Mental Disorders and Traditional Healing Systems Among the Dogon (Mali, West Africa)

Roberto Beneduce

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ROBERTO BENEDUCE

Based on research at the Regional Center of Traditional Medicine of Bandiagara (Mali), this paper outlines characteristics of the Dogon systems of traditional health care, with particular reference to mental disorders. After considering the characteristics of some therapeutic figures (diviners, healers, etc.) and discussing the major nosologic categories inherent in mental disorders, the role of a complementary (semantic, hermeneutic) approach is emphasized together with the need to correlate the use and social significance of nosologic and therapeutic ritual categories with present cultural changes.

INTRODUCTION

During several missions to the high Dogon plateau in Mali (Beneduce, 1988; 1989; 1995), I studied the prevalence of mental disorders in the population of the geographical area which constitutes the Fifth Region. I was particularly concerned with cultural representations of illness and with local healing systems.[1] One of the particular aims of the Regional Center of Traditional Medicine (hereafter TMRC) where this research was carried out, was to analyze the populations' recourse to traditional medicine and to explore local medical resources (healers' knowledge of medicinal plants, possibility of producing "better traditional drugs," implementation of a complementary model of mental health care, etc.) (Coppo, Pisani & Keita, 1992; Beneduce & Koumare, 1993). Consequently, I worked with traditional healers in the treatment of mental disorders and analyzed certain local nosologic categories. This analysis comprised the first steps towards interpreting the system within which mental diseases are represented, identified and treated.

Although different ethnic groups are present in the region, the Dogon make up almost 90-95% of the population in rural area (the other groups are represented by Peul, Bozo, Songhay, Sarakole, etc.), and 75% in the semi-urban area of Bandiagara. The representations and the categories analyzed, in spite of numerous lexical contamina-

tions (because of the many Dogon dialects: Tomo Kan, Donno So, Toro So, Bondu So, etc.) and the cultural aspects, influenced in particular by the Bambara and Arab cultures, are still relatively original in character; therefore, we will refer primarily to data and materials of the "Dogon culture." In the following paragraphs I shall consider four aspects in particular: (1) the cognitive-symbolic structure of Dogon medicine and its basic characteristics (types of healers, some nosological categories of mental disorders, and causal models); (2) the principal expressions used by patients to communicate their experience of illness; (3) the problems of metaphors involving the body in the language of patients suffering mental disorders, the importance of their accurate study for transcultural psychiatry, and a critique of psychosomatic interpretations; (4) the "psychosocial relevance" of themes, myths and traditions which seem by now to have disappeared from common consciousness, but which are ardent in the symbolic networks underlying notions of mental illness. These aspects will be considered in the light of cultural dynamics and the dialectic between change and stability in Dogon medicine.

Research on the protagonists and categories of a medical system, especially if addressed to defining possible strategies of interaction between the conventional medical system and the traditional system of healing, must necessarily analyze carefully the dynamics, changes, and new elaborations which characterize the use of concepts (etiological interpretations, representations of the illness, references to traditions) as well as concrete health-care behaviors. Ethnographic analysis thus must precede clinical or epidemiological study.

At this point a digression on the status of ethnographic research among the Dogon is necessary. In a recent article, Van Beek (1991) criticized many of the interpretations and conclusions Marcel Griaule made in his famous (and much discussed) *Dieu d'eau*. Van Beek, (1991) along with many Dogon, had trouble retracing even a minimal part of what Griaule claimed he had found fifty years ago. This does not necessarily mean that "the Dogon of Van Beek" are more real than "the Dogon of Griaule." Apart from some ethnographic disagreements, the most decisive criticism of Griaule's work has come, in my opinion, from Leiris in *L'Afrique Fantôme* (1934) criticizing the methodology and ethics of a study in which information and materials were, on occasion, literally "extorted" from the population.

Van Beek's criticism invokes a realistic conception of culture, particularly in the idea that more or less legitimate testimonies of it exist. This view, however, reproduces a homogenous and compact image of culture that in the end disregards the significant changes and contradictions that characterize all traditional communities and societies, even the Dogon who have had relative stability and impermeability to external influences. Moreover, a body of recent research has cast light on the profound transformations taking place in traditional medical systems in the region, where syncretisms, overlappings and changes articulate the complex relationship between stability and change. As illustrations, it is enough to mention the significance of "cultural resistance" in rituals of possession in relation to the colonization of the Songhay of Niger (Stoller, 1989) or the specialization of gender in some traditional therapies in Morocco brought out by Bakker (1992).

In the work I conducted on the high plateau of Bandiagara and in some of the villages of the plain (not on the cliff sites chosen by Griaule and Van Beek), I found support for quite a few classical ethnographic observations but at the same time found no trace of others. For example, the notion of "force" (*nyama*), which Van Beek had a hard time tracing, was frequently utilized in the explanatory models of the traditional healers and patients we met. This same concept is used, among others, to explain the negative influence emanating from women who have died in pregnancy (referred to below in the *yapilu* category). I do not feel that this is a contradiction (as Geertz (1973) writes, coherence belongs to ethnographic research, not to cultures), if we keep in mind the misunderstandings created by the use of the term "traditional," and especially, if we are inclined to consistently review ethnographic sources and evidence, as is done in other historical research.[2] A theme that may not be relevant today to the Dogon religion may demonstrate significant relevance to other contemporary expressions of this culture, at other "levels of symbolization" (Obeyesekere, 1990), or in particular strategies of reworking individual and collective experiences such as therapeutic rituals for mental disorders. To speak of relevance does not necessarily mean to speak of *awareness* by all the members of a given culture. Cultural dynamics form an extremely complex theoretical problem; thus, the expression "among the Dogon" used here, is just a way of saying where one has worked, without any pretense to describe what the Dogon, in their totality, think or do in relation to a

particular problem ("mental" illness in this case; the quotation marks are apt, if we keep in mind the different meanings this term has in the medical systems considered here and in Western psychology).

Method

Information concerning local nosologic categories was obtained primarily from three sources: (1) healers previously counted in a census; (2) patients coming for clinical consultations at the TMRC clinic; and (3) other privileged sources of information for a more in-depth investigation of certain particular aspects. Healers were interviewed mainly in the villages where they lived or where they practiced their therapeutic work (including Bandiagara, Bodio, Dukombo, Tegouru, Aougine, Nandoli and Ningari) and a record was made of their type of training (apprenticeship in the family or with a healer, revelation, etc.), their religion, the illnesses they treated, the most prevalently used therapies. In some cases they were interviewed during meetings of the Association of Traditional Therapists, founded in 1991, which were held periodically at the TRMC in Bandiagara. The loosely structured interviews were always conducted in the presence of interpreters who had specific competence in local medical systems. In one case, the interpreter was also training to become a health worker. The recorded and transcribed interviews were generally cross checked by a second interpreter to reduce possible misunderstandings and errors.

