PSYCHIATRY AND THE PENC: COSMOPOLITANISM, ‘MEDICOSCAPES’, AND FAITH
AT CLINIQUE MOUSSA DIOP, DAKAR, SENEGAL

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Dedication

In gratitude to my Lord, Karin, Jean, and Tennyson.
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acknowledgements</td>
<td>iv</td>
</tr>
<tr>
<td>Abstract</td>
<td>vi</td>
</tr>
<tr>
<td>Introduction</td>
<td>1</td>
</tr>
<tr>
<td>Dakarois Psychiatry, Clinique Moussa Diop, and Emerging 'Medicoscapes'</td>
<td>65</td>
</tr>
<tr>
<td>Chapter One</td>
<td>101</td>
</tr>
<tr>
<td>Inclusiveness, Silence and Apoliticism: Global/Local Interpretations of Sufi Islam at Clinique Moussa Diop</td>
<td>136</td>
</tr>
<tr>
<td>Chapter Three</td>
<td>180</td>
</tr>
<tr>
<td>Staff Meetings (La Reunion), Consultations &amp; Other Performances of Professionalism</td>
<td>232</td>
</tr>
<tr>
<td>Chapter Four</td>
<td></td>
</tr>
<tr>
<td>The Medicoscape as ‘My Brother’s Keeper’</td>
<td></td>
</tr>
<tr>
<td>Conclusion</td>
<td></td>
</tr>
<tr>
<td>Anthropology and Psychiatry: Conflicted and Cooperative Bedfellows or The Penc and Models of Oscillation in Global Relationships</td>
<td>241</td>
</tr>
<tr>
<td>Bibliography</td>
<td>241</td>
</tr>
</tbody>
</table>
Acknowledgements

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Abstract

In the age of Doctors Without Borders, the Bill and Melinda Gates Foundation, and other organizations engaged in the fight against illnesses in a global context, the case of Clinique Moussa Diop is of remarkable significance, because it makes psychiatry, a local practice into an international approach. Clinique Moussa Diop is a psychiatric facility tucked away in a corner nearest the morgue and mosque on the grounds of Fann Hospital located in Dakar, Senegal. From Djibouti to the Ukraine, the clinicians working and being trained at this clinic hail from many different parts of the world. They are united by a commitment to the psychopharmacological biomedical model that as it flows globally forms a ‘medicoscape’. They are also implicated in an Islamic ethos articulated on a sign at a fork in the road leading to the clinic that reads: “Every man is his brother’s keeper.” How are we to understand these studies in inclusive oppositions (Beck 2006)? This dissertation investigates the question is this clinic a cosmopolitan space precisely because it brings together these oppositions? The oppositions – faith and science; the Koranic injunction on the sign in a 94% Muslim country with 7 doctors for every 100,000 people; and ultimately the presence of international players in such a national space—are at base constructions of the cosmopolitan conundrum of how to relate the universal and the particular. That conundrum opposes universal, Enlightenment ideals of individualism, -- psychopharmacology—with particularity, local Sufi collectivist ideals, epitomized by the prayers offered during the bi-weekly group therapy session known as the penc. Ultimately, the dissertation argues that the opposition found in the clinicians’ use of psychopharmacology and the Islamic penc form a false binary. I employ subsequently a biological metaphor as borrowed
from Jean-Loup Amselle, writing in *Mestizo Logics* (1998), and argue that, “the relationship between these elements, must not be conceptualized in terms of oppositions and cleavages, but rather in terms of oscillation… of multi-belongingness.” It is in terms of this multi-belongingness that I discerned the subject positions of the clinicians as couched in terms of global ideals of professionalism. The current medicoscape, was defined by the doctors’ adherence to these globally ratified professional ideals such as using the DSM-IV. At the same time they prayed during the *penc* group therapy sessions. Rather than view the clinicians according to the false binary of Muslim versus scientist, my data revealed them to be *professionals* united by an ethos of multi-belongingness. Their response to this oscillation gave the project its ethnographic purchase. Describing this multi-belongingness revealed the manner in which the clinic was at once a cosmopolitan space and yet consistently superseded current definitions of that term.
Introduction

Dakarois Psychiatry, Clinique Moussa Diop, and Emerging ‘Medicoscapes’

Clinique Moussa Diop is a psychiatric facility tucked away in a corner nearest the morgue and mosque on the grounds of Fann Hospital. This teaching hospital, located in the Fann-Hock region of the city of Dakar, faces Rue Cheikh Anta Diop, a commercial strip replete with restaurants such as the French-inspired La Provencale and nightspots such as the American-inspired Just for You discotheque. Moreover, the street is covered in make-shift stalls that sell everything from still-warm, recently roasted peanuts to fresh produce. These stalls are manned by itinerant merchants who are for the most part Senegalese. There are multi-colored stalls —in varying structural condition—bustling with activity ringing a rectangular space that forms the entrance to the hospital complex. This space is also full of taxis and taxi drivers leaning casually waiting for their next fare; there is the noise of patients and their family members soliciting taxis to travel to various parts of the city. The din is augmented by the sound of voices issuing from the stalls speaking loudly in Arabic, Wolof, the lingua franca of Senegal, and in French, the country’s official language. The Arabic is spoken by the Lebanese, Moroccan, and Algerian merchants who own most of these stalls at the entrance. These men can be seen milling around on a typical morning dressed in grey, white, and black traditional Muslim robes or boubous. Their attire blends in becoming unremarkable with the appearance of the patients many of whom are in more casual ‘Western’ attire: Adidas tennis shoes, Sebago deck shoes, jeans and miniskirts; contrasting strikingly with the high fashion dresses with modishly pointed shoes that the older women wear accompanying ill family members or children to the clinic. Peppering the
whole scene are the grey uniforms with Roman collars of the nuns that can be seen coming and going throughout the hospital complex and entering for work on a typical morning.

The clinic itself is situated to the right of a fork in the main road in which the taxis jockey for position. At this fork in the road there is a sign that reads, “Tout homme est le gardien de son frère” which I translate as “Every man is his brother’s keeper.” The sign has resonances of the Bible’s Genesis 4 verse 9 in which the Lord asks Cain where his brother Abel is, and Cain responds, “I don’t know. Am I my brother’s keeper?” In an odd articulation of a Judeo-Christian precept, the powers-that-be at the hospital would seem to affirm that we are in fact called to care and watch-over our neighbors. What are we to make of all of these studies in contrasts? There is the commerciality of the street as contrasted with the non-commercial caregiving economy that defines a hospital; there are the contrasting languages; there are the contrasting clothes that speak to disparities in class/caste and age groupings; there is the presence of Roman Catholic nuns in a Sufi Muslim country; and there is the contrast of a Judeo-Christian sign implanted as the articulation of the reigning mission of a hospital that serves a patient population that is resolutely Muslim in a country of roughly 94% identifying as disciples or talibe in Wolof, of that faith. I would argue this is a cosmopolitan space given these “inclusive oppositions” as Ulrich Beck would define the term (see Giri 2006). My dissertation, then, pursues the descriptive claim that this is a cosmopolitan space. But I also seek to better define notions of cosmopolitanism by paying close attention to the debate in its study over universality and particularity. It is my contention that we can best view this complex problem by looking at the collectivist/individualist elements of therapy at the clinic. We will find that the interplay of the latter two elements of psychiatric therapy indicate that rather than forming a binary –on the one hand universalism and
on the other hand particularity—the two *oscillate* in terms that Amselle might use (see Amselle 1998).

In terms of describing the cosmopolitan nature of Clinique Moussa Diop we find that most of the clinicians, who are the focus of the dissertation, hail from various points on the globe, from the Ukraine to Djibouti; from France to in its not-so-distant past, the United States. What unifies these disparate points of derivation? Principally, the biomedical model where the latter is defined by a positivistic orientation to medicine. This orientation features the use of psychopharmacology, but additionally cutting-edge treatment modalities that employ the blended model of drugs and talk therapy that form the crux of psychiatric treatment on most wards in the world today. Again, we find a study in contrasts, however, because the use of talk therapy at the clinic, as found most notably in the use of a bi-weekly group therapy session known as the *penc*, sits at times comfortably, and at other times in a highly fraught relationship to the biomedical regimens, because it is cast as a Muslim event. Indeed, the story of the Sufi *marabout* or religious figure who leads the *penc* and his role as a former patient has a lot to tell us about the collusion or commingling of the biomedical with the spiritual. This *group* therapy is a study in contrasts as well because it also implicates individual-oriented practices. Because the *penc* has aspects that are collectivist in orientation such as the presence of family members during its proceedings we can again see the oscillation that forms the centerpiece of defining what cosmopolitanism might mean in a medical context in Senegal.

**Theoretical Orientation**

In an effort to characterize medical cosmopolitanism, I employ the work of Arjun Appadurai (1996) and his concept of –scapes to argue for global flows of medical epistemologies
such as biomedicine, its accompanying commitments to technologies that equally flow from one global spot to another, and its avenues for knowledge-production that find for example most of the clinic’s physicians doing a stint in France as part of their training. The term I come up with is medicoscapes to describe this global flow. The term is also used by Angelika Wolf et. al in 2003, but her use fails to address the mutual influence that indigeneity has had in dialogue with global, ‘modern’ medicine. In fact, as the clinic’s second-in-command told me the first day of my fieldwork, there is only modern medicine practiced at the clinic. This statement flies in the face of the clinic’s history since its inception in 1957 of using ethnographic techniques and at one point ethnographers to cull from the rural regions of the nation mental health practices that were unique to Senegal and had as their antecedents animistic, pre-Islamic practices. In other words, the clinic has a long history of incorporating practices in its treatment protocols, that were non-Western and as it was construed at the time, non-modern. How to explain the discrepancy in what really amounts to a recent development? I would argue this shift represents the incursion of a novel medicoscape. To be sure there have always been some form of global flows of medical knowledge but as Appadurai sees it these flows have accelerated and increased in uniformity in the post-colonial, globalized moment. Or have they? Would not a more apt characterization of the current global moment return us to a description of the cosmopolitan? In order to address that question then, I employ the term ‘medicoscapes’ as a descriptor for the operation of such international health-promoting bodies as WHO, the use in a psychiatric context of globally ratified diagnostic tools such as the DSM-IV and the ICD-10, and the increasing use of pharmaceuticals. But I extend my argument beyond this to employ the term cosmopolitanism to speak to a state-of-affairs that witnesses a diminution of the apparent antinomies between the global and the local, the modern and the traditional, and the scientific and the faith-based, in
favor of a biological model borrowed from Amselle (1998) that argues for “oscillation” between the supposed poles of these contrasting constructions of social life.

I have already alluded to the influence of Appadurai upon this work. His notion of –scapes allows me to participate in the broad-ranging discussion applied to globalization and theories of the ways that modernity and postmodernity can be construed in terms of interactions between subjects who come from different parts of the world. Most of the clinicians at Clinique Moussa Diop come from different places in the world. Because of this fact, I have deployed the notion of ‘medicoscapes’ to speak to those facets of medical knowledge-production that unite them and provide them with a common language. Appadurai’s notion of –scapes addresses this common language and the way that language manifests between their varying ways of taking up therapeutic challenges.

There is a problem that emerges in addressing the question of a common language. That problem is, how are we to analyze non-homogeneous settings? What are we to do when the people among whom we are doing research come from different places? The history of medical anthropology features the treatment of one locale or another. This work treats clinicians and patients as largely homogeneous. But in the case of Clinique Moussa Diop the clinicians came from different parts of the world. And though they were united by the biomedical model and in most cases by Islam, they also had very heterogeneous approaches to treating patients. Medicoscapes as a concept is designed to describe and theorize the interaction of this heterogeneity and homogeneity.

So it is that I am in dialogue with authors such as Angelika Wolf, Stefan Ecks, and Johannes Sommerfeld. In their chapter in Medical Anthropology: Local Anchorings, Global Definitions (Saillant & Genest 2005), entitled History and development of Medical Anthropology
in Germany, they speak in terms of ‘medicoscapes’. They define the term as, “landscapes of people and disperse organizations in the vast field of medicine, which self-constitutes in localities but which, at the same time, re-connects places, human beings, and the institutions of that field” (Wolf et. al 2005: 245). This dissertation employs this definition of medicoscapes but in an effort to argue for a more precise analysis of the ‘vast field of medicine’ by using a model of oscillation as found in the authors’ reference to “at the same time”. Because it is this constant tension and fluctuation; this give and pull between the local and the global that defines the international flavor of clinicians’ backgrounds and their heterogeneous relationship to models of therapy that are in biomedical literature thought to be universal. I am indebted to Amselle for this model of oscillation as a defining feature of social scientific knowledge-production.

Amselle in his text *Mestizo Logics: Anthropology of Identity in Africa and Elsewhere* describes an oscillatory model of social scientific analysis that borrows from biology. He argues that in anthropology we must begin to think “in terms of oscillation, of systole and diastole, of shrinkage and dilation, of multiple-belongingness” (Amselle 1998: xi). I appropriate Amselle’s biological metaphor to speak to the “multiple-belongingness” of the clinicians at Clinique Moussa Diop who belonged in a mixed-up fashion to medical regimes, to faith regimes such as Islam, and to research/training regimes. I describe this mixing. And medicoscapes as a term speaks to its international inflection and/or implications.

The dissertation traces this oscillation in an application of a methodology that itself posits conversations between actors as the space in which social life is realized. I conducted multiple hour long Hollan-esque person-centered interviews with the whole array of clinicians at Clinique Moussa Diop: psychiatrists, medical students, psychologists, social workers, and nurses, in a way that for its own part indicated a localized cosmopolitan economy of care. The evidence I
gathered led me to the conclusion that what was most unique about Clinique Moussa Diop and what tells a significant story for all psychiatric practitioners the world-over is the manner in which *spirituality* is defined at the Clinique. If we examine the role of nuns for example we find that the binary of Judeo-Christian and Muslim dissolves. We can speak then of a cosmopolitan approach to religion that features a constant negotiation of Christian and Muslim elements. This negotiation is defined in part by a commingling of these two faith systems a fact metonymically represented by the sign at the fork in the road on the hospital grounds. Collectivism in part becomes a stand-in for the commingling of faiths. But at the same time it indexes highly local understandings of the concept or ideal type. So, within a Dakarois, local context collectivism is construed in terms of the observance of the Muslim faith as members of one of the three Sufi Brotherhoods that so shape the sociopolitical landscape of Dakar. Collectivism is also defined in Senegal in terms of roles within the family. But given the sociopolitical precedent that those brotherhoods engender, the notions of spirituality as captured in Sufi practices at the clinic during the *penc* allowed me to engage with not just the history of colonial psychiatric practices, but also with the current political arena as well as the current international psychiatric scene. I tracked therefore back and forth between the local and global contexts finding repeatedly a quotidian negotiation of urban life that saw the clinicians and patients alike deriving meaning from both their faith in Allah and their faith in science. My oscillation as a participant/observer not only mirrored their own, but it allowed me to get a handle on the way that urban contexts in the postcolonial moment though frequently fraught are defined by “multi-belongingness” as Amselle says. And in fact the social scientific pursuit can only be successful to the extent that it fashions for itself a lexicon and vocabulary to speak to this mixing. That this implicates notions of the spiritual makes for an awkwardness in our analysis for those of us coming from Northern
or Western contexts, because most of us are not among the faithful. But the reality is the people among whom we study, the Senegalese, utilize faith as much as science to fashion meaning out of their lives. Moreover, they actively find ways to commingle the two, -- science and faith, Islam and Christianity—in an act of cosmopolitanism that is worthy of study, if only because, it helps us gain perspective on alternative sociality. The incorporation of the spiritual in our analysis of cosmopolitanism facilitates an engagement with the production of norms that makes psychiatry as a field of endeavor so fascinating. In some ways psychiatry is a process as much as a set of practices of de facto subject formation. In its study therefore one can see the most cherished values, norms, sanctions, prohibitions, and other defining features of culture as a much-cherished anthropological concept. And by examining the culture of Clinique Moussa Diop set as it is against a backdrop of global market relationships –those fresh air market stalls, taxis, restaurants, and discotheques—we can see meaning-making in situ. That this meaning making is defined by inclusive oppositions speaks both to the current global moment but also to the state of anthropology itself. We need a model for addressing the commingling of faith and science that the hospital sign that we are “our brother’s keeper” articulates and reminds. The commingling of faith and science cannot be understood without referencing notions of the collective and the individual, because both social constructs demand an engagement with the body as a physiological entity as well as a socioculturally mediated body of Islamic faithful. There are other permutations of the relationship between collectivism and individualism and their interplay. The most significant one was the relationship that the clinician drew between notions of the collective as the family and as the family of the three Sufi Islam brotherhoods as mixed with notions of the active personal agent or individual. The individual was conceived of largely in terms of French ideals of individualism, but also as a body that needed a medical intervention.
This latter meant the individual patient was seen as such because s/he needed drugs, whose employment while responsive to statistical trends nevertheless is tailored to each individual patient. It is the use of the doctors’ notions of the collective as pertaining to the family both extended and religious as well as the professional attitudes they formulate around ideals of treating each patient as a distinct person that inform the use of for example the *penc* in which again we see the interaction of both the collective and the individual. The use of these ideals sketches the contours of Dakarois psychiatry in its historical development during the years directly following the end of colonial rule. But the use of these ideals also gives shape to the contours of Dakarois psychiatry in the *postcolonial moment*. To be sure the concepts of individualism and collectivism had specific meanings for the clinicians.

**Collectivism and Individualism**

*Collectivism: The Family and the Sufi Islam Brotherhoods.*

The clinicians used the term ‘collectivité’ to refer to the presence of the family. They also used the term to signify upon the broader societal constraints that their patients experienced, principally in terms of Islamic observance. Chief among these social demands placed upon them as social agents was the mandate to have children. As we will see the notion of reproduction emerges in many contexts as a referent for social worth. It also indexes successful role-playing most especially in terms of gender. But to be sure, these demands were placed upon social actors principally in terms of observance of the tenets of Islam, which for my Senegalese interlocutors was understood in terms of Sufi Islam.
Therefore, when I use the term ‘collectivism’ I am referring to two groups: the family and the Sufi Islam Brotherhoods. ¹ Within the context of these two groups, there is a display of uniform, standardized practice to which social actors are expected to conform by conceding personal interests.

The aspect of conformity of my use of the term ‘collectivism’ is informed by Kernan and Greenfield’s notion of ‘group cohesion’. ² Speaking in the context of team building among girl basketball players in Los Angeles, the authors clarify my use of the term ‘collectivism’:

“…group cohesion should be a goal for which all team members are willing to sacrifice…”

Three crucial concepts are found here that inform my use of the idea of collectivism: first, the notion of group cohesion; and second, the notion of team; and finally, the ideal of sacrifice.

The concept of [1] group cohesion speaks to the uniformity, standardization, and conformity that allow the [2] team or group or organized body to elicit the [3] sacrifice of personal interests on the part of the individual. Group cohesion addresses the goal of the collective to cohere around ideals of ‘team playing’ and relinquishing of individuality. If collectivism is defined then in terms of adherence to the ideals of team playing and sacrifice how

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¹ These brotherhoods –the Mouridiyya, the Tijaniyya, and the Qadriyya— are highly unique to Senegal. I analyze them and their presence/absence in the penc and other clinical practice in chapter two.

² To be sure there have been recent challenges to the notion that the West is itself individualistic in orientation. But these studies such as Kernan & Greenfield’s Becoming a Team: Individualism, Collectivism, Ethnicity, and Group Socialization in Los Angeles Girls’ Basketball (2005) and Kusserow’s (1999) De-Homogenizing American Individualism: Socializing Hard and Soft Individualism in Manhattan and Queens both define the two terms in an American context. My use of the term of individualism therefore is I would argue consistent with the American literature on the topic. I refer the reader to these articles because they document the very interplay of which I am speaking: that between individualism and collectivism. Their arguments referencing ethnicity in the first article, and class in the second—expose the degree to which the urban landscape in the postcolonial moment is refracted through the lens of both individual expressiveness and collectivist ideals.

All of these rubrics for professionalism are themselves at once standardized and in the same instance highly personal from practitioner to practitioner. So, for example, doctors’ choices of when and how to apply certain diagnoses varies from practitioner to practitioner. Again, there is a negotiation between the collectivist ideals of the universal application of diagnostic criteria and their personal application by the psychiatrists.
are we to define the individuality that one is called upon to sacrifice? The sacrifice that I am talking about usually involves the social actor in Dakar giving up personal self-expression in the context of familial relationships and relationships between themselves as patients and their individual expressions of their faith. In other words when the clinicians used the term ‘collectivité’ they were referencing the norms of sacrifice of personal expression and desire for the broader good of the family and community of faithful. So, for example, the clinicians often encouraged the patients to have children as was expected of them both in terms of their family responsibilities but also in terms of their roles as Muslims. At the same time though the doctors made a point of telling patients to take their medications and to generally comply with treatment e.g. make it to their consultations, take appropriate doses, and follow-up with the clinician if there is a worsening of symptoms or the side-effects grow too extreme for functioning. But there was an additional feature to the individual responsibility patients were expected to take for their treatment. They were also expected to engage in those aspects of treatment that involved them in self-revelation. In other words they were expected to talk.

Individualism/Individualité

I use the term ‘individualism’ references this talking and speaks to an ethnographic observation that I made: On numerous occasions family members were silenced both during the penc and in consultations between patients and physicians. The clinician would say, “let him/her speak for themselves”. We see in this utterance two aspects of ‘individualism’ as I use it: personal independence and self-actualization.

To explain, when I use individualism, I am using it in the context of French ideals –which would I would argue inform any application of the notion in Senegal as a former French colony. These ideals saw a conflict between notions of individual-ism and individual-ity. As to the
former, in the 19th century, Steven Lukes clarifies, “individualism implied anarchy and social atomization” whereas “individualité implied personal independence and self-realization” (Lukes 1973: 8). So the most fruitful definition that can be applied to a clinical context is that of the French 19th century usage of the term individuality to speak to my observation that among the clinicians at Clinique Moussa Diop personal independence—the patients speaking within the context of family for themselves—all towards achieving their own sense of an ability or capacity to fully realize their full potential.

However, the interplay between the two ideas is present in the clinicians’ admonishment that I just mentioned. There are the patients who while encouraged to express themselves are also sent away or called away when that individual expression gets disruptive. As we see in the ethnographic instance, there are structural features designed to meet the needs of the patients and those designed to allow for a collective experience. On the one hand, the expression of individuality on the part of the patients is refracted through the lens of engagement with the collective context, i.e. patients are expected to negotiate their independence and self-actualization within the constraints of the presence of family members and the broader pence group. Again, we find the oscillation to which I have already referred.

The two terms of ‘individualism’ and ‘individuality’ as consistent with their development and deployment as concepts within French ideals of citizenship are presented in very present tense ways at the clinic. The fact that urban dwellers were given suffrage leads me to believe that during the colonial era the French ideals—circa the late 18th century after the French Revolution—of citizenship were present as local social coinage in Senegal as a French colony. It is however the much later use of ego-centered therapies that leads me to believe these ideas were/are present at the clinic. As we will see it is by recourse to notions of the ego that we see
both the concept of *personal independence* and *self-realization* at the clinic. These ideas were imported from France in part in terms of the colonial suffrage, I would argue. But also in the context of psychiatry via the presence of certain treatment modalities—such as Lacanian psychotherapy—that in their global sweep involved the very use of such terms as ‘ego’ to speak to the encouragement of expressions of self that are unique to each *individual*. The use of ideals of the ego are so ubiquitous on wards around the world as to form a sort of vernacular. This speaks to the influence of Freud on the science of psychotherapy. The training the doctors receive in Lacanian psychotherapy, while limited due to budget constraints (see Bullard 2005) speak to the use of ideals of ego-centered and therefore individualistically oriented psychiatric principles. We can see this most clearly in the context of a book entitled, *L’Oedipe Africain* in which the principles and concepts of Freudian psychoanalysis were applied to the Senegalese social context. The ideas of ego and the notion of family are interrogated in the book (Bullard 2005) by applying the Freudian concept of the Oedipal conflict to an African context. A foray into this conflict would carry us too far afield, but suffice it to say that it involves Freud’s concepts of relations between family members such that these become the major influences upon the emergent ego. I look more fully at the deployment and the influence of Freudian ideas upon the professionalism of the clinicians in Chapter Three. There we will see the presentation of these ideas that implicate the influence of the family nucleus on the emerging ego and the clinicians’ training in these very same concepts. We will see them in the context of the work of the neo-Freudian French psychoanalyst Lacan. Two points however need to be made at this juncture: first, Lacan himself was working through Freudian ideas about the family and its influence on the individual. Second, from a historical perspective, these ideas are representative of the early postcolonial psychiatry in Dakar certainly and represent the presence of
psychoanalytical precepts as garned from the authors psychologist Marie-Cecile Ortigues and her philosopher husband Edmond Ortigues both of whom were French expatriates. Working at Fann they applied such Freudian concepts as transference and ego to an African context in an effort to theorize the “cultural and universal dimensions to the psyche” (Bullard 2005: 171). The expression of the concepts of transference and ego by these French expatriates working at Fann Hospital during the earliest postcolonial years (1966) indicates that there were circulating ideas of psychoanalysis with its emphasis on treating the individual at the clinic. This book, L’Oedipe Africain, represents the currency of Freudian ideas of individuality during the early postcolonial/late colonial era, I would argue. And the exposure however brief to Lacanian, neo-Freudian concepts which I address in Chapter Three, represent the continuing influence of Freudian ideas about the development of the individual psyche. The other factor bearing upon the continuing European influence felt at the clinic that the Ortigues’ presence indexes is the presence of European interns. These young people most of whom are pre-baccalaureate students index the degree to which France and other European locales from whence most hailed continues to exert its influence upon the clinic. The ideas many of which are Freudian in orientation are present as personified in their participation in clinical training. Tracing the history of the presence of these ideas at the clinic takes us back to the early postcolonial years of the clinic. But they also reveal the influence of France upon the emerging science of psychiatry at Clinique Moussa Diop of Fann Hospital. The ideals of Freudian psychoanalysis can be seen as operative in the space between clinicians and patients. In other words they are revealed in the dialogue such as “let the patient speak” opening up between the clinicians and their patients. So it is that we can see the individualism of the clinicians as much as that of the patients in the interaction between patients and their doctors. The extent that each clinician was more or less committed to the use of these
ideals becomes a lens by which to view each clinician’s interpretation of Freud and his applicability to the patient in an act of professional interpretation of the psychiatric medicine in which they were being trained. The fact of the individual expression of clinicians’ attitudes towards their professional training loops back to our earlier discussion of the individual/collectivist interplay. It does because it reveals attitudes not just to the individual but also to the individual as s/he interacts with the family or as I have said, the collective. The point to be made at this point is that one of the central features of Dakarois psychiatry is again an interpretation of the family and its relationship to the ego or the individual’s expression of self. To be sure I conflate here the experience of the patients with that of the clinicians. In other words both clinicians and patients can be said to be individualistic. The notion of transference/countertransference allows me to make that assertion. The concept of transference and the process of transferring to the patient the clinician’s own experience of ego known as countertransference create the backdrop against which therapy progresses. In my efforts to characterize more fully the common experience –read: shared—experience of the therapeutic encounter, I want to better describe this interaction, in part because it was a central feature of the Ortigue’s application of the Freudian model and because it is a part of the clinicians’ vocabulary in speaking of their interactions with patients. The concepts of transference and countertransference are descriptors for the clinicians’ understanding of what goes on in therapy – both in terms of their self-expression and in terms of their apprehension of how their patients are experiencing their illnesses. Because of the presence of this discourse –that of the concepts of transference and countertransference—we can speak of the shared experience or those aspects of the therapeutic encounter that are at once common and in some respects divergent between clinicians and their patients. I likewise had a shared experience as an ethnographer living and
interacting in their midst. And it is because of this common experience that I can [a] address the emerging egos of the clinicians and [b] address my own ego commitments as an anthropologist. It is my argument here that the clinicians’ own experiences of their egos speak to their emerging individuality within the collective experience of the clinic and its encouragement of certain ideals of professionalism. So, how can we construct a model for this common experience that I call the *transferential economy*. I need therefore to answer that question to define transference/countertransference within the context of Freudian concepts of therapeutic encounters.

*Transference/Countertransference*

Throughout the dissertation I track from the argument that clinicians and patients share a common experience: that of an evolving individualism. The Freudian notion of transference and countertransference speak to this common experience by arguing that within the therapeutic dyad there are dynamics that implicate the clinician’s own perceptual and normative constructs just as much as the patients –although ideally these effects are minimized most frequently by the clinician’s own psychoanalysis. The professional ideal of transference and countertransference defines Freudian ego-centered therapeutic approaches. My term *transreferential economy* refers to both transference and countertransference. Transference is defined as the situation in psychotherapy in which patients project onto their analysts past circumstances found in relationships with powerful figures such as parents who shape the way that the *individual* emerges as an integrated ego.\(^3\) ‘Ego’ as I am using it refers simply to the unique sense of self. Countertransference refers to the clinician’s own projections of ‘ego’ onto the patient. The

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\(^3\) See Corsini & Wedding (1989:600) as an example of a definition of the concept in relationship to the nuclear family as found in Freud’s work. I am defining it in part within the specific context in which I saw it operating, that of the clinic.
transreferential economy is defined therefore as the interaction between the patient’s ego and the clinician’s. The two are intertwined. Because they are intertwined the clinician’s own sense of self is implicated in the therapeutic encounter just as much as the patient’s. These constructs were thought to be features of the clinician’s own familial experiences and they raised subsequently their own “issues” on the part of the clinician as s/he found their own self-narratives implicated and seen as perceptual frameworks for understanding the patient’s pathology. I give credence to the concept for two reasons: because the doctors spoke of it themselves and also I observed its operation among clinicians in terms of both their professional behavior towards patients, and additionally, in terms of their interpersonal behavior. So, for example, I had the following interaction with a clinician treating a patient who wanted to be called Martine Mendi.

