical or epidemiological

effectiveness. The field data nevertheless show that *besesandingan* and *melangun* were mobilized during COVID-19 to limit contact, regulate access, reorganize residential space, and reduce perceived exposure to disease. Table 2 summarizes the activation conditions, participants, spatial arrangements, implementation procedures, duration, and primary evidence associated with the two protocols.

Table 2 Implementation Characteristics of Besesandingan and Melangun

Protocol	Activation Condition	Participants	Distance or Location	Main Practices	Duration
<i>Besesandingan</i>	Signs of illness, suspected exposure, recent contact with outsiders, or visits by people from outside the community	Individuals considered ill or exposed, household members, visitors, and members of the receiving community	Informant-estimated separation of approximately 50–100 m; gradual approach during visits beginning at an estimated distance of approximately 50 m	Physical distancing; separation of healthy and ill individuals; indirect communication; temporary residence in a <i>sesudung</i> ; delivery of necessities without close contact; customary authorization before closer interaction	Variable; no uniform duration was established in the available interview records
<i>Melangun</i>	Death of a family member, perceived misfortune, epidemic threat, or a wider danger believed to affect the household or community	Bereaved household, extended family, or community group	Relocation from the former residence and <i>genah pasaron</i> to another forest location away from commonly used routes and contact with outsiders	Collective relocation; avoidance of the previous residence and burial area; establishment of temporary residence; reduction of contact with outsiders; reorganization of household or communal space	Variable; the available interview records did not establish a consistent period

Note. Distances associated with *besesandingan* were based on informant estimates and approximate field observations; the field researchers did not conduct systematic measurements.

As summarized in Table 2, *Besesandingan* and *Melangun* operated at different perceived threat levels. *Besesandingan* was used when risk was localized around an individual, household, visitor, or suspected exposure. Its implementation emphasized physical distance, indirect communication, temporary separation, access regulation, and

customary authorization before closer contact. By contrast, *melangun* was undertaken when illness, death, or misfortune was perceived to threaten a wider household or community group. In such circumstances, the response extended beyond interpersonal distancing to collective movement and reorganization of household or communal space.

The scale of the response, therefore, increased in relation to the perceived scale of the threat. Localized risks were managed by controlling proximity and interaction, whereas broader threats prompted changes in residence and mobility. The COVID-19 response did not emerge as an entirely new set of practices. Informants instead described it as an adaptation and intensification of customary measures already used to manage illness, contact with outsiders, death, and communal danger. The evidence thus suggests a tiered response system: *besesandingon* regulated interaction around localized illness or suspected exposure, while *melangun* reorganized household or communal space when the threat was perceived as broader or associated with death.

3. Integration of Spiritual Rituals and Herbal Healing

Interview and field-note accounts indicated that SAD healing practices combined plant-based preparations with ritual mediation rather than treating them as separate forms of treatment. In a field-note account, Tumenggung Melayar Tuah explained that herbal medicine was not considered fully effective without *basale/bedeki* and guidance from Badewo (personal communication, November 26, 2020). He described medicine administered without ritual mediation as comparable to a body without a soul. His account indicates that medicinal plants were understood to acquire their appropriate healing function when used within an authorized ritual process.

Medicinal plants were therefore not treated as independent therapeutic substances. Their use formed part of a broader healing process involving the patient, family members, ritual practitioners, plant materials, and Badewo. Informants described *basale/bedeki* and herbal preparations as mutually supporting components: plants provided the material elements of treatment, while ritual mediation was believed to provide the guidance required for their selection, preparation, and administration.

Informants further explained that the healing process depended on maintaining appropriate relations with Badewo and observing *pantangaon*. In a joint field-note account, Tumenggung Ngerip and Tumenggung Meladang described protection from illness as reciprocal. Community members sought protection and healing guidance from Badewo through *basale/bedeki*, while they were expected to comply with customary prohibitions and protect forests, trees, waterways, and ritual spaces associated with spiritual life (personal communication, November 26, 2020). Violations of these prohibitions were believed to disturb the conditions necessary for healing and expose individuals or the wider community to illness or misfortune.