Consultations were carried out at the TMRC and also intended for the preliminary study of the *gamma* representations (a local nosologic category close to the vast group of rheumatic or parasitic articular diseases) (Coppo, Fiore, Koné, 1990) and of *tibu sugo* (epilepsy: in this case the research preceded the setting up of a program which took charge of epileptic patients in the Bandiagara district) (Beneduce, Fiore, Salamanta, 1990). For patients with epilepsy, a different clinical file was used from that for those with mental disorders. During visits with patients or their families, questions were asked to learn the names of the illness in the local tongues, the traditional etiologies indicated by the healers or by the family members, and the type of therapy.

Patients with mental disorders, came not only from the Fifth (Mopti) Region but from others as well and, in some cases, from bordering states. The cases we considered are a heterogenous sample in which we analyzed the reoccurrence of certain factors, themes and ex-

pressions related during the visit. A parallel study dealt with the administration of the SRQ and PSE to another sample of patients. (cf., Carta, Coppo & Mounkoro, 1992; Koumare, Diaoure & Miquel-Garcia, 1992). Another chapter of the research, as yet not completed, concerned the ethnobotanic identification of the plants containing psychotropic substances that make up part of the therapist's prescriptions.

The most prevalent language is *Donno So*; we will point out when terms belong to other dialects or languages, in particular *Fulfulde* (Peul language) and *Bamanan* (Bambara language).[3]

DIVINERS, TRADITIONAL HEALERS AND NOSOLOGIC CATEGORIES

In whatever form the diviners intervene, they play a key role and participate actively throughout the healing system (diagnosis of the disease, identification of its causes and of healers able to treat it, prescriptions of the preliminary sacrifices to be carried out, etc.). Divination represents a special moment in traditional therapies, conferring unity to its different phases and permitting the jump from commonsense explanations offered by patients' kin to the interpretation of the "disorder ideology" which is used by healers and diviners. The role of divination goes well beyond the domain of illness or therapy. Divination also constitutes a complex strategy of re-elaborating the meaning of events for the individual no less than for his group (a "*machine à penser*," according to the apt expression coined by Adler and Zempleni (1972) for Moundang divination in Chad). The divination procedures as a whole function as strategies of control of the aleatory or threatening dimension of the events through a body of prescriptions (precautions to take before undertaking a journey or a new activity, sacrifices to make to avoid bad consequences), whose logic is comparable in some cases to that of "speech acts" (Austin, 1962; Searle, 1969).

The general term used to indicate diviners is *almaga kanne* "those who do divination." *Nummo gendun* refers to those who read "look at hands," *yanga yeru vèlè* to those who interpret dreams, while *kele manjin* is the term used for diviners who "shake the cowry-shells" using these shells to foresee the future and for the other operations mentioned above. This is the most ancient form of divination according to an elder healer from the Nantana village.

There are other forms of divination found throughout the region. The most celebrated is the pale fox divination (*yurugu kundune*, "those

who put questions to the fox"), while the term *wanu-sidu* generically defines the different forms of geomancy. Other types of diviners are those who foretell events simply through sight (*ku mai yeene*), those who speak with the departed souls (*dege-dege kundun*) or who recognize the future through particular images made by leaves placed on the surface of water in a bowl (*di-dandun*). Calame-Griaule (1965), subdivides the forms of divination into those in which knowledge is extracted by the same diviner (forms often practiced by the priests and similar to prophecy) and those in which some type of "support" is necessary: for example, cowry-shells, pale foxes (the most frequent), dreams, earth. Geomantic techniques require a long learning process and are not without risk as they involve a domain (knowledge of the future) that is not considered human.

Healers frequently turn to diviners, especially when the disease is difficult to treat or for indications of sacrifices to be carried out. Sometimes it is the therapist who attends a divination session to learn if his patient will pay the agreed price for the treatments that will be administered or to learn if the spirits that have provoked the disease are willing to leave the patient's body. When this is the case the function of divination partly changes from deciphering the nature or cause of a disease to what the future holds for the therapist and to the actions he will undertake.

Regarding the interpretation of causes (in the wider sense of the term), the etiology of "consequences" and the etiology of "conjunctions" (according to the terms proposed by Vandermeersch, 1974) generally exist side by side. Each interpretive reference offered by the diviners or therapists can only be understood if placed in relationship to the particular conditions in which it is enunciated and in the interpersonal context to which it refers. Even in Dogon medicine, Zempleni's (1969) observation of the traditional medical systems in Senegal is true. "The system of interpretation provides a common language for the therapist, the patient and the family, through which the collectivity apprehends the pathological experience, takes charge and manipulates it. In the end, the process of interpretation begun in this way *necessarily* moves toward the cure, the sick person powerfully aided in mastering the idiosyncrasies of his illness experience" (emphasis added).[4] Today, on the other hand, in Mali as elsewhere, increasingly

rapid and complex social-cultural changes have diminished the social relevance and therapeutic power of diviners' interpretations.

In the region where this research was carried out, the practices and reference systems used by different types of healers and herbalists are, in most cases, still firmly anchored to animist traditions. *Djon-djongonon* is the term that literally means 'he who gives remedies, he who treats.' The healers, sometimes alone, at times assisted by a family member, gather the medicinal plants needed to prepare the different remedies for the patients with knowledge acquired through the family, another therapist or a "revelation." The name *Binu,* is used to identify those who received this knowledge in a state of possession and who for the rest of their lives—often with some resistance because of the many prohibitions they must respect—carry out particular social and religious functions. When they are possessed (a trance-like state similar to that characterizing their initial revelation experience), they run into the bush, foaming at the mouth, overcome by convulsions, going toward the secret place where the "fetish-objects" or sacred stones (*dugoy*) were left by another priest or by a healer of the same family.[5]

The villagers' perceptions of the healer carry the ambivalence common toward someone who must interact with negative forces and unknown spirits, a blend of fear and respect. This ambivalence grows stronger as the diseases treated by the healer become more dangerous, since "the science of remedies is also the science of poisons" (Calame-Griaule, 1965). Some healers also carry out particular social tasks, for example, as a member of the category of "impure men" *inne puru*, the only ones able to come in contact with impure and contaminated substances, such as particular types of cadavers or menstruating women.

Along with these healers, there is a growing number of Muslim religious healers known by the French term *marabout* or *morune* (a term derived from the contamination of the Bamanan expression *Mori*). It is to the marabout that one generally goes for the treatment of ailments that are not "sent from God," that is those whose origins are believed to be "supernatural" (sorcery, witchcraft). The marabouts deal mostly with such problems as sterility, impotence, repeated abortions, epilepsy and insanity. The marabouts' therapeutic practices frequently demonstrate elements of contamination and complex syncretisms: for example, the prescription of sacrifices or the use of vegetable remedies. Among the forms of therapy they employ, we observed fumigation and

the use of holy water (*nasi*), sprayed into the orifices of the patient's head because it is believed that the spirits responsible for the disease enter through the nose, ear or mouth. Most frequently, we observed the preparation of amulets with verses of the Koran written on papers that are soaked in water that the patient then uses to wash in or drinks.[6] The unanimously acknowledged "theoretical" flexibility of the healer is reflected in the extreme eclecticism that often characterizes the attitudes of the patients, whose own health care behavior is not "coherent." As other works have documented in patient health care behaviour (Fassin, 1992), the only logic is the search for a cure or some type of relief. With regard to this problem, Jong de Joop (1987, p. 30) writes: "When an individual is confronted with suffering, he may proceed to one or to several of the health sectors. Within these sectors there are *different interpretations reflecting different systems of meanings and norms*" (emphasis added).