The clinician whom I shall call Adil and who I describe later in this introduction, said she suffered from what he termed a “florid mania” (une manie majeure). His interactions with her were complex and frequently I would see her leave the consultation room, go and change clothes, and return during her sessions with Adil. During a session I witnessed she left the consulting chamber and returned in a formal boubou some fifteen minutes later interrupting his session with another patient with the words, “I’m ready” (je suis prêt). On many occasions I saw her following him around. Finally, I asked him one afternoon sitting with him casually in the consultation room about her and her treatment. He said on August 30, 2007:

A: Personally I think she is manic but at the same time a bit hysterical. Her case interested me a lot (m’intéresse beaucoup). In her gatherings with friends she is able to talk to her friends but with her mother she mixes things up (elle mélange); she speaks like a person with mental illness (une folle): with the family; with her mother…sometimes she is normal, but then she isn’t normal.
I: What do you mean by ‘normal?’

A: She is capable of discussing things without making any mistakes…

[At this point one of the nurses enters and she chimes in that Martine refuses to take her meds. She says to Adil that he is too easy on her (tu es un peu facile). Adil returns to the conversation after the nurse has left.

A: She has a lot, a lot of hysteria. It manifests in the family. There is a remorse that manifests: an unconscious conflict. The only way to treat it is to make that which is unconscious, conscious. This is done through discussion: but I am blocked (je suis bloqué). There has to be transference, countertransference; She wants me to be her husband (elle veut que je sois son mari). She wants to make love here; she doesn’t want me to talk to other women; she wants little gifts; if I talk to other women she becomes aggressive and she tries to hit them. But the countertransference is too massive. It frightens me (ça me donne peur) and so I don’t want to talk [to her] more. For me it is necessary to have a lot of patience. Today her mother asked me a question. She asked if her daughter was ever going to get well…We must help her mother. I listen, I observe: what is her problem. In the process of discussion she is asking something different entirely…she is saying, when she sees others are uncomfortable she gets uncomfortable. She tries to show she is not afraid. That’s why I say it’s hysteria.

In this passage we see many of the signal features of psychoanalysis of a Freudian bent. First, we find the concept of hysteria which Freud really set out to define and most especially in the Victorian era in terms of a gendered ‘reality’. Freud argued hysteria was by and large a woman’s ailment. Thus, Adil calling Martine hysterical directly implicates Freudian theories of the psyche and particularly as an expression of a highly gendered pathology. Hysteria is a reference to an illness that features a heavy dose of social disorientation caused by fear. So it is that Adil makes note of the social context: the ubiquitous family; but he also mentions her fear as caused by her unconscious remorse. These two are highly loaded with Freudian conceptions of the ego. First, the notion of remorse as causing hysteria is a classic Freudian construction of that pathology (see
Freud 1989: 762). And second the Freudian-defined concept of the *unconscious*. The remorse as Peter Gay’s edited volume of Freud’s papers (1989) comes loosely speaking from sublimated aggression within the nuclear family or triad of father/mother/child. The referencing of the *unconscious* remorse gives us two central tenets of Freudian ego-centered theorization: first, the notion that unconscious drives come from family history; second, the notion of aggression as *sublimated* remorse. This sublimation leads in women’s cases to hysteria as they deal with their aggression which becomes an over-compensation for the fear they have within the context of social situations. So for our purposes we can see very real indications that Freud is a part of Adil’s conceptual framework. But that is not all, of course because Adil also implicates himself within an economy of fear. He says he gets scared by the countertransference he experiences with Martine. In this instance he is using a colloquial understanding of transference that has grown in currency in Western clinical contexts. This understanding of the transreferential economy argues that transference/countertransference is really defined by the sexual ideations patients project onto their therapists (transference) as these ideations stem from unresolved sexual tensions within the family and coming from family history; and the sexual ideations that the clinicians themselves project onto their patients. We are left unclear as to whether Adil is acknowledging his own sexual responses to Martine and whether he thinks he shares them but what is clear is the degree to which his own understandings of transference as a concept mediate his apprehension of Martine’s illness as found within a familial and domestic sphere and economy: “she wants me to be her husband”, he claims. The central features of Freudian psychoanalysis are presented clearly in my conversation with Adil, then: the diagnosis of hysteria; remorse as related to aggression; the family system –her mother and even Adil’s
concern for her mother; and finally and for the purposes of this section of the introduction, the reference to the transferential economy.\(^4\)

So, Adil’s performance of professionalism i.e. his employment of Freudian theories speaks to both his ego in as much as it speaks to his interpretation of those theories as much as it speaks to the needs of the patient. So it is that in my analysis of the transreferential economy I can focus principally on the emergence of the practitioner’s ego as related to his use of ego centered therapies. We can therefore concentrate on the idiosyncratic presentation of self of the clinician and gain an understanding of the individualism present in the therapeutic encounter. But there is additionally a way that the clinicians operate as a collective that speaks to not just the emphasis placed upon individual approaches to the professional attitudes in which the clinicians are trained. We look at this collective in Chapter Three but I want to point out that these collective attitudes are shaped in the context of the emerging medicscape. The epistemological glue uniting this collective is the biomedical model.

*Biomedicine/Biomedical Model*

The biomedical model for its own part is scientifically-based. It employs the following aspects of science: pharmaceuticals, statisitical science in terms of its diagnostic tools the DSM-IV and the ICD-10, and cutting-edge technology including cell phones, laptops and PowerPoint. The scientific orientation of the biomedical model hinges upon treating the individual. But its use in a psychiatric context, is as I have said, combined with talk therapy. The combination of the science of the biomedical model along with talk therapy is the subject of Luhrmann’s *Of Two

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\(^4\) The transreferential economy implicates my role at the clinic, as well. Katherine Pratt Ewing. in her article, *Revealing and Concealing: Interpersonal Dynamics and the Negotiation of Identity in the Interview* (2006) calls for an anthropological methodology that is cognizant of the ethnographer’s own conceptual and explanatory model[s]. Accordingly, I sought to foster a certain reflexivity in my work.
Minds (2000) and provides a description of the American model of psychiatry that has heavily influenced psychiatric practice in other global contexts.\(^5\) It is the use of the blended model that forms the substance of the Senegalese engagement with Western models of treatment. So when I say biomedical model I am referencing this blended model.

**Sartorial Codes**

One aspect of the biomedical model is the advent of altered sartorial codes that accompanied a liberalization of psychiatry. This liberalization by which I am referencing a move away from long-term internment and asylum-based treatment, witnessed the gradual transition away from clothing habits such as the wearing of scrubs by clinicians on wards towards the wearing of clothes that were thought to reduce the inequities in roles played out on the ward. In other words, doctors and nurses began wearing clothes that rather than indicate their clinical stature, saw them instead wearing clothes that spoke to the equity of the clinical setting. Because anyone in the milieu could affect the kind of transformative moments that might bring healing it was though that clinicians should wear clothes that better approximated [a] the patients’ experience of the broader social context; and [b] the cooperative nature of treatment in which patients were empowered alongside their doctors and attending nurses to effect their own changes in condition. So sartorial—a big word in this case for ‘clothing’—codes speaks to the semiosis or symbolic language—hence ‘code’—that those clothes came to index. I refer to sartorial codes in terms of the concept of collectivist global expectations of how a clinician is supposed to present himself. I employ this term to address interpretations of their collective

\(^5\) See such articles as Locating HIV/AIDS and India: Cautionary Notes on the Globalization of Categories by Niranyan S. Karnik; The Anxieties of Globalization: Antidepressant Sales and Economic Crisis in Argentina (2004) as well as Diagnostic Liquidity: Mental Illness and the Global Trade in DNA both by Andrew Lakoff (2005); as well as The Efficacy of Traditional Medicine: Current Theoretical and Methodological Issues by James B. Waldram (2000) as examples of some of the issues raised by the ascendancy/maintenance of biomedicine in a global context among them American and other Western sites.
sense of professionalism. But additionally their approach to their expression of individuaity and therefore their personal independence as found within gestures of self-realization. This returns us to our earlier definitions of the terms ‘individuality’ and ‘individualism’. For we can identify through the use of these terms the interplay between the individual, presentations of self, alongside collective constraints such as ways of wearing clothes; and the way these behaviors and codes bring into relief issues of recognition and identification that I describe in terms of the transferential economy; and the way this is mediated by approaches to the biomedical model – which also can be seen in the clothes doctors wear among other aspects of clinical life—the way that the clinicians interact with the highly heterogeneous set of variables that shape not just their acts of professionalism but also their interactions with their patients.

In terms of interactions between clinicians and patients the principle focus of the dissertation is the group therapy session known as the penc and the way it mingles with ego-centered practices in a way that at once indexes global psychiatric trends as well as indexing highly local interpretations of those trends. We can broaden our perspective and see how a discussion of these interactions as occurring within the spaces of the penc gathering and the consultation chamber address current debates within theories generated around notions of cosmopolitanism. This discussion throughout the dissertation is designed to clarify what we might mean by universalism and particularism. Before we analyze these issues I want to turn to the penc itself as an entrée into a possible ethnographic setting for the development of ideals of collectivism and individualism that I am employing as a lens whereby to see the debates in cosmopolitan theory over the aforementioned universality and particularity.
The Penc

The 23rd of February, 2007. 11am. Clinique Moussa Diop, Dakar, Senegal. With sirens blaring in distant parts of the city, there are 12 men and 14 women who have gathered for an event. They are seated in a circle. Wearing a bright white traditional boubou contrasted with a black and white scarf, the leader of the event takes up his position on a prayer mat in the center of the circle. He places his hands in his lap, palms turned upwards, and fingering prayer beads, begins to pray. One can overhear the words, “O Allah Akbar.”

There is one psychiatrist present. He sits calmly looking on while all of the nurses and patients turn their palms upward and join in the prayer. Some of those present join hands. One man has a prayer book in his lap.

After he has prayed, the leader welcomes everyone who has come explaining he has been given permission by the Chief of Medicine to conduct this group therapy session known as the penc. He turns to me looking for greetings to the group. I greet the group and launch into my IRB script. After I am finished and am certain everyone has understood, the leader welcomes me. He turns to the physician looking for approval to begin the group. The leader begins by explaining the ground rules: everyone can speak when they are given their turn and people can leave the group, coming and going, when they wish. The leader encourages the participation of the patients’ family members who have accompanied the patients to the clinic for their hospitalizations.

Drums are brought out and there is singing and playing of the instruments. At some point a woman cries out seemingly unprovoked. With complete control of the group, the leader silences her and she eventually leaves. A man gives another man a newspaper which he begins to read as if completely oblivious of the purpose of the unfolding event. Perhaps in order to bring
the man back into participation, the leader crosses to the man and spits into his hands and touches the man’s head. The man remorseful begins to pay closer attention.

The leader says in Wolof, “tambali”: “let’s begin.” The doctor nods in assent. The leader throughout the event will glance in the direction of the doctor, as if seeking approval. In this respect, the doctor supervises the event. The doctor is clad in a white shirt, khaki trousers and Nike tennis shoes. He gestures for the leader to begin with the patient to his right.

After he has given his approval, the leader turns to the group and begins with the first patient seated to his right. He says, “why are you here?” The woman takes out a bag of something and begins to eat. Another patient, a man, gets very angry and attempts to smash his music device. He is called away from the group by his family accompanier. A woman enters. She mentions Wade, the President of the Republic. She turns to the leader, who says, “I am the President (jaraaf) of the penc.” and begins to talk to him. He interrupts her and he says he will explain what is going on with the patients in actuality. He says the patients must take their medications. The woman interrupts and says, “it’s the family. The medications (garab bi) do not work.” The sirens—sounds of the city—seem to blare even louder only this time they are joined by the sound of loud music as the leader turns to the next patient in the group and says, “No tudd”: “what’s your name?” As he initiates the conversation with this patient, another person leaves and two French interns enter.

The Muslim prayers; the capacity to come and go at free will; the presence of family members; the encouragement to take one’s medications; the observation that the medications do not work and that the actual problem is with the family: all speak to an interplay between elements of therapy that are designed to speak to individual concerns—such as the freedom to
come and go at will—and those meant to speak to the concerns of the family and the larger collective, such as the presence of the family members at the group, and the collective prayers. The interplay between the collectivist orientation of the group therapy and the individual expression that so characterizes its expression speak to a heterogeneity that I would call cosmopolitan. These elements seem to oscillate between individualism and collectivism in this description: the one ideal type informing the other from moment to moment.

The daily interaction between collectivism and individualism—separated for analytical purposes—is demonstrated in our vignette by the voicing of the leader that patients need to take their medications alongside the patient’s response that the illness was really an expression of problems within the family. In the context of the clinic’s daily operation ideals of the family emerge as a way of speaking to collective experience. Among the problems I found and which I demonstrate here were for example: sexual tensions; tensions over proper medication compliance; domestic violence and conflict; issues over how to properly allocate resources within the domestic economy, and so on. Given the woman’s pronouncement that it is really problems in the family and not the medications, we can see the tensions that expose debates within international psychiatry about the role of psychopharmacology and treatment modalities designed to meet the social issues in which illness manifests.⁶ Among the most consistently employed modalities is group therapy. The penc group therapy session held at Clinique Moussa Diop as I have described it is an example of one such modality. These modalities fall principally beneath the rubric of ‘traditional medicine.’ The literature in so-called transcultural psychiatry is

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⁶ See Kleinman (1980) for a discussion of the distinction between the social context for the emergence of sickness which he terms, ‘illness’ and the biological aspect of sickness which he terms ‘disease’. As to debates in international psychiatry over the use of social psychiatric interventions versus psychopharmacology the reader is referred to The Anxieties of Globalization: Antidepressant Sales & Economic Crisis in Argentina by Andrew Lakoff (2004) and Mental Health & Mental Illness: Out of the Closet? By Carol T. Mowbray & Mark C. Holter (2002).
replete with examples of the current use of traditional treatment modalities to treat social
illnesses. Let me consider one such intervention.

Clinique Moussa Diop’s progenitor, Henri Collomb used the work of the anthropologist
Andras Zempleni (1966) on the ancestral spirit worship complex of psychiatric treatment ndop,
to institute the presence of a marabout at the clinic. For many years—and in the current
moment—there is the presence of a traditional healer at the clinic and this innovation was
instituted during this era. More on Collomb later, but for now I want to provide this as an
example of an alternative modality that incorporated traditional elements to treat not just the
patient but the social context in which the patient experiences a sense of wholeness. This
complex features a ritual known as ndop which though in later years became a sort of popular
entertainment form, was marked by seven involved aspects of treatment. There was the
commencement in which the illness was identified during which also the ill person is led back to
the stage of an infant; the following moment in which the measures to be taken to alleviate the
illness are identified; next the naming of the ancestral spirit said to be plaguing the patient by
possession; the measures applied to place this invading spirit into a type of domestic altar; the
rebirth of the patient; the sacrifice to the spirit followed by a communal meal; and finally, the
construction of a domestic altar to propitiate the ancestral spirit at any given occasion that the
patient might deem necessary. These seven aspects of treatment became the grounds upon which
Collomb instituted a program in which spiritual leaders were brought to the clinic to assist in the
healing process. The signal feature of this intervention was the notion of the return to the
collective on the part of the patient. For example, Zempleni writes:

The illness, singularizing and a source of perturbation, becomes a sign.
A sign of an ancestral demand which envelops the lineage in its entirety.
The troubles of the subject are nothing less than the localized eruptions
on the epidermis of the family. The seizure of the illness is no longer individualized, but becomes a family concern. The act of submission on the part of the [individual] achieves nothing unless the [family] takes on the illness itself and submits itself for its own part to the will of the ancestor (Zempleni 1966: 438).

In this passage the collective is understood to be the family and its role is implicated alongside the individual experience of the ill person. Subjectivity is here cast in terms of the experience of the illness and the relationship this compels between the four social entities implicated: the family, the patient, and the lineage conceived of in terms of the fourth, the ancestor. The goal of treatment –and this is where Collomb saw the most significant efficacy of the traditional event—was to “reintegrate the individual into one totality” with the collective or family (Zempleni 1966: 438). We know for certain that Collomb saw matters in these terms because of his incorporation of its ritual elements at the clinic. This as an example of a socially mediating treatment modality that revolves around three factors worthy of note: first, the notion of the collective and the individual within that collective; second, the clinic’s use of the ritual’s healing properties in its own approach to mental illness; and finally, the research done by the anthropologist, Andras Zempleni, that made the intervention possible. Having provided some sense of the way that anthropology played a role in the successful development of social therapies at the clinic – namely Zempleni’s study of ndop-- I want to look next at anthropology’s constructions of the relationship it has with biomedical interventions. This section will return us to the debate over the role of psychopharmacology.

Given sociocultural anthropology’s defining concern over what constitutes the social, it is appropriate that many anthropological analyses of the role a certain social psychiatry or a psychiatry sensitive to social issues might play in its interaction with psychopharmacology has
fallen mainly on the side of critique of pharmaceuticals. One of the most current example of debates in anthropology over the role of psychopharmacology is Joao Biehl’s *Vita* (2005). In this book Biehl’s critiques the role of psychopharmacology as itself a social intervention that fails to address the social issues of poverty, racism, and sexism that plague Brazilian urban contexts. He examines in depth and with great sensitivity the life history of his central protagonist a woman he calls Catarina. He locates his unfolding drama—the narrative of her deterioration from a neurological disorder misdiagnosed as mental illness—in a clinic he calls Vita. He calls the process by which she is at once abandoned by her family and then implicated in a social system that equates gender, race, class with compromised health, her collapse into a zone of social abandonment. She does have agency it should be made clear and was actively engaged in repudiating or at least critically engaging with her experience via a journal/dictionary that she wrote chronicling in a powerful posesis her experience in this zone of abandonment.

A central feature of her documentation and indeed Biehl’s in his ethnography/life history that itself recalls the work of Ruth Behar in her book *Translated Woman* (1993), is his interrogation of the role that “medical science” plays in her interaction with those charged with her care. Medical science as Biehl construes it indexes the role most especially of pharmaceuticals in the characterization of her illness, its progression, and its eventual deleterious effect on her well-being. Constructions of the roles that the aforementioned sociological factors might have in the understanding and treatment of her illness[es] is foreclosed, precisely in accordance to and as a function of the intervention of pharmaceuticals. We find then in the use of such drugs—members of the metaphoric “family” of drugs known as psychotropics—as Haloperidal, levomepromazine, and biperiden and nitrazepam ,the manner in which “as a routine moment…medical science is operationalized” which gives witness to the way that a
“pharmaceutical surplus” interacts with “individual bodily tolerance” in such a way as to first, remove her from the care of family members and secondly, to thrust her into the domain of the state-monitored body. She then is removed by the family of drugs from the experience of the family; she is removed from an existentially ratified body into an alienated, disarticulated physiological body (see Biehl 2005: 147-149). The operationalization of this removal is achieved through the socially mediated functioning of drugs. But this mediation is rendered invisible by a discourse of science. It is with this in mind that I would argue there is an imposition of a universalizing discourse of biomedicalization—understood to be the pharmaceutical intervention—that impacts individual experiences of the body and the body within the context of the collective. Biehl takes for granted the “operationalized medical science” as a universalized set of psychiatric practices. My dissertation is focused on assessing a case study of the manner in which it has become a feature on the international psychiatric scene. For it is the interaction of the universal—biomedicine—and the particular—Catarina’s body—that we can see the manner in which global flows impact specific bodies. And it is important to note that my analysis reveals the way that the science of medicine itself collapses and at other times resuscitates individual voices in its efforts to provide adequate health care in a global context.

If we return to the vignette that began this section of the introduction we can obtain a clearer picture of the operation of the globally ratified sense of the therapeutic encounter. First of all, the penc is a group therapy. That means it is a technique designed to elicit reactions to the therapeutic milieu that are thought to be efficacious because of their expository or revelatory properties. A standard textbook devoted to Current Psychotherapies (Corsini & Wedding 1989) provides the best description of Adlerian group therapy that I think is most suitable in the context of its use at Clinique Moussa Diop: “...the group is conceptualized as a ‘reexperiencing of the
family constellation’” where the latter are quoting the work of the Adlerian psychotherapist Asya Kadis (see Corsini & Wedding 1989: 83). This quotation is significant because it draws upon and in part defines the work of a psychotherapist—Adler—that is someone in direct descent from Freud; and second because it returns us to notions of the operation of the family. Because I am defining the collective in part by referencing the family, it seems suitable to think of group therapy in these terms. But as the textbook reveals much farther on, group therapy is distinguished from the operation of the family because group therapy has no history (see Corsini & Wedding 1989) unlike the family. The penc is distinguished as are all Adlerian therapeutic developments from family systems theories. I return the reader to these sets of theories when I more thoroughly define my terms—the term being ‘collective’ which in the context of Senegal is in part itself defined by the family—but for now I want to assert that where the penc differs in its defining features from other group therapies is the degree to which it seeks to activate the history of the family by Collomb’s innovation of the family accompaniers. It is to this aspect of the vignette that I turn now.

One of Collomb’s signal innovations was family accompaniment for the duration of the hospitalization. In our vignette the penc leader encourages the family accompaniers to speak up. Their presence is designed to allow a context for the emergence of a healthy ego, I would argue. These accompaniers provide first and foremost a gauge for measuring the success of the therapeutic interventions. With this regard, their presence allows the clinicians to observe the patient and his/her conduct in ways that are restricted for them under normal circumstances. So, for example, family members observe the behavior of the patient at bedtime: are they sleeping? Is their sleep restless or relaxed? Is the patient eating? Eating too much? Too little? Is the patient taking his/her medication? What side-effects is the patient experiencing, and so on. Where the
clinicians are restricted in their capacity to regulate and monitor the patient on the ward, the family accommodator acts as an adjunct to the clinical process. Second, the family accommodators act as surrogates for the broader society. With this regard, they are meant to serve as regulators or members of society’s aspects of surveillance. Norms production is implicated in this role. The family sanctions, norms, values, etc. become central to this expression of the presence of the family accommodators. Finally, the family members serve as reinforcers of the biomedical model itself. They are designated as in the service of making certain the patient engages in compliance behaviors with regard to the drugs. The woman mentioning that the drugs (garab yi) are not the problem but the family (mbokk) is really the location of the issues is at once a reference to her own role as a monitor of the context of the successful deployment of the therapies administered by the clinicians. Perhaps more importantly and intuitively the mentioning of family difficulties indexes the patient’s difficulty with displaying socially sanctioned behaviors. Finally, for us as ethnographic analysts it highlights the degree to which we can say that it is within the family structure that problems are perceived. With this regard, we can see in references to for example domestic violence and other issues, that the norms of the society are being contravened by the patient. Accordingly, the problem is not with the drugs, as she says, it is with behaviors that are manifesting within the family system. We might think of Martine Mendi’s case in terms of this contravening of societal norms: expressions of aggressions and inappropriate solicitations of sex and/or marriage proposals, the last seen through the lens of not just Islam but Muslim gender roles: women do not make marriage proposals.

The other defining aspect of the penc is the praying, in terms of expressing the relationship the patient has with the collective. I explained earlier on in my definition of terms section the notion of the Sufi Brotherhhoods that so define social life in Senegal. For now, I want
to observe that the prayers give to the proceedings the ratification of Islam. This is a fraught aspect of the therapies because as some of the clinicians observe and argue religion has no place in a *modern* psychiatric facility. Moreover, many of the schizophrenics’ concerns and manifestations of symptoms have to do with religious and quasi-religious ideations. These clinicians argue that while Islam is a central feature of social life for both themselves and the patients its role as an expression of collectivity is at once problematic on an individual case-by-case basis and yet a necessary aspect of treatment as it forms the basis for a re-entry into social life. So, it is perhaps, that the *penc* leader is encouraged to use Islam as a way to reinforce the acceptance of the biomedical model; this is also found in the vignette. The role of Islam in the *penc* also indexes the role of the three Sufi Brotherhoods in political expression.

So it is that the *penc* leader as a religious figure lays claim to a politically loaded role: he calls himself the President (*jaraaf*) of the *penc*. With this regard he is linking religious expression to political expression or role playing. The elections of 2007 were right around the corner when the *penc* leader made his pronouncement. The patient’s mentioning of the President Wade—who won the election, significantly—grounds the proceedings in a broader sociopolitical context. The *penc* leader’s claim then is designed to place him in a role of leadership that is implicated in his role as religious leader. He becomes Wade in the context of the *penc* but he also does so according to the popularity of the latter figure in a collective context. This religious leader is saying in effect—I would argue—that he is a *popular* and *populist* leader; he is saying, ‘I too am capable of leading with the surety of popular assent. Moreover, he is saying, ‘I as a political figure am to be respected.’ This role-playing designates the *penc* as a quasi-political space just as much as it is a religious one. Or perhaps more aptly we see the connection between
the individual expression of voting power and notions of neo-liberal citizenship as it mingles with religious expression.

I have sought in this section of the introduction to address some of the key aspects of the vignette. I leave the role of the psychiatrist for later discussion as it forms a key part of my discussion of the medicoscape that the vignette demonstrates. For now, though, allow me to observe that the psychiatrist forms a backdrop against which those features of the professionalism and its incumbent power become salient. The psychiatrist’s presence officially ratifies the event just as much if not more so than the Islamic practices that are observed. He stands in for the official; the professional; the medical production of the cosmopolitan scene.

The scene is cosmopolitan in part because of its heterogeneous elements: there is the role of biomedicine which the psychiatrist represents alongside the faith-based healing intervention of the leader –his laying on of hands; there is the contrasting and yet uniting perspective on politics; there are at once the individual patients and at the same time the normative representative of the collective in the person of the family accompanier. While these aspects of the session do not implicate necessarily global flows –though I argue they do later on given the precedence of the biomedical model and its accompanying discourse on science as a universal in its psychiatric application—they do form an internal sense of the cosmopolitan, in terms Appiah might apply to a given local context (see Appiah 2006). As Appiah argues in his discussion of Constitutional Law and on to gay marriage, there are ways that universalizing difference impacts us in local contexts just as much as in global ones (see Appiah 2006:70). So it is that we can speak of a cosmopolitanism among the patients and clinicians during the penc. These elements represent negotiations of difference that unite/reconfigure/dissolve notions of the neoliberal state and citizenship within its [un]boundedness. Returning to my thesis it is the interaction of these
elements, this oscillation that in fact informs the emergence of social life. The co-presence then of biomedicine and faith is at once *sui generis* to the local Senegalese context while at the same time representing interactions with larger more global concerns and attitudes and approaches to psychiatry. This is what I mean by cosmopolitanism. But surely just as the family has a history the broader rubric of cosmopolitanism as a description of the human family deserves some explication. How then in fact has the African concept of the family emerged as a referent for the larger African collective? It is to this question that I now turn. But before we seek an answer to that question I want to preface our discussion with a biographical foray into Collomb’s emergence as a central figure in African psychiatry, in part because we cannot understand psychiatric conceptualizations of the family in Senegal without turning to him. After that I want to turn to a sketch of the man who had the greatest influence on Collomb and his conceptualizations of African culture by referencing the work of Georges Devereux. This latter discussion will return us to our discussion of colonial constructions of the African collective. So, I begin with Collomb who remains to this day the reigning influence upon psychiatric discourse at the clinic.

**Henri Collomb, and a New Ethnopsychiatric Medicoscape**

Who then was Henri Collomb? Born in 1913, (he died in 1979, still having his work published), Collomb came to Senegal in 1959 after spending most of his career in the military. He became chief psychiatrist from 1958-1978 reinvigorating the clinic upon the ruins of the asylum system instituted during the colonial era by the French (Zempleni 1980: 85).

Collomb had a long history with the French military. He served with the Free French Forces during WWII and was scheduled to leave with an artillery unit for Libya when he was
called instead to Ethiopia to serve as Haile Selassie’s chief physician. Collomb followed his service in Ethiopia with some time in Indochina (an experience that troubled him because he could not understand, “why we were fighting”) (Boussat & Boussat 2002: 418). During both military terms Collomb served as a physician only. It was not until after this extensive service that Collomb completed his education in psychiatry. Collomb’s commitment to cross-cultural understanding may come from his experiences in other parts of French colonial Africa and Asia. (Bullard 2005).

In 1965 Collomb founded the journal, *Psychopathologie Africaine*, in which he wrote about his ideas of a blended psychiatry. Collomb discussed his approach for a blended psychiatry in many places, not just his own journal. He called his approach “social psychiatry.” I would argue, however, that Collomb’s ‘social psychiatry’ was in fact a form of ethnopsychiatry because it, like its signal practitioner, the British psychiatrist J.C. Carothers, shared a distinct vision of African *culture* that persisted throughout his -- Collomb’s-- textual delineations of his therapeutic approach. Ethnopsychiatry is that odd system of medical practice and praxis developed principally in the early years of Empire --both French and British—that set as its defining task the definition, delineation, and empirical understanding of what Jock McCulloch, following J.C. Carothers –the chief proponent of British ethnopsychiatry—calls ‘The ‘African Mind.’ There are two competing aspects of the theories that developed around the medical

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7 As I said, biographical information about Collomb is hard to come by. My source here whom I paraphrase is Alice Bullard (2005) writing in an article that bemoans that very absence of information, entitled, “The Critical Impact of Fanon and Collomb: Race, Gender, and Personality Testing of North and West Africans.” Her source is an article entitled , “A Propos de Henri Collomb (1913-1979): De la psychiatrie coloniale a une psychiatrie sans frontiers” by Boussat & Boussat (2002) in L’Autre 3 (3), 411-424.

8 For an example see “Psychiatrie et cultures: considerations generales” in *Psychopathologie Africaine Vol.2*:259-271.

9 McCulloch has written two monographs entitled respectively, *Colonial Psychiatry and ‘The African Mind’*(1995), and *Black Soul white artifact: Fanon’s clinical psychology and social theory*(1983). In the former, he
movement to understand colonized peoples in terms of their psychological functioning: First, these theories seemed to be not based upon a universalist paradigm curiously enough—although one could argue it was by way of broad comparison—but rather upon a sort of radical historical particularism and cultural relativism that would have done anthropology proud. But secondly within that relativity, all Africans were said to be primitive and more akin to children, and crucially, according to Freud, neurotics. They were thought to be intellectually underdeveloped for many reasons, all successively proven and then dispelled. So there were two competing discourses that as dialectically related synthesized into a portrait or portrayal of the African as childlike, and morally compromised in terms of his presentation of culturally mediated social formations that characterized the two world powers’ approaches to the imperial impulse.