The obligations associated with healing consequently extended beyond the patient and ritual practitioner. Community members were expected to avoid actions believed to damage ecological or sacred relations, including contaminating rivers, cutting ritually significant trees, and violating restrictions surrounding ritual spaces. Requests for protection from Badewo were thus accompanied by obligations to maintain customary, ecological, and spiritual order. Healing involved not only the administration of herbal preparations but also compliance with *pantangaon* and the restoration of appropriate relations among community members, the forest environment, and spiritual entities.

Field observations documented preparations associated with *basale/bedeki*,

including selecting secluded forest locations or sites away from routes commonly used by surrounding communities. Access to the ritual area was restricted, particularly for outsiders, in accordance with *larong*. These restrictions prevented the field researchers from directly observing the central ritual performance. The available field evidence was therefore limited to observations of the preparatory setting and interviews conducted before and after the ritual.

Informants explained that a temporary ritual space or pavilion was prepared, with the patient and immediate family positioned in its central area. They reported that ritual mediation and the administration of herbal preparations were carried out as interconnected components of the healing process. The plants used in these preparations were obtained from *Tanah Gedong Obat*, a forest area maintained as a source of medicinal plants. These descriptions were derived from informant accounts rather than direct observation of the central ritual performance.

Informants described *Tanah Gedong Obat* as a designated forest area supporting the collection of medicinal plants used alongside *basale/bedeki*. Tumenggung Jelitai and Tarib recalled that the medicinal plant repository had previously contained approximately 140 species but had declined to around 128 species (personal communication, November 26, 2020). They associated the decline with forest clearing and the expansion of oil-palm plantations in and around SAD's customary territory.

The reported figures reflect informants' recollections, as the study did not include a botanical inventory. The field data, therefore, document community perceptions of declining medicinal plant diversity but do not independently verify the precise number of species. Nevertheless, the accounts indicate that changes in forest cover were understood to affect both the availability of medicinal plants and the continuity of ritual-based healing associated with *Tanah Gedong Obat*.

Table 3 summarizes the plants explicitly mentioned in the interview accounts and the ritual or medicinal functions attributed to them by the informants.

SAD Plant Name	Scientific Identification	Part Used	Reported Traditional Function	Preparation or Ritual Context
<i>Setube/Setubung</i>	Not botanically identified during fieldwork	Bark, subject to verification in the field notes	Associated with newborn care and regarded as ritually significant	Its use was described as subject to customary and ritual restrictions
<i>Tenggeris</i>	Not botanically identified during fieldwork	Not specified in the interview records	Regarded as a ritually significant tree rather than an ordinary medicinal material	Cutting the tree was identified as a violation of <i>pantangaon</i>

Note. The table includes only plants explicitly identified in the available interview accounts. Botanical identities and reported plant parts were not verified through voucher specimens, botanical collection, or expert taxonomic examination. The reported functions represent informants' customary knowledge and do not constitute evidence of clinical effectiveness.

As shown in Table 3, the ritual significance of plants did not necessarily depend on their direct use as medicinal substances. Some plants were valued for their association with sacred restrictions, customary obligations, or specific stages of life. A ritually significant tree such as *tenggeris*, for example, was protected from cutting rather than processed as an ordinary remedy. Plant knowledge, therefore, included rules concerning protection, access, and appropriate use in addition to information about preparation and administration.

The field accounts further indicate that the use of medicinal plants was regulated through customary and ritual authority. Their availability depended on continued access to forest areas, particularly *Tanah Gedong Obat*. The reported decline in plant diversity was consequently understood as threatening both herbal knowledge and the continuity of ritual healing. Overall, the findings show that plant-based healing was embedded within ritual authority and spiritual guidance. Medicinal substances were not treated as independent remedies but as components of a broader healing process involving the patient, ritual practitioner, family, plants, and Badewo.