Clinical histories showed that individuals made recourse to different health sectors and to different therapeutical figures, each one referring to a particular system of symbolic references and therapeutic strategies. In a series of 52 cases, the pattern of health care seeking was: traditional treatment once 36%, traditional treatment several times 31%, modern medicine 7.8%, modern and traditional treatments 4.7%, self care or family treatment 1.6%, and no treatment 19%. Among the cases we observed, there were some failures.

Case A

Adraman K., a 30-year old farmer whose "character changed" after an accident in Ivory Coast. When he returned home he became aggressive, attacked relatives and neighbors for no reason and said "crazy things." He ate alone because he was sick and weak. Before coming to the TMRC in Bandiagara, he had been taken to a marabout in Wori with whom he stayed for about two years, but the marabout's treatment was unsuccessful. He then went to Douentza to see a healer for one year who treated him with fumigation but again there was no improvement. Finally, he went to a *féticheur* in the province of Koro and stayed with him for eighteen months, but again the treatments failed.

CASE B

Hambara S., a 28-year old tailor, had experienced panic during the night about ten years earlier while he was in the capital Bamako. He could not stop trembling and after a few days became feverish. Subsequently he suffered frequent episodes of panic and would run for no reason as though he were fleeing. He became aggressive with his family who reported he "makes strange gestures when he speaks." They took him to Sinanko, to a marabout with whom he stayed a few days. The marabout wrote verses from the Koran on some pieces of paper. These were dipped in water and soaked three times a day. He washed himself with the residue every evening. After an initial improvement, his problems returned and his mother took him to Aougine, a fairly isolated village famous for its healers. The patient stayed there fifteen days and was subject to fumigations and washing. The symptoms disappeared but after about two years they returned. The patient was taken back to the first marabout, whose treatments brought satisfactory improvement for a few months, but after a year the situation was once again serious. He then went to another healer near Koma but after the first failures returned to his village where he heard about our Center.

In general, the choice of one or another form of medicine or healer, seems little influenced by the patient's education and schooling (Coppo, Pisani & Keita, 1992). In the case of mental disorders, self- or family-care is almost never a choice in the locally-conceived hierarchies of resort (Beneduce & Koumare, 1989).

It is therefore difficult and perhaps useless to make a rigid classification of healers and practices that demonstrate surprising elasticity, even when referring to the discrete but constant influence of biomedical models. Biomedical models appear in the rare but significant use of stethoscopes and also in conventional drugs used by some healers (personal observations in the village of Birimburo, May 1989) and in the attempt to "adapt" local interpretations of the illnesses and symptoms to biomedical diagnostic criteria—at times resorting to expressions and metaphors in which it is also possible to identify the effects of colonial language. This last aspect suggests caution in the systematic application of the "emic" category to the descriptions and accounts of medical systems by healers and other privileged sources of information. The development of local associations of therapists and

in general "the professionalization of traditional medicine," contribute to these complex transformations.[7]

The traditional categories of mental disorders demonstrate a certain instability, and perhaps it would be more useful to speak of "units of representation" rather than of pure nosological categories in the sense that biomedicine gives to this term, keeping in mind the wide use of preferential connections which are never established definitively between causes, symptoms and disease. We need to remember that if verbal transmission is advantageous from a mnemotechnical point of view, when an oral account of etiologic notions is resorted to, the inevitable effect will be the high "particularization" and "personalization" of this degree of etiological knowledge (Zempleni, 1985). On the other hand, outside a mechanistic conception of disease, the classifications and interpretations of disorders respond to changing needs, so that a pathologic entity or its onset can be identified and explained according to particular circumstances, social context or individual history. As Good (1977) wrote in his studies on the semantics of disease in Iranian culture, syndromes and symptoms run together and the meaning of disease in folk concepts forms a "semantic network" in which the relational and affective aspects, and cognitive and experiential data are intertwined.

We have listed below a few of the terms currently used to denote the principal forms of mental disorders treated by healer specialists. The use of the term "specialist" must, however, allow for a *symbolic nexus* based on etiology: this explains why those who treat madness often treat leprosy, or why therapists who deal with epilepsy are generally those who treat sterility and impotence. Mental illness is, in any case, identified by behavioral signs and symptoms easily perceived in relation to a culture by their divergence from tradition and social norms (for example, among the expressions frequently used to describe abnormal behavior are phrases such as "he does not pray regularly any more," "he talks loudly even when speaking to elders," "he is always alone and refuses to be with others of his own age group"). To these we must add the physical and behavioral signs identified and diagnosed only by healers in the earlier, less noticeable stage of the illness. Nosological categories and interpretative patterns consistently reveal, not only in the case of mental disorders, a *humoral* model of illness. In the case of epilepsy, the convulsion was explained by a traditional healer

from the village of Sadiabrassouro as a consequence of the accumulation in the lungs of a liquid normally present in the intestine; drooling from the mouth during the crisis is caused by the anomalous circulation of this liquid. The illness called *gamma* spreads through the *kazu* (term which indicates the veins, nerves, and articular tendons) throughout the entire organism, "eating away" the bones, "biting" the flesh, causing pain and in some cases immobility or more serious complications.

Traditional healers frequently use dual classifications: a particular illness can be defined as feminine or masculine, cold or hot, wet or dry, in reference to its progress and seriousness as well as to the particular expressions of symptoms. Some of these dual classifications are applied to other areas (in botany, for example, in relation to the variety of plants to be used as a remedy; or relative to food and drink) and are part of the common lexicon. In the following paragraphs we examine some of the expressions frequently used by patients to describe their symptoms.

A. Forms of Madness. *Kéké, wéze, cice*, or *wede* are the terms in different Dogon dialects that refer to madness, the serious behavioral disorders that, when past a certain threshold and prolonged over time, frequently bring on the marginalization of the patient (*wéze* also has among its meanings 'to tear', 'to rend'). Almost all healers identify at least two forms of madness: "cold" and "hot." The first (*cice ton*, 'uncertain' or 'insidious' madness) groups such symptoms as behavioral inhibitions, groundless crying, insomnia, not fulfilling tasks expected of one's social role (for women: not caring for children and the home; for men: refusing to work in the field, etc.). These tend to be symptoms in which the onset is generally described as gradual. According to a healer in the village of Ama, in this type of illness, the afflicted person may even give the impression of being in good health; illness would be identified mainly by the following behavioral traits: "the patient lowers his head when he meets others, he laughs without reason, is absent. It is difficult to recognize at an early stage and not everyone is in agreement as to its cause. For some it is provoked by *jinns*, for others by a *dabali* (sorcerer), still others say that it is *ejere* ('wind'). The patient can accept work if it is offered. For the most part he is calm, although a second later he can attack the people that are near him and then become spontaneously calm again."