Collomb developed his own brand of ethnopsychiatry that departed and formed a critique of the British—read: Carothers’—brand. It is his notion of African culture, and collectivity that I want to turn to now.

There were important differences in Collomb’s brand of ethnopsychiatry and Carothers’. Despite the pernicious presence of a universalist paradigm when addressing mental health concerns as applied to the formerly colonized subjects—and it must be remembered citizens as were the Dakarois, a fact which I think allowed Collomb to so privilege the indigenous belief systems and place them to some extent on a par with the Western biomedical model—Collomb distinguished himself from the ethnopsychiatrists of Carothers’ ilk, by positing a medical practice and praxis that was uniquely suited to address the concerns of the Senegalese patient. He chooses as his focus the development and eventual implementation of ethnopsychiatry, tracing historically its rise and demise. In the latter text devoted to Fanon, he gives a brief history of the set of theories that circumscribed the medical approach.
made few claims to understanding the concerns of all Africans and I think this was in direct refutation of the ethnopsychiatric agenda.

He also positioned himself in opposition to the statistical ‘science’ and theorization about the physiological differences between so-called Africans and Europeans. He made no measurements of Africans’ brain size and cranial capacity. In fact, though the first instatiation of the clinic was under the heading of neuropsychiatry, Collomb refuted the singular goal of a scientific –read: biomedical—understanding of Senegalese pathology. He argued there could be no science without the mediation of culture. Culture for him, in the context of Senegal, meant in one way or another addressing the concerns of the collective and this was construed in terms of the family. Thus, constructions of the concept of the family are central to the emerging idea of the African collective.

Collomb shared with his ethnopsychiatric colleagues that he much maligned –presumably Carothers though he is never named explicitly—a conceptualization or construal of African culture as collectivist in orientation. So, he writes, returning to the culmination of his work in a Canadian journal, of traditional approaches as positive because they are collectivist in orientation, a perspective echoing Carothers’ earlier construal of ‘African’ culture as collectivist in its commitments. Collomb:

The healer with the consensus of the sick, their family, of the collective, of the ancestors, repairs the aggression of the aggressor…The sick person is viewed as a victim: the group shares his illness and helps him…(p.464).

The discourse of the healer is the discourse of a collective therapeutic approach…The expulsion of the aggressor restores order to the group. (p.464).

It is not a question of assimilating the psychiatrist with the healers and transferring the procedures of the cure in another culture but simply by taking the example of the traditional African therapies to accord them more respect in the immediate perception of the mental illness, in the midst of a familial and social
environment, giving more respect to the social existence of the sick individual. (p.465)

The key, then, to apprehending this medicoscape, is to grasp the degree to which Collomb is actively negotiating a tension between biomedical interventions which are to be found on a global scale, and an approach that is applicable to the Senegalese context *sui generis*. That that tension itself was felt globally is in part the point of the indeterminancy of medicoscapes, but also part of the point is that this tension or perhaps more aptly the constant *negotiation is still operative at the clinic*. But it is so in a perpetually deferred and unresolvable manner. That is to say it is perpetually imminent or as I say *emerging*. The definition of the medicoscape as an encounter between the indigenous and the global or the modern and the traditional while *operative in the field, among my interlocutors*, itself emerges as much more oscillatory to return to an Amsellian construction.

Although Collomb and Carothers had different approaches to the ethnopsychiatric agenda they did seem to agree that Africans were more *family* oriented. Where they differ however is in the very real therapies that emerged from this colonially derived discourse. For Collomb care of his Senegalese patients was of paramount importance. And he saw the need to make his brand of psychiatry speak to their cultural needs as much as to their psychological ones. That his perception of those cultural needs was based on older colonial paradigms did not concern him. He sought to heal and he founded his clinic on the very real basis of providing cutting-edge clinical interventions. What has emerged now is a medicoscape that while in dialogue with both Carothers of the ‘50s and Collomb of the late ‘70s, witnesses the cardinal facet of Collomb’s approach falling into disrepair when faced with technological advancements in the field of medicine. There are better drugs that pinpoint and alleviate disease than there were in Collomb’s
day. Subsequently, the penc has less saliency as a therapy. Yet it persists. It does so because it speaks today to the crucial role of Islam and its careful negotiation of animistic notions. But in my five year span of studying the penc I have noted its deterioration. And its current status can only be explained in terms of an emergent medicoscape that finds the ascendancy therapeutically of pharmacological interventions. Its persistence, then, can be explained in two ways. First, it speaks to the clinicians’ and patients’ own perception of their culture as collectivist despite evidence that suggests this too is in a perpetually deferred transition within the parameters of the post-colonial situation. And second, it speaks to the clinicians efforts to apply international standards of care that are at once collectivist –group therapy is done all over the world—and yet balanced with ego centered. The clinicians successfully negotiate these sets of principles and concerns on a daily basis at Clinique Moussa Diop. How are we to locate Collomb’s project historically within a French trajectory; for surely Collomb was responding to trends not just stemming from the British colonies but from his own cultural matrix. It is to Georges Devereux that we now turn to locate Collomb’s innovations within a French cosmopolitan trajectory.

George Devereux, Universal Cultural Patterning, and Metapsychiatry

Momar Gueye –the erstwhile head of Clinique Moussa Diop—in 2000, invokes in an article published in Psychopathologie Africaine, George Devereux as the progenitor of the French form of ethnopsyhiatry that so influenced the work of Henri Collomb (Gueye et al. 2000). With that in mind I want to discuss the American psychoanalyst and self-proclaimed ethnologist, who with detours of his own into the Iliad and Beethoven’s Fifth, stood as a polymath astride the African “cross-cultural psychiatric” scene as a proverbial Gargantua. It is his notions of universality and particularity that inform the discussion in this dissertation of cosmopolitanism. We begin, then with his definition of Culture as a universal; proceed to his
conception of ethnic pathology; and finally turn to his delineation of what he termed *metapsychiatry*.

Writing in his text, *Basic Problems of Ethnopsychiatry (Essai d’ethnopsychiatrie generale)* –written twelve years after the founding of Clinique Moussa Diop and so in 1970—Devereux sets as his ambitious task the circumscribing of a specific hybridization of psychiatry and anthropology. He calls—as did Collomb—his approach pluridisciplinary and argues that, “[t]he autonomous science of ethnopsychiatry –that is, of psychiatric anthropology or anthropological psychiatry, the label chosen depending on the *use* to which this pluridisciplinary “pure” science is put –must therefore have as its key problem the coordination of the concept of “culture” with the paired concepts “normal” and “abnormal.” (Devereux 1980: 3). In order to gather suggestive and empirical data for his assertion of this “pure” science Devereux makes recourse to a concept of Culture –that he himself writes wr*it* large—that following the work of Wissler, is universal in conceptualization and application. He writes, “[i]ndeed, regardless of the variety of cultures, the simple fact of having a culture is a genuinely universal experience, and man functions as a “creator, creature, manipulator, and transmitter of culture” (Simmons 1942) everywhere and in the same *way*. *Pari passu* the Mohave feels about his culture the way the Eskimo feels about his, and the way the American infantryman feels about his Garand rifle is probably identical with the way Rome’s Balearic warrior felt about his slingshot” (Devereux 1980: 69). Crucially, then, culture is construed as *static* and *universal*. Equally worthy of note is the degree to which these very same concerns formed the content and substance of Carothers’ own ideas about culture and more specifically, *African culture[s] sui generis*. Where the two would seem to diverge is on the point of contextualization, however. For Devereux the context of the emergence of culture was situated within paradigms of *ethnicity* rather than race—to such an
extent that he derides Jung’s concept of the *racial unconscious* (see Devereux 1980: 6). For Devereux—and despite taking issue with the neo-Freudian school[s] of thought that presumably situate their evolving discourse within a matrix of demographic concepts such as race, gender, and class e.g. Lacan—rather than racial [stereo]typification as was the purview of Carothers, he turns to a notion of ethnicity that allows him to describe to some extent *ethnographically* and within a constantly shifting image of psychiatric anthropology, and beyond description to adumbrate a theory of practice that consistently argues for the aforementioned universality and staticity within a framework of highly specific—and one might add idiosyncratic and individual—*interpretations* of cultural phenomena. He advances his position by turning to what he terms *ethnic disorders* and thereby provides a trenchant critique of Carothers’ own ethnological data such as it was.

By considering such cultural manifestations of ethnic disorders as *amok* among the Malay and *berserk* in a Scandinavian context, Devereux is able to argue that, “[o]ne encounters a wide variety of ethnic disorders in the world. Each culture area, perhaps even each culture has at least one and often several typical disorders of this kind. In fact it is my impression…that the number and diversity of ethnic disorders in a given culture reflect its degree of psychological sophistication; that is, they offer an indication of the extent to which the society as a whole takes the individual and his personality into account” (Devereux 1980:27-28). There are two aspects of this quotation that we recognize: the first is the recourse to a certain universalistic relativism that Devereux seems to occlude in his own analysis opting as we have seen to argue for universal cultural patterning. But in the above quote there is at once the highly specific relationship that *each* culture has with its individual personality structures alongside the *uniqueness* accorded to each culture. The *apparent* contradiction can be explained by noting that Devereux, unlike
Carothers, seeks not to argue for specific mental faculties but assumes the mental functioning of humans is roughly or more or less the same across cultures however much those cultures may vary in cultural expression. At this juncture, then, we can turn to Devereux’s ideas about what should constitute the substance of such a psychiatry that would travel across cultures.

Devereux argues against the use of transcultural psychiatry as a descriptor and/or analytic to describe his school of ethnopsychiatry. He prefers metapsychiatry (emphasis his). He explains, that metacultural psychiatry seeks to address not just the theoretical orientation of the clinicians but also his practice or better yet his therapeutic technique[s]. These practical concerns we will see in Chapter Three heavily influence the development and deployment of the idea[s] surrounding the successful formation of the psychiatric professional at Clinique Moussa Diop.

To sum up, though Devereux was not an ethnopsychiatrist of the African ilk, I have included this brief foray into his theories as a prelude –a necessary one given Devereux connection with French psychiatry out of whose crucible Collomb was shaped—to my discussion of Collomb because the former is to this day said to be the initiator of the discourse surrounding the effective clinical ideas that the doctors and other professionals at the clinic employ in both their practice and praxis (see Gueye et. al 2000). The latter two terms I do not conflate in part because I want to argue that the clinicians’ praxis can be best defined in terms of a set of political commitments. While silent as we see in Chapter One this political agenda is based upon de facto ideas that go to the heart of the psychiatric intervention in as much as these ideas get instantiated around concerns central to both anthropology and psychiatry: namely, the delineation and determination of what Devereux characterizes as notions of the normal and abnormal. With this regard and with his connection to theory based upon Americanist
ethnography as transplanted to a Continental context –France—we can see Devereux’ positioning within the ever-present medicoscape.

Devereux, French psychiatrist, American ethnologist; Collomb French-trained psychiatrist expatriating to Africa where he forms a unique brand of psychiatry that addresses lapses in British discourse over both African culture and its universality versus its particularity. These two, along with Carothers, speak to both the emerging medicoscape and its conflicts over the role of science in treating mental pathology, but also to debates that I would argue are of a cosmopolitan nature. As I have said, however, these conflicts –over the role of the traditional and the modern; over science and faith; over differing forms of colonial governance and its incumbent conceptualizations or stereotypifications of African culture—all speak to a world in which these false binaries –at least in clinical practice—oscillate. We can see then through the lens of the collectivist/individualist interplay the development ad infinitum of discourses around issues of universalism and particularity. I have shown here the relationship with colonial science and its medicoscape to the development of the paradigms that shaped the emergence of Dakarois psychiatry. Now I want to turn to the current, postcolonial moment in an effort to go beyond a simple portrayal of the colonial legacy and speak directly to the sociopolitical formations that characterize the use of the penc and the other innovations Collomb made.

Collomb in Conversation with Devereux’ Legacy

The obituary for Henri Collomb, tells the story, in part, of the development of a new ethnopsychiatric tradition, that itself implicates a new medicoscape. The global flows of medical knowledge-production, and implementation of those theories, in this case falls within a paradigm of colonialism, and its subsequent [re]production in a postcolonial context. Senghor, the then President of Senegal wrote the obituary placing Collomb’s work in a de facto political trajectory,
and *de facto* republican citizen subject formation that finds its antecedents in the colonial governance project of some three hundred years. Senghor puts it as follows, “Henri falls on the side, then, of a traditional psychotherapy, such as that practiced in Senegal, at the crossroads of animism and of Islam, despite and at the same time under the effects of three centuries of a French presence.” (Senghor 1979: 138).

But what are we to make of the *institutional structures*—those three centuries of French presence—that circumscribe what Gupta calls the *postcolonial condition*. As Gupta presents the matter, debates within postcolonial scholarship frequently define postcoloniality in terms of “structural oppositions” that “pit a system of meanings and symbols” that are non-Western and frequently construed as “indigenous” against the “universalizing discourse of the ‘West’” (Gupta 1998: 5). He places these so-called oppositions in an historical trajectory and poses the question, “[d]oes “postcolonial” signify that colonialism is no more than an historical legacy in the present?” (Gupta 1998: 7). In the context of Senegalese psychiatry it is clear that the answer to Gupta’s question is in the negative. Postcoloniality, I would argue, following Gupta rather than implicating these oppositions can be seen most effectively in terms of the interactions or interplay between the body politic—the collective—and the physiological body or the individual sense of well-being and health. In this instance the physiological entity constantly intermingles with, cross-references and mutually influences the historically implicated body politic.

In an essay entitled, *Genealogies of the Body Politic*, cultural critic Goldie Osuri examines the work of Senegalese filmmaker Ousmane Sembene. The book is *Postcolonialism: Culture and Identity in Africa*, and so it pertains to our discussion of the central notions that we might say define first the experience in a Senegalese context of postcoloniality but additionally connect it to the pursuit of a distinct psychiatric approach as found at the clinic. How to do that?
Well first we must look at the manner in which Osuri –deploying Foucault’s concept of genealogies—looks at the body in Sembene’s work. He argues that rather than forming Foucauldian genealogies, Sembene’s films articulate unique approaches to “map[ping] the destiny of a people” (Foucault 1984: 81)” that implicate the postcolonial body in efforts to engender emancipation. He writes of this body and its relationship to the collective as follows:

At an irreducible level, the human body denotes a biological phenomenon that is the contraption of skin, flesh, blood, bones, etc. Yet from the moment of its birth, this material entity absorbs as well as responds to the social, political, economic and cultural environment in which it is born. On a larger scale, this body is part of a collective, the body of people[s], who similarly absorb and respond to a given environment. In this regard the concept of the “body politic” is relevant…, The body politic is thus a symbolic field where power and knowledge with reference to socio-politico-economic relations invest themselves within and subjugate the individual and collective human body (Aluwalia & Nursey-Bray 1997: 93-94).

We glean from this quotation two important ideas: first, the body for Sembene and as we have seen in the work of Collomb is cast always against the backdrop of the collective body; but and this is the second point, that collective is invested with power: it is a body politic. And not unlike Hobbe’s Leviathan it gains its power from the submission of the will of its individual members and the operation literally of their bodies. The body politic then can as Foucault would have it subjugate the individual. But this analysis is based upon a faulty assumption and it is one marshaled frequently contra Foucault: that is the question of agency. Sembene’s acts of creation are themselves articulations that counter the operation of the collective –read: political body. For Osuri it is Sembene’s innovative approach to film to posit that the “…the colonial relationship…still exists under the guise of independence and in the form of neo-colonialism” (Aluwalia & Nursey-Bray 1997: 97). As Osuri sees matters Sembene formulates a vocabulary for emancipation from neo-colonial power structures. He concomitantly formulates oppositional or
counter-narratives in the very act of accurately assessing and portraying the impact of colonialism in both its older and present-day forms. In terms then of the body, Sembene links narratives of the operation of that body in the context of the broader body politic that in one way or another argue for the varying operation of daily semiosis—"symbolic field"—in the act of subjugating individual and collective human bodies. An example that Osuri occludes but that I think is very reflective of Sembene’s assaying of this symbolic field is his film *Mandabi*, in which the central protagonist is given a symbol of emancipatory wealth: a money order from his nephew living in Paris. The man goes around all of Dakar looking for a way to cash the money order and his efforts, ultimately unsuccessful, implicate his very corporeality in a web of social relations that place him within a global economic order while at the same time finding him in a highly local and subjugating expression of political corruption, ennui, and ineffectiveness. The body politic is sick here to the degree that it by linking up with global economic relationships must subsequently make its comprising members impotent. So it is that because he has no birth certificate the protagonist of the film cannot cash the cheque from his nephew who is himself an émigré in France. The film is in Wolof and so is designed to speak to a Senegalese audience first and foremost. The protagonists’ peregrinations around the city of Dakar and his interactions with cruel agents of the city and the lumpenproletariat within the urban system find resonances in his body: he grows increasingly ill as the film progresses. Here we find that the man is ill to the degree that he is impotent in his interactions within a local set of socio-politico-economic structures. That the two milieu—the Francophonic and the Dakarois—are not discrete is in part Sembene’s indictment of neo-colonialism. And the act of telling the story mainly to a Senegalese audience is indeed Sembene’s act of resistance. He indicts the body politic.
So to link up my analysis to the earlier discussion of the *postcolonial condition* we find here a network of relationships that implicate the Senegalese in broader neo-colonial relationships that foster a dependency of the social body on the metropole. Because the money order comes from France, it is clear that its financial efficacy can only be seen in terms of Gupta’s “structural oppositions”. That is to say, the opposition of monied France is pitted against the daily realities of an impoverished body politic in Dakar. The structural oppositions are manifold here: Wealthy Paris/ poor Dakar; Working Immigrant/impoverished static urban dweller; viable laboring body/old decrepit Uncle; and so on. And these oppositions are furthermore cast in the idiom by Osuri in terms of the relationship of the physiologic body and the collective. But our analysis must not end there, as Gupta would caution us, for at the clinic the relationship between the physiological body and the collective experience of the body is construed as a universal. The use of the biomedical model and its adherence to drug regimens I would argue is by definition universal in its scope and agenda. This agenda is experienced through the particularity of Senegal and more specifically, Dakar. Defining a Dakarois psychiatry then is telling a story of a melding of influences many of which are global with local experiences and definitions of the body. Given the deployment of notions of local experiences on the part of physical bodies and political bodies, we need at this point to locate our discussion in a specific space. For as Sankaran Krishna publishing this year explains, there is a “time-space compression” that can be defined in terms of the speed with which we can travel from locale to locale in the world, as a central feature of globalization. We too in this dissertation travel with great speed from the West to the East; from Africa to the US; from North to South, so it is incumbent upon us to lessen the effects of this compression; to somehow address the resulting jet lag of shifting and sifting through the discourse on globalization and cosmopolitanism as
expressive of specific occupations of space. The danger here as Gupta further clarifies is that: “[t]he opposition between “the global” and the “local” itself depends on a spatialized dichotomy that needs to be questioned…” he warns further that we need to be wary that this dichotomy creates narratives that “very often fail to acknowledge that “the global” too originates from some location: Eurocentric assumptions are thus smuggled in at the same time that they are being theoretically disavowed” (Gupta 1998: 24-25). So it is that I ask that the reader be sensitive to the generating of knowledge that is itself considered to be both universal i.e. neutral and representative of geographical science while at the same time generated by myself within highly localized narratives of place and space. I call this next section, then, “the setting” in an effort to index the significantly theatrical presentation of data. That is to say, there are elements in the presentation of such “data” that are very geared towards producing certain effects that are themselves fashioned to produce a certain picture of the world. This picture is a stage picture and gives a specific valence to the notion of the “stage” that I apply to international psychiatric knowledge-production. This production can be found or situated within a mise en scene that delineates the relationship between space and history; between space and innovation; ultimately between space and faith.

The Setting

Clinique Moussa Diop is located in the southwestern, Fann-Hock region of Dakar. Dakar, with a population as of 2007 of roughly 2.7 million, in a country of over 12 million, was once known as the Paris of West Africa. Not unlike its colonial metropole, Dakar was the glittering crown of French West Africa. Despite the end of French colonial rule in 1960, it continues to have a strong relationship with France. It has become a crowded and energetic metropolis full of
open-air markets in which commerce takes on the appearance of festivals. This commercial activity that so shapes daily life in the city indexes the position of Senegal as the westernmost point on the continent of Africa. Located at 14, 000 Latitude and 14, 000 Longitude, it is perhaps because of its proximity to the West that the nation and more specifically the port city of Dakar, has occupied such a privileged status in terms of colonial and postcolonial geopolitical relations.

In terms of those geopolitical relationships, Senegal’s currency, the CFA, is backed by France, its continuing principle trade partner. In recent years, however, Senegal has witnessed an increasingly productive relationship with China, Japan, and the US. The nation has a long-standing presence of North African and Middle Eastern influences as well, going back into its pre-colonial past with the incursion of Berbers who some sources say brought Islam to the nation (see Gellar 1982).

The presence of these North African influences and their subsequent expression in market life can be seen readily at Clinique Moussa Diop, as I introduced the scene at the beginning of this chapter. Directly in front of the clinic, is a narrow passageway leading into the mosque and morgue, there is a garden loaded with spiky fronds of large cacti and birds-of-paradise their sharp pink and peach noses reaching heavenward. The circular drive, as punctuated by this garden, leads to the front steps of the clinic, which in an innovation during my time at the clinic, is now staffed by a young woman who greets entering visitors, family companions, and the ill.

The clinic itself, upon entering, has directly to the left of the entryway, a closed cage-like window that marks the quarters of the main nurse. Directly across the hall from this room is the waiting chamber for the chief of the clinic, Professor Momar Gueye’s office. As one comes upon this waiting room, one sees makeshift, ancient couches, a few chairs and a doorway leading to the Professor’s secretary’s office. At the back of this room is the entrance to the Professor’s
office. His office is a dark room with only a small window as a source of light, and with a desk stacked high with official looking documents.

Back in the hallway and down that passage there is the clinic’s archives that is packed with volumes such as the DSM-IV and numerous publications of global psychiatry such as the journal *Transcultural Psychiatry* whose multi-colored volumes peer out at one as one sits at the narrow tables for students in the center of the room. Farther down the hall, there is the clinic’s left wing in which there is located the room for art therapy, and a space where generally crowds of upwards of twenty patients a day are gathered awaiting consultations with nurses or doctors, who will dispense usually drugs and give injections.

Going the opposite direction from the entryway and to the right of the Professor’s office, there is the clinic’s right wing. Directly next to his office there is a room in which the social workers hold sway. Continuing down the hallway, there is a large office that invariably was the headquarters for one of the French students doing internships of four to five weeks at the clinic. Father on, there is to the right, a stairway that leads up to patient’s rooms.

The right side of the clinic also has the main consultation rooms; the nurses offices; the office of the clinic’s second-in-command; in its rear a phalanx of patient rooms –for the most critically ill, I surmised; and the indoor *penc* space. The *penc* has an out-of-doors space as well, and this can be accessed through this right wing of the clinic. This outdoor space features a bottle-green plastic canopy and various car rapide seats and benches. Most of the patients and staff attending the *penc*, however, sit on the low wall that encloses the space.

The building has cheerful white and rose-colored walls. The building despite the nature of its serious proceedings, has a bit of a festive air as patients’ accompaniers come and go with
the requisite greetings of hello (“bonjour”) or in Wolof “na nga def”, and nurses in bright uniforms prowl the halls corralling patients.

The clinic is semi-private and subsequently it employs a five-tier pay scale. There are [1] the patients who are as the social worker Doudou explained, “indigent” and who have the capacity to pay only very little. They must get certification attesting to their indigency from the prefecture, and are required to contribute 10% of the fee for hospitalization, which costs 25 thousand CFA for ten days. [2] Those patients who are not indigent, but do not have the means to pay are “protected” by the social assistance program of the clinic. They are required to pay 50% to defray the costs of their hospitalization. [3] There are those whose employment status confer upon them insurance, in which case the employer “is obligated” to pay. [4] There are those who are “errant” and for example “collapse in the middle of the street”; these folk receive treatment free of charge. Finally, [5], there are those who are called the “grand patrons” and who pay for the whole of their hospitalization. As part of the fees, and as with some clinical settings in the US, even laundry can be done at the clinic, so that one sees clotheslines outside in the clinic’s inner-courtyard, directly across from the outdoor penc space. Rooms with private toilets cost an additional 17 thousand CFA adding up to 42,000 CFA for ten days. It costs 5,000 CFA for a physical examination.

The doctors in training perform these exams. That said, in the hallways of the clinic, the only doctors to be seen are usually on their way to the archives and are more often than not visitors. The doctors in training, who serve ‘on the ward’ and some of the other clinicians who will be the focus of the dissertation, and to whom I turn now, are usually ensconced in consultation rooms in the right wing of the clinic, which acts as the ward.
Dramatis Personae

During my year at the clinic, I conducted multiple hours worth of interviews with clinicians and doctors. These interviews were semi-structured and lasted no less than forty-five minutes. The interviews covered mainly daily operations at the clinic as well as experiences with clinical training; performance expectations; compensation, and other rubrics for the professionalization process on the part of the clinicians. I worked closely with doctors whose names I have changed to protect their privacy: the erstwhile Adil, Fatou, Ghallib and Fareed. I attended their consultations, rounds, and weekly training modules known as The Staff Meeting (La Reunion). I interviewed multiple times, the clinic’s head psychologist, Katya. I also performed extensive interviews with the clinic’s resident religious leader, and director of the penc, named Mamadou. And finally, I observed the comings-and-goings of the Professor though he never afforded me the time of an interview. Introductions to these personages are in order.

Fatou

Fatou is in her late thirties. She has been at the clinic since 1997, and after our stay in Dakar, moved on to work for an NGO, assisted by her excellent grasp of both French and English. She was the second-in-command at the clinic and oversaw the training of the fledgling physicians. She is quite an authority figure wielding a firm hand over her protégés. She also does supervision with this cohort of physicians and says she attempts to weed out those who are unsuited for the profession.

With the patients, most of whom she does not see personally due to her stressful schedule as a professor at the University of Cheikh Anta Diop, and her extensive travel regimen, she is kindly though professionally reserved. She possesses a keen ability to cut to the chase when it
comes to interactions with her students. She is nevertheless generous with her time, and emerged as a helpful figure in determining the full scope of the care provided at the clinic.

Adil

Dr. Adil was in his third year at the clinic and finishing his required doctoral dissertation or memoire. Adil’s dissertation focused in part on the role and theories of Henri Collomb, the head of the clinic from its inception in 1956 to 1969. As I will address in Chapter One it is with this regard and within the context of other conversations with other clinicians, that we can see the abiding influence of Collomb on current clinical practice.

Dr. Adil as we will see has traveled extensively in his training as a physician. Though youngish, only in his early thirties, he comes from Djibouti and has five children. He is a devout Muslim—as are all of the clinicians—and proffered some critiques of Senegalese Islamic expression, that I address in Chapter Three.

Ghalib

Ghalib is the oldest of the training doctors at 35, and was in his second year going into his third during my stint at the clinic. He comes from Brazzaville, Congo, is married and has three children. He is in the Congolese military with the rank of captain. He says he enjoys the regimentation of the military, but he nevertheless has no grand ambitions for a career as a military man. He derides the bureaucracy of the upper echelons of military service. That said, he says he joined because he liked the uniforms.

Ghalib frequently grilled me on my motivations, training, and preparation for conducting my research. As we will see, my encounters with him seemed the most fraught, in part I suspect, because he disapproved of the open-endedness of my interviewing technique (I consider this technique in the next section of this introduction).
Characteristically, perhaps, given his military service, Ghalib was the most authoritative of the clinicians. He too exhibited however as we will see joking behaviors with his patients.

He will be one of a few psychiatrist in his country once he has completed his training. Although this was the case with many of the doctors, and that fact is important, it seems to be very significant given the current political climate in Congo. With so much social trauma, I think Ghalib sees his role as a psychiatrist to be especially significant, with broad ranging implications.

_Fareed_

Dr. Fareed was 32. He hails from Guinea and was frequently put in charge of speaking with Peul patients. He worked first as a physician in villages in his native country. He says he chose the psychiatric speciality because in Guinea there are only three psychiatrists for nine million inhabitants. He too was in the process of writing his thesis whose topic was the conflicting states of psychotics.

Fareed had one of the more interesting perspectives on the African recourse to traditional healing, in the face of the availability of biomedical interventions. He acknowledged that there are illnesses that can be treated without biomedicine, but he claimed that the genuinely operative factor in these cases, was *time*. For him, time healed these wounds, not so much the efficacy of traditional methods.

Fareed seemed to be one of the clinicians most committed to the biomedical intervention. In one interaction with a family member of a patient, the familial accompanier complained that his sister was not eating, to which Fareed responded firmly and confidently, “the meds will help her eat…”
Mamadou

Mamadou is unmarried which is unusual for a man born of 47, born on February 1st, 1958. As the most charismatic figure in this dissertation—except perhaps for the Professor—I save a more thorough presentation of Mamadou for later. For now, I would describe him as a very imposing figure. He was tall and frequently clad in expensive looking European suits and coats and tie. He also wore the most resplendent boubous on occasion. These fashion statements helped to place him among the professionals at the clinic, despite the fact that he was a former patient and during my stay still was in the care of Dr. Fatou.

Mamadou was the nominal religious head of the clinic. He conducted the penc. His prayers gave the group therapy its distinctively Islamic inflections. Mamadou, nevertheless, seemed to have a very personal expression of his faith and displayed some behaviors such as being a prolific smoker that were highly unorthodox in terms of Muslim practice. These behaviors indexed the urbane and cosmopolitan character of the clinicians’ routine expressions of self. More broadly speaking these behaviors indicated the force of Western influences at the clinic upon not just sartorial codes but additionally faithful observance of Islam. I consider Mamadou’s role more circumstance in Chapter Two.