Discussion

The findings reveal three interconnected dimensions of the SAD health system. First, disease classification linked bodily symptoms with customary conduct, social contact, ecological signs, and spiritual relations. Second, *besesandingan* and *melangun* operated at different social and spatial levels in response to localized and broader threats. Third, plant-based treatment was embedded within ritual authority, customary obligations, and guidance from Badewo. Taken together, these findings indicate that diagnosis, prevention, and healing were organized through a relational logic rather than as separate technical interventions. Health was understood not solely as an individual biological condition but as dependent on relations among persons, customary authorities, the forest environment, medicinal plants, and spiritual entities.

The first major finding is that SAD disease classification did not separate physical symptoms from social, ecological, and spiritual interpretation. Violations of *pantangaon*, contamination associated with outsiders, and spiritual or ecological disharmony were analytically distinguishable but not mutually exclusive. A single condition could be understood simultaneously as bodily weakness, a violation of customary order, and a disruption of relations with forest or spiritual entities. The perceived cause of illness, therefore, shaped both diagnostic interpretation and the response considered appropriate.

This relational orientation explains why diagnostic practice included recent conduct, contact with outsiders, dreams, bird vocalizations interpreted as *petako*, and possible violations of *pantangaon* alongside visible physical symptoms. Within the SAD explanatory system, these indicators were not peripheral beliefs attached to an otherwise physical diagnosis. They were part of the process through which customary leaders identified the type of disturbance believed to have occurred. Diagnosis was therefore concerned not only with determining what condition a person experienced but also with

identifying which social, customary, ecological, or spiritual relationship might have been disrupted.

This finding is consistent with Kleinman's (1980) argument that health systems contain explanatory models connecting causation, diagnosis, and treatment. The SAD case adds to this perspective by showing that customary prohibitions, nonhuman signs, and spiritual relations actively informed diagnostic reasoning. They were not merely retrospective interpretations applied after physical symptoms had been identified. The findings also support Najib's (2020) description of SAD cosmology as a relational field involving humans, the forest, and spiritual entities. The present study extends this literature by demonstrating how these relations entered practical decisions concerning diagnosis and treatment.

The findings also contribute to wider efforts to understand Indigenous health systems without automatically translating their categories into biomedical equivalents. Ting et al. (2025) emphasize the need for analytical approaches that take relational ontologies seriously, while Cox (2016) and Smith (2021) criticize frameworks that reduce Indigenous religious and knowledge systems to residual belief or superstition. In the SAD case, *petako*, dreams, *pantangaon*, and interactions with outsiders were significant because they organized causal interpretation and guided responses. Their analytical importance lies in how they function within the SAD health system rather than in whether they correspond directly to biomedical diagnostic categories.

Marcel's concept of *esse est co-esse*, or being as fundamentally being-with, helps interpret this structure because illness was understood through the relations in which a person participated rather than as a failure located exclusively within an isolated body (Marcel, 1950, 1965a). Social conduct, customary obligations, ecological relations, and spiritual signs became diagnostically relevant because each could indicate a disruption in the relational conditions of health. Marcel's emphasis on participation, therefore, helps clarify why bodily, social, ecological, and spiritual elements remained coherent within the same diagnostic system (Marcel, 1965b, 1998).

SAD disease cosmology consequently functioned as an operational classificatory system connecting causal explanation, diagnostic interpretation, and treatment selection. It should not be reduced to a set of detached supernatural beliefs. Its significance lies in the practical relationship it established among perceived causes, signs of disturbance, and customary responses.

A second pattern concerns the differentiated organization of customary responses to perceived threats. *Besesandigon* regulated localized risks through physical distance, temporary separation, indirect communication, and controlled access. *Melangun*, by contrast, involved wider residential reorganization when danger was associated with death, misfortune, or threats affecting a household or community group. The scale of the response, therefore, increased according to the scale of danger perceived by community members.