Contrary to this first form, in *cice ban* ('red madness, hot'), patients are described as aggressive, "having eyes injected with blood, laughing

and singing in a loud voice, spitting continuously. They may take off or rip their clothes, express incoherent proposals or say incomprehensible things."

These two forms of madness sometimes have connotations of feminine (or 'sweet,' *wede sinye*, in Tommo So) and masculine. Almost all the therapists interviewed agreed that the first form, although less disturbing from the viewpoint of social conduct, is in any case: it is worse more difficult to treat and can more easily evolve towards the total deterioration of the intellect (*hakilé*: "spirit, mind").

B. Wind and Bush. The term "wind" is an etiologic-nosologic concept found in many cultures of West Africa. In Donno So it is *djede*, in Tomo-kan *ejere*, in Bamanan *finye*, in Fulfulde *hendu*. 'Wind' is often given a causal role in common ailments such as measles or meningitis, and in their transmission (wind is an empirical fact confirmed in the case of meningitis, which peaks in the months when the Harmattan blows); 'wind' is also another name for smallpox. The word covers an extremely broad area of complex symptoms and diseases, among which are mental disorders ("wind" is also considered a synonym of madness). An encounter with a whirl of dust and wind, interpreted as a sign of the presence of a jinn or demon, is often cited as the first episode of stupefaction, fright, or panicky terror, marking the onset of the more serious forms of madness (*kinde kindu mara boli* literally means 'the soul leaves and gets lost").

Some healers have attributed completely different symptoms to this category, such as sudden falling, loss of strength, paralysis of a limb. From a semantic and symbolic point of view, the category is partially assimilable to another term frequently used with double etiologic-nosologic meaning, that is 'bush' (*ogulu*): "the bush (*olu*) is the source of all strength and wisdom, feared for its unpredictability but needed for a constant flow of energy and knowledge into the village" (Van Beek, 1991, p. 146). It is not rare for the patient's kin to use the native term *ogulu* to indicate both the disease and the cause, and use finally the words *ogulu belem* ('people, spirits from the bush') to specify the spirits that inhabiting the bush and believed to cause the disease (*wéze ogulu belem*, 'madness caused by the people from the bush'). Equivalent terms in Bamanan and in Fulfulde are respectively *kungo bana* ('disease of the bush') and *laddé* ('savanna'). Bisilliat's (1981-1982) observation on the nosologic classifications of Songhay is appropriate in

our case too, although to a lesser extent; for the Songhay, the term "bush" sanctions the separation between the space inhabited by the village, controlled by man and under his laws and the mysterious space of the untilled, unknown territory of the savanna, inhabited by beings who are potentially present although they may not be immediately perceived: a place where a different logic prevails, the dominion of spirits and jinns, where man is forever exposed to the unexpected. In this particular condition of psychological risk, there may easily occur what, to borrow an expression from De Martino (1948, 1959) might be defined as "the crisis of presence," or the individual's vacillation and inability to make choices, decisions and direct his or her actions. In these circumstances at one extreme there may be a manifest state of stupor and hebetude or at the other terror and panic.

C. Yapilu. The term, *yapilu*, literally meaning "white woman" in Donno So, is translated by Kervran (1982) as "hysteria" ("*yapilin*, hystérie, esprit qui est censé donner cette maladie"), but this translation seems inappropriate to us because it restricts a complex, heterogeneous system of meanings in Dogon myths and beliefs to a single Western psychiatric category. This word has been used by some healers to refer to patients, for the most part females, who present complex symptomatology (refusal to eat, refusal to nurse and care for their children, incoherent language, confabulation or *wo so sade*, apathy, etc.) that could, in some cases, be assimilated to a form of puerperal psychosis. But a conventional psychiatric diagnosis is still a long way from clarifying the meaning evoked by this word, rooted in the customs that regulate the behavior to be followed when a pregnant woman dies.

Yapilu is a nosologic category and at the same time an interpretation that gives sense to very different kinds of events (individual or collective ones, such as crop infertility, and drought). There is an evident tie linking the spheres of reproduction, fertility and death, as the death of a pregnant woman or the sterility of a woman constitute a serious threat to the community as a whole. These problems have another indirect expression in the "ritual of foulness," that concerns barren women, or women who give birth to stillborns. During this ritual, members of the association *ana-mondyù-gin* ("people who make foul things": Kervran, 1982) represent in ritualized form a sort of reversed social order.

When a woman dies during an abortion, a pregnancy or just before giving birth to a baby, "the vital breath separated too abruptly from the body can never join those of the other dead..., then "the *yapilu* will pursue living beings, above all women and children, with its hate and jealousy" (Paulme, 1940, pp. 531-532). No one can take possession of the objects belonging to these women without incurring grave consequences (madness, death) and only a particular group of people, holders of the homonymous "fetish-object," are authorized to take care of the body of the deceased (rituals concerning the cleansing of the cadaver, prayers, burial after extracting the fetus which will then be buried separately, etc.).

Putting together different testimony, the *causal agent* (who? or what?) directly responsible for the *yapilu* disease, would be the *yàma* (vital force, energy)[8] of the objects belonging to the deceased, the soul which has returned among the living or, depending on the case, the fetish offended because of broken taboos related to it. The *mechanical cause* (how?) responsible for the various disturbances is represented by the effects of the evil action produced by contact with these negative forces (contamination, loss of equilibrium among the various components of the person); finally, the *original cause* (why?) is represented by the transgression of the norms that regulate the burial of women who have died in particular circumstances.

In the interpretation we were given by an informant, the name of the disease is derived from the hallucinatory image that obsessively appears to the patients: that of a procession of women dressed in white. According to Paulme (1940) the term originated from the custom of covering the body of the dead pregnant woman with a white shroud (and not, as is their habit, white and blue), while according to a traditional healer of Bandiagara, the term derives from the pallor of the patient ("spirits drink her blood and she becomes more and more pale"). Other sources have also stated that entombment takes place preferably inside hollow logs or in a crevice in the rocks and not in direct contact with the earth, to avoid risks of contamination and crop infertility.

For the treatment of this disorder, only healers who possess the corresponding "fetish" (*tooroun*) or "object" (*gèli*) can intervene with some probability of success, restoring the social order and group equilibrium through complex sacrifices. In another Dogon dialect, Tomo-So,

the "fetish-object" is called *i-nanbé*, or "the mothers of children": this is probably an example of symbolic inversion, since this fetish-object[9] and the therapeutic power that emanates from it, has, as its realm of action, dead *women* who have not actually *given birth* and postpartum mothers who, among their symptoms, fail to take care of their offspring. In some of the interpretations offered by those interviewed, there was a relationship between the idea of contamination, the individual disease and the possibility of transmitting these pathogenic forces via the family. The husband of the deceased is labeled *iri kejene*, "he who cuts the breast" ("to cut the breast" is a courteous linguistic form, an euphemism to say "rape a woman." *yanu*): only after having raped a woman in the bush and having "transferred the disease into her body" can he return to the village and find a new wife (Beneduce, 1995). Similar information can be found in other research (Dieterlen, 1941).