Professor Gueye

Momar Gueye is the other highly charismatic figure in this narrative. He is a man of considerable stature both physically and professionally, having published extensively as the head of the clinic since the early 1970s until the present. He was a student of Henri Collomb.

As his student, the Professor looks the part of the accomplished French intellectual. He like Mamadou wears expensive suits and ties. But he also wears brilliantly colorful boubous on Fridays – the day professionals all over the city of Dakar wear traditional garb to work.
Gueye’s nephew remains an enduring friend, on a personal note, and my pre-field experience had me staying at the Professor’s home enjoying the company of this nephew who saw me through that first span of time in the country. That said, by my return to the clinic I had no considerable contact with the Professor, in no small measure because he was frequently absent from the clinic. The Professor traveled a good deal. I consider his absence in greater detail in Chapter Three.

**Katya**

Katya is the resident head psychologist. She was a woman in her late 30s, was married to a Senegalese man that she had met in Moscow and herself hailed from Ukraine. She has two children, one of whom was born in Senegal. She wears fashion-conscious clothes to her advantage. She is able to establish rapport, I observed, by cutting a fashionable swathe with both patients and clinicians.

Katya was frustrated by her administrative duties as she oversaw most of the European interns coming to the clinic. That said, she seemed well suited to this supervisory position as she was the most adept at analyzing the limitations of the therapeutic encounter. I consider Katya’s role in greater depth in Chapters Two and Four.

These doctors and clinicians were gracious enough to allow me to see both the limitations of the therapeutic encounter as well as the promise of Dakarois psychiatry. Of course, there were limitations and potentialities in my own approach to the research and so it is now to my methodology that I turn.
Methodological Considerations

In an effort to generate data that would speak to at once the international flavor of the clinic, as well as its clinical and theoretical commitments, I deployed an interview technique developed by Douglas Hollan, called the *person-centered interview*. Douglas Hollan in an essay entitled, “Developments in Person-Centered Ethnography” calls for a methodology in which the anthropologist focuses “on the individual and on how the individual’s psychology and subjective experience both shapes, and is shaped by, social and cultural processes” (Hollan 2001: 48).

While it would seem to be a methodology that favored more the subjective experience of patients, I found that it was more the story of the clinicians that needed to be told. Moreover, as the individual personalities of the clinicians emerged as so remarkable, Hollan’s person-centered methodology most adequately addressed both the individual-centered approach to therapy that so marked the clinical encounter, but also seemed to tell the story of the emergence of the therapists’ egos themselves. I have been alerted to this aspect of my ethnographic methodology by Kesha Fikes. It is important, she pointed out to me, to ask the reader to pay close attention to the way that data is framed in terms of recorded—*largely via written note taking as opposed to digitized or mechanical recording*—conversations and interactions. These interactions were unscripted for the most part; they were at least 45 minutes in duration (though many ran beyond that time horizon); and they occurred many over meals in the restaurant that acted as the staff cafeteria of sorts, *La Provencale*, which as I mention at the very beginning of this introduction faces Fann Hospital and is directly across the street. There were also other interviews that occurred in the clinic’s archives—in hushed tones—and in the consultation chamber.

Highlighting the encounters I had in these spaces allows for a dimension of the research to emerge that is centered on each individual.
So, I also paid close attention to the *voices* that were elicted during these encounters. I have therefore sought to construct a narrative that places these voices in conversation. The reader will find then not a standard rendering of ethnographic voicing but rather transcripts of interviewing, short snippets in the form of quotations taken from conversations, and paraphrasing. I felt this approximated the manner in which clinicians speak to one another. They use at times direct quotes from their patients; they recount stories; and they write-up conversations they had with patients in such a way as to communicate either the exact words of a patient or the gist of what the patient was saying. Utilizing this approach to writing-up on my part speaks to a desire to steep the reader in the codes or symbolic system used at the clinic.

Finally, I observed behavior alongside talking because this was indicative of the type of professional training the clinicians receive in monitoring their patients’ behavior. So that, again to get a true picture of the clinic, I felt it necessary to use the very approaches the clinicians used themselves as this would best communicate the organizing principles behind not just that professionalization but also its relationship to forming adequate transreferential economies. This two-pronged methodology –voicing and interviewing, and observation formed the crux of my approach to gathering data, This is related to my other introduction of concepts because it tells the story mainly of the way that transreferential economies were constructed; additionally, it tells the story in the clinicians’ own words of the construction of a specific semiotic world that led the clinicians through the rigors of becoming psychiatric professionals. That this world was cosmopolitan in nature speaks not to just the goal of the dissertation in terms of describing this space but also addresses the very nature of ideals of universals as construed in terms of universally applied and ratified approaches to treatment. It also addresses the local context: the particular which I gloss as Dakarois psychiatry. While I recognize the fase binary of this
localizing force as placed in a global context—every perspective as Gupta reminds comes from somewhere—part of what my methodology did was allow me to pay attention to and listen for, while also implicating the behavioral presentations of self, the stories the doctors told themselves about the interactions between the Dakarois, the particular, and the universal, largely the biomedical model. Ferreting out the relationships between these contrasting voices through interviewing those inhabiting Clinique Moussa Diop and through observing their bodily hexi I was permitted to gain a perspective on Dakarois psychiatry and more specifically Clinique Moussa Diop’s psychiatric agenda and protocols. 10

Close Observation

In terms of documenting these bodies in space as material representatives of social life, I observed clinicians (and to some extent their patients) and their behavior. Reading in an ethnography should however never take precedence over observation. Luhrmann addresses the foreignness and accompanying familiarness of the social and psychic terrain for the ethnographer working specifically in psychiatric clinical settings. She writes in her book, Of Two Minds: An Anthropologist Looks at American Psychiatry (2000):

I became fascinated by what psychiatrists saw, how they knew what they knew, Whether they were right, and what that even meant…Psychiatry forces upon you, more abruptly and with an in-your-face confrontation, the lessons anthropology is meant to teach: that the landscape of human thought and feeling is more gaunt and jagged but also more breathtaking than most of us, Horatio-like, have dreamed of in our little local worlds. I thought that if I could describe the way I was learning to see, which is the way psychiatrists are taught how to see, I would be doing what every anthropologist is supposed to do, but by traveling into the familiar, not away to the exotic. (Luhrmann 2000: 5; italics mine).

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10 The reference to bodily hexi falls in line with Pierre Bourdieu’s theories of the interactions between the socially mediating forces of class, gender, sexuality, etc. that in the case of the clinic can be said to have influenced the way the doctors occupied the various spaces that comprised the clinical structure (see Bourdieu 1984). The term finds its antecedents in the work of Marcel Mauss and is to some extent an application within a statistical format of his concept of “techniques of the body.”
So it is that the key to Luhrmann’s methodology and a key feature of my own within the context of the transferential economy was the possibility for not just an analysis of discourse and rhetoric but additionally a focus on the description that Luhrmann speaks of here; I wanted to be able to describe bodies-in-motion and pay close attention to the manner in which those self-same bodies occupied space, how they clothed themselves, their bodily hexi and the lexicon or vocabulary of the body as well. I borrow from Luhrmann the powers of observation and description. This entailed a certain silence in the face of the heavy emphasis placed upon talk. That demanded that I listen carefully and take serious notes about not just how patients and clinicians interacted verbally and therefore psychologically but also how they behaved in those interactions. I also sought to describe the spaces in which interactions occurred and the various implements and minutiae that comprised the material context in which encounters occurred. There is then in this dissertation a good deal of attention paid to describing people, things, and the thinginess of people.

**Chapter Sketches**

**Chapter One: The Penc in Historical and Contemporary Context:** I trace the theories that most contributed to the development of the penc. I then look at how these theories inform the current use of the penc. I argue here that the penc was developed within the context of colonial medical ‘science’ that featured an emphasis on the characterization of the African Mind and Culture as collectivist in orientation. The work of Collomb forms the substance of this chapter as he is still studied at the clinic today and is the largest influence on both the use of the penc and its collectivist ideals.
Having described the *penc* in the aspects of its history and in terms of its current usage, I turn in Chapter Two to a description of its central feature: the presence of Islam. Entitled, *Inclusiveness, Apoliticism, and Global/Local Interpretations of Islam, Chapter Two* examines the *penc* as a religious event in part because for example both patients and clinicians are expected to pray. This chapter, therefore provides an analysis of the way Islam is interpreted at the clinic.

Islam is interpreted at the clinic in two ways: first as a *global* practice uniting the clinicians coming from various places on the globe. And second as a practice that encourages religious and political inclusiveness. I discuss the global variation of Islamic observance. I turn next to local interpretations of Islam. Because there are a plethora of approaches to Islamic observance both locally and globally, and there are also other faiths represented at the clinic –the nuns—the clinicians encourage inclusiveness. This inclusiveness is defined as *apoliticism* because it is in response to historical political conflicts between the Sufi Islam brotherhoods. By tracing the history of these political conflicts, I argue that collectivist ideals of what constitutes faithful observance of the tenets of Islam is eroding in favor of politically expressed individualism. As the faithful vote for example they do not do so according to the dictates of their brotherhoods as they did in the past. Because there is a religious dimension to political expression in Senegal, another example of the encouragement of inclusiveness is with regard to other faiths found in Dakar. This becomes readily apparent at the clinic with the presence of nuns and other Catholics who serve as nurses and psychologists. I conclude then that the form of apoliticism found at the clinic speaks to local and individual interpretations of what constitutes the *umma* or the global Islamic collective. I argue that apoliticism defines the inclusiveness that unites clinicians of different Islamic traditions –both globally and locally—and of other faiths.
Chapter Three, after having established the primary glue uniting clinicians in the use of the penc –Islam—turns to a description of the use of the biomedical model at the clinic as the medical epistemological glue uniting the clinicians. I take up the principle training module, the staff meeting (la reunion). I also examine some of the other aspects of training and the way these factors figure into an international calculus of rationales and orientations to the biomedical model. So, Chapter Three, entitled, Staff Meetings and Other Aspects of Global Professionalism takes up the practice of staff meetings (la reunion) as forming a foil of a professional nature to the clinical practice of the penc. I locate these meetings as training devices in terms of global protocols of what defines a trained, professional psychiatrist. I describe such aspects of the global ideals of professionalism as mastery of both clinical theory alongside biomedically informed case management. By looking at such defining features of professionalism as sartorial codes; training in different psychotherapeutic techniques such as for example Lacanian therapy; use of diagnostic tools such as the DSM-IV and the ICD-10; and clinicians’ physicality and/or bodily hexi as demonstrated in clinical consultations. I analyze those aspects of ‘on the ward’ behavior on the part of clinicians, as they express local interpretations of global ideals of psychiatric professionalism. I argue that the application of these ideals within an economy of transference and countertransference feature the emergence of clinicians’ egos that speak to individualistic self-expression and self-actualization. So for example my observation of the way that various clinicians use stamps to ratify prescriptions becomes a way to speak to the individualism of the clinicians in the very act of helping their patients interpret their own individuality even as they prepare to reenter the family fold. This chapter connects with our earlier discussion of the penc by arguing that acts of professionalism, along with Islam, form the central content for the use of that therapeutic intervention.
Furthermore, by locating these acts of professionalism within a transference/countertransference economy we can begin to see the manner in which the global protocols that inform and define the clinician’s role at the clinic emerge as salient on an individual level.

Chapter Four: **The Medicoscape as My Brother’s Keeper: The Tenets of Islam as Applied to Biomedicine** ties Chapters Two and Three together. The epistemological glue that brings together the clinicians and patients are concepts of Islam and biomedicine as *commingled* or as Amselle would characterize it as expressing a sense of multiple-belongingness on the part of the clinicians (because they are expected to belong to both the world of science and the world of faith).

The injunction found on the sign at the entrance to the clinic to “be my brother’s keeper” is formulated around a concept of biomedicine that sees it conjoined with Islam. Having analyzed the role of Islam at the clinic in Chapter Two and the unique presence of the clinician in Chapter Three, I focus in this chapter on the encounter between patient and clinician as expressed within biomedicine. I argue that biomedicine is conjoined with Islamic liturgical and rhetorical practice that while *sui generis* and in conflict at times with the generalizability of the medicoscape combines to place Senegalese at once on an international psychiatric scene as both agent *and* recipient of the dictates, formulations, epistemologies, technical and technological practices of the medicoscape. That this medicoscape is defined in terms of an individual adherence to for example drug regimens, is here contrasted with the injunctions towards collectivism as found in keeping with the Islamic dictate to be my brother’s keeper. This dictum is however set within a view of not just Islam but at times competing but as we have seen in Chapter Two largely cooperative belief systems such as Catholicism. It is with this regard that we can see the deployment of certain ethical or moral codes that subsume the smaller rubrics of
biomedicine and the interactive faiths. I examine closely this ethical regime in an effort to find ways to speak to the sign at the fork in the road. I pose the question here how can we see the operation of the medicscape as an ethical device? We are forced to return to an oscillatory model because that ethical device is itself based upon the medicscape as a universalizing discourse that has particular applications. The interplay between the individualistically and positivistic orientation of the biomedical along with the collectivist constructions of Islam returns us to the central thesis that the two forms of social expression are in fact related in a oscillatory fashion.

The title for the Conclusion is The Penc and Models of Oscillation in Global Relationships. I conclude by calling for a model in the social sciences of reconciling so-called collectivist societies with individualistic ones. By referencing the work of Amselle, I return to the paradigm of oscillation that best explains the cosmopolitan, postcolonial, urban landscape of Dakar, Senegal. The point of this concluding chapter is two-fold. First, in a self-reflexive gesture I reiterate Amselle’s thesis that anthropology needs to be a science that analyzes mixing. And second, that that mixing is the best way to characterize African postcoloniality. If we use a paradigm of oscillation –of mixing—we can better view Senegalese culture as non-static, politically complex, and ultimately as implicated in global relationships.

Towards that end, I now begin our discussion by addressing the temporal mixing of colonial constructions alongside postcolonial realities in characterizations of both ‘The African Mind’ and ‘African Culture’.
Chapter One

The *Penc*, Clinique Moussa Diop, and Senegalese Psychiatry in Contemporary and Historical Context

On a sunny afternoon in August, I sought out Adil who had proven to be very helpful in my interviews. He was still working with a patient, so we agreed to talk after he was finished. We met subsequently at the library. We were leaving and Adil told me he was going to call a friend who would accompany us to *La Provençal* where we were scheduled to have lunch. We waited again and so I decided to go inside and get my belongings so that Jeanne, the librarian, could close up if Adil and I proved to go too long in our interview.

Adil’s friend came down from her work. Her name was Beatrix. She was a sixth year med student doing her rotations for her degree. We arrived at the restaurant and after we found our seats, Adil remarked that he “usually [sat] on the other side. I have my place that I go to every time I come here…” I asked him if he wanted to go to his regular spot and he remarked that some times “change is good.”

I initiated our conversation by asking about the clinicians’ education. Specifically, I wanted to see how significant Henri Collomb’s presence and theories impacted their education. My hypothesis was we could “measure” Collomb’s influence as derived from his departure from colonial ideas about what constituted effective therapy in his day, and we could subsequently gain a perspective on clinicians’ training in a postcolonial context. But my analysis given my interaction with Adil and Beatrix would also prove Gupta right: postcolonialism is not just surmising the colonial legacy, it is a condition that implicates global relationships, that in this case involved knowledge-production and applications of that knowledge in a manner such that
we can identify the operation of the medicoscape. My hypothesis seeking to measure Collomb’s influence proved accurate given the following interview. Beatrix began the discussion:

BEA: Our educations are universal. It is what we have studied that allows us to work together despite coming from so many different places. So that that which comes from France can be applied here for example. At least at the intellectual level.

Beatrix provides the example that Africans actually come to the biomedical doctor as a last resort.

BEA: There is a conflict that happens when the ill come to the clinic as a last resort but at the same time they recognize that the medicine of the white people (paju tubab) works.

ADIL( chimes in): There are two sides: the Occident in terms of treatment and the indigenous and so there are two different contexts for treatment. In terms of globalization… globalization was limited because the two different contexts were not equal. Collomb came to Senegal…Dakar… and he brought certain tools to deal with acculturation and all the issues of Dakar’s entrance into the modern world, if you want to call it that. But what I have found is that because there are two different contexts, the illnesses that people suffered with were different! So, Collomb had to intervene in terms of the social or at the level of tradition… you see? So, he used a lot of techniques, that he brought to the clinic, like the accompaniers, liberty for the patients to come and go at will, and he used the penc as well.

ERIK: But Collomb is not the only psychiatrist in Africa to argue for the use of the tools of social science to meet the needs of postcoloniality…There was Collomb, yes, but also Lambo in Nigeria, and the most important of all, Frantz Fanon.
BEA: Yeah, I’ve heard people mention him, who was he?

ADIL: Me too…

ERIK: Fanon was one of the most famous psychiatrists in Africa. He really was the one who came up with a language of revolution for the Algerians.

BEA: Yeah… I understand…

ERIK: Why do you think people haven’t heard of him or don’t discuss him here in Senegal?

BEA: I don’t know…

ADIL: I don’t either… can you write it down?

ERIK: I think it has something to do with peace…

BEA: You mean…

ERIK: Yeah, I mean Senegal became a free country peacefully…

BEA: Yeah, that may be it… Senegal did not have a war to get its independence.

ERIK: Like in Algeria.

BEA: Like in Algeria; we didn’t fight for our independence.

ERIK: But why not Fanon? In the US you can’t really take a course on colonialism without talking about Fanon… Actually, you really can’t take a course on social theory without learning about Fanon… But by the same token, people don’t talk about Collomb in the US, even psychologists… not even Lambo.

ADIL: Nigeria.

ERIK: Yeah, in Nigeria…
We sit in silence for a moment and then I ask about the clinic’s historian, the Belgian scholar, Rene Collignon, and his unoptimistic view of the way the clinic operates right now. Adil launches into a diatribe about his experience at his defense for his thesis. He explains that the other person defending that day had written 50 or so pages in 14 font, whereas he had written 60 in 12 font. He seemed genuinely miffed and frustrated. He relayed the story that he knew his committee had not read his thesis because he was able to talk about certain sections of it and they said, for example, that he hadn’t introduced his topic and/or thesis until page 55 but he knew for certain he had done so on page seven. He gives another example in which he used some statistics not so much to discuss the numbers as to introduce the ideas of Collomb and the way the other hospitals had changed their policies because of his influence. The stats were merely to show the use of stats themselves and how that changed at other hospitals after Collomb. He said that this was possible in part because Collomb introduced international ideas through his journal *Psychopathologie Africaine*. Adil concluded by saying, “They are not serious [French idiomatic expression for ‘sincere and hardworking’]. They don’t read enough [meaning the documents that students generate as well as other professional materials].”

We learn about several aspects of Collomb’s influence. First, Betatrix claims that their educations are ‘universal’. How are we to understand this notion of universal? What implications does it have for our efforts to grasp the relationship between the universal and the particular in as much as that relationship forms a crucial aspect of cosmopolitan studies? Finally, what relationship does her claim have to a history of claims about the nature of African or specifically Senegalese culture? I want to address these questions in turn. We begin with the cosmopolitan debates around the issue of the particular and the universal.
First, Martha Nussbaum speaks in terms of the universalistic aspect of her notion of cosmopolitanism with reference to the Stoic ideal of the ‘world citizen’ and in the very same instance by articulating a normative claim; namely that we ought to behave in such a way as to recognize our universal human experience and ontological status as human beings. She argues then with reference to this two-fold agenda, “[w]e should recognize humanity wherever it occurs, and give its fundamental ingredients, reason and moral capacity, our first allegiance and respect” (Nussbaum 1996: 7). It is in these terms that we can define the universal in the context of cosmopolitanism as the unifying experience of the human in terms of the experience of reason and moral claims. So, for example, Ananta Kumar Giri quotes Fred Dallmayr as saying that Nussbaum “by defining reason as the universal human “essence” her account renders differences non-essential and marginal” (Giri 2006: 1282). Giri in his review of the literature brings us to an understanding to the debate over particularism and universalism when he goes on to say speaking of the work of Luce Irigaray that she challenges us “to inhabit a space of ‘in-between-traditions’ rater than a self-confident contract between a triumphant universalism and a supposed particularism” (Giri 2006: 1282). We will touch on that in-between-traditions piece directly; for now, let us return to Beatrix’ claim that it is the universality of the clinicians’ education that unites them. I would argue Beatrix is articulating a “top-down universalism” that mirrors Nussbaum’s normative claim for the universal experience of humanity. To be clear, Nussbaum makes an argument for a cosmopolitan education that Beatrix would seem to be saying best describes the education the clinicians working at Clinique Moussa Diop receive. Nussbaum writes of this type of education: “this means that students in the United States, for example, may continue to regard themselves as defined partly by their particular loves –their families, their religious, ethnic, or racial communities, or even their country. But they must also, and centrally,
learn to recognize humanity wherever they encounter it, undeterred by traits that are strange to them, and be eager to understand humanity in all its strange guises” (Nussbaum 1996: 9). My descriptive claim, then is that the clinic is a cosmopolitan space precisely to the degree that it favors this universal sense of humanity vis a vis an application of reason, while at the same time incorporating the various elements of that universality that can be said to be local and culturally contingent, but significantly not morally contingent. That universality is to be understood in terms of the unification of the community of man precisely to the degree that we operate with reason and moral codes that are to some extent similar or in certain cases –as in the Judeo-Christian-Muslim-- the same agendas. Citing Hegel’s claims for defining the modern state in terms of allowing ‘the principle of subjectivity to attain fulfillment in the self-sufficient extreme of personal particularity, while at the same time bringing it back to substantial unity and so preserving this unity in the principle of subjectivity itself” (Hegel 1991: 124), Robert Fine conflates Hegel’s unity with the notion of the cosmopolitan. He explains that “[i]n this conception, the unity of the cosmopolis, no less than that of the state, cannot be conceived apart from the will of individuals who retain their particular interests, identities and rights, for its principle is to harmonize species-wide universality with the freedom and well-being of individuals…” in this way, “the universal and the particular are finally reconciled” (Fine 2003: 462). It is with reference to these notions of reason –read: education—and morality that we can understand Beatrix’ claim for a universal education. But she also says this is at the intellectual level. She then goes on to invoke the particular by arguing that French psychiatric ideals have to contend with traditions in Senegal that are unique. So that the practice of going to a traditional healer before seeking the services of the psychiatric professional is itself a unique expression of cultural mediation on the part of the Senegalese. We find here an articulation of a cosmopolitan
space precisely in Nussbaum’s terms—the interaction of the particular cultural commitments alongside the claim that what unites is the notion of a universal education that finds its expressive force in a common humanity—that find their antecedents in the terms of the ancient Stoics on to Hegel’s claims for a unifying subject formation. Homi Bhabha locates this relationship with the particular and the universal both spatially and temporally “in the value system of the European Enlightenment” (Bhabha 1996: 49) whose antecedents are of course in Hegel. Beatrix’ claim for the unifying force of their universal education can be found in articulations of what she herself identifies as an intellectual trajectory stemming from engagements with that Enlightenment tradition as exemplified in Senegal’s connection to France. That is where Collomb and his influence comes in; for Collomb as a French expatriate brought as Adil says certain tools to deal with Senegalese acculturation, for example, that were formulated around his unique interpretation of the universal attributes of an international psychiatry—Adil references *Psychopathologie Africaine*—as applied to the *traditions* he found on the ground in Senegal. In this way we find the negotiation of those aspects of the clinicians’ training that is theoretical in relationship with those that are practical or clinical in manifestation. It is with reference to Collomb’s understanding of the Senegalese traditions—in terms of an intellectual or theoretical tradition that itself comes from France—we find the grounds for his innovations of which the *penc* is a cardinal example.

Collomb’s innovations were to some extent at the level of *tradition*. As Adil asserts it was with regard to Senegalese traditions that Collomb most significantly devised innovations to treat illnesses that as Adil asserts further, were *different*. It is with this regard that Collomb assembled his pluridisciplinary team of ethnographers, and other social scientists, physicians, psychologists, social workers, nurses, and the European interns. I have addressed this team in
terms of the work of the anthropologist Andras Zempleni in the introduction. But here it is important to make two points: first, that the use of these actors was geared towards understanding the *particular* context in which illness manifested and was understood (an example as we have seen is the illness associated with ancestor worship that was treated with the *ndop* ritual); and second, that the use of these actors speaks to the constructions of mental illness as found in the extant ethnopsychiatric tradition. As to the latter, there is a direct line of descent from Enlightenment ideals of universality in which we find the application of these theories to Africans. We find in this regard the inverse of the positive articulations of cosmopolitan universalism such that the particular context of African psychosis for example was occluded in favor of the ultimately negative application of psychiatric ideals that did not successfully incorporate local understandings of mental illness. Collomb sought to correct this occlusion in psychiatric ‘science’ by marshalling the service of the culturally relativistic social science of anthropology. So, when Adil references tradition he is speaking of Collomb’s use of this team of social scientists alongside psychiatric professionals. The story of this team reveals the history of colonial constructions of mental pathology among Africans. But we can go beyond the notion of an historical legacy by positing that it was a system of relationships that defined the colonial condition in terms of these concepts of the universal and the particular. This system implicated Collomb in dialogue with such global actors as Britain, but additionally in responses to the colonial constructions of African mental pathology in dialogue with other African countries and presumably cultures, as well as other global locales. We see then in Beatrix’ reference to a universal education not just the influence of these global actors as members of an international community of psychiatric professionals, but also the relationship this history has with the
postcolonial condition as found metonymically in relationship to the clinicians’ current education.

But Adil and Beatrix’s unfamiliarity with Lambo and Fanon speak also to the postcolonial condition. This unfamiliarity is expressed in terms of a disjunct between the historical trajectory of the development of African psychiatry and its current instantiation. These physicians’ understanding of their specific relationship to Collomb and his approach links up with expressions of the universality of professionalism. Understandings of the role of the psychiatric professional and his relationship with extant psychiatric knowledge-production can itself be seen to be highly local and to some extent limited. The medicoscape at once broadens horizons by arguing for a universal science; but at the same time in the postcolonial instance it creates distance between geopolitical actors. The particular case of Senegalese psychiatry involves Adil and Beatrix in a psychiatric discourse that is highly local. So it is that Collomb is largely neglected in the history of psychiatry in Africa (see Bullard 2005). But by the same token the greats are also neglected in a Senegalese context: Lambo and Fanon are only superficially known. This unfamiliarity shows the medicoscape is indeterminate and at once spatially inclusive while at the same time spatially and temporally dispersive. Our subsequent apprehension of the normative claims of cosmopolitanism is forced to grapple with the way that the local and the global interact and are mutually influential. At both the level of education and at the level of traditions—both Western and Senegalese—there is a commingling that makes the world a smaller place while also forcing it into configurations that broaden its scope. This can be seen as I have alluded to the notion of a cosmopolitan education that Beatrix references.

Nussbaum suggests that one example of her definition of cosmopolitan education—which as we have seen is an apt description of the cosmopolitanism of the clinic’s brand of education—
is to be found in notions of the family. She writes: “we are helped immeasurably by looking around the world to see in what configurations families exist…”. This call to look at family configurations as an example of a possible way to treat a cosmopolitan education addresses the notion of the family as the site for the deployment of cultural attributes. It emerges as significant here because Collomb too held the idea that the family was central to an application of his theories of a particularistic oriented psychiatry; in other words, Senegalese psychiatry could best be developed according to those principles thought to constitute Senegalese cultural traditions chief of which was the notion of the collective. This collective was defined by Collomb in large part by his interrogation of the Senegalese family. So it is that I want to now turn to Collomb’s engagement with the theoretical framework of family systems as a way to address his characterization of the family in Senegal. We will also see that these ideas were cast in the context of global ideas about the family. As to the contemporary moment, as I have said, the family defines the notion of the collective used at the clinic. This fact has its roots in Collomb’s work and forms yet another way of measuring his influence on practices at Clinique Moussa Diop.

**Family Systems Theory in the Context of the Penc**

On a typical Wednesday or Friday penc day the patients and the family members who accompany them filed into the space. The accompaniers most often sat next to the patient. In some cases, I observed them performing such duties as restraining their family member if they were displaying disruptive behavior; but more frequently whispering gentle words of encouragement to patients who were reticent. A typical interaction between the penc leader and an accompanier might go as follows:
MAMADOU (PENC LEADER): What is your name?

ACCOMPANIER: My name is Aadama.

MAMADOU: Your younger sister is ill?

ACCOMPANIER: Yes, she is ill.

MAMADOU: Is she sleeping well?

ACCOMPANIER: Slowly but surely; it’s getting better.

MAMADOU: Does she have medication? Is she taking it?

ACCOMPANIER: Yes.

MAMADOU: Is she taking fluids?

ACCOMPANIER: Yes.

MAMADOU: Does she eat dinner?

ACCOMPANIER: Yes.

MAMADOU: Does she eat lunch?

ACCOMPANIER: Yes but she doesn’t like it [difficulties eating are a feature of clinical depression, it was explained to me later].

MAMADOU: Have you gone home/do you guys leave the hospital and go home?

ACCOMPANIER: No. Not yet.

MAMADOU: Great! Thank-you.
Conversations with accompaniers invariably take this standard format. Questions posed to accompaniers centered around the daily behavior of the patient: are they eating; are they sleeping; are they taking their medications. Occasionally, conversation would drift onto the topic of the patient’s treatment, so one day the following conversation transpired between the brother of a patient and the penc leader:

MAMADOU: What is the problem?

ACCOMPANIER: He has problems with women.

MAMADOU: What is the problem with women?

ACCOMPANIER: His wife is mean.

At this point, Mamadou might switch to French in deference to the clinical nature of the conversation and to the demands placed upon him to also meet the needs of the clinical staff not all of whom speak Wolof:

MAMADOU: You have said that his wife is mean. Why do you say that?