The observed protocol for approaching the Sungai Kejasung settlement demonstrates that prevention was not reducible to physical distance. Distance was combined with recognition, communication, customary mediation, and authorization. The gradual approach enabled community members to identify visitors, assess the purpose of their arrival, and decide whether closer contact should be permitted. Spatial separation thus formed part of a wider social procedure regulating the conditions under which interaction could occur.

The roles of the Jenang and Tumenggung further show that customary health practices were embedded within social and political authority. Prevention did not depend

solely on individual willingness to maintain distance. Recognized authorities mediated communication, regulated access, and coordinated interaction between the community and outsiders. This finding complements previous descriptions of SAD customary governance by demonstrating how authority operated concretely during encounters involving perceived health risks (Najib, 2020; Pahmi et al., 2023).

The findings also extend earlier accounts of *besesandigon*, forest withdrawal, and *melangun*. Ridwan and Sari (2020) documented the adaptation of SAD customary practices during COVID-19, while Sandbukt (1988) and Prasetyo (2017) showed that mobility and spatial reorganization have long formed part of SAD responses to ecological, social, and communal disruption. The present study adds a more differentiated account by showing that distancing, controlled access, temporary separation, and relocation operated at distinct social and spatial scales.

Comparable patterns have been reported among other Indigenous communities. Dayak Salako responses combined ritual and communal restriction (Fatmawati & Dewantara, 2022), Orang Asli communities had limited contact with outsiders and reorganized movement during COVID-19 (Idrus, Man, Williams-Hunt, & Chopil, 2021), and the Sasak communities integrated inherited practices with formal health measures (Sumardi & Wahyudiati, 2021). The distinctive feature of the SAD case lies in the relationship among localized distancing, staged interaction with outsiders, customary authorization, and wider relocation. These elements formed a differentiated system rather than a single uniform rule.

From Marcel's relational perspective, physical separation did not necessarily entail the suspension of social responsibility, as relations can be maintained through fidelity, presence, and responsibility even when immediate proximity is restricted (Marcel, 1950, 1965a). In the SAD case, distance was used to preserve the community's relational integrity. *Besesandigon* restricted proximity while maintaining obligations to communicate and provide necessities, whereas *melangun* reorganized household or communal space when danger was perceived as broader. Physical separation was therefore interpreted as one expression of relational responsibility rather than its absence.

The pandemic accounts explicitly described *besesandigon* and movement farther into forest areas. This broader withdrawal reflected a spatial logic comparable to that associated with *melangun*, although the available accounts should not be taken to establish that every pandemic-related relocation constituted *melangun* in a formal customary sense. The evidence more securely demonstrates that existing principles of distancing, restricted access, and spatial withdrawal were adapted to perceived COVID-19 risks.

These findings do not establish that *besesandigon*, *melangun*, or forest withdrawal prevented COVID-19 transmission. The study did not include systematic testing, epidemiological surveillance, or a comparison group. The reported distance of 50–100 meters was based on informant estimates, and reports of no known transmission were not independently verified. The study's contribution is therefore ethnographic rather than epidemiological: it documents how SAD communities interpreted risk and mobilized customary practices during the pandemic. Any comparison with public-health distancing recommendations must remain descriptive and cannot support claims of superior effectiveness.

The findings consequently expand the understanding of community-based epidemic responses by showing how distance, communication, authority, and mobility were coordinated at different levels of perceived risk. Localized threats prompted regulation of proximity and access, whereas broader threats prompted changes in household or

communal space.

Previous ethnobotanical studies have primarily documented plant species, plant parts, preparation methods, and reported applications among SAD communities (Andhika et al., 2015; Indriati, 2014; Sapina et al., 2022). The present findings add that plant knowledge was embedded within ritual procedures and customary restrictions. A catalog of species and uses, therefore, captures only part of the healing system. The meaning and use of plants also depended on ritual authority, access to particular forest areas, and observance of customary obligations.