Calame-Griaule (1965) proposes a complex, suggestive interpretation of this sexual violence: an expression of "social egoism" that would drive the dead woman's husband to transfer the negative forces inside himself to a woman who is a stranger to the group (almost always a Peul woman). Calame-Griaule interprets the act of violence and the ritual that accompanies it as the equivalent of the original act of incest between the earth and the fox narrated in Dogon mythology.

D. Tibu sugo. Although this term refers to epilepsy, we mention it for its relationship to mental illness. Prognostically, because it is believed that if the ailment is not properly treated it leads to a true form of madness. Symbolically, because epilepsy, together with madness and leprosy (*neme*, often defined as "the great disease"), is one of the "bad diseases" (*lulo paze*) that socially stigmatize and marginalize those affected. Among the causes invoked to explain the occurrence of *tibu sugo* are those that refer to madness: bush spirits, sorcerers, poisoning, transgressions by patients ("he has killed and eaten a crocodile, his totem animal," said of a patient by a family member). Not by chance do healers also deal with *tibu sugo* and *neme* when treating mental illness.

Epilepsy, as research in other countries has also documented (Jong de Joop, 1986-1987), is generally identified with remarkable diagnostic precision both by the healers and the lay person and it is easily differentiated from other convulsive syndromes such as fevers, frequent in infancy, that are called *yanga saza* or "bird of the night" (*foondu* in Fulfulde, *kono* in Bamanan). In this case, the name refers to etiology, since

"the bird of the night," according to many of the people interviewed, is directly responsible for the convulsions and their complications in children. A zoological identification is possible with an owl, but a strict identification is not very significant from an anthropological point of view because many of our interlocutors say they have only heard about it.

Tibu sugo, literally 'fall like a rock,' is held to be highly contagious by a large part of the population, above all in its "feminine or humid" form (as in other African cultures, the means of contamination is identified by the foaming at the mouth during a crisis: Beiser, Burr, Ravel, Collomb, 1973). In Fulfulde and Bamanan other types of descriptive denominations are used that refer to a different symptom (*kiri kiri* and *kiri kiri mashjen*, literally meaning "tremble"). Because of the contagiousness and seriousness of the illness, patients affected by *tibu sugo* are often kept hidden by their families. They may lose their jobs, be abandoned by their spouses or live isolated from the rest of the family in shame (Beneduce, Fiore, Salamanta, 1990; Uchôa, Corin, Bibeau & Koumare, 1993).

The causes of these disorders are generally attributed to the supernatural. For this type of etiology we can identify three principal groups: (1) witchcraft and sorcery; (2) collective spirits (inhabitants of the rivers, earth, savanna or "people of the bush," such as *Andoumboulun, Yeban, Meleka*; "people or genies of the waters," such as *Nommo*, rarely so indicated and instead designated with substitutive names); (3) spirits of the Islamic tradition (demons or *seytané, jinns*).

With some exception, the description of physical and behavioral characteristics of the entities belonging to the last two groups does not differ significantly from that of our interviews nor from those reported by other authors. Both the healer and the diviner may refer to one or the other of these categories, citing the disease whose meaning is first agreed to. It is a matter of consensus between healer and patient or group which is used by healers in their work of "symbolic manipulation" to ensure possibilities of success. Encounters with demons or casual meetings with annoyed spirits are the most frequently reported causes.

Together, spirits, jinns or witchcraft contribute to the structure of local paradigms of suffering, or the particular ways in which mental disorder is produced, described, interpreted and treated. References to spirits of Dogon or traditional Islamic culture reflect, even at this level,

the (often contradictory) interlacing of rhetorical strategies and different symbolic universes. We can safely surmise that the frequency with which supernatural and magical causes are invoked in the interpretation of mental disorders is also related to the presence of new mechanisms of social control replacing the traditional ones. If transgression of prohibitions and taboos is important in explaining the illness, in many cases this represents the space in which the significance of individual deviant behavior and gender conflicts can be "renegotiated" with respect to the group.

In rare cases, patients offer an explanation that explicitly invokes a magical action brought on by other people. To assume that an act of witchcraft or sorcery is the origin of the disorder is a morally charged interpretation that risks creating tension and bad feelings within the group. The terms generally used are *dùgo* ("to poison," "to make witchcraft," eventually carried out by sorcerers); *dabali* or *dabile*, *koumo* (literally meaning "hand"). These are part of many other diagnoses healers or diviners reach after one or more sessions of divination. In our experience, it is rare for ancestors to be cited as responsible for the onset of the illness even though they may have exercised more than a marginal role in the past in many areas of community and social life (for example, division of territory and choice of names).

Other causes, which in any case do not exclude the preceding ones, are attributed to episodes of great fear (*nè* in Donno So, *siran* in Bamanan) or true panic occurring for example after an encounter with jinns or terrifying dreams, the stress of migration and the frequent use of drugs that have "destroyed the brain" (*bondu yamade*), insomnia (reported by many patients as the cause of the mental disease and as a symptom without distinguishing between the two). Hypotheses by patients and their families on the causes of mental illness do not seem significantly influenced by social status or education.

Naturally, a magical origin is attributed to other diseases such as the disease called *yanga ken*, literally meaning 'arrow in the night,' whose recurring symptom is the presence of an abscess, a phlegmon or a fistula, localized for the most part on the neck or head, on the arm or a lower limb. In this case, millet stems thrown by the aggressor-sorcerer at the victim or a spell left on the road traveled by the victim would cause the disease. The significance of the night, as a time of pre-

cariousness, fragility and prohibition finds indirect confirmation in its appearance in the nosologic categories (e.g., *yanga ken, yanga saza*).

Despite the fact that the individual patients belonged to different cultures, in the region where we worked, explanatory models of the disturbances referred to a similar array of causes, with relatively few intercultural differences. For example, at the TMRC, the Peul patients (belonging to a population of nomadic shepherds that travel great distances and move every day in impervious, solitary spaces), more often than Dogon patients cited the "bush" or encounters with "genies" as among the causes of their diseases.

Illness Worlds

In this section we shall review some of the expressions most often used by patients when speaking about their symptoms. Linguistic analysis reveals a complexity in expressions that definitely refutes the claims made by the "evolutionary model" of mental illness. According to this model, in many traditional cultures the vocabulary used to express a difficult experience is "poorer" and lacking in the terms that are abundant in the psychological lexicon of Western cultures. This was assumed to have been particularly true in African cultures and justified claims that depressive experiences were uncommon. (Green, 1914; Littlewood & Lipsedge, 1989).

In the case of depression, the lack of an equivalent term in the traditional nosologic systems was considered by some authors to be evidence of the lack of a corresponding concept, a supposition that has been abandoned.[10] In any case, the opposite tendency to unify very heterogeneous experiences, behaviors and disturbances in the same psychiatric category ("depression") seems no less problematic (see Kleinman 1986; Kleinman & Good 1984).