ACCOMPANIER: Because… [At this point the accompanier trails off in an effort perhaps to preserve the privacy of the patient. Sometimes accompaniers would grow reticent when faced with either a large group or a group that seemed to have too many strangers: foreign researchers or students doing internships at the clinic (and known in Wolof as tubab; the term also glosses as ‘white people’). Also, at times doctors would intervene and instruct patient accompaniers not to delve too deeply into personal matters. This contrasts markedly with my exposure to clinical
settings in the US, where group therapy frequently is seen as therapeutic precisely because of its revelatory properties.]¹

There are at least three crucial aspects of this vignette that are worthy of comment: first, there is the reference to drugs and drug regimens (do she have meds? Is she taking it?) and second, there is an analysis of behavior as observed by the family member; finally, there is the preservation of confidentiality. As to the first, the reference Mamadou makes to the medical regimen indexes the overwhelming influence of the biomedical model. While the penc is a quasi-religious event there is nevertheless a reinforcement of the scientifically ratified and universally applied biomedical model that is defined by the use of the drugs Mamadou mentions. It is part of the family role to make sure the patient is not just taking his medication but also and by extension adhering to the protocols of the clinic. In this regard and secondarily the family accompaniers can be seen to be fulfilling the role of surveillor. They assist in the successful operation of the treatment by participating in observing and/or monitoring the patient’s behavior. This however, in the third instance is mitigated by notions of confidentiality that at once preserve the dignity of the patient but also place the illness in a social context in which mental illness can be said to be not just an ill for the patient but also an ill that the social body may find problematic. There is a silence around these concerns that broadens into a silence around other social concerns such as faith, and political affiliation. I examine this silence in Chapter Two. For now it is important to note that confidentiality is an index of not just the dignity of the patient but also of the norms of the culture such that the patient’s behavior may be viewed as compromising

¹ I address the possible ramifications of the presence of foreigners upon the transreferential aspects of the therapies in both Chapter Three and Chapter Four. At this juncture, it is important to simply note that therapy with researchers watching is not the same as standard therapy. This becomes especially important in our discussion of the talk therapy practiced by the clinicians in their consultations with patients.
their presentation of self and therefore a certain silence must pervade notions of illness and of treatment.

The notion of silence speaks to the compromised sociability on the part of the patient. The clinicians’ viewpoint was that the practice of accompaniment allowed for the return of sociability to the patient. The maintenance of confidentiality as seen in the vignette becomes an index for the return of the patient to sociability. While not directly referenced in the vignette, the concern the accompaniers have for their sick family members can be seen in a positive spin upon the surveillance that in part defines their role at the clinic. Family accompaniment can be understood as a rubric for the return of familial affection. The preparation of the patient for their exit from the therapeutic milieu is tied to not just the return to sociability, but also to the insistence upon the use of the biomedical model and the accompanying emphasis upon drugs and compliance. These aspects of family accompaniment can be seen in the following conversations with clinicians. These conversations confirm the image of accompaniment as a way to engage the patient in a web of relationships upon which the family system hinges. In many respects we find here a way of addressing the intense exposure to scrutiny that the moment of confidentiality indexes: namely, the act of speaking for the patient, a role the family accompanier takes seriously. A role however that the clinicians argue is necessary but not without its pitfalls. In fact returning us to the universal application of the biomedical model, we see these pitfalls as articulated within concerns over the proper individuation of the patient. In the following snippets of conversations we find then the goals that the clinicians see in the application of Collomb’s precedent of family accompaniment.
Clinicians’ Views of Accompaniment

Ghalib on accompaniment

Ghalib had a perspective on the role of accompaniment at the clinic that speaks to theories of the family and was the typical view held by clinicians:

Accompaniment is a therapeutic technique that incorporates the presence of the family. The family member is a witness to both the crisis and the cure. They can explain what is going on with the patient. They are the medical representatives in the family and when the patient leaves they can explain to the family what is going on with the patient.

Dr. Rosa (a frequent visitor to the clinic who worked at L’Hopital Principal):

One has to respect the social models of the patients. Here there is respect for life, so one must adopt in the milieu the norms of life. One must permit the development of a certain minimum of sociability. So, the visits of family members and accompaniment allow the patient to recuperate the affection of the family. The accompanier makes the clinical experience [toujours ouvert] always open [meaning the accompanier allows the patient to return home on occasion given the clinic’s open-door policy, by which patients can leave at will. With the presence of the accompanier these family visits are facilitated and so:] and the patient is prepared to leave [the clinic].

Julie, the art therapist

On June 22nd, 2007, I had an interview with Julie the art therapist at the clinic and she had this to say about the practice of accompaniment:

There are definitely negative moments but for the most part it is useful. Here’s a story: I treated a young woman who was very, very depressed. She wanted an examination outside of the regular operation of the clinic. It was her sister who prevented it. She had a certain force in the life of the patient that meant she was too present [trop present] in her therapy. The patient then couldn’t be helped. The doctor said, “I can’t help her”. She never came back. It was impossible to construct a rapport with the patient. This is not usually the case in the atelier. Each one of my patients is expected to share. In some cases, it is the parent/the Father who causes the problem.
Family systems theory as conceptualized by Julie in patriarchal terms became fashionable in the 1950s directly when the clinic was getting its start. Emphasizing Freudian theories around the Oedipal Complex and the Elektra Complex, such thinkers as Stack Sullivan and Gregory Bateson (an anthropologist) endeavored to contextualize schizophrenia within a broader social context by formulating the theories of family systems.²

Collomb takes up the issue of the family directly in his chapter in *The Child in His Family* (Koupernik, Anthony J. and C.), entitled, “The Black African Family”. He examines the issues surrounding family therapy and the theories that form the basis of his use of family accompaniment at the clinic. He addresses three points (at least) that we will find form a pattern in the development of the use of the *penc* at the clinic as well as the history of the development of the clinic itself. These three points are: [1] the universalizing impulse when it comes to African family structure[s]; [2] acculturation and urbanization; and [3] increased individuation. As to the first, Collomb invokes the notion of ‘Africanity’ to speak to the overriding presentation of the family structure—or better yet *system*—in an African context. He explains: “This unity [that of the whole of African experience], made up of the whole of the elements to all societies within traditional Africa, is ‘Africanity’” (Collomb & Valant in 1979: 359; italics his). For Collomb there is a universal—a unity—African experience of which the family is one of the basic aspects. As to point two—the deterioration of the family in the throes of acculturation and

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² Corsini & Wedding’s textbook, *Current Psychotherapies*, has this to say about Stack Sullivan: “Sullivan moved away from a biological explanation [for schizophrenia] and toward a psychological one, sensing that the primitive relationship between mother and child was critical in schizophrenia...Therapy was moving toward a system concept” (Corsini & Wedding 1989: 460). As to Bateson, they discuss him in terms of his ‘double bind’ theory in which, “a person is put into a situation in which whatever choice he makes is unacceptable” (Corsini & Wedding 1989: 461). According to Bateson this double bind was the experience of the schizophrenic in the family system. The child, for example, might be told by its mother that it is loved but the message is conveyed in a cold manner. The double bind of this communicative event would cause the child to be bewildered and ultimately to withdraw (see 461). These behaviors are then labeled abnormal and the child is “put away”. For our purposes we might say the person assumes the sick role. More on that later in this section.
urbanization-- Collomb observes: “The unity of the African family depends on a traditional idea of the family.” But this traditional organization is today subject to external pressures due to the rapidity of modern social changes. These disintegrating forces grow as the phenomena of Western acculturation, urbanization, and industrialization become more widespread” (Collomb & Valantin 1979: 360). Two subsidiary points at this juncture: first, concerns over acculturation and urbanization in a global context formed the backdrop of post-colonial attitudes towards mental pathology; and second, it is perhaps not too grand a leap to suggest that it was the preservation of the family ‘organization’ that led Collomb to implement the use of accompaniment at the clinic. And indeed this was confirmed for me by clinicians who ventured to say that the family is crucial to treatment because the family is at the heart of African culture. Accompaniment for these clinicians came to signify the effort to meet the needs of traditional culture as well as meeting the dynamics of a swiftly disintegrating sense of what they thought of as collective identity. And this brings us back to the discussion of the three features of the article that I wanted to highlight, for increasing individuation was a process that while never completed remained in constant tension with the collectivist attitudes that Collomb argued were central to Africanity. He writes of individuation: “In the series of structures which continue and overlap – the individual, the family, the society, the family is growing weaker, while the individual and society are growing stronger” (Collomb & Valantin 1979: 366). He continues: “Modern techniques separate the generations and lead to individuation through competence, competition, and the need to excel… The Family Council and all other counsel or advice in general, which serve as communication links as well as frames of reference, are losing their hold and are no longer listened to. By the time they reach adolescence the men realize that they are individuals,
concerned only with themselves and for themselves, responsible for their own destiny and in opposition to others” (Collomb & Valantin 1979: 382).

There is an apparent interplay located in the presentation of these three points—individuation, acculturation and urbanization, and African traditional culture—that compels Collomb to describe the African family in terms of a “…kinship network which is widely extensive, very tightly woven, and very complex, and in which, for each function and for each situation, attitude and behavior are defined by tradition. In each society [in Africa], the boy or girl learns progressively during childhood about the rights and obligations of each kinship role they will have to assume. Nothing is left to improvisation. This social organization ensures an extraordinary solidarity. There is no place for solitude. Each member of the group is duty-bound to give mutual aid and protection. The complement to this is a quasi-total investment in relationships with others, a rigidity of behavior, an absence of liberty and autonomy…” (Collomb & Valantin 1979: 371). It is then the tension between the traditional family ‘organization’ and the emergent process of individuation that makes for a crucible for mental illness.

Most significant of these mental illnesses, for Collomb as with other family systems theorist was schizophrenia. He explains, “The breaking up and disorganization of collective identification models, the dislocation of the group, the gap between the generations, the contradictions of education, and the solitude within the lineage and the brotherhood pave the way for schizophrenia which is increasing in the cities. The disintegration of the family makes it no longer possible for it to fulfill its functions; there is no longer any continuity between demands made on the child and those made on the adult. Authority generates conflicts and separates individuals rather than uniting them. A social pathology develops…” (Collomb & Valantin 1979: 82)
386). For Collomb, then, pathology develops at both the micro – schizophrenia—and the macro levels – social pathology.

In terms of social pathology Collomb connects the emerging dependence of the individual on abstract categories such as the State and Government, to the deterioration of the family: “On all levels of economic and social life, interference by the State and by political institutions is growing, resulting in a modification of family structures” (Collomb & Valantin 1979: 366). ‘Modifications’ that Collomb clearly sees as deleterious. These are all facets of the aforementioned processes of acculturation and urbanization.

It is odd that Collomb fails to connect these processes with colonialism the most pertinent “political institution” that had preceded the then contemporary “interference by the State.” In fact, he does not mention colonialism in any critical manner, opting for the looser and rather ahistorical term of ‘Occidental’. I do not want to make the same mistake and seek in the rest of this chapter to link Collomb and others brands of psychiatry to colonial ideas about Africanity – i.e. so-called traditional African culture—The African Mind, and the science of biomedicine as a burgeoning presence on the international psychiatric scene in the early years of the clinic. It is with this regard, significant that the header for the text, *The Child in His Family*, is: *The International Yearbook for Child Psychiatry and Allied Disciplines*. I would argue this speaks to the international protocols of which family systems theory was clearly a feature, that were developing around notions of sound psychiatric treatment most especially for schizophrenia. These international protocols I refer to as forming a medicoscape.

I want to return to the *penc* if only because it, alongside Collomb’s innovation of accompaniment, are the most unique aspects of treatment at Clinique Moussa Diop. Indeed, both practices stem from the same impulses: first, to integrate patients into an otherwise alien
therapeutic practice by using their own familiar semiosis; and second, to promote adherence to
Collomb and other theorists’ ideas about the collectivist orientation of African culture sui
generis.

The *Penc* in Historical Context

The term, *penc*, means ‘gathering’ in Wolof and indexes rural conditions and practices: a
past in which the country had fewer developed urban centers. My interlocutors explained to me
that the *penc* was a gathering that was held at the outskirts of a village to discuss issues facing
the community as a whole. The use of the *penc* at the clinic, which dates back to the clinic’s
naissance in the early ‘60s under the tutelage of Collomb I would argue indexes a colonial past
just as much as it does a ‘traditional’ village and rural practice. It indexes a *conception* of Wolof
culture that views the African as community oriented or in other words, collectivist in attitude.
The notion, then, that the *penc* is ancient and ‘traditional’ actually says more about conceptions
of the most effective manner to treat Senegalese patients than it does the village life which are
said to be its antecedents. So, what are the parameters of that conception of the Senegalese
patient? In the next section of this chapter I will take up that question by positing that there are
two forms of colonial psychiatry that are implicated in the notion that one needs to use
collectivist oriented treatment modalities to intervene on behalf of the mentally ill. In order to
pursue that route we must consider more in depth the work, arguments, and theories of Henri
Collomb.

Perhaps most important of all, then, Collomb made the claim contra the
ethnopsychiatrists like J. C. Carothers (as mentioned in the Introduction), that Senegalese
pathology could only be understood and subsequently treated by examining closely the *culture* in
which the pathology emerged. Additionally, he sought to understand indigenous forms of therapy, hence a blended approach, which necessitated the presence of social scientists—chiefly ethnographers—at the clinic. Leopold Senghor calls this blended approach a “traditional psychotherapy” (Senghor 1979: 138).

But Collomb preferred the term ‘social psychiatry’ to describe his blended approach. Collomb’s theory of ‘social psychiatry’ also placed him within the discussion of the swiftly ascendant biomedical model—and therefore in dialogue with the international psychiatric community. He wrote for example:

The truth is in Western psychiatry, and above all in Western biological psychiatry, with its conceptual medical models, its medicinal therapies, the white scrubs, its clinical devices, the hospital beds…[there is] The Medical School [that] teaches in effect how to recognize mental illnesses, how to reveal their biological causes, and how to treat them with drugs more or less specific [to the disease]… (Collomb 1973: 348).

Clearly, then, his critique was aimed at not just ethnopsychiatry in general, but rather at an emergent medicoscape in particular that tied the fortunes of the patient to biological interventions. His own ideas were emergent, however, within international debates, so that in 1979 he concludes:

The new interest in international organizations in traditional medicine, Africa in particular, (WHO) is explained by the desire of populations to rediscover a cultural identity that has escaped them (Collomb 1979: 459).

The reference in the first quote to the all-pervasive Medical School was a direct critique of the training doctors, those working with him among them, received in Occidental schools, which were principally located in France. And from the second quote we see Collomb accommodating

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3 Senghor puts it as follows, “Henri falls on the side, then, of a traditional psychotherapy, such as that practiced in Senegal, at the crossroads of animism and of Islam, despite and at the same time under the effects of three centuries of a French presence.” (Senghor 1979: 138)
what he perceives to be international trends that exhibited an interest in indigenous medical practices. There are two points to be made at this juncture. First, Collomb seems to be negotiating in ways that are extant today at the clinic, the global trends or medicoscapes that themselves pull in two different directions: the one towards a positivistically oriented set of treatment modalities and relationship to medical technologies; and the second, in the direction of validating indigenous health maintenance behaviors. Notice the dates though; it was work done by Collomb and others who had pushed this agenda onto the international psychiatric scene, by the late 1970s. The second point is, Collomb imagines perhaps nostalgically, but certainly in a politically loaded manner, that populations are seeking their cultural roots and therefore the international psychiatric community had better watch its p’s and q’s and heed the call for a psychiatry sensitive to indigenous practices. These debates remain at the heart of psychiatric theorization as applied to postcolonial metropoles. In the current medicoscape, therefore, there persists a call for a sort of ‘social psychiatry’ that Collomb in part set out successfully to define for an international community of clinicians. Towards that end, Collomb founded the literary organ of the clinic, *Psychopathologie Africaine*, which was intended to participate in on-going debates in Pan-African contexts. The body of work produced by the journal however has outstripped these boundaries as I think Collomb hoped and not unlike its charismatic progenitor has come to play a role in discussions of clinical approaches in other parts of the world.

Collomb wrote for journals in other parts of the world, himself, especially the Francophonie world, and in one such journal, we find my quibble with Collomb that his was a complete departure from ethnopsychiatric tradition. Collomb wrote an article entitled, *From Ethnopsychiatry to Social Psychiatry*, in the Canadian Journal of Psychiatry, months before his death and published posthumously. It is never clear whether Collomb opposes pharmacology, but
I think, not, given the elite status of the pharmaceutical tradition at Fann Hospital where Clinique Moussa Diop is housed. He did not oppose it, but rather saw it as only a supplement to on-going socially oriented therapeutic modalities which by virtue of their sociality were considered to be traditional, hence Senghor’s reference to “traditional psychotherapy”. But it is with reference to the traditional that I see Collomb only partially re-formulating the earlier ethnopsychiatric concepts of not so much perhaps the African mind but certainly the African mind (read: Senegalese) in relationship to African culture. That is to say, Collomb shared with his colleagues that he much maligned, a conceptualization of African culture as collectivist in orientation.

In contemporary context we can go beyond the colonial legacy and pace Gupta we can argue that Collomb’s innovations place the Clinique at the center of debates over an emergent global psychiatry. With this regard, the penc emerges as a group therapy that is not too unlike those I have observed in the US. What distinguishes it from this other context? The presence of Islam. Certainly there are also formal channels in Western context for spiritual expression and even orthopraxy such that there are chaplains on many wards in the US. But in group contexts in the West prayer and other religious observances are strictly discouraged if not forbidden. In other words in formal group therapy sessions you will not find clinicians praying along with their patients. I am sure there are conflicting examples but as a rule religious observance is discouraged among most especially clinicians. This is not the case at Clinque Moussa Diop where countering Bhabha there is rather a sacralization of public space (see Bhabha 1996: 51).

Towards understanding what he terms vernacular cosmopolitanism, Bhabha asks, “is it possible to be “culturally particularist” without being patriotic? Committed to the specificity of event and yet linked to a transhistorical memory or solidarity?” (Bhabha 1996: 43). He goes on to call for a secularization of the public sphere (p.51). With the penc the opposite process seems
to be occurring and it is so precisely in terms of cultural particularism as related to a transhistorical memory or solidarity. For the *penc* is a specific event that via Collomb is linked to a memory or solidarity over not just the traditional in a Senegalese context but also the traditional—read: Enlightenment—in a French context. The ideals surrounding the *penc* and its use come from an *encounter* between the two nations: it promotes a sense of multiple-belongingness as the patients negotiate Islam alongside the French and colonially derived notions of African or Senegalese culture and in turn alongside the emphasis placed upon the foreign biomedical model. It is the commingling of these elements that gives the *penc* its distinctive character. But Bhabha also suggests there is a conflict between articulations of a human community and the cultural particularity that leads to a neoliberal patriotic subject formation. What are we to make of this patriotism? As we will see in the next chapter, the clinicians promote an apolitical agenda at the clinic in such a way as to diminish the negative aspects of particularist political agendas and commitments. That they do so with reference to Islamic practice and a commitment to an inclusivity that manifests both in terms of local interpretations of for example Koranic based orthopraxy as well as with regard to other faith systems such as Catholicism speaks to the way patriotism is challenged as a broad rubric for sociopolitical allegiances. We examine the process of silencing such divisiveness and the accompanying fostering of an inclusive environment in the next chapter. But before transitioning to the next chapter I want to return to the *penc* in an effort to more fully characterize both the ways the group therapy session accommodates Bhabha’s ideas about vernacular cosmopolitanism and the ways the clinic’s context departs from his ideals. In so doing I hope to move us along in our understanding of not just the unique brand of cosmopolitanism at the clinic, but to also add to a possible definition of this cosmopolitan space as one which oscillates between secular and sacred
never fully dissolving into either social—and as we will see, political—binary. It is then to a
description of the penc in the contemporary moment that I now move.

The Penc in Contemporary Context

I introduce two new clinicians in this section: a nurse named Awa and a social worker
named Doudou. I reintroduce Dr. Adil. These three refer to the penc in contrasting manners. For
Awa and Doudou the penc is a positive force in treatment. Dr. Adil for his part gives a more
nuanced view of the group therapy. His concerns about its use reference the role of Sufi Islam at
the clinic that will be investigated more thoroughly in Chapter Two. He also helps clarify the
role of the penc leader Mamadou and provides some clues as to why he has become the leader
and why he seems to be so charismatic in that role. In Chapter Two I turn to Mamadou’s
charisma. For now, I simply want to note that Mamadou’s presence as part of the institutional
structure and use of the penc was not always viewed positively. This may speak to my argument
that individual self-expression is constantly being negotiated with the ideals of collectivism
voiced by both doctors and patients. The ideals derived from the ego-centered therapies both
provided grounds for Mamadou’s presence while also exposing the weakness of using him as
penc leader.

Awa

On a fall day in August I met with Awa at La Provencale, the restaurant I have already
mentioned that is directly across the street from the front gates of Fann Hospital (see
Introduction for map of hospital that houses the clinic). Awa was wearing a dark blue veil and a
white lab coat. Her face was always framed by a veil. I refer here to her professional demeanor because as we will find in the words of Henri Collomb the progenitor of the clinic, lab coats are associated with a certain clinical habitus that was in his day critiqued but has become current at the clinic; at least with Awa and the other nurses who all wear these lab coats, regardless of gender. Furthermore, this change indicates the clinic seems to be less and less committed to the ethnographic specificity that so characterized it in the 1960s. By this I mean, the use of ethnographic detail to determine such attributes of the therapeutic milieu as what to wear. Awa is in today’s context, a clinician precisely because she wears a lab coat. Curiously enough, this is counterbalanced with the veil.

Additionally, the presence of lab coats speaks to the very real need to [a] separate themselves from the patient population through dress codes; and [b] the need to be circumspect in the handling of drugs and medications. This latter is achieved in part by wearing sanitary lab coats. This lends itself to an appreciation of those parts of the biomedical model that work or are present for very real or actual clinical motivations.

Awa remarks that she is “only” 25. She began working at the clinic in 2001. She says many times during the course of the interview that she enjoys working at the clinic. I press her to explain in greater detail why she enjoys working at the clinic, joking with her that she has said it so many times that she must have some pretty firm and well thought out reasons for her assertion. She responds, “They take the care of patients very seriously, and there are both good doctors and good nurses. The patients here are treated well. They build a family here at the clinic

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4 Awa wears the open-faced veil known in standard Arabic as the *hijab*. This veiling is seen only on some women in Senegal and she for one claims she does so mainly as a fashion statement and not out of some trenchant religious practice. It is then an expression of her ego or unique sense of self.
whereas at Thiaroye they are locked up. They [the doctors] are like parents at the clinic. Oh, and there’s also the *penc*, which means one is always in contact with the patients.”

The reference to ‘parenting’ makes me think of Freud and the transference/countertransference economies that emerge within psychodynamic—and ego-centered—therapies. The family or at least the familial system is referenced and to some extent reified (see the earlier discussion of the family presence on the ward). The repeated references at the clinic to the family should be emphasized. The lens of the psychotherapeutic intervention would seem to be reversed, however. That which is being healed is not so much the patient in relationship to the collective, but rather, the family in relationship to the patient. This seems to be a reversal of the classic ‘sick role’ (Fogelson personal communication). Consistent with family systems theory, the patient is not so much sick as the family is sick (Fogelson personal communication). Thus, the transference and countertransference of successful therapy as evoked in the Oedipal and Elektra complex and the sets of concerns that we recognize thanks to Freud as related to childhood and the patient’s experience within the nuclear family, go beyond simply metaphor. The metaphor of therapist as parent, then, emerges as a metonym for the broader social construction of the family. The *sine qua non*, of this family structure and its relationship to the therapeutic intervention is the *penc*.

So, returning to the *penc*, I asked Awa for more specifics about its function at the clinic and her view of it as a therapy. She explained that the *penc* serves the purpose of allowing accompaniers to explain to the patients what is really “going on” when the patients refuse to discuss their issues. In the penc forum, the family accompaniers can help the patient to.

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5 Awa speaks of Thiaroye Psychiatric Hospital which as I surmise is a locked ward. It would appear though in later research that it shares with Clinique Moussa Diop the practice of allowing family members to accompany patients for their hospitalization. Thiaroye itself is a city of around 22 thousand. It is a largish suburb of Dakar and it is southeast of that city, but also sits along the Atlantic coast.
understand their hospitalization; because the patients are ill, the accompaniers can, additionally, speak for them to both clinical staff and other members of the milieu. Finally, in the *penc*, family members are able to discuss their observations of the patient’s behavior, e.g. how they spent the evening and how they subsequently slept; what they did, then, before going to sleep; and ultimately, how the treatment is progressing. As for the patients, the *penc*, “gives the patients the opportunity to speak of themselves and their illnesses. Many say, ‘I am not ill’ but this is an opportunity to confront their illnesses. Also, those who are afraid of speaking, can speak. I think you can really see the evolution of the illness.”

We see in Awa’s observations the degree to which she considers the *penc* an expression of the familial bonds. As representatives of that familial bond, the accompaniers are co-opted within a system of providing care, by providing a level of surveillance to aspects of the hospitalization. They are also implicated subsequently in norms production of the clinic as they bear witness to what is normal within the family and broader social context. They monitor with the intent of providing a much needed conduit for the intervention of the biomedical model into the social –read: familial—realm. According to the biomedical model –whose standards are globally ratified in the DSM-IV and the ICD-10—the accompaniers’ observations are provided with meaning by the staff of clinicians. So, for the bulk of depressives for example, sleeping too little or too much is considered an indication that the patient is still ill. Such a description of the expression of depression is located in the diagnostic tools I have just mentioned. It is the accompanier who is enlisted to observe and comment upon these sets of behavior in the clinical context. That which is deemed appropriate is sanctioned then by the collective as defined within the family system, according to *global* standards.
Doudou

On a July morning, Doudou and I walk over to La Provencale. He is clad in contrast to Awa in a casual, green and blue polo shirt and dark blue trousers. Doudou suffers from hypertension that he claims is the root of his noticeable stutter. When he speaks it is frequently difficult to understand him. He is a social worker and having arrived himself for neurological treatments to help with his high blood pressure, --the hypertension being the source he says of his stutter—has stayed on to work. He has been at the clinic since 2003.

He was 42 years old at the time of interview. He has two children one primary school aged and the other a toddler. Seated comfortably at the restaurant, he rests his elbows on the table and speaks of his wife and children. He does so because he believes that, “even if you don’t have anything, you must have children.”6 He tells the story of having met his wife accidentally on a car rapide one fall day riding to work. He explains they immediately connected because, “she had work, and I had work.” His wife works as an accountant, and he brightens when he speaks of his family. The concern for employment is significant in a country where the unemployment rate is at 48% according to 2007 measurements. But additionally, employment registers in an economy of intimacy. Clearly, part of what connects these two people is the possibility of making a life as a couple because both parties are making a living individually. In Collomb’s chapter in The Child in His Family, Collomb speaks of the challenges facing families...

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6 I spoke with a woman in an informal setting who told me, “if you say, ‘I cannot have children because I can’t afford them’, I would respond, “you have to have children, even if you can only feed them sand.” The pressure to have children, then, is palpable and I was asked by newly made acquaintances regularly whether my wife and I had children. When I responded, ‘no’, their proverbial expressions would cloud over and they would inquire ‘why not’. When I explained that my wife and I were students and really couldn’t afford to expand our family at this time, they would respond, ‘you have to have children, no matter what.’ This proclivity towards family building may in part explain the youthfulness of the population, but I have no statistical evidence to bolster my argument, only anecdotal evidence. Indeed, even Collomb to some extent bemoans the lack of statistics vis-à-vis grappling with the issues around family building, calling these statistics “fragmentary and approximate…” (see Collomb & Valantin 1979: 362). This is to say, these statistics are unavailable at this time in part because there are no regulatory bodies to make these measurements.
because of the changes in labor attitudes. He observes that, “…the idea of the individual salary and a monetary economy to replace the subsistence economy has been introduced” (Collomb & Vallantin 1979: 365). While in rural settings women are restricted to the local marketplace—as in much of West Africa—in the urban setting women are expected to be viable in the larger arena of the global marketplace. Women are seen as just as implicated by global financial markets as much as men in Dakar. Because unemployment rates were so high a great deal of symbolic capital went into having a job. In the morning the streets of the city then were clogged with both men and women going off to work seemingly always pressed for time. And there were training schools nested within every corner of the city.

Doudou trained for one year at NAS (The National School for Specialists) and then transferred for a two year stint at The National School for the Development of Social Health (ENDSS). I include these biographical details for two reasons. First to highlight the significance of the nuclear family as opposed to the formation of the extended family that was found most frequently at the clinic among patients, And second to focus some attention on the relationship between labor or employment and the family. The two are interrelated. I think there is a shift towards the smaller nuclear family in the face of challenges that employment and unemployment bring to the family system. Collomb confirms my observation:

Development and modernity are accompanied not only by new institutional models, new types of behavior, and new values, but they also threaten to disorganize family life….The family nucleus becomes the standard model…(Collomb & Vallantin 1979: 381).

We can glean from Collomb’s assertion that development and modernity have brought about a deterioration of the extended family model as constituting the notion of collective, a sense that
part of the concerns have to do with the presence of market forces, global in scope. Furthermore it has brought about a shift in expression of gender roles:

The slowness with which these changes are occurring in rural environments helps to avoid crises in family life. But in the city things are different: the autonomy of the head of the household is increased, the wife hankers after more freedom but rarely has resources of her own, while the children drift away from the parents. (Collomb & Vallantin 1979: 376).

The deterioration of the extended family in relationship to the evolution of a model of nuclear families is set here in an urban context. City life then with its development and modernizing forces emerges as a source of the increasing individuation of the family and its members. Collomb concludes: “Relationship to the group has lost its strength and has been replaced by other narrower and more narcissitic investments” (Collomb & Vallantin 1979: 383).