The distinction between medicinal and ritual plants was not absolute. Some plants were important because they were protected, restricted, or associated with particular stages of life rather than because they were processed as ordinary remedies. *Tenggeris*, for example, was described as a ritually significant tree that was protected from being cut. *Setubung* was associated with newborn care and customary restrictions. These examples broaden the meaning of ethnomedical knowledge to include rules governing protection, access, and appropriate conduct, as well as information on preparation and administration.

Marcel's concept of participation helps interpret this healing structure, as it resists reducing beings to isolated objects defined solely by their instrumental properties (Marcel, 1965a, 1965b, 1998). In the SAD accounts, plants were not treated as isolated substances whose significance derived only from their material characteristics. Healing involved a configuration of relations among the patient, family, practitioner, plants, forest, customary obligations, and Badewo. Therapeutic meaning was therefore interpreted as emerging through participation within a mediated relational process. This interpretation does not establish pharmacological efficacy, nor does it imply that SAD informants themselves used Marcelian concepts; rather, it clarifies how the different elements of healing formed a coherent whole within their accounts.

The reported decline in *Tanah Gedong Obat* from approximately 140 to 128 species should also be interpreted cautiously. The figures were based on informants' recollections and were not verified through a botanical inventory. Nevertheless, they are analytically significant as an expression of community concern about ecological loss. Informants linked forest clearing and oil-palm expansion to declining access to medicinal resources. The concern, therefore, extended beyond botanical depletion; it also involved the weakening of the social, ritual, and ecological conditions through which healing knowledge was transmitted. This interpretation is consistent with studies documenting the effects of land-use change on SAD livelihoods and customary territories (Pahmi et al., 2023).

The findings indicate that the continuity of SAD healing was understood to depend simultaneously on ecological conservation, customary authority, ritual transmission, and access to medicinal plants. In the informants' accounts, environmental change threatened not only the availability of plant materials but also the relational system through which those materials acquired meaning and were incorporated into healing practices.

Viewed together, the three themes show a common relational sequence: diagnosis identified relations believed to have been disturbed, prevention reorganized relations in response to perceived danger, and healing sought to restore them through ritual, customary conduct, and plant use. This sequence provides the study's central theoretical contribution.

Marcel's account of *esse est co-esse* offers a conceptual vocabulary to explain why the bodily, social, ecological, and spiritual dimensions remained connected. His philosophy understands existence as constituted through participation and relations with others rather than as the possession of an isolated subject (Marcel, 1950, 1965a, 1965b,

1998). The argument is not that SAD practices directly confirm Marcel's philosophy or that SAD cosmology should be translated into European existential terminology. Rather, Marcel's emphasis on participation helps interpret the coherence of a system in which health depended on relations among individuals, customary authorities, nonhuman signs, forest resources, and spiritual entities. His framework functions as an external interpretive aid rather than as a substitute for SAD categories.

In medical anthropology, the findings show that Indigenous health systems may organize diagnosis, prevention, and healing through categories that extend beyond biomedical distinctions among physical disease, social behavior, environmental context, and religious belief. For ritual studies, the findings demonstrate that ritual was not merely a symbolic response following illness. Ritual structured understandings of causation, therapeutic authority, ecological obligation, and the appropriate use of medicinal resources.

Recognizing the internal coherence of SAD health knowledge does not require accepting every reported practice as clinically effective. Epistemological respect concerns whether a health system is understood on its own terms, whereas claims of clinical, botanical, or epidemiological effectiveness require independent forms of evidence. The present study supports respectful engagement with SAD knowledge while maintaining clear boundaries around claims that were not empirically tested.

The findings also have practical implications for health engagement with SAD communities. Communication and intervention should involve recognized customary authorities, including the Jenang and Tumenggung, from the planning stage. Approaches that bypass established authorization mechanisms may conflict with customary procedures governing safety, access, and interaction. Health programs should therefore consider household- and community-level relationships rather than focusing exclusively on individual compliance.