The terms used by patients are constructed and communicated within the semantic networks characteristic of their culture, but reveal at times a mixture of different languages and dialects in their search for the most meaningful or "pertinent" expression. Culture is a process characterized by linguistic exchanges and metaphoric drift. The analysis that follows of certain terms and expressions concerning the components of a person, mental disorders, or more general experiences of stress, takes into account, however, the limitations of past studies of ethnomedicine, and the risks of reification due to excessive emphasis

on the "ostensive" value of terms for disturbances and illnesses in other cultures (Good & Del Vecchio Good, 1982). It seems appropriate to place our description of illness terms in the context of a brief summary of concepts of the person in Dogon culture, as well as some of the expressions most frequently used by patients in referring to suffering. Concepts of the person and their components offer the necessary background to terms that not only designate, but confirm and legitimate various types of experience as "disorders." In other words, in regards to the functioning of the person and its components, there is no knowledge of what is "normal" that precedes knowledge of what is "pathological": the logical relationship between the two is generally circular.

It is only within broad discursive contexts that individual terms used by patients acquire significance, a significance that is constantly shaped in the process of narrating and re-elaborating experiences of illness. This not-always-conscious process aims to communicate in a way that not only satisfies the patient and his or her entourage but also all those concerned with the problems involved. This contextual approach may reduce (but certainly not eliminate) the many problems involved in translating complex terms from one language to another. For further views on this subject, see the interesting study by Hallen and Sodipo (1986).

According to Dogon representations, the fundamental components of the person are:

(1) The "body" in its properly physical dimension (*gozu*), with its organs and functions; some organs are involved in particular activities (memory, language and communication, intelligence) and so they have a strong symbolic value: heart, head, supraclavicular space, etcetera.

(2) The "vital force," the individual's power (*nyama*). This component is present in inanimate objects, plants, and also animals, it has ambivalent properties and plays an important role in magic rituals, witchcraft, therapeutic abilities, healing practices and diseases.

(3) The "double," or the shadow (k*inde kindu* or *kikinu*; *mbeelu* in Fulfulde), that is present at the birth. Griaule (1938) and Dieterlen (1941) defined these principles "souls," but the term is too "meaning-laden" and we prefer to avoid it.

According to classical researches of French anthropologists, k*inde kindu* or *kikinu* are described in Dogon culture as eight different principles ("le terme *kikinu* ... est une contraction de l'expression *kindu*

kindu désignant le principe directeur de la personne. Cette répétition n'est pas fortuite; elle exprime l'existence dans l'être humain de couples d'«âmes», l'une mâle et l'autre femelle..." (Dieterlen, 1981, p. 206). However, the informants and healers we interviewed on these problems did not speak of eight "souls" but only of a *double principle*: a) the shadow and b) the essential, spiritual quality of a person (that abandons him or her a short time before the death; see also Coppo, 1993). *Kindu kindu* is generally invisible, and only some individuals can perceive it.

The term *kinde* is clearly *polysemic* and indicates the heart, the liver and in some cases the organs contained in the rib cage (above all the lungs), but the term also has another meaning which refers to: the heart and the brain (*ku bondu*) as the places of the spirit, vital principle, affectivity and language.

The term "memory" is generally expressed by *mandigu-pala* (literally meaning "long thought"), but the same expression also indicates reasoning or thought: m*andigu-sen* and *mandigu-pazé* stand respectively for "good reasoning" and "incoherent, confused or bad reasoning." In the Dogon language, if it is hard to understand what a person is thinking or feeling, an expression such as *inde kinde ne soto inde yaga igi bibelele* ("that which is inside a person, others cannot know") can be used, whereas the term that gives a sense of innerness or centre is *kinde*, at times substituted by *kolo* (which means both "empty" and "internal").

Hakilé or *yiru* are the "spirit" or the "mind" in their more cognitive meanings. They refer to psychic functions as a whole (memory, intelligence, etc.) that have their place in the brain and characterize each individual. Both *kinde kindu* and *hakilé* play an important role in dreams. These terms can be found in phrases such as "be careful" (*hakilé kana*), while a more general meaning would be *kazaba* "to watch over something" or "pay attention to something." The term *hakilé* is much more often used in a series of expressions concerning the more serious forms of mental illness, such as *hakilé wili* "high spirit," "mixed or confused mind," etc., that want to avoid the use of the terms *kéké* or *wedé*, which are more stigmatizing from a social point of view. A parallel use regards the terms "head," *ku* and "brain," *bondu* ("high head" or *ku ingili*, "overturned head" or *ku bilyade*, "overturned brain" or *bondu bilyade*, etc.).

In Donno So, the loss of general interest or loss of a taste for life, is indicated by the term *kindé woine mai sele le won* ('My heart is disgusted with everything'). A dubious state of great uncertainty is expressed by "*kinde lei lei*" (literally "heart two two," or double heart, or to be two things, in two different states at the same time); two patients who presented serious obsessive-type disorders used this phrasing to describe their experiences. Similar linguistic solutions are present in both Bamanan and Fulfulde (*hakili fila fila*, "intellect, spirit, two two," to have the mind, the intellect suspended between two contradictory states).

The term used to indicate a state of worry is *àlmi*; when the state of unrestfulness exceeds a certain level you can say *ku-kommu* ('tied head' or 'to have a fixed idea,' a preoccupation that keeps you from doing anything else). A sad state, which is not particularly worrisome is indicated by the term *kinde yayade* "heart that cries," while a state of real anguish can be expressed by the preceding term but more strongly by *kinde yamu* "destroyed, ruined heart." The Bamanan equivalent, also sometimes used by patients whose mother tongue is Donno So or Fulfulde, is *kamanagwan* (Koumare & Coudray, 1989, unpublished paper), a state of profound inner tension in which the person has lost his or her points of reference, feels unable to find a solution alone and implicitly asks for help (a less serious state of doubt and uncertainty is *konona fili*, innerness is in fact *kono*, while *fili* means "error, mistake").

Dusukasi, "heart that cries," is a Bamanan expression used to indicate states of sadness or mild melancholy that are not particularly serious. Anxiety associated with the sensation of heart palpitations—again in Bamanan—has its onomatopoeic expression in *dusukun pan pan* "heart that beats." If, instead, anxiety (*diatige*, "broken, cut shadow") exceeds a certain threshold becoming pathological, it is termed "disease" *diatige bana* (in Bamanan the three components of the person are the body, *fari*, the double or shadow, *dia* and the soul or spirit, *ni*). A state of serious depression, the refusal to live that could reach suicidal tendencies was expressed by a Bambara patient, hospitalized in the psychiatric division of the "Point G" Hospital in Bamako, by the term *ni ma danga* "that my soul be cursed."