The fact that these issues are recognized at the clinic today is confirmed in *Psychopathologie Africaine*, where the Professor, Momar Gueye writes in 2000, “A number of psychiatrists [at the clinic] have declared that society is evolving (towards a certain modernism) and a certain part of the population is situated of a sort between two cultural expressions (between tradition and modernism).” (Gueye et al. 2000: 269). The therapeutic modality designed to bridge the gap is the **penc** but Gueye goes on to acknowledge the clinicians have an ambivalent attitude towards its use. Doudou represents those who do not have such an attitude. He said:

The *penc* functions as a treatment for the ill. Because the ill do not want to communicate, the *penc* forces them to communicate. In fact, everyone is obligated to speak. The doctors evaluate the treatment, whether or not it is working. The *penc* also aids in knowing the problems of the clinic. So, the *penc*, helps evaluate; forces the issue of communication; and helps identify the problems of the clinic.
Doudou was a man who, while drifting in and out of the clinic, because of his regimen of in-home visits, never seemed to be stressed by his work load; he also seemed to make time for the patients at every opportunity and I would frequently see him discussing hospitalizations with patients in hushed tones in the chairs off to the right of the main waiting room. Doudou, however, in the seventy or so penc I attended, was never present. I think this was because his patient home-visits frequently demanded too much of his time. That said, attendance at the penc was not obligatory and many of the clinicians with whom I worked would not attend. This fact I think speaks to the evolution at the clinic of the model for treatment. It nags, and, despite the other explanation, it indicates that he may in fact have an ambivalent attitude after all.

*Dr. Adil*

Adil has the more ambivalent attitude. He gives a critique of the *penc* that is thoroughgoing and somewhat nuanced. Adil says, “Mamadou wants to appear as a marabout.\(^7\) That disrupts [clinical practice] a little because certain patients have problems with religion…, the principles of the *penc*, because it has prayers, [is problematic], because praying is for the mosque. On top of that, the majority [of patients] don’t understand Arabic…”

Where many articulated the opinion that the *penc* only has positive value in the therapeutic milieu, Adil finds problems. These problems have a religious dimension that I discuss in greater detail in Chapter Two. He also has a critique that registers in terms of the biomedical and ego centered modalities utilized at the clinic, and the supposedly traditional practice that gives definition to the *penc*. Adil notes the tension between the biomedical and the

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\(^7\) A ‘marabout’ signifies a religious leader. The marabout is a curious figure in Islam as a West African phenomena. Within the economy of Sufi Islam as practiced in Senegal, he is capable both of giving good health and taking it away. Adil’s critique has three dimensions. First he wants to criticize Mamadou for his presence at the clinic as a *healer*. Second, he wants to offer a critical view of Sufi Islam as practiced in Dakar. And third, he wants to critique Mamadou himself and his own presumption of a professionalism that is beyond him, according to Adil, forming a sort of *pose*.  

96
traditional by referring to the religious ideations of some of the schizophrenics, and bipolar patients that seek care at the clinic. Psychosis can manifest in terms of delusions related to religion. It would be unfair to both Adil and Mamadou to suggest that this is an easily resolved problem. For both, Islam is central to their lives, but for Adil it is not to be used or at least its employment is problematic in his efforts to administer care according to a Western model. I want to take up his critique of Mamadou as an individual in a moment. For now I want to acknowledge the conflict Adil experiences according to his own religious convictions in terms of Islam and the prayers, presented in the penc and its conflict with the positivistic orientation of the biomedical model. The penc is bad science.

But as I will argue in Chapter Four it actually colludes with the biomedical model, with Mamadou consistently reinforcing that model’s use at the clinic. Adil’s problems would seem to be in terms, not just of the penc’s science but also more in terms of Mamadou and the theatricality of his presence at the clinic. Mamadou’s presence is good theatre, then, but for Adil, it violates his own ideals of what a psychiatric professional is supposed to look like. It is in this sense, bad theatre. Adil’s critique of Mamadou’s presence at the clinic has to do with Mamadou himself and the impression Mamadou gives off.

Adil on Mamadou

Adil explains his concerns about Mamadou by deploying ideas of biomedical observation of psychosis. He references, then, Mamadou’s own story or narrative and how it has implicated the use of the penc. It is in these terms that Adil tells the story, echoed by Dr. Fatou, that

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8 For a discussion of this phenomena, see Psychiatric News November 17th, 2006, Vol. 41, Number 22, Page 22. In this article by, Joan Arehart-Treichel, a study conducted by Phillipe Huguelet, attempted to document the relationship between psychosis and religion. The results were to be used to develop therapies utilizing religion to make an intervention into the religious ideations of many psychotics. Huguelet’s study entitled, Toward an Integration of Spirituality and Religiousness Into the Psychosocial Dimenction of Schizophrenia” is posted at http://ajp.psychiatryonline.org/cgi/content/full/163/11/1952.
Mamadou himself was a patient. He came to the clinic in what Adil termed was a florid mania. He arrived—consistent with his observations and arguments about the religious dimension of psychosis—with delusions that he was a powerful, connected, and pious marabout. He was, he claimed, a religious leader and healer of the highest order and indeed was the most important marabout in the country.

Fatou devised a treatment (brilliantly, according to Adil) in which Mamadou was told he needed to lead the penc as a function of his significance as a marabout. In his administration of the penc he, however, had to tell patients the importance of following the treatment regimens given patients by the clinical staff. There followed a cognitive disjunct, because Mamadou’s own problems had to do with his refusal to take his own medication. Mamadou was in the double-bind of telling patients to follow their doctors’ orders. He was failing at applying these values that came out of his own religious convictions to his own life. So, Mamadou began taking his medications. He got well, according to the clinical staff. He, at least, no matter how one measures efficacy, no longer thought he was the greatest marabout in Senegal. He did not, however, give up the religious dimension of his psychosis completely, its grandiosity was considerably reduced though not fully dissolved. So, the doctors reasoned that he should continue as the religious leader of the penc. This conceit demonstrates the at times high theatricality in assuming clinical roles at the clinic; as we see these roles are informed by adherence to the tenets of Islam (Fikes personal communication). In these terms, one can see how the clinicians’ ideals about what constitutes healthy subjectivity is found in terms of a balanced view of one’s religious commitments and role within the umma. Second, it reveals the commitment the clinicians have to giving Mamadou the trappings of participation in the clinical community. We can see the aestheticization of the treatment program at the clinic. That
aesthetization is theatrical in part because it is really an approach that encourages a certain impression of Mamadou’s marabout status. It is in this regard that we find Goffman’s later use of his theatrical metaphor and his accompanying notions of impression management. These notions show a transition towards a theatrical metaphor characterized by cooperation rather than competition.

I also want to link this to the emerging medicoscape by suggesting that it is the conceptualization of the connection between psychosis and religion in a clinical and biomedical sense that allows Fatou and Adil’s treatment of Mamadou to have saliency for the clinicians. This conceptualization is global. The emerging medicoscape implicates patients such as Mamadou in a regime of impression management. This type of role playing—or impression management—finds its expression in his role as religious leader within a collectivist paradigm. The collectivist paradigm or characterization of so-called African Culture has been extant at the clinic since the days of Collomb and argued for by the earlier, colonial ethnopsychiatrists. The doctors provide a therapeutic context designed to treat for example, one emergent ego, namely Mamadou’s by employing the patients’ social commitments to collectivism. After all he is viewed as healthy only in relationship to his role in the group therapy sessions. My point in part is that these commitments themselves developed in dialogue with colonial conceptualizations of African Culture. Patients, then, have absorbed ideas of their own culture from colonial sources among them psychiatric ones. These ideas and discussions of Collomb’s work are still extant at the clinic today. So it is that as we saw in the interview that began this chapter, Adil, writes his thesis about the history of the clinic. A story whose chief protagonist is Collomb.

It would be inaccurate to suggest, however, that the doctors and other clinicians do not also share the commitment to the umma—understood to be the Islamic collective—as presented
within and also giving definition to the patient population. The doctors too raise their hands and pray when Mamadou leads the group in prayer. Rather, there is in this and other gestures a successful negotiation—or oscillation—of the connection between biomedicine and Islam. Mamadou’s story balances biomedicine and traditionally derived therapeutic modalities. It is because of these inclusive oppositions that I refer to the clinic as a cosmopolitan space. But as I have already suggested the story does not end there; there is a certain inclusiveness in terms of French-derived neoliberal notions of the citizen. Because of historical relationships between the three Sufi Islam brotherhoods, expressions of observance of Islam that both links and at the same time forces currents of divergence between the three, has political ramifications. These ramifications are shrouded in silence at the clinic, all towards making this a safe-space of inclusion. Furthermore, the oft fraught relationship between Islam and Catholicism is also glossed over under the heading of peace and cooperation. It is to the development of an apolitical silence that I move in the next chapter. It is within Bhabha’s paradigm of cultural particularity in the face of transhistory that we find the articulation of a vernacular cosmopolitanism as I argue in the next chapter. But it in relationship to this inclusiveness as expressed with the sign at the fork in the road—every man is his brother’s keeper—that we find a possible way of sacrilizing the public sphere in ways that are productive in a normative sense and perhaps at least in a descriptive sense better characterize the relationship between the collective and the individual in the postcolonial moment in Dakar.
Chapter Two

Inclusiveness, Silence and Apoliticism: Global/Local Interpretations of Sufi Islam at Clinique Moussa Diop

Friendship nourishes society like water a tree—

Mamadou on July 11th, 2007

May 9th, 2007. The penc. Mamadou wore a tweed jacket; blue shirt and gold tie. He sat on the prayer mat. He explained the prayer process that begins each penc: “When you are ill, it’s God. So you pray.”

July 11th, 2007. Mamadou in an interview, addressed the presence of the Islam in the penc in terms of its history and in terms of its current function: “The penc in the villages had Muslim elements and traditional ones. Muslims came from other countries and brought their religion. They implanted their religion but there were traditions. There were traditions that had to be respected. The good [were kept] and one allowed the bad [practices] to fall away. For example, drinking wine... At the clinic, the penc is for friendship. And friendship nourishes society like water a tree.”

In his utterance about friendship we see the role of Islam at the clinic: to promote inclusiveness. This inclusiveness then is defined by the encouragment towards friendship as the patients are removed from the political strife that has characterized the relationship between the three Sufi Islam brotherhoods within the political landscape of the emerging nation-state of Senegal. We understand this inclusive attitude to this conflictatory interaction between the Sufi
Islamic brotherhoods in terms of the generation of a cosmopolitan space in which social actors of contrasting views towards the role of Islam in designating political agency interact, mutually influence one another and actively reconcile their differences. Kwame Anthony Appiah calls for this sort of political reconciliation in the sight of difference within a nation when he says, “our political coexistence, as subjects or citizens, depends on being able to agree about practices while disagreeing about their justification” (Appiah 2006: 70). In Senegal it is precisely this agreement about practices –Muslim practices e.g. prayer 5 times per day—that allows for a common existential vocabulary to emerge but there is disagreement about the justification –e.g. the justification that the exercise of that faith should have with forming a secular or sacral state—that expression engenders in the effort to make political decisions. Mamadou locates these differences in terms of the history of the arrival of Islam to Senegal.

So, Mamadou in referencing the history of Islam’s arrival in Senegal from other countries he indicates that this history was implicated in fraught relationships with tradition. He sees the incorporation of this tradition as forming the bedrock for the unique expression of the three Sufi Islam Brotherhods. For example, it is in relationship to interpretations of tradition that the argument for and/or against the secular state emerge as salient for Senegalese citizens. Cruise O’Brien offers a portrait of the brotherhood based vote during the 1983 election over who was to succeed Senghor as President of the Republic (Cruise O’Brien 2003: 18). Consistent with the history of the brotherhoods, the brotherhoods were thought to be voting blocs. But as Cruise O’Brien argues it was with regard to this election that we see the emergence of a “defiant” electorate in which brotherhood members voted not according to the bloc but according to individual concerns. This returns us to the fraught interplay between the collective—the Sufi Islam brotherhood—and the enfranchised individual or citizen. As Cruise O’Brien argues, “[i]n
adopting the symbolic mode, or turning the holy symbol to political purposes, the organized
groups in effect are entering a process of political negotiation... The faithful at the same time are
making their own assessments, how to define themselves most effectively in political terms, self-
definition in relation to the state” (Cruise O’Brien 2003: 27). It is in terms of this process of
political negotiation between the brotherhoods and the development of the self-defining voter
that we find the interplay of the individual and the collective. And it is with reference to this
interplay that we can see the way that the “implausible nation-state” with its “component social
parts far from homogenized: different language groups, ethnic groups, religious groups, still
learning to live together, perhaps only beginning to learn to value the state” has come to have
meaning for individual political and religious actors. This cosmopolitan space then is comprised
of difference and we can see that difference playing out at the clinic in terms of individual
interpretations of Islam alongside group expectations. The ontological glue holding the
expression of inclusive oppositions in this space is however silence. The clinicians encourage a
resolution or negotiation as Cruise O’Brien elucidates over religio-political space. This constant
negotiation over what the state means is metonymically represented at the clinic. The question
becomes, what does “clinic” mean as a collective body in which difference of religious and
political expression gains saliency? The clinicians reformulate the question by asking, “how can
a clinic be productive of social –read: religious and political—actors? Their answer: only via
silence in the face of contestations over what “clinic” means. So for example, rather than see
conflict among its patients the clinic has fostered an apoliticism via the encouragement of silence
in the face of both political and accompanying Muslim differences of opinion. By encouraging
silence they have answered the “how to form a healthy subject –read: citizen—question by
creating an inclusiveness. This is the defining feature of Mamadou’s concept of friendship.
By using Robin E. Sheriff’s article, *Exposing Silence as Cultural Censorship: A Brazilian Case* (2000), and Andrew S. Mathews’ *State Making, Knowledge, and Ignorance: Translation and Concealment in Mexican Forestry Institutions* (2008), I will characterize the practice of silencing political division at the clinic. Because this silence is one of the central features of the practice of Islam at the clinic, I will subsequently be providing a portrait of Islamic practice at the clinic. I have a secondary agenda as well. I want to tell the story not just of the local interpretation of Islam, but also the story of the interpretation on the part of clinicians of the unifying force of Islam. I connect the two stories by arguing that Muslim practice at the clinic casts the friendship and inclusiveness not just in terms of the three Sufi Brotherhoods but also in terms of the broader Islamic collective. In addition, friendship is interpreted as forming connections with Catholicism. Underneath the umbrella of friendship the inclusiveness that defines the concept connects practitioners of Islam who come from different parts of the world and have their own unique traditions of Islamic practice, as well as connecting the Catholic nuns who work as nurses and psychologists many of whom also come from different parts of the world, with their Muslim fellow staff members. The silence that has developed at the clinic is also in terms of global ideas about both Islam and Catholicism themselves forces uniting diverse populations.

There is finally a third story to be told. And that is the way that Islam colludes with the biomedical model at the clinic. These three stories are interrelated because the glue that unites the different practitioners of Islam is the supposedly neutral application of the biomedical model. Where clinicians may not agree on what role Islam should play in the *penc* they nevertheless all encourage Mamadou’s belief that it should reinforce the scientific model upon which clinical practice is based in large part. And it is in terms of Mamadou’s charismatic presence that the two are linked.
I want to turn to my definition of silence now because it gives meaning to the collusion of the biomedical and the Muslim commitments of the clinicians.

Complicating the Notion of Silence at the Clinic

One day towards the end of the rainy season I sat down next to a female patient. We spoke of her illness at first. She explained that she worked as a hairdresser and that when she got ill—depressed she explained—she was unable even to bathe. She lived with her sister. And when she was sick she was unable to go to work to help out with the family expenses. She explained that it was her “duty” to help out. That it was an expression of her faith. She was Baay Fall. A sect of the Mouride brotherhood that believes work is the way to get into Paradise (see my later discussion of the three brotherhoods). I pressed her to speak further of her experience of being a Baay Fall and she grew quiet. She nodded when I would offer my explanations of what I understood to be the theology of the Baay Fall. She would however not speak of it. I asked her why she was so silent on the topic; why had she grown quiet. She shrugged her shoulders and said simply, “I don’t like to talk about it here. They might think I’m crazy. And I have been taking my medication and so I feel better. I don’t need to talk about it. I’m just here to get a new prescription.”

We might interpret this young woman’s silence or reticence in terms of what Robin Sheriff describes as ‘cultural censorship’. Sheriff explains the concept in terms of her Brazilian field site and her metadiscursive analysis of what people say about their silence on the topic of democracia racial or ‘racial democracy’. She writes:

Although there may be meaningful, even profound, psychological motivations underlying this silence, it is socially shared; the rules for its observance are
culturally codified…Given its social and customary nature, I call this type of silence *cultural censorship*… (Sheriff 2000: 115).

Sheriff’s explication of her term ‘cultural censorship’ informs my definition of silence in two ways: first, she acknowledges there may be profound psychological motivations for the silence; second, she acknowledges that it is socially shared.

As to the first, in the vignette, the young woman suggests that her silence is in relationship to *perceptions* on the part of clinicians of her illness. And as to the second, the young woman in my vignette suggests *they* might think she is crazy. The clinicians have created an environment in which talking about her unique experience of her faith is forbidden. Because it is attached to her illness it is occluded in her speech acts. So she displays the behavior of silencing *herself*. Where my analysis differs with Sheriff’s then is the degree to which I want to suggest there was in my ethnographic situation no distinct line between cultural censorship and self-censorship. Sheriff argues there is such a distinction to be made: “cultural censorship [is] a term that distinguishes itself from the assumedly individuated processes that are often called self-censorship…” (Sheriff 2000: 115). In my case individual expression of Islam was silenced. Why? Moreover, Sheriff distinguishes her silence further by saying, “it is constituted through and circumscribed by the political interests of dominant groups.” That is why the young woman silenced herself. It was at once a form of self-censorship – because that behavior entailed the silencing of herself—and a form of cultural censorship because it was linked to the political interests of a dominant group. Or I would argue the interests of the clinic to promote an apoliticism. We will see why this apoliticism in the next section of this chapter. For now, though, I want to turn to Mathews’ article to get a better picture of the politics of silencing.
In his discussion of Mexican forestry policy Mathews describes a situation in which “…silencing rival forms of knowledge is a necessary part of producing scientific knowledge…” (Mathews 2008: 485). So it is that the young woman in my vignette describes her relationship to her medications as forming the context for her refusal to discuss her faith as Baay Fall. She is giving credence to the biomedical model. But she also seems to be suggesting that she doesn’t need to talk about it precisely because it is a part of her life that is reserved for other contexts than the clinic.

The silence I experienced on the subject of the unique expression of Islam was pervasive. I had few conversations about Islam with patients. Returning the focus to the clinicians, I pose the question, why would they want to silence the patients’ speech about their faith? The answer is: because of the political implications of expressions of faith. So they promoted an apoliticism. This brings me to a discussion of the peculiar politics of the Sufi Islamic Brotherhhoods.

The History of Political Subjectivity in Dakar

The history of Dakarois political subjectivity is intimately linked to the advent and emergence of Islam in the nation’s capital. Tracing the history of the emergence of Islam follows a trajectory of the formation of numerous indigenous empires. I will examine one such empire towards arguing that Islam is the central figure in the emergent drama of Senegalese nation-state identity. I will then, however, turn to an Islamic movement. This movement sets the stage for the emergence of a dialectic in which there is an emptying of the political from Islamic practice, alongside the affirmation of the political. My approach is not, however, novel and is highly indebted to Sheldon Gellar (writing in the 1980s), and Cruise O’Brien (in more recent scholarship).
Gellar cites the Tekrur empire as the beginning of a mass movement towards Islamitization in the 11th century. The populace in question was the Tukulor and beginning with their leader, War Jabi, this period witnessed a large metaphoric migration towards the Faith of the Book (see Gellar 1982: 2). He says, “over the years, Tekrur became a training ground for Muslim clerics and missionaries operating throughout the area of modern Senegal and West Africa.” The point of Gellar’s argument here –namely that Islam and the emerging modern nation-state of Senegal are inseparable—is to locate Senegal within a matrix that features Islam on the one hand and the formation of elites and chiefdoms on the other.

According to Gellar, those elites formed a position within the Senegalese caste system. With its social stability, that system lent itself to the development of ideas that were conducive to the spread of Islam. That stability as it translated via the royal courts made for a state stability that in turn made for ample feeding ground for the incursion of traders, clerics, and court advisors (see Gellar 1982:4). It could be said, then, that without these players—the traders, clerics, and court advisors—there would be no Senegalese state. Many of these traders, clerics, and court advisors were Muslim. Their presence in the state structure and/or bureaucracy meant that Islam was a continuous presence on the Senegalese political scene because it itself held a fascination for the Senegalese largely because of the charismatic leadership of the aforementioned players.

This brings us to the second historical moment which is recorded by John Glover as occurring in the era around 1200 C.E. The movement in question is that of the Jakhanke. Of them Glover writes:

From their new base [in the early part of the 13th century], the Jakhanke spread into much of Senegambia in the following centuries imparting their own brand of Islam characterized by a high level of scholarship and teaching and a pacifist
interpretation of Islam’s role in society at large in which religion was held to be politically neutral… [this] pacifism would influence Islamic notables, such as Amadu Bamba, in later centuries… (Glover 2007: 27).

There are two crucial aspects to this historicization of Islam’s development in the Senegambia region. First, there is the apoliticism of the movement; second, there is the historical trajectory leading from the Jakhanke to the progenitor of one of the Sufi Islamic brotherhoods in Senegal, namely the Mouridiyya, and its founder Amadu Bamba. As to the former, describing the development of any sort of political subjectivity in Senegal demands wrestling with the dialectical process by which apoliticism also gathered steam and operated as a sort of counter-discourse. As to the latter, and the incubation and birth of the three brotherhoods, much has been said and it is to this historical precedent that I now turn.

*The Three Brotherhoods*

As I mentioned the clearest history of the three brotherhoods and their current political commitments comes from Cruise O’Brien. He explains that there have been, historically, three brotherhoods in Senegal. They are the Qadiriyya; the Tijaniyya; and the Mouridiyya. Sufi Islam in Senegal is distinguished by these *tariqa* (‘ways’ or ‘orders’) that define themselves according to a social economy of a “particular prayer formula and (sometimes vestigial) devotion to the memory of the order’s founding saint (variably distant in time and space)” (Cruise O’Brien 2003: 50).

Qadiriyya “is a global order, owing its presence in Senegal largely to the early nineteenth-century missionary activity of Moorish lodges north of the Senegal river” (Cruise O’Brien 2003: 50). According to Cruise O’Brien the Qadiriyya can only very loosely be termed a
brotherhood because its adherents believe in the interventions of very local saints as opposed to a nationally ratified saint; commitment is to a local shaikh.

Following on the heels of the Qadiriyya are the Tijaniyya, in terms of historical development and deployment of a specific Sufi set of liturgical practices. The Tijaniyya were founded, says Cruise O’Brien, by a Moroccan cleric named Ahmad al-Tijani who died in 1815. With three lodges the order is inclined towards internecine strife, but it remains the largest group of Sufi adherents in Senegal.

The third of the Senegalese tariqa is the Mouridiyya. With a global regime of entrepreneurialism, the order is the wealthiest of the three, and has as its natal home the growing metropolis of Touba, to which adherents and the curious make pilgrimages.¹ The order was initiated as an offshoot of the Qadiriyya by Amadu Bamba in the mid-to-late 19th century. This saint went through periods of exile, that rather than having a deleterious effect on his primacy, acted instead to sediment his role as a holy representative of Allah.² The group saw a quasi-splintering with the ascendency of one of Bamba’s disciples, Cheikh Ibra Fall whose followers are known as the Baay Fall. They conceive of themselves as Baay Fall first and in a curious violation of Muslim orthodoxy, Muslim second.³ They are noted for their commitment to hard work as the avenue to salvation and inclusion in those who will enter Paradise.


Senegalese Sufism is largely Sunni in orientation (Cruise O’Brien 2003:56) in terms of placing the religious practices in a global context. It is crucial to recognize however that Senegalese Sufism occupies an uncomfortable position within the *umma* or holy community of Muslim believers, hence Adil’s claims, for example, that the pilgrimage to Touba to honor Bamba is really akin to the Christian belief in Papa Noel: having no truth value for the larger body of believers. By making vernacular ties to Iran and the Arab Emirates, ethnographically speaking, I found in a present tense context that Senegalese Muslims identified strongly with a conservative form of Islam.

In the many cabs I took each and every day, there can be seen images of Bamba and other saints; and there is the very visible presence of the Baay Fall with their Rastafarian dreadlocks and patchwork, second-hand clothing (significant in a country in which sartorial codes are based so heavily on innovation and cutting-edge modish fashions); and while there are requisite Qu’ranic verses placed alongside these images and representations, it is clear that Senegalese Sufism is highly local. The political strife that characterizes the interactions of the three brotherhoods since the early to mid 20th century is perhaps an epiphenomenon of the highly localized nature of these religious practices.

There are of course certain dimensions to the localized nature of Senegalese Sufism that I have occluded here, in particular the transition from a rural expression of the brotherhoods to a more urban centralized formulation of the faith[s]. I have also not treated the issues of internal political structures. And I have neglected to address the role of gender –they are after all called *brotherhoods*—in the formative process of the brotherhoods. Having acknowledged these lapses, I would contend that more to the point of this chapter are the political machinations that form the backdrop for the development of the three brotherhoods. Considering these conflicts will allow
me to reflect on the colonial power dynamics that themselves in part defined the emergence of the brotherhoods as political players. It is these political conflicts that I now want to examine.

A History of Political Strife

According to Cruise O’Brien, “[t]he political strength of Senegalese Sufism owes much to French indirect rule, under which the brotherhoods flourished more than ever before, but it also owes a lot to the particular local example of the Mouride Brotherhood –founded, as it was, at the very moment of French conquest of the Senegalese interior” (Cruise O’Brien 2003: 52). That said, Gellar argues that, “[p]rominent Muslim leaders like Amadou [sic.] Bamba, Malick Sy, and Seydou Nourou Tall realized that they could not drive the French out by military force and thus decided to make their peace with the colonial regime in exchange for a free hand in preaching and organizing their followers within the framework of the Muslim [Sufi] brotherhoods” (Gellar 1982: 13). Coupling the two historians, we see that the Muslim saints made recourse, to a collectivism—as they organized their adherents—in what would later become blocs of political subjects. In this instance the political subjectivity characteristic of Senegal was attached to the colonial practice of extending to urban dwellers suffrage. No wonder, then, that the Mouride established their own urban center in the country’s interior hinterlands –Touba. As a feature of the consolidation of power, the clerics sought to mobilize a rural populace in the service of very urban elite concerns. At the center of this rural populace’s political sway was the peanut economy with as Gellar and Cruise O’Brien report, the clerics being allotted large tracts of peanut-yielding land (see Gellar: 13; Cruise O’Brien: 52). Crucial to my argument that political subjectivity in Senegal has a heavy dose of apoliticism—as represented at the clinic by silence—is the point that during the colonial era the marabout were accomodationists, accepting the regime begrudgingly but with a certain amount of pragmatic opportunism.
Senegal won its independence in 1960 and the years immediately following the end of the colonial regime saw the power of the clerics, known as *marabout*, increase or perhaps more aptly, *intensify* as their ambitions were given freer reign. There was strife however between the brotherhoods, with them following a variable trajectory of urbanization and continuing accommodation of principally France.

The early 1960s was marked by intense competition between political parties, with the *Union Progressiste Senegalais* (UPS) emerging as the victor, a win brokered by the first president of the nation and the leader of that party, Leopold Sedar Senghor. Part of Senghor’s effectiveness as a leader and statesman can be attributed to his Catholicism. He was able to present himself as neutral in the battles among the brotherhoods for power. The 1960s, then, under Senghor’s tutelage saw the foundation of the UPS as the single party. This would be the case until well into the late 1970s. For their part, the brotherhoods during this period attempted to leverage their power among the peanut farmers in the rural regions of the nation to garner political clout. It is crucial to see the manner in which the emergence of the socialist welfare state was tied to the developing process by which the brotherhoods were urbanizing and beginning to make their presence known in the large urban centers such as St. Louis and Dakar. For our purposes, I want to tie these developments to the persistent effects of a trend towards informal apoliticism. Cruise O’Brien is worth quoting at length on this score:

> Competition between brotherhoods has above all been a matter of political power. Mourides correctly believe themselves to be the best organized and most effectively unified brotherhood, in contrast with the Tijaniyya, which is divided into three lodges that recognize no overall leadership...From 1960 the government of Senegal instructed its demographers not to gather census data on brotherhood membership, the question being regarded as politically explosive; the result being a demographic vacuum... The problem for an
observer, as for civic peace in Senegal, was that both Tijanis and Mourides have believed themselves to constitute national majorities (Cruise O’Brien 2003: 60).

1970s and ‘80s

The strife boiled to a head in the 1970s with interbrotherhood rioting in the environs of Dakar (see Cruise O’Brien 2003: 7). The conflict indexes the brotherhoods increased presence within an urban context. It also points to the conflicts inherent in Senegal’s colonial past, because it is tied to this urbanization process and the practice of urban elites having the vote. As Cruise O’Brien argues, “[c]onfrontation in the 1970s is however not with the whites, rather with the black Africans who looked for leadership from Muslims who were said to be tainted by their past collaboration with the French colonial government, including as “collaborators” some of the past leaders of the Senegalese Tijaniyya…[The] riots that followed in 1979, [were] a dangerous situation but [they] then stabilized by a reassertion of the authority of age, of the senior leadership in the two brotherhoods involved. This episode of confrontation may be seen as an exploration of the relation between religion and nationality, the symbolic Amadu Bamba presenting a claim to current national leadership. The subsequent retreat from inter-brotherhood confrontation is the re-assertion of a devotionally plural idea of nationhood in Senegal” (Cruise O’Brien 2003: 8). And so, curiously enough, the conflict which was between the two major political players –given the decentralization of the Qadiriryya—of the Mouridiyya and the Tijaniyya, was marked by what Cruise O’Brien refers to as “a non-confrontational style (“We are all Muslims, one Book, one Prophet”)” (Cruise O’Brien 2003: 7). For my purposes it is significant that the semiotic field in which religious symbols were marshaled in the service of both democratic and socialist forces, was characterized by a discourse of non-confrontation. In a
quotidian sense this downplaying of religious symbolic difference has led to a certain apoliticism. The Senegalese do not relish talking not so much politics which they will weigh in on with enthusiasm, but rather religious affiliation as associated with politics. Indeed, in as much as the Senegalese do not discuss in an urban context such as the clinic, which brotherhood they belong to, they fail to then discuss the weight of the collective sense of voting along the lines of those religious commitments.