Documentation and conservation initiatives should likewise avoid extracting plant names and reported uses from their ritual and ecological contexts. Protection of *Tanah Gedong Obat* should be understood as both ecological conservation and knowledge preservation. Collaborative documentation should respect *larong*, community decisions concerning restricted knowledge, and the authority of SAD participants over what may be recorded and published.

The study's main strength lies in its access to customary leaders and its combination of individual interviews, joint conversations, field notes, and direct observation of accessible practices. The observed entry process at Sungai Kejasung provides a concrete example of how distance, communication, and customary authority operated together during an encounter with outsiders. The explicit distinction between directly observed practices and informant-reported practices also strengthens the transparency of the analysis.

Several limitations must nevertheless be acknowledged. The three-month fieldwork period did not capture seasonal variation in health and ritual practices. The field researchers could not directly observe the central *basale/bedeki* performance because of *larong*, while *melangun* was described through informant accounts rather than direct observation. Interviews were not audio-recorded, so some statements depended on contemporaneous written field notes. Distances were not systematically measured, epidemiological outcomes were not independently verified, and the study did not include a botanical inventory or voucher-specimen collection. The reported decline in medicinal plant species, therefore, represents community recollection rather than a verified botanical count.

The emphasis on customary officeholders may also have limited access to knowledge held by women, younger community members, and individuals involved in domestic care, childbirth, childcare, and everyday healing. In addition, the customary positions and community affiliations of supplementary participants should be documented as fully as possible to clarify the basis of their contributions.

Future research should employ longer-term, participatory designs that involve women, younger community members, ritual specialists, and customary authorities. With community consent, such studies could examine intergenerational knowledge transmission and document ecological changes affecting *Tanah Gedong Obat*. Botanical, clinical, and epidemiological assessments would require separate collaborative research designs that respect customary authority, community control over knowledge, and restrictions surrounding sacred practices.

Conclusion

This study shows that the SAD health system organizes illness, prevention, and healing through an interconnected relational framework. Illness was classified not only through bodily symptoms but also through customary conduct, contact with outsiders, ecological signs, and spiritual relations. *Besesandingan* regulated localized threats through distancing, temporary separation, indirect communication, and customary authorization, whereas *melangun* addressed broader threats associated with death, misfortune, and household or communal displacement. Plant-based healing was likewise embedded within *basale/bedeki*, guidance from Badewo, observance of *pantangaon*, ritual authority, family participation, and continued access to *Tanah Gedong Obat*. These findings indicate that SAD health practices are linked to causal explanation, diagnosis, prevention, and treatment rather than treating them as separate domains.

The study contributes to medical anthropology and ritual studies by demonstrating how an Indigenous health system can be examined through its own relational categories without reducing them to biomedical equivalents or detached supernatural beliefs. Marcel's concept of *esse est co-esse* provides an interpretive vocabulary for understanding this coherence: diagnosis identified relations believed to have been disturbed, prevention reorganized relations in response to perceived danger, and healing sought to restore them through customary conduct, ritual mediation, and plant use. The contribution of this framework is not to equate SAD cosmology with Marcel's philosophy, but to clarify how bodily, social, ecological, and spiritual dimensions remained integrated within the empirical accounts. The findings also suggest that health engagement with SAD communities should involve recognized customary authorities and should respect community procedures governing access, communication, ritual knowledge, and ecological resources.

These conclusions must be understood within the study's limitations. The three-month fieldwork period did not capture seasonal variation, the central *basale/bedeki* performance and *melangun* were not directly observed, interviews were not audio-recorded, and reported distances were not systematically measured. The study also did not include epidemiological testing, botanical inventories, voucher specimens, or clinical evaluation; consequently, it cannot establish the effectiveness of customary practices or verify the reported decline in medicinal plant species. Future research should employ longer-term and participatory designs involving women, younger community members, ritual specialists, and customary authorities. With community consent, further studies could examine intergenerational knowledge transmission, ecological change in *Tanah*

Gedong Obat, and the relationships between customary health practices and formal healthcare while respecting SAD authority over sacred and restricted knowledge.

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