The wealth of expressions we have only partially and briefly cited and used here to describe experiences of anxiety, sadness, pathological uncertainty and unrestfulness, demonstrates the still largely

unexplored complex semantics of illness (and in particular of mental disorders) in these cultures in which there seems to be no clear separation between the "psychological lexicon" and the "somatic lexicon" of suffering. In particular, these data question the conclusions of those who have sustained that the experiences and expressions that referred primarily to the body were consistent with an elevated incidence of "psychosomatic" disorders considered *typical* of traditional and rural cultures such as the one the patients we interviewed came from. To date, we have not been able to verify this correlation in our research.

In my opinion this misunderstanding also derives from the conflation of expressions referring to the body as the *only* code of expression with symptoms referred to as the *sole* problems which patients are able to express adequately. This conflation forgets, however, that the body represents an appropriate "idiom" to describe the illness and constitutes *per se* an infinite and generally effective (since shared) reserve of metaphors, that it is in other words and at the same time "matière et forme du symbolisme" (Augé, 1988). Finally, if expressions and terms recurring in the patients' accounts are somatic, it should also be underlined how this applies in particular to those parts and organs that possess emotional symbolic resonance ("heart that cries," "cut shadow," "tied head," "overturned head," etc.).[11]

It can be speculated that the lack of knowledge of local languages, the well-known problem of "metaphorical non-equivalence" and the attempt to adapt different models and experiences of illness and healing to codes of expression of Western culture (cognitive *vs* emotional, psychological *vs* somatic) have had an important role in determining similar conclusions (Lutz, 1984; Pandolfi, 1992; Sharp, 1994). The recognition of the symbolic and communicative value of disorders therefore, requires a methodology that permits understanding the data and experiences in their full significance.

On the other hand, we must admit that recourse to expressions that refer to somatic symptoms—or if you prefer to a sort of sophisticated phenomenology of the body—is very frequent. Patients with psychiatric disorders whom we visited in the Bandiagara district often reported symptoms such as paresthesia, sensations of "living things" or "animate things," that move within the body, (localized to the abdomen, throat, head or eyes), disturbing perceptions in the nostrils or ears "of things that want to enter," "hot body," headaches, and asthenia.

Before hastily reaching a "psychosomatic" interpretation of the referred symptoms, we should also consider the frequent presence of organic disorders and parasitic diseases in the population (malaria, schistoso maiasis, oncocercosis, etc.). These endemic diseases partially explain some of the types of symptoms and the common linguistic expressions used to speak of one's health problems.

Although too small a sample to be representative, it is worth mentioning that in a group of 62 patients visited at the TMRC between December 1992 and March 1993 for mental disorders, clinical and laboratory data confirmed a diagnosis of parasitosis or other concomitant infections (that were for the most part "Sexually Transmitted Diseases) in 43% of the patients. A nosologic category of Bambara medicine, *mara*, usually translated and treated by health workers as "oncocercosis," is used by the population and traditional healers as a diagnosis for a number of behavioral disorders. Research on the subject, conducted at the Psychiatric Division of Point G hospital in the capital, found that more than 30% of the patients diagnosed as afflicted with *mara* actually presented oncocercosis. Similar observations had already been made many years before during another study conducted in Nigeria by Leighton and colleagues (1963). These data partly confirm what Fabrega (1974) has described as the methodological distortions brought about by a "mentalist" approach in ethnomedicine, an approach bound "to obscure the influences that biological components have on illnesses."

A very important aspect for us concerned how patients narrated their story of problems and ailments. It was evident that tiredness, pain, itchiness, fever, insomnia, fright, distress, the sense of inadequacy with regard to social tasks and expectations of the group (which includes such problems such as sterility or "brain fag syndrome") are felt in their *interaction* and are therefore perceived as an indistinct state of discomfort and suffering. As expressions of different disorders in the *same* person, these different aspects can be experienced as a single story identified, described and interpreted (both by the patient and healers) in a discourse in which the ranking of health problems and their interrelationships are radically different from those characteristic of biomedical language or psychological idioms.

In these "explanatory models," that do not make use of the mind/body dichotomy, even the "time" of a symptom or a disease is narrated

according to a non-Cartesian logic. Different symptoms can be connected in a continuum, the construction of which sorely tries the anamnestic criteria used by biomedicine. For example, one patient described a foot injury, that occurred while cutting wood many years before as the beginning of the ailments that brought him to the TMRC for problems currently defined as "psychiatric."

Another consequence of this fluctuation in how the syndromes and symptoms are correlated is as follows: when transcribing interviews with therapists, even with the same therapists, contradictions are not infrequent, making the construction of a taxonomy or traditional nosologic "system" often artificial (if not impossible). These contradictions also demonstrate the difficulty of adapting knowledge rooted in the oral tradition to the written word.

CONCLUSION

With reference to some of our introductory observations we would like to underline how certain themes, though perhaps not discernible in classical ethnographical analysis, persist at different imaginary levels and reappear in daily life. For example, in the interpretation of the causes of an illness offered by healers and diviners, in the content of a hallucination or in the way some patients associate the beginning of their illness with the transgression of rules or values that are meaningful from a cultural point of view (the symbolic meaning of twins, or the role given to *yama* of objects belonging to a dead woman to explain the insurgence of *yapilu*, to name a few of the themes whose importance, according to Van Beek (1991), would not in fact correspond to the Dogon culture described by Griaule (1938)).[12] These connections have been found in the stories of quite a few patients and can reveal the "hidden" network of explanatory models that give meaning to suffering and illness.

This hidden level, explored and knowingly manipulated by the healer, is significant for the effectiveness of traditional therapies. It is evoked through the gestures, metaphors and symbols that characterize therapeutic rituals.[13] For example, the case of *yapilu*, symptomatology observed prevalently in puerperal women, implies the need for a traditional animist ritual (the practice of burying the fetus separately from the mother) that Islam is eliminating and also recalls the history of the exodus of the Dogon population when healers from Mandé brought

the *yapilu* fetish with them, establishing the law that ruled the burial and the circulation of the goods of women who died in pregnancy. At the same time, through the particular interpretation of the sickness, a name given to the *illness*, the sufferer is provided with a meaning and given reassurance, the therapeutic power of medicinal plants can be "activated" by the "fetish-object," and finally, a reason is found for community problems and hidden conflicts (gender, social and other).

In shaping affective and emotional experiences as well as behavior patterns and norms, the social-cultural context creates a singular congruency between itself and the experience of individuals. Geertz (1973, p. 108), described this congruence as an "aura of factuality." Leach (1984, p. 444), in turn, alludes to it when he says that "most human beings, most of the time, act as if (cultures) were real"; for La Barre (cit. in Stein, 1990, p. 88) this congruence is proof of how "in the reverberant nature of the social animal it is impossible to see where culture ends and character begins." In the course of social, religious and economic change, when a belief or a particular cultural representation partially or totally loses the proper aura of factuality, behavioral disorders create a sort of "idiosyncratic field" where those representations can take form again. Migration, in particular, plays a key role in making earlier reference systems unstable.

Only an adequate methodology can shed light on such connections. As Good and Del Vecchio/Good (1982) propose, a "meaning-centered approach" helps to explore the symbolic and phenomenological structure of illness experience and the way in which events of illness find their particular affective resonance in individuals and groups.