That said, given the high prevalence of doctors at the clinic, as I discuss in Chapter Three, hailing from many parts of the continent and the rest of the world, it should come as no surprise that politics and religious affiliation were not frequent if ever heard conversations. But as I am arguing here, it goes much farther than that. The clinic sought to promote a certain political subjectivity that displayed the capacity to accommodate differences of opinion. Rather than having one central set of tenets in its production of norms there was at once a commitment to Islam but it did not seem to matter what form of Islam. Subsequently, there were no discussions of the up-coming elections.⁴ There was silence on both religious affiliation and political affiliation, both among practitioners and patients. I would argue that part of professional habitus as created within global ratifying bodies and transplanted to Senegalese or Dakarois soil—and therefore articulating the medicoscape—was to avoid discussions of politics. Many other norms were inculcated but on this one there was I would argue a de facto formation of an apolitical subjectivity. The connection between faith and politics was mystified in an effort to shape a subjectivity that was inclusive and non-confrontational.

The 1980s saw a gradual alignment of the Tijaniyya and Qadiriyya with the state. These two brotherhoods argued that the only way for there to be an Islamic state was if it were a

⁴ The 2007 elections in Senegal that Mouride Abdoullaye Wade won in a landslide.
Mouride one, and given the Mouride adherence to such heterodox practices as the pilgrimage to Touba rather than to Mecca (known as the Grand Magal), this state would not be a truly Muslim state. Therefore, they concluded, the current state should be supported as a secular one, thus mitigating against the then incipient dominance of the Mouride in state praxis. The conflicts of the 1980s, then, witnessed a good deal of “aggressive talk” vis a vis state formation. The ripping apart of the republic along religious lines had finally eased to a simmer with, “a continuing negotiation, an exploration of possible relations between religious allegiances and political power –talking to God, talking to the state, talking to the people” (Cruise O’Brien 2003: 62).

1990s to the Present

This period saw the emergence of the current president and Mouride adherent, Abdoulaye Wade as a political force in his own right. Beginning in 1978, and as an epiphenomena of the political unrest of that era, Wade’s Parti Democratique Senegalaise (PDS) began gaining ground by earning 18 seats in the National Assembly.

Abdou Diop became president in 1980, and experienced sharp criticism from Wade and the PDS. As the PDS gained ground, Wade began to position himself—though he had done so even during Senghor’s reign—as the next leader of Senegal. Wade finally won the 2000 election and his reign has witnessed a Pax Dakarois. As Cruise O’Brien puts it, during the present era— with Wade winning his reelection bid in 2007, during my tenure in the country—“[s]tate leadership in Senegal encourages devotional togetherness on a national scale” (Cruise O’Brien 2003: 12-13). I would argue that that devotional togetherness also speaks to a certain political pacificity that is a feature of the current political landscape. I want to place this political landscape in its historical manifestations in the context of the clinic, all towards arguing for the silence that I have mentioned in the earlier portions of this chapter.
Senghor, Collomb, and Silence in the Face of Independence

Consistent with the influence of France, Senegal’s first president, Leopold Sedar Senghor, was Catholic in a nation with under 5% following that faith. That Senghor was outside of the Sufi matrix is telling. It reveals not just the association and accommodation of Senegal of French laicite, but also the degree to which the Senegalese sought to find a non-conflictatory way to develop their sense of national identity.

Senghor knew Henri Collomb and he even gave his obituary at the great expatriate psychiatrist’s death (I discuss this obituary in Chapter One). Senghor, in the year of 1979, one year prior to his stepping down as president, praises Collomb for his expression, with his School of Dakar, of the fullest ambitions of independence, and he significantly connects this to religious praxis:

Henri Collomb defined traditional psychotherapy such as it is practiced in Senegal, at the crossroads between animism and Islam, and despite and under the effects at the same time of three centuries of French presence…[this psychotherapy] is an analytical and synthetic discourse, interrogation and response. The bipolar opposition between the individual and the group is surmounted thanks to the Healer, who, under the auspices of the ancestors, participates in the science and the power of the I am that I am: of God. It is this science and power, this science-power that the Therapist, at once a knowledge-producer, priest, and doctor, puts into play (Senghor 1979: 138-139).

Senghor begins the obituary by mentioning the independence that had been won some twenty years earlier. But he fails to mention Collomb’s role as a public intellectual in terms of the movement towards independence in that self-same era. This is because at least in the public record Collomb made no political statements regarding the movement towards independence. This is an example of the silence that the leaders of the clinic displayed.
Why should this be surprising? Given the notion of the medicoscape, it seems that it was a feature of the Western-derived notions of professionalism that clinicians were to be just that clinicians and not activists. Moreover, it is clear in my own experiences as a clinician that practitioners even in our own cultural context are encouraged to be silent on political matters; politics do not belong in the professional psychiatric milieu. But, I would argue, matters are deeper in the Senegalese context. In the Senegalese context the clinicians promote an apoliticism among their patients that is characteristic of the broader urban push towards a national political imaginary that is inclusive. The Islam that might splinter this push into factions is silenced. An apolitical stance is generated towards fostering a non-conflictatory oriented individual. I want to move, now, away from the historical context for this silencing towards the contemporary moment.

**Silence, and Apoliticism at the Clinic Today**

Placing the silence at the clinic today in terms of the promotion of the apolitical subject demands an ethnographic example to sketch out what I mean by ‘silence’. Let me begin with the ethnographic portrait of the occluding of a politically activated Islam at the clinic. I do so with reference to actually all of the political forces that have been present in the development of a national imaginary as seen—or not made visible—at the clinic. I think, then, it is no coincidence that there are present at the clinic Catholic nuns. Just as Senghor, the presence of these nuns speaks to the neutrality of Catholicism. I want to turn, then, to an interview I did with Helene, one of the aforementioned nuns who was studying to become a psychologist. I want to record her perception, which I think is generalizable, that clinicians are meant to investigate disease issues as opposed to broader sociopolitical ones or to extend Kleinman’s terms, illness.
Helene and the [A]politics of Inclusion

Helene is a Congolese Carmelite nun in her early thirties. She had been at the clinic for several months when I met with her, on August 30th, 2007. On this day early in the rainy season, I waited for her on the front steps leading to the interior of the clinic. I waited for a few minutes and then returned to the library where I worked on my notes for a while. She didn’t come to retrieve me so I went out to the front steps again and she was there, talking to someone. I returned to the library where I found my notebook (I had been prepared for her not to show so I was somewhat unprepared when I found her there waiting for me).

I retrieved my notebook and I asked her if we could talk on a bench that was to the left of the front door, facing the road leading to the clinic. She acquiesced and we began the interview:

ERIK: What is your favorite course and why?

HEL: I have finished my coursework. I just have this internship.

ERIK: What is a typical day like for you?

HEL: On Monday I go on the patient visits where we make rounds of the patient rooms. I find this very interesting; we see what the patients’ needs are. I usually find one or two patients who haven’t had the opportunity to really express themselves during rounds and I sit down and talk with them.

On Tuesday we review charts. We attempt to identify what the patients’ needs are and how they are doing at the clinic. The doctors read the charts and we discuss them. I make suggestions as do the others. I also make reference to the things I have seen at the clinic and what I have spoken with the patients about.
Wednesdays are for the *penc*. We also do patient interviews where we talk to the patients and those who accompany them.

Thursdays are for personal interviews.

Fridays are for former patients and consultations with patients and doctors.

ERIK: What sorts of problems do you encounter?

HEL: We see a lot of depressives. They have problems with their families. They want to express themselves. We listen to them and what they feel they need to be helped. Sometimes we can help them simply by having an interview.

In supervision we explore what we see at the clinic. We speak of the difficulties we encounter. This helps to best orient the treatment at the clinic.

ERIK: What does “la prise en charge” mean to you?

HEL: The path one takes in treating a patient. Also, the patient interviews and psychotherapy.

ERIK: Let’s switch tack for a moment. Tell me what you think is normal? How would you define normality?

HEL: That signifies the norms. The demands society makes of a person. So, for example, they are working on a road and they bar the route. A normal person asks if they can pass. Norms depend on the context and in what domain. Sometimes people end up at the hospital because they can’t respect the norms of society within the appropriate domain.

ERIK: What do you think are the most important norms of Senegalese society or what norms do you see broken the most that end up in making someone get hospitalized?
HEL: Aggression gets a lot of attention. Rudeness. When people don’t obey the rules and when this makes it difficult for the family to work. Frequently people go to a marabout first and if that doesn’t work then they end up at the hospital.

ERIK: Can you think of a particular case that has interested you the most?

HEL: I find all the cases interesting. Each brings with it its own particular difficulties. I really want to learn. But I really find those cases that involve some sort of cultural problem that really is the central issue. So for example when my neighbors refuse to talk to me, how and why is this a sign of mental illness here in Dakar? Sometimes it is the family that expresses concerns. Yeah, I find all the cases interesting.

ERIK: You said you are here to learn. Is there anything in particular that you are studying?

HEL: I am working on cultural issues. What happens culturally that gets expressed as mental illness. I study the symptomology that is peculiar to Senegal. I want to learn about the cultural mechanisms that the patients use.

ERIK: What do you mean by cultural mechanisms?

HEL: I am doing a retrospective study. I am looking at the old charts of doctors to see if the patients’ orientations culturally have influenced their treatment. So for example the patients who are animistic or believe in maraboutage as the base of their illnesses is this mentioned in the patients’ charts. The patients who believe in sorcery is that mentioned. The evil spirits (les jinnes). And do the doctors find that is really the problem. Does this influence the treatment. Do

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5 The term maraboutage denotes a belief in the supernatural power of Islamic leaders and their capacity to render a person both well and sick (see M. Diop et. al 1966: 85-86 for a discussion of maraboutage as a curing modality for mental illnesses.)
they go ahead and only treat it with drugs. Do they find a cooperation between traditional approaches and modern ones. Because it really is a belief.

ERIK: What do you think this cooperation might mean? Do they use the same “talk therapy” approach along with herbs…

HEL: Well, all I know about right now is the way things are done in Congo. In Congo there are ceremonies that are traditional that if one doesn’t follow bad things happen. So people believe but at the same time they are “croyant” and so when the ceremonies aren’t done people come to the Church and the priest will pray and sprinkle Holy Water and this in a way replaces the older ceremony.6

ERIK: What are some of the differences you find between the Church and Islam?

HEL: I am here to learn about Muslim culture. Christians and Muslims have the same way of looking at things. We believe in one God. I am trying to understand how they see God.

This interview presents her commitment to clinical practice. As a student she is looking at cultural factors and how they influence hospitalizations. She describes in the first part of the interview her typical week. We learn from her description that her training is largely clinical in orientation. But the interview ends with her addressing some of the contrasts in beliefs about illness and its cure in the Congo. Her presence then is one of contrasts. She contrasts her culture as a Congolese along with her Catholicism.

From Helene we learn or can see how part of the mission of those heading the clinic is to invite and encourage the incorporation of different belief systems. More significantly is the way

6 Croyant is the French term for faithful or believer. It usually denotes someone who is specifically a follower of the Roman Catholic faith.
that she glosses over the *differences* between the two—Christian and Islamic—faith systems. We believe in the same God. I would argue Helene’s presence at the clinic, which was not generalizable to the other clinics in the city, speaks to Professor Momar Gueye’s commitment to building an inclusive sense of faith.

How then does this relate to the creation of an apolitical subjectivity? Helene’s presence at the clinic implicates the same encouragement of neutrality that we see in Senghor’s presidency. Like Senghor, as a Catholic Helene is neutral on the subject of political strife between the Islamic brotherhoods. But she is not just Catholic. She is also Congolese. This fact leads me to believe that Gueye’s encouragement of her presence speaks to his desire to have an international clinic. Having an international clinic means finding a way to address cultural differences. One aspect of those differences is faith. Both Gueye and Helene acknowledge these differences between faith systems and gloss over them by fostering an environment of inclusiveness. I think Gueye encourages the presence of international students because he wants to instruct the patients in neutrality or perhaps more aptly inclusiveness.

There is however in the *penc* a counter-discourse to inclusiveness. In the *penc* patients are allowed to voice their idiosyncratic expressions of their faith. Some say, for example, I am Baay Fall. Others admit to believing in the positive aspects of Wade’s presidency. So, I want to analyze apoliticism in terms of the *penc* now. This analysis serves to demonstrate how the rule of silence is enforced during the *penc*. It is done so oxymoronically. Because the *penc* is a space in which patients can break the rules, we see the operation of the rules more clearly.
Apoliticism and the Penc as a Transgressive Space

One day in the outdoor penc space, Mamadou seated on the prayer mat, dressed in an expensive looking lilac shirt, purple tie, and dove-grey suit, turned to me, as the patients and practitioners gathered for the event, and said with a yellow-toothed smile, “I am the president (jaraaaf) of the penc.” In the brief moments I had left to me before the group had grown too large for private conversation, I asked him to explain. He said, “I am in charge of the penc.” The group had swelled and I was unable to follow-up with him, as the gathering moved into high gear and the penc began.

Mamadou had earlier claimed to be the President of the penc but he had done so in the context of being a religious leader. And indeed I had seen him perform rituals of healing on several occasions. One day, for example, I had watched him take the hands of a man who could not move his arms, and ask, “do you want to be healed? Then, give me your hands”. The man had stiffly attempted to raise his hands to be placed in Mamadou’s own, but Mamadou despite the man’s visible pain, had had to take his hands and hold them. He then touched his head to the hands and proceeded to pray over them in a barely audible Arabic. Finally, he began to snap his fingers and pass his hands over the patient’s hands. After three or four such snapping episodes, he released the man’s hands and said, “Allah bless you. [mungi sant Yallah]”

This in fact was Mamadou’s pattern. He would arrive at the clinic an half-hour or so before the penc, before his morning espresso and he would move swiftly around the hospital grounds going first to the children’s ward to administer blessings, and then, to the adult wards where we had met the patient with the stiff arms. Finally, he would come to the clinic and take his coffee and then position himself for the penc. If anything, then, Mamadou was a sort of Sufi faith healer. How and why did he think of himself as the president of the penc?
Mamadou’s voicing of a relationship between politics and the religious practice of the penc speaks to the rule of silence. The penc is a space in which patients can speak of anything. They can address then their religious affiliations. Mamadou as leader of the penc is allowed to connect the religious praxis with the political in this transgressive space. It proves the rule that in other contexts this was considered inappropriate and subsequently was silenced. An example:

April 27th, 2007. Mamadou gestures to his face and heart as he asserts that he is a marabout. He explains the rules of the penc: Everyone must speak, including clinicians. Fatou at this point reminds Mamadou that clinicians are to speak at the end of the session because, “if we don’t end with us the ill will say what we say.”

Mamadou then begins the session. He turns to patients, asks their name and how they are doing. One patient during the proceedings claims there is nothing wrong with him. He explains continuing that he is here because he walked for a long time in the sun outside of the Presidential Palace. He was taken in by the police and then released home, at which time his family brought him to the clinic.

He wanted to see Wade, he explains. He was told by the authorities at the Palace that Wade is not here. He tells the story of how he arrived at the Palace: He had been fired from his job at the bank and so he walked to the Palace to see if the President couldn’t intervene on his behalf.

A second and third example of the discourse around religion as found in the penc:

May 4th, 2007. A patient named Aadama Fall explains she was born in Touba. She is a cook. She is asked by Mamadou if when she is ill she can do anything around the house to forestall her illness. She says no. She says, “I am searching for the key to open the door [to her
illness].” She then explains that she knows she is ill when she cannot work because she is a committed Baay Fall. She then asks Mamadou what his questions have to do with her questions about her illness. Mamadou explains that in order to heal we need information about her life.

May 11th, 2007. There is a man singing Koranic verses on the television. Mamadou turns up the music and dances. Finally, at a quarter to twelve the session begins with Mamadou’s prayers. Mamadou offers: patients will heal and doctors will do their part. Patient 1 speaks. He is wearing a Bob Marley t-shirt. Mamadou asks him about it. He says Bob Marley is his idol.

“All reggae men are Big Men.” They provide him with a grand view of his life. Bob Marley has taught him that if he doesn’t do what others ask of him he will enter paradise. If he does do what they tell him he will go to hell. He explains that he smokes cannabis and so he must stop doing what others tell him e.g. to continue smoking. Mamadou tells him to take his medication and stop smoking. Mamadou concludes by telling him that he needs to find new friends.

Even as Mamadou encourages the patient to take his medications we see the commitment also to dialogue in which patients are permitted to speak with impunity about not just their illnesses but also to those aspects of their illnesses that are related to both their faith and their political commitments. But it is Fatou’s comment that becomes so revealing. Patients are expected and encouraged to speak in the penc in such a way that suggests it is a space in which conversation of all kinds is permitted. Why else caution Mamadou that the clinicians should go last so as not to influence what the patients say or talk about? As we see in the vignettes those conversations featured references to faith and politics. Moreover Mamadou’s assertion that he is the president of the penc links him as a religious figure with politics. The silence that I have described is a rule broken in the penc by Mamadou and the patients. It is rule because of the
potentially disruptive force of religious and political discourse. The presence of the *penc* as a therapeutic modality indicates the emphasis placed upon apoliticism, precisely because it forms a counter-discourse.

Mamadou’s charismatic presence confirms the presence of both the silence and the counter-discourse. It speaks to his role as both patient and as a clinician of a sort. He was a liminal figure serving both a clinical role as well as being caught in his own position as a patient (see Chapter One). Mamadou’s position within this social economy argues precisely for the silencing of political agendas. As a liminal figure he could emerge as a charismatic figure because he broke the rules. It is in these terms that we can see the rationale for the way he connects his role as marabout with the contemporary political situation. His role is designed to give the patients the freedom to speak of politics and faith.

But there is an additional factor. It is Mamadou’s ratifying of the biomedical model. “Take your medication” he exhorts the patient. It is this exhortation that links the local form and expression of Islam and its political ramifications to the clinicians’ own positions vis à vis these practices and opinions. For just as the *penc* is transgressive it is so as an avenue to arguing for the efficacy of pharmaceuticals. Mamadou’s didacticism is a dance that reaffirms the primacy of Islam –his literal dance to the Koranic verses being sung on the television—and at the same time biomedicine.7

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7*A word on the television. It is of note that it too is located in the *penc* space. Additionally, it is to be watched only during patients’ free time. Most of the time the religious programming was not permitted. Rather shows of for example J-Lo performing were encouraged. But patients some times snuck in the religious programming. This sneaking speaks to the indeterminacy of religious expression at the clinic. In my observations, when patients did watch this programming they did so in silence neither indicating subscription to the espousals of faith nor contradicting it.*
I would say that Mamadou’s primary commitment was to Islam. So, I want to consider Mamadou’s expression of his faith before concluding. They give ethnographic specificity to the presence of Islam on the ward as expressed in the penc. I conclude with a summary. I move forward by arguing that the presence of Catholicism and Islam; biomedicine and faith; both speak to the medicscape as a global and local interpretation of the role that faith can play alongside science in administering effective care.

Mamadou’s Eblutions and Prayers

As Mamadou explained to me, the act of prayer among Muslims begins with eblutions. The faithful Muslim, who prays five times per day facing the direction of Mecca, begins by taking a taste of water. Next, one cleans the hands; first, the right three times and then the left the same number of times. Then, one takes another bit of water and brushes the teeth and then the entire mouth. One then cleanses the nose by blowing outward; next one begins the process of cleaning the body: first, the arms are washed with water; one then cleans the head going from backwards to forward, one pass only; next, the ears, again, one time only. Finally, one finishes with the feet, beginning with the big toe and proceeding to the smallest.

Mamadou said of the eblutions, “You have to clean [the body] very well, in order to be pure and “proper” [propre] before praying. One has to be proper. Also, the place where you pray has to be proper [appropriate]. Yeah, the place where you pray has to be proper…”

Despite these behaviors, all of the eblutions were absent from the penc; all except the practice of taking off one’s shoes before sitting on the mat, or touching it with one’s feet by for example walking on it. The occlusion of the eblutions was made permissible, then, by the use of the prayer mat, which made the space a holy one. The prayer mat became the locus of holiness for the proceedings. So, the observances, which would have been prohibitively difficult to
practice at the clinic, were at least represented by creating a devotional space and by praying in that space. There were contradictory features of the presence of Islam in the penc space. One of which concerned Mamadou himself. There were for example, references to smoking cannabis. And there were Mamadou’s tobacco stained teeth.

The fact that he smoked should have rendered him ineligible for the status of religious leader, but it did not, in part because Islam in Dakar is not as orthodox as it is in the rural regions and certainly elsewhere in the umma. That said, much has been written about the relaxing of Islamic norms in many places around the globe; and, though it is important to note that these norms vary in both expression and conservatism, it is clear that in the urban context of Dakar such prohibitions as not smoking and not consuming alcoholic beverages that are features of most if not all Islamic contexts, are being made less stringent and their enforcement less strident.

The reference, then, in the interview that began this chapter to the ‘traditional’ practices indexes the complicated relationship of animistic beliefs, adherence to the tenets of Islam and the emerging urban and modern context. The presence of the ‘traditional’ along with modernity leads to unique interpretations of Islam. For example, Mamadou, in the earliest interview mentions the prohibition against drinking alcoholic beverages. At every boutique in the city one can buy beer. Harder liquor is available in the grocery stores. So how are we to understand the presence of violations of Islamic orthodoxy? We can understand this in the context of Dakar as a bustling, modern cosmopolitan metropole. It is with this regard that Mamadou’s assertion that he is the President of the penc gains its saliency. By calling himself the President of the penc, Mamadou is placing himself in an urban, modern belief system. One that allows him to smoke. So the occlusion of the eblutions and his smoking, emerge secondarily, as gestures that also activated the penc space politically. The reason Mamadou was allowed such laxity in his Muslim
practice was because of his role as the leader of the *penc* a role that was ratified by his presence in the sessions as a marabout.

Mamadou’s role as *marabout* was centered around his prayers partially in Arabic before, during, and after the *penc*. I want to end this chapter by documenting those prayers. Not just in an effort to give the reader some ethnographic sense of the religious convictions that made the *penc* an experience of faith for both patients and clinicians. But also to record Mamadou’s own interpretation of the role of Islam in shaping those experiences.

*Mamadou’s Prayers*

Mamadou’s prayers fell into three categories he explained to me one day in the month of August. There was the initial prayer known as *Al-Fatiha*; the second uttered during the *penc*, *An-Nas*; and the third called *Al-Falaq*. These prayers were surats from the Qur’ran and demonstrate Mamadou’s superior knowledge of the Book, as well as his grasp on quasi-Arabic (parts of the prayers were in Wolof). They also illustrate how much Islamic discourse shaped the functioning of the clinic: Mamadou’s presence speaks to the ascendancy of Islam over ‘traditional’ practices, as well as indexing the orthodoxy of expressions of faith. Finally, they indicate the clinicians’ perceptions of what was permissible in terms of a healthy subjectivity. Mamadou’s prayers (Seck, personal communication):

*Al-Fatiha*

1. In the name of Allah, the Beneficent, the Merciful.
2. All praise is due to Allah, the Lord of the Worlds
3. The Beneficent, the Merciful.
5. Thee do we serve and Thee do we beseech for help.
6. Keep us on the right path.

7. The path of those upon whom Thou hast bestowed favors. Not [the path] of those upon whom Thy wrath is brought down, nor of those who go astray.

*An-Nas*

1. Say: I seek refuge in the Lord of men,
2. The King of men,
3. The God of men,
4. From the evil of the whisperings of the slinking (Satan),
5. Who whispers into the hearts of men,
6. From among the jinn and the men.

*Al-Falaq*

1. Say: I seek refuge in the Lord of the dawn,
2. From the evil of what He has created,
3. And from the evil of the utterly dark night when it comes,
4. And from the evil of those who blow on knots,
5. And from the evil of the envious when he envies.

I am not qualified to parse these Qu’ranic verses, so I offer them as standing on their own, in an ethnographic sense. Mamadou was a remarkable figure at the clinic and his aptitude for Islamic liturgy and theology can be seen in these verses. He was indeed the president of the penc, not just because he was connected to a history of urban enfranchisement, but also because he represented the successful incorporation of Islam into the emerging neoliberal state.
But we return to Helene to find that this is a cosmopolitan space precisely because it is a shared space in terms of faith. Mamadou on the one hand and Helene on the other argue for a consistent negotiation of the differences in the faith systems and the inclusiveness that motivates and gives the grounds of possibility to their reconciliation. The grounds for reconciliation are additionally to be found in the universalizing discourse of biomedicine. As Helene asks in her retrospective study of doctors’ habits, “do they go ahead and only treat it [the pathology] with drugs? Do they find a cooperation between traditional approaches and modern ones. Because it really is a belief”. But she is asking questions of this universalizing discourse. She is in effect particularizing it; she is making it suitable and informed by the local context. What is really unique then to the clinic is the process by which the modern treatments are localized within paradigms of tradition. Those traditions are Muslim, but they are also more heterodox than that: they are Catholic to the degree that as Helene says both Catholics and Muslims serve the same unitary God. The presence of Islam alongside biomedicine then charts a history –that of colonial interventions—while at the same time indexing postcolonial systems of relationships between faiths that are equally related as we have seen to outside influences. It is the role of faith as conjoined with science that links the heterodox experiences of the clinicians. This is witnessed to in their educations and in the structure and practice of the penc. And as Helene reveals there is a lot of talking. This talking forms the crux of a certain set of professional practices chief of which is psychotherapy or at least psychodynamic approaches to the therapeutic intervention. These professional approaches, such as Lacanian psychoanalysis, are global but resonate within local economies of faith and science. Furthermore, these therapeutic interventions revolve around notions of the relationship the patient as a singular node in the therapeutic encounter has with the collective –the family and as we have seen in this chapter, the Sufi brotherhoods. That set of
relationships—the patient with the collective—finds its apotheosis in an apolitical expression of subjectivity. Or at least the clinicians want to construct a connection between healthy or normal expressions of subjectivity that instantiate a political agency that rather than activated in the milieu is deferred indefinitely towards fostering an inclusive citizenship. Healing with this regard becomes an act of silencing the conflict inherent in the cosmopolitan space.

Conclusion

Seeing Mamadou as an agent within the history of Islam as both a faith practice and a practice with political ramifications, allows us to better see the silence in operation at the clinic. His transgression of the clinic’s rules by his declaration of his presidency emerges as an indicator of the degree to which political discourse was associated with pathology at the clinic. While Mamadou’s proclamation can be viewed in terms of his own diagnosis of bipolar disease, it can also be seen in sociocultural terms as an illness, in terms of his role as a sort of clinician. This role implicated him in an apolitical agenda. By referencing the current political scene, Mamadou was initiating a discourse that would have been potentially disruptive. What is important to acknowledge is the degree to which this type of discourse was seen as normatively bankrupt. Mamadou was engaging a type of narrative that indexed at once the Pax Dakarouis and in this regard was to be lauded, but at the same time dialectically speaking referenced the threat of politics as usual in a Senegalese context. The only safe space for utterances related to faith and politics was the penc itself. Because it was a therapeutic practice designed to facilitate the expression of concerns among both patients and clinicians, it was rendered effectively neutral. Neutral because it was a structural feature of practice at the clinic that allowed for political and
faith concerns to be diffused. Patients were allowed to acknowledge their faiths and their political ideas in such a way as to take the sting out of the forced silence with regard to these issues.

Mamadou’s role as a marabout points to the relationship of the silence on faith/political matters, alongside his didactic reference to the biomedical model. This didacticism implicates the inclusive aspect of relationships at the clinic. His insistence on the efficacy of the biomedical model helped tie both Islam and medicine to a global inclusiveness. This global inclusiveness was defined by a belief in a monolithic Islam, that at the same time was counter-balanced with exposure to other belief systems i.e. the nuns and their Catholicism.

Defining successful treatment exposes a metonym for the issues facing Senegal as a nation-state. How to make ‘space’ for other viewpoints in the effort to foster flexibility on an international or geopolitical stage? At the clinic, patients such as Mamadou, provide the connective tissue between Islam and the productivity of the state, at least metaphorically. They actively produce this ‘space’, or at least are taught to during their hospital stays.

We see this in the context of the penc because of the encouragement to pray alongside the commitment to the biomedical model. Mamadou admonishes patients to both pray and take their meds, in general to follow their doctors’ and clinicians’ interventions. In doing so he links the patients up to discursive practices that are heterodox and heterogenous and that bring together the traditional and the modern; the local and the global; and ultimately, the inclusive and the exclusive.

The question then arises was there no resistance or counter-discourse to Islam and moreover, the biomedical model? I saw none. There obtained a certain smoothness to relations at the clinic. This smoothness I have argued here was to some extent implanted, not unlike the Islam that Mamadou spoke of; but what of the patients’ agency? Consistent with psychiatric
hospitalization in other global contexts, patient agency is almost by definition severely limited. Part of the point of psychiatric hospitalization is that it operates according to certain de facto notions of what is normal. Subsequently, patients were molded into proper agents, or subjects, or ultimately individuated egos both in terms of their [a]political subjectivity and in terms of their observances of Islam.

I want to outline the clinicians’ own molding as individuated egos, in the next chapter. Within the transreferential economy the clinician’s own work and training implicates them as agents, as emerging egos. It is to their performance of self in their training, their staff meetings, and consultations that I turn in the next chapter.
Chapter Three

Staff Meetings (La Reunion), Consultations & Other Performances of Professionalism

Ker Xale Yi. Literally, The Children’s House; I stepped into Ker Xale Yi and was greeted with row upon row of chairs. Some metal, as I would soon learn, which were intended to be occupied for those of lesser status in the clinical pecking order; others were wooden. These chairs were placed in a large arc that reminded me of the auditorium orchestra seating for the audience at a Greco-Roman theatrical presentation. As one neared the front of the arena, there were plush, forest green chairs placed for the faculty and guest luminaries, coming from all over Africa and places in Europe and the European diaspora such as Canada.

I was early, so the space was empty. I sat close to the door, so as to communicate that I thought of myself as a humble observer and not worthy of taking up a spot meant for those who were there to be trained. As students gathered I greeted Fatou, Adil, Ghalib, Fareed, Katya, and others. All of whom took up seats in gradation according to their significance in the chain of command.