The analysis of how nosologic categories (or better, units of representations or "noxemes"[14]) are woven into representations of disease sheds light on the limits of the concept of culture-bound syndromes (Simons, 1985). This perspective looks more to context than to categories and understands the distinctive "cultural" aspects of disorders and syndromes not in their specific symptoms but rather in the meanings built around them and communicated within the different *Lebenformen* (Wittgenstein, 1953), that is, in connections among individual experience, biological and environmental factors, myths and symbols that belong to a certain cultural group. To cite Low (1985) when we speak of "bush," *yapilu*, "wind" and other terms, we are faced with "culturally interpreted symptoms" or, in other words, with a context of

culturally defined meanings and strategies, that enable people to interpret and control psychophysiological and pathological processes. This view, among other things, enables us to understand better the influence that cultural and social transformations have on the semantic and symbolic structure of these categories and practices, that is the dialectic between change and stability in their meaning, as no different from what happens in the evolution biomedical systems of knowledge.

NOTES

1. The Regional Center of Traditional Medicine began its activity in Bandiagara in 1987. The census of traditional therapeutic activity, clinical consultations of patients affected with epilepsy and mental disorders and, collaboration with healers, were among its first objectives. Subsequently, local traditional therapeutic associations were promoted, a multi-complementary system was elaborated to take on psychiatric patients, and the activity of gathering and storing medicinal plants began along with the production of six "better traditional drugs" (Médicaments Traditionnels Améliorés), which were then introduced to the national pharmacopeia. Presently new ethnobotanical and ethnomedical research is underway, together with regular collaboration with the healers and support of local medical resources. Since 1994, economic support of these activities by the Italian program for cooperation and development has been temporarily suspended.
2. We are evidently before "cultural constructs" which, while today less widespread and less influential in Dogon society, have not for this reason exhausted their "psychosocial relevance" (see: Sachdev, 1989) for similar considerations on Maori society). These aspects have been emphasized by Obeyesekere in regards to religious texts in India: "Meanings are sometimes inaccessible or unknown to the specialists. I have often interviewed priests and exorcists who were excellent *performers*, but I got no exegesis on the names of deities, places, and so forth mentioned in some of their religious texts. I think this is a phenomenon of all ancient traditions: names of places, persons, and deities are mentioned, but they have ceased to have relevance for contemporary religion. Hidden meanings are only too common in ethnographic texts, but their existence is rarely conceded by us." (Obeyesekere, 1990, pp. 221-222).
3. For typographical reasons we have simplified the local terms, putting them in script; in general when an "e" or "o" is underlined, they are pronounced as an open vowel and an underlined "n" takes the place of a nasal ng sound; to simplify the text, indication of the particular Dogon dialect in which terms and phrases are expressed has been occasionally omitted. A linguis-

tic revision of the Dogon and Fulfulde terms found in this work is still in process.

4. "Le système d'intérpretation fournit un langage commun au thérapeute, au patient et à la famille, langage grâce auquel la collectivité compènétre l'expérience pathologique, la prend en charge et la manipule. Enfin, le procès d'intérpretation ainsi inauguré conduit nécessairement vers la cure un malade puissamment aidé à surmonter l'idiosyncrasie de son expérience morbide." (Zempleni, 1969, p. 192)
5. The description of this possession corresponds fairly closely with the myth of Binu Serou, the totemic ancestor who, according to the myth, was the first and only person to perceive and understand the importance of the word pronounced by Nommo divinity. Nommo was the first mythic being (Griaule, 1938, p. 157), "feared as none other, commanding open water (not rain)" (Van Beek, 1991, p. 146).
6. "Although not all marabouts, especially not those who have specialized in legal or theological studies, practice the manufacture of charms—or will easily admit that they practice the lore of amulet-making as part of a marabout's training. After his Qur'anic education, a marabout gathers the required knowledge by studying with one or more elder marabouts and by self-study of imported, published books on magic, and, if a tradition of marabouts exists in his family, of an inherited, handwritten collection of notes and instructions in this field" (Mommersteeg, 1988, p. 501).
7. During one of the meetings of the Association of Traditional Therapists of Bandiagara (1992), there was a lively debate among some of the healers, with one of them proposing to identify the illness called *gamma* as nothing more than an expression of what we doctors called high-blood pressure. In the course of the discussion (exemplary of the new elaboration and structuring of an area of knowledge once it begins to become professionalized), this therapist stated that he himself had been healed only after he had been treated with drugs appropriate for this illness. Other healers objected to this equivalence, with some bitterness; they insisted that *gamma* was characterized by quite different symptoms and that this illness had existed among them long before the "white doctors" came.
8. For the *nyama* or *yama* notion, see Griaule (1938), De Ganay (1941) and Calame-Griaule (1965). Its translation by a single concept is impossible: Ambivalence, mobility, quantitative unsteadiness, and possibility of transmission, represent its fundamental characters. Its importance in the origin of diseases is often underlined by the healers we encountered.
9. Relative to the use of the term fetish, see De Surgy (1985).
10. "The fact that a disease term may be a good indicator of underlying folk concepts does not justify the inference that the lack of a particular term indicates the absence of a corresponding concept" (White, 1982).
11. "Inasmuch as bodily experiences are understood through the social categories that establish them as "natural" symbols...both psychologization

and somatization can be conceived as cultural constructions of psychobiological processes... Counter to the established views of Western mental health professionals, from the cross-cultural perspective it is not somatization in China (or in the West) but psychologization in the West that is unusual and requires explanation" (Kleinman, 1986, p. 56).

12. A patient accompanied to the TMRC in the summer of '89, and subsequently treated successfully by a healer from the village of Bodio, was terrorized by having involuntarily stepped on and killed a snake in Ivory Cost where he had been working. We then learned that the patient came from a cliff village where there was a strong conviction that the python or "big snake" (*yùguru nà*) is the form manifested by a mythical ancestor. See Bouju (1984, p.33 & 229).
13. The analysis of symbolic efficacy and the interpretation of therapeutic powers (that is to say the transformative effects) of the metaphors in traditional therapies, beyond the psychophysiological parallels highlighted by other authors (Bibeau, 1983; Laderman, 1987; Sherzer, 1983), should consider the Wittgensteinian notion of "perspicuous representations" (*Übersichtliche Darstellung*) another theoretical wedge of great importance. Perspicuous representations are those that "mediate comprehension, that consist in fact in 'seeing the connections'" (Wittgenstein, 1967) which involves the process of "finding and inventing intermediate members" (Wittgenstein, 1953, p. 122). (The second citation includes the fundamental term "invention": the therapeutic metaphor actually works when inventing intermediate "rings" or images, showing connections). On the relationship between metaphor, symbolic efficacy and therapy, note particularly Kirmayer (1993).
14. *Noxemes* are "dynamic aggregates of illness representations, etiologic axes and therapeutic models that show a relative constancy even in different geographical and cultural areas" (Beneduce, 1991, p. 19).

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