On these Thursdays, then, I found Fatou sat mainly in a green chair. Katya sat in a chair towards the front of the room, unless she were leaving early to administer some care for a patient or to fulfill one of her many (frustratingly so) administrative duties usually involving taking care of the French and other international students who had come to the clinic for brief training sojourns. The other, younger doctors –both usually in terms of age but also in terms of training exposure—sat clumped towards the rear of the auditorium.
On this Thursday they filtered in noisily greeting one another; nurses, social workers, nurse aids, and other staff entered and there was a general din of greetings and hushed talk of clinical concerns, or louder, plans for the weekend; the making of lunch dates; scheduling work around the clinic.

This was a staff meeting (La Renuion). This staff meeting was the defining training tool at the clinic. The chair placement seemed to communicate an economy of social relations that was highly stratified. It reminded me of the Senegalese caste system. The doctors knew in an act of professionalism to permit the enforcement of the clinical hierarchy.

A little, laptop PC was placed on a small table, directly in front of the green chairs. A screen was pulled down, after much consternation and search for the tallest member of the gathering. Finally, with a flourish Madame Martine Fourre entered wearing a yellow sun-dress, and high heel espadrilles. She was a charismatic leader of a sort. And she sat at the front of the room in a green chair, looking as if she were holding court.

The Children’s House. It is a space of not just liminality but also domesticity. Consistent with Gal’s (2002) fractal analysis of public and private spaces, The Children’s House, is a private space, locked away in a corner of the clinic’s complex, that is used for a general gathering, therefore forming a public. The articulation of this relationship is fractal. According to Gal (2002) that signifies that the Children’s House is a liminal or ritual public space as nested within a broader private space of domesticity. This relationship describes the spatial aspects of the staff meeting as a training tool. In this chapter, I turn to the other aspects of the staff meeting. In particular, I examine the meeting in terms of the content taught. I argue that an examination of

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the staff meeting in terms of the presence of Martine Fourre implicates the habitual presence of outside speakers at the meeting. The staff meeting then emerges as a foil to the *penc*. In the former it is outside forces that speak to the collectivist expression of daily life at the clinic. By contrast the *penc* is highly localized and is a public within a private.

Contrasting the two gatherings forces us to grapple with the staff meeting as an event that separates the clinicians from the patients. The content of this separation is *professionalism*. As professionals the doctors’ egos emerge. So, after describing the training in professionalism, in terms of ego-centered therapies –chief of which is Lacanian psychoanalysis—I turn to a description of the way that professionalism is expressed in consultations between physicians and patients. I also look at clinical rotations. In both I pay attention to sartorial codes. I also examine clinicians’ bodily hexi in their consultations.

Examining the expression then of the clinicians’ egos in the consultation room returns us to Chapter One and the role of Henri Collomb at the clinic. We see the ideals of collectivism that he taught in contrast at times and in others in collusion with the clinicians’ individuality. We will see the limits of notions of collectivism as a paradigm for treatment. We will view these notions and their connection to Lacanian psychiatric practice, as shown in a continuation of the vignette that began this chapter. Ultimately, we are allowed to contrast colonial constructions of what Collomb termed *Africanity* with postcolonial presentations of self. These postcolonial presentations of self are shaped in terms of global standards of professionalism. It is to these global standards that I turn in the next chapter. Beginning here though, I want to first better outline the Lacanian therapeutic project and/or process as taught by Martine Fourre. I argue that the presence of Lacan and the other heterogeneous elements of the staff meeting place it within the context of a cosmopolitanism that exemplifies Bhabha’s call for a secularization of the public
sphere. Indeed, if the *penc* is a religious event ratifying that Faith of the Book, then the staff meeting is a *secular* event ratifying those elements of the universalizing discourse of the biomedical model. Returning us thus to the medicoscape, we find that a rather strict observance of biomedicine that is defined in terms of professionalism that find the clinicians in the throes of balancing and commingling their exposure to Lacanian psychoanalysis with their own faith in Islam, leads the clinicians in definitions of pathology that are at once universal and at the same time counterpoised with local interpretations of mental illness. This chapter thereby situates more thoroughly biomedicine in its particularity and as a competing discourse in terms of the faith regimens found in the last chapter. We begin then with the clinicians’ exposure to Lacan as a way to situate the cosmopolitan nature of the medicoscape.

**Capote**

In order to get a handle on the heterogeneous nature of the clinicians’ exposure to Lacan and my application of Bhabha’s notion of vernacular cosmopolitanism, we must first acknowledge the differing views of the science of biomedicine that that exposure represents. It is with this regard that we can see the contrasting particularity of the biomedical model even as it articulates international ideals of professionalism which the clinicians are expected to master. With this regard I want to begin with Madame Fourre and her presentation of self because her presence articulates the cosmopolitan aspects to the medicoscape. Indeed, her way of dressing speaks to the global trends in sartorial codes on the part of clinicians. There are two crucial factors having to do with Fourre’s sartorial presentation. First, the lack of a lab coat speaks counterintuitively to the ascendancy of the biomedical model; and second, her outfit speaks to the influence of Collomb on the European aspect of the medicoscape.
So, addressing each of these: since liberalization and anti-asylum effects of the anti-psychiatric movement, onwards around the world, doctors and other clinicians were encouraged to adopt “casual”, non-clinical dress.\(^2\) This occurred during the late 1950s and early 1960s and can clearly be found in Fourre’s choice of rather casual clothing. There are two points that need to be addressed before we move on to the second issue of Collomb’s influence.

First, Fourre’s clothes were also appropriate for the hot weather. That said there were clinicians at this meeting who wore lab coats, so her clothing was not intended solely to be a response to the weather. And even it were it still amounted to a stance vis à vis appropriate clinical dress. Second, her clothes were fashionable. This fact I think speaks to the assertion of a unique sense of self or ego. This assertion can be seen to be an oscillation between collectivist ideas and expressions of her unique sense of self. On the one hand fashionable dress speaks to socially accepted ideas of what is appropriate to wear. By the same token, fashionable dress is an interpretation of what is socially acceptable. So that her wearing of the heeled espadrilles represents her unique sense of what is socially acceptable. It is an expression of her *personal style* and therefore her ego. In part because they are fashionable spring and summer shoes worn

\(^2\) See Tham S.W.; Ford T.J. Journal of Mental Health, Volume 4, Number 3, 1 July 1995, pp. 297-300(4) for a discussion of the American context. See an article in *Telegraph.co.uk* by Auslan Cramb, dated June 19th, 2001, for a discussion of the controversy over ‘casual’ dress among clinicians in a contemporary and European context. Such factors as body piercings and provocative dress among clinicians is addressed and shows the degree to which Fourre’s dress can be seen both within a global context of efforts to mitigate against clinical hierarchy, while in the same instance reinforcing the sets of concerns around issues of sexuality and expressions of individuality on the part of clinicians. The transferential economy that I addressed in the introduction, rears its head here and we find the line between effective treatment presentations of self on the part of doctors and staff and the necessary demarcation that patients in at least a European and American context feel they must have between themselves and their practitioners. See also, Governing the Captives: Forensic Psychiatric Nursing in Corrections, a Journal article by Dave Holmes; Perspectives in Psychiatric Care, Vol. 41, 2005, for a very interesting article pertaining to Foucauldian derived notions of appropriate care within the context of the panopticon and the imperative to punish. In this context dress emerges as a loaded concept, that mitigates against the successful transference agenda, which itself seeks to rehabilitate as well as deliver the necessary –so they conceive of matters—regulatory norms production. Finally, there are several articles dating to the years of these transformations in clinical habitus beginning right when the clinic was founded around 1957, in the International Journal of Social Psychiatry. That then these were ideas circulating within a global context is self-evident.
in France, and to some extent in other Western contexts, such as the US. I never saw another clinician wear heeled espadrilles. I will now turn to the discussion of Collomb’s influence having established the relationship between personal style, and casual dress.

Collomb seemed to prefer casual or non-sciency dress. He repeatedly addressed, therefore his concerns over the wearing of scrubs at the clinic. He understood the wearing of casual dress in terms of deconstructing patient/clinician hierarchies. Here, there must be a nod to the anti-psychiatric movement, in which a critique was advanced that sought to demonstrate that doctors could be said to be empowered by such sartorial codes as the wearing of Power Suits and other dress that separated clinicians from patients in the milieu. Necessarily, then, in order to mitigate against these power relations, the playing field was leveled, and this was interpreted according to ideals of dress. Significantly, moreover, these critiques of dress were felt globally. In the local context in Dakar how the body was clothed became central to communicating the egalitarian ideals of French citizenship. At the same time casual attire reinforced paradoxically the medical establishment, because after all, doctors could be seen to be wearing their casual attire as an expression of their professionalism. This feature of the medicscape, present as early as the era I have identified –from the late 1950s through to the 1970s when the anti-psychiatric movement was most prevalent in France—reveals a model that oxymoronically was designed to create pathways to mutual understanding between clinicians and patients, but which is dialectically or symbiotically related to larger concerns over giving the impression of professionalism. Rather than, nevertheless, be a pose I would argue this impression management is nested within very sincere concerns for empowering a patient population that is at once
connected to those who treat them, and yet need some demarcation from these very same
caregivers in order for effective transference to occur.³

There were also Power Suits at the Reunion. Why the discrepancy? I would argue the
contrast between on the one hand suits with colorful ties or formal traditional boubous is
reflective of the tension within the medicscape over a clinical professionalism versus a
professionalism that is more theoretical. Frequently, those in suits were presenters, but not
always: those who were higher in the clinic’s hierarchy could almost always be seen in more
formal dress. Their presence on the ward was minimized, however. So, the wearing of more
formal clothes speaks to the power dynamics present among clinicians themselves. Additionally,
those who sported less formal wear were expressing an adherence to that aspect of the
medicscape that was a globally ratified sense of professionalism on the ward. For example,
clinicians on the wards were never seen attired in suits or even formal boubous. They always
wore tennis shoes, deck shoes, short-sleeved shirts, jeans, and khakis. Thus, Fourre’s attire can
be seen to be consistent with notions of professionalism that were responsive to the global trend
towards wearing casual clothing on the ward as opposed to in the professional context of the
staff meeting. She was validating the experience of the students present for her talk. There are
two points to be made here: first, dress was expressive of hierarchy; and second, dress was
expressive of the deconstruction of hierarchy as seen within the dyad of professional doctor, and
patient.

³ My own commitments to the psychiatric interventions at the clinic, while informed by critiques such as
Biehl’s Vita, nevertheless implicate in regimes of knowledge-production and ontologies of medical interventions
that can be characterized as positive. I find there is a good deal of efficacy to be found in the application of the
biomedical model. Nevertheless, this conviction is informed by a sense that that efficacy cannot be separated from
broader sociocultural concerns such as for example, follow-up behaviors and compliance behaviors such that what
emerges is a medicscape as fraught with efficacy issues that are as much cultural as they are real. The real, in this
instance cannot be separated from belief about efficacy as well as power regimes that themselves always bear in an
anthropological context to be deconstructed.
No matter her dress, we were there to see this famous psychoanalyst and teacher speak about what I learned a few moments later, was the film *Capote*, starring Philip Seymour Hoffman as the bedeviled and beleaguered homosexual author. Much has been written about the conservatism of French psychiatry towards homosexuality (Morris personal communication), but rather than turn to that literature, I offer an ethnographic account of this specific instance of a French-inflected psychoanalytic practice that was tailored to a Senegalese context.

Curiously enough, Islamic discourse on homosexuality and the prohibitions against it in that faith, were evacuated. This speaks to the international discourse around the issue; these professionals were being trained despite their unifying commitment to their faith, in the most contemporary attitudes towards pathology. Consistent with the French psychoanalytic tradition towards homosexuality, the very discussion would seem to speak to a pathologizing of this expression of sexuality (Morris personal communication); but I would argue Fourre’s foray into a Lacanian understanding of homosexuality was designed to liberalize a somewhat recalcitrant audience. By turning to what she said about the film, I hope to shed light on the conceptualization of Lacanian psychoanalysis as taught at the school. But first some notes on the film itself.

The bulk of *Capote* is based upon a biography written by Gerald Clarke, and published in 1988. The film traces principally, Capote’s trip to a small Kansas town, named, Garden City, in 1959, to write what was initially meant to be an article on the murders of a local family, the Clutters, who lived in the outlying village of Holcomb. In an eerie coincidence the town would prove to be a sort of Garden of Eden for Capote in which he would have a relationship with one of the men implicated in the murders. The relationship with this man –Perry Smith—would feature a fall from grace on his part and an envelopment in a world of shadows and deep
depression as he awaited the verdict for the killers’ trial, and subsequent series of appeals. There has been some suggestion that Capote may have had a sexually intimate relationship with Perry Smith. On surer footing is the fact of Capote’s descent into alcoholism as he waited for the final resolution of Smith and his co-accused, Dick Hickock’s, trial and numerous appeals. The wait really, the biography suggests, was not anxiety-ridden for Capote because he desired their acquittal, but rather because he very much wanted to see a resolution to his book based on the crime entitled, In Cold Blood. The movie spends around two thirds of its time focusing on the relationship with Smith, and the remaining portion on Capote’s decline during the waiting process. It is a sad movie and ripe for psychoanalytic analysis, in part because of the fraught relationship between artist and subjects. It brings up issues of power, recognition, sexual identification, fame and pecuniary success, and ultimately the formation of the ego around these self-same issues.

Fourre took up and worked through some of these issues, by beginning her analysis and subsequently organizing her talk around three ideas and/or principles: [1] what she termed the ‘realized fantasy’; [2] the construction of the ego in terms of parenting; and [3] the mirror stage as a descriptor of the transferential economy, and related issues of identification and recognition. Let me discuss each in turn.

The realized fantasy describes Capote’s reification and relatedly recognition of self within his desire. His relationship with Smith becomes an expression of a deep-seated desire for a father figure. This is coupled with an attraction for the figure who best stands-in for that desire or the objet petit à. Smith becomes the central figure in a drama that implicates Capote’s childhood alongside Capote’s adult ideations and reification of the masculine. For Fourre, the realization of this fantasy can be found in the interactive moments in which, for example, Capote
repeatedly makes eye contact with the criminal. Their first moment of sight is a highly charged
moment of mutual recognition, that dialectically reinforces Capote’s narcissism. He sees himself
in Smith, and by desiring the latter, desires a certain self-expression or self-actualization.

At one point, Nell Harper Lee, Capote’s companion on his trips to Garden City, and
Alabaman childhood compatriot, says of Truman’s relationship to the book, and its promise of
fame and recognition, “Truman in love with Truman.”

For Fourre this desire for self-actualization represents a mirror. The object of
identification the erstwhile objet petit à is mirrored back to the protagonist in the drama of self-
knowledge, and self-identification. Perry mirrors back to Capote the imago or long-lost love for
Capote’s father. The individuated ego, however is triangulated and features the mother’s role as
well. So, we have Truman’s ambivalent relationship with his mother. In a speech delivered to
Smith, Truman tells a harrowing story of a childhood spent imprisoned in hotel rooms while his
mother cavorted with paramours, usually newly acquired. The story, as Truman says, is intended
to create a ground of identification. Yet within the system of the real aspects of their relationship
—understood to be those factors that are not symbolic or ideational—he speech is articulated
against the backdrop of an equally harrowing disparity in class, and wealth, between the two
men. Truman says, “you know you and I are not so different” by telling the story which
characteristically (for this is a motif of the film: namely, the dexterity with which Truman uses
personal admission to elicit trust) results in the giving of confidences. Smith and Capote develop
what Fourre calls an intimate reality. This reality is in sharp distinction from his chic reality.

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4 Harper Lee is the author of To Kill a Mockingbird, a text that is curiously and ironically, more taught in
most schools, than the contemporaneously more celebrated In Cold Blood, which made, as the film tells us, Capote
the most famous writer in America.
The two are captured in contrasting shots of the prairies of Kansas and the darkness-shrouded skyline of Manhattan.

There is too by way of an exposition of the raw nerve of the unrequited love for a father figure, a scene in which Capote is holding a party after an enormously successful and validating reading from the finished sections of the manuscript. A man says, “your portrait of those men was terrifying…terrifying”, after which he summarily exits. Truman, in his element and laughing raucously, cries out, “Stop that man! Come back here! Dad!” He turns to his guests, “Have you met my father? He hasn’t spanked me in years…” For Fourre this scene signifies two aspects of the pathological psyche: first, there is the contrasting and conflictual relationship between the protagonist, Capote, and the pre-lingual and the post-lingual. With this regard, there is the manifestation of ego in the context of the familial or at least parental relationship that requires the nurturing that defines our childhood frailty and desire. This desire becomes a posteriori an unresolved configuration of healthy identification with the parent[s]. This healthy identification is a mirroring back that ultimately fosters healthy narcissism. Capote cannot meet his own needs because they were not met successfully in his prelingual phase, that is, before he had the language to articulate those needs. In the post-lingual phase, then, he is caught in a cycle of ever-deferred gratification. A circumstance that to some extent defines our existential condition in modern, urban oriented culture in the West, says Lacan.

For Lacanian physicians this mirroring back has its antecedents in expressions of self. These expressions of self are couched in terms of language. The pre-linguistic phase precedes the mediation of culture. It is defined by the relationship with the parental figure[s]. For these physicians there must have been a sense of recognition, given the supposed primacy of the family in Senegal. And that I think is in part the point. For Fourre, to return to the Lacanian ideas
she was teaching, there was then, a certain commitment to an ideal of African culture. Namely, that ‘African’ culture is to be distinguished by its investment in the family system. The problem she identifies is the “chic” reality. This reality is characterized by interactions that are rendered smooth by virtue of the emptiness they reflect back to us in the process of mutual recognition. Rather than finding in the Other a sense of self, one finds in the self, a sense of self ad nauseum and in perpetual feedback. This is a cancerous narcissism, this chic reality, and it perhaps in my interpretation is what Fourre wants to say speaks to us across the current urban landscape in which treatment is offered at the clinic. There is a move away from the family ‘culture’ towards an emphasis on a rigid subject-formation of the individual. This move to Lacan ruptures the stereotype of African culture as only collectivist in orientation. It also explodes the notion that African culture is in any way static, and ahistorical. As concerns emerge in Senegal’s positioning in an international community, and as Dakar develops into an increasingly swelling urban center, psychic difficulties emerge that Baudelaire might characterize as those of a nature-divested, industrializing, alienated, and alienating, city.

I interpret the use of Lacanian ego-centered therapy by the clinicians then as a means to address this increasing individualistic alienation. So it is that according to Fourre, Capote is the quintessential flâneur, strolling and observing but connecting meaningfully with no one. He is a recorder who becomes as he says, a “monster” whose humanity is only restored in the act of recognition with his protagonist. But because of Perry Smith’s criminal act of murder he is also a monster. Capote, in his act of writing the book becomes a monster because he flattens Smith’s subjectivity into language. That flattening makes Capote a monster because he divorces Smith in his act of recognition with the man from very real socioeconomic and political issues. In this case, capital punishment and a criminal justice system that render Capote’s moments of
identification half-baked. The writer, then, Capote, emerges as a figure that Fourre sees as pathological not because of his sexual orientation per se, but because that orientation entails a smoothing of ego into a constant mirroring without any solid sense of identification.

Why did Fourre choose this film? The reason was actually lost upon some of the clinicians.

On January 10th, 2007, one of my first weeks at the clinic, after the Christmas break, I had brunch with a student clinician named Agathe who said, “I didn’t understand why [the seminar on Lacan].” She remarked that there were two aspects of the film that intrigued her: first, Capote’s voice was that of a woman. Second, the motif of Capote’s eliciting confidences (gagner la confiance). As to the first, Capote’s voice was that of an actress in the French version. Secondly, I have already mentioned this motif. For Agathe as she went on to explain it was the manner in which Capote profited from lying or at least manipulating others to gain their confidence that formed the substance of his pathology. It was in other words his assertion of his own agenda that fascinated Agathe. She went on to explain that Capote was never interested in the pain of the community but instead wanted to sate his own desires. While Agathe did not know or was uncertain why they had been shown the film, she took away from it the conflict over the interests of the collective and Capote’s efforts to self-actualize. Despite Agathe’s perspective we cannot be certain that this was the central agenda for showing the film. What is crucial though is the fact that that is what Agathe took away from it. Agathe’s analysis indicates the commitment she held to collectivist concerns. She exclaimed that it was difficult to follow the discussion (difficile à comprendre). Nevertheless that is what she took away from it. The fact that she was a student being trained in Collomb’s treatment modalities is significant here. She went on to observe that Lacanian psychoanalysis was a “modern” approach that works
(améliorer). And for her everyone could change as a result of using these modern practices such as the Lacanian psychoanalysis. She said, “each person on the team can change” (*chaque personne dans l’équipe peut changer*)

Speaking of the therapeutic team as implicated within the therapy offered at the clinic was a central tenet of Collomb’s approach. He believed that anyone could participate in the healing process. Moreover, he had clinicians participate in the *penc* voicing their concerns along with patients precisely because he believed in the necessary malleability of the clinicians’ own views of therapy. The process by which the clinicians emerge as professionals is seen here in this instance within the referential and transreferential economy that shapes the doctors as protagonists themselves. Stepping back for a moment, we can see then in the sartorial codes, the self-expression with cell phone ring tones, the use of the most up-to-date technology such as expensive PCs in order to do PowerPoint presentations, and the manner in which the doctors use their bodies, their postures at desks during consultations, the manner in which they write notes including their penmanship, speak to professional habitus and hexis. This habitus and hexis implicate global trends in medical treatment, procedures, and professional attitudes. How?

Because the clinical models the doctors are trained in are globally ratified models e.g. Lacanian psychoanalysis. Moreover the technology, the clothes, and the procedures are all generalizable and presumably universal e.g. physical examinations. It is with regard to these universal practices that I now turn, both in an effort to sketch out the emergence of the doctors’ egos but also to show that that emergence is shaped by international ideals of what a psychiatric *professional* is supposed to look like. So, I want to turn my attention to the consultation space and the bodily performances on the part of clinicians in this space.
Consultations and the Aestheticization of Professionalism

There are at least three aspects of the several consultation moments I will present here; first, they feature a certain economy of transference/countertransference that concerned the doctors immensely; second, they contain a certain commitment to self-monitoring, and a monitoring of the elements present in the therapeutic encounter; and third, they center around notions dear to Lacan of the emerging ego in the context of a constantly shifting socially mediated sense of reality. I want to look at consultations and clinical rotation experiences taken from work with Adil, Fareed, and Ghalib. In each we see clearly the transferential economy that implicates the clinicians’ own ego development against an urban, global landscape as much if not more so than their patients.

Adil and Bison, Bulls and Lions

One Spring day that year I attended a therapeutic interview or consultation with Adil in which a young man fidgeted as he spoke. His head awash in sweat he said as he mopped his brow with a handkerchief:

ALAIN (THE YOUNG PATIENT): I have difficulty sleeping…

ADIL: Why what’s going on?”

ALAIN: I am tense…

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5 I conflate ‘therapeutic interview’ with ‘consultation’. This type of discussion familiar to Western audiences as ‘med supervision sessions’ with psychiatrists, is in the context of Clinique Moussa Diop more of an interview. It is also a consultation, though, featuring the patients’ questions as posed to the clinicians. The ideas of consulting and interviewing then inform my view of the talk therapy practiced at the clinic. I take ‘talk therapy’ literally and without loading the notion as much as it is in Western context. When I use the term talk therapy I am referencing the talking that occurred in the therapeutic encounter. I would say additionally that that is really what forms the substance of talk therapy in Western clinical settings: the clinician and patient talk. In some instances e.g. psychotherapeutic ones such as Freudian analysis the patients does almost all of the talking. These types of sessions were also found on the ward at Clinique Moussa Diop; indeed patients were always encouraged to do the bulk of the talking as opposed to the family accompaniers as I have mentioned in Chapter One.
ADIL: Are you married? How are things with your wife?

ALAIN: They’re fine…

ADIL: How’s your sex life?

ALAIN: We don’t have sex…

ADIL: Why not?

ALAIN: Because I can’t keep an erection… [je manque de la force].

ADIL: Your dose is too high. I’m going to write you a prescription and we’re gonna’ cut your dosage in half and see how that goes…

ALAIN: Great! How long will it take to work?

ADIL: You should be fine in a week. We’ll see what to do if it doesn’t work by your next visit.

ALAIN: Merci beaucoup, monsieur le docteur.

ADIL: No problem. Now, go do what Allah wants and make some babies…

[The young man gets up slightly stumbling as he pushes away from the consultation desk and he shakes Adil’s hand vigorously and departs. For his part, Adil too pushes away from the desk and stretches and looks at me and smiles. I return his gaze, a bit taken aback at what I think to myself is a highly didactic exchange for a psychiatrist to have with a patient.]

By way of explanation for the highly didactic nature of his response to the patient’s concerns, in a later conversation with Adil, he reported to me:

…psychotropic drugs have significant sexual effects. Dr. Ibrahima [a doctor at Thiaroye] wrote a thesis on these problems in which he showed that patients are not helped because they avoid talking about these issues but in discussing them the clinician can create a successful therapeutic connection. It reassures them.
Adil then gave as an example the following story:

I had a patient come in. He answered all the requisite therapeutic questions but complained that each night he was having dreams about bison and bulls and large lions. I realized that he was having these dreams because he was experiencing potency issues. So I raised the issue with him. He confirmed that this was what was happening…

Adil prescribed a three-pronged approach: [1] he diminished the dose of the patient’s medication; [2] he prescribed a stimulant; and [3] he asked him to have his wife help him to get aroused: presumably through foreplay.

This exchange highlights the highly fraught heteronormative environment that saturated therapeutic encounters at the clinic. There were prescriptions both literal and figurative in this vignette around issues of the appropriate rules of engagement between a man and his wife. This instance also highlights the transreferential economy at the heart of a Lacanian oriented set of therapeutic practices. To wit, the patient in discussing sexual issues with Adil, places in language the deep seated embodied experience of impotency. In doing so with a male therapist he is emphasizing and implicating the manifestation of desire for the therapist, whether that be in terms of a desire to be intimate on the level of the replication of the parental dynamic or to simply be intimate with Adil as an expression of masculinist heteronormativity.

Every day when I went to the boutique that is across a path covered in construction debris, in relationship to our home in Dakar, the patrons would ask me, “Ana sa jabar” which means “how is your wife” the more colloquial way of asking is, “naka sa soxna” which leads me to believe they were taking a more formal stance with me. With that formality they were indexing my presence as a foreigner. But they were also bringing me into a social economy that placed symbolic capital in the marriage relationship. These sorts of conversations while
anecdotal match up neatly with Adil’s suggestion to the patient during the consultation that he be intimate with his wife. Presumably, Adil connected his patient’s lack of initiative with women to not just his sexual inhibitions, but to a semiosis—bison, bulls, and lions—in which the patient could not perform. This semiotic field was expressive of and produced a certain pathology.

A central feature of the exchange is also the recourse to pharmaceuticals. By taking his medication at a later time in the evening he would be able to get stimulated enough to have successful sexual interactions and so sustain a successful marriage.

The dream about bison, bulls, and lions then becomes a semiosis of concerns around issues of potency. But of equal importance it links therapist and patient in a web of transference that gives context and meaning to their experience of their masculinity in an Islamic world in which manhood is defined in part by marriage coupled with the inception and rearing of children.

*Consultations with Ghalib or Patient Number Four*

I arrive at 9:05 am and Dr. Ghalib has not come in yet. I greet the young woman at the main entrance table, who has been placed here in an innovation since my arrival, to answer questions for entering patients. I then turn to go into the suite of sleeping chambers/consultation room. I realize I should leave my computer in the library. I return to the library amidst a flurry of greetings. I leave my computer and return to the phalanx of suites. I await the doctor. I hear another doctor arrive—Fareed—and then Ghalib arrives. I think I am to meet Fareed but it is Ghalib this time around on Wednesday.

The fourth patient Ghalib saw that morning in October, illustrates in part the desire professionally to control the therapeutic environment. This aspect of professionalism implicates the ego of the clinician. Control means the capacity to keep the therapeutic encounter within the parameters of socially acceptable behavior. But it also indexes or implicates the doctors’ own
unique sense of self and his capacity to control the clinical situation. Finally, it indexes the clinician’s engagement with the parameters of a globally ratified sense of the aforementioned professionalism. Let us turn to the vignette in which we will see these factors in play.

A young man in an aqua boubou and his taalibe (disciple) in white, entered. The young man Ghalib explains later is the son of a marabout. He will most probably assume the position of marabout after his father steps down. The older man is his disciple. Ghalib greeted them in Wolof. Then he switches to French and asks, “Tu parles Français?” [do you speak French?] “Non”, the patient responds. Ghalib then quips, “Je ne parle pas Wolof [I don’t speak Wolof]”. Comment vas le faire? [how are we going to do this?] Patient 2’s accompanier has stayed as a translator I realize in a few minutes.

Ghalib asks, “What voices does he hear?” The Modecate it is reported, “places him at ease.” They laugh.6

He doesn’t have children yet. He would like to, Ghalib repeats what he says this time in Wolof, “begg na [he would like it], oui.” Ghalib asks, “deux ou trois” Also, how many wives does he want?” “Four” he responds.

Ghalib asks if he hears the voices of people who do not exist or those that exist? He hears those that do not exist. Does he see people that others cannot see? He says, “yes.” Are they the voices of men or women. They are the voices of “people.” What do they say to you? Does he know they are simply in his head? When he leaves the house or goes out he doesn’t hear anyone.

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6Fluphenazine decanoate belongs to the family of anti-psychotics known as phenothiazines. It is used to treat schizophrenia, which patient number four seemed to exhibit the classic symptoms of: auditory hallucinations. It is administered via injection.
What does he see? Does he continue to see? He continues to see but they are much less distinct. How is his sleeping? He gets up at 7am and goes to bed around 10pm. Does what he is going through make him sad? Yes. Ghalib says we are going to ease his suffering.

Ghalib asks if he has been eating. They laugh and he says, Café-au-Lait and bread. He is to return in 3 months. Does he feel tired when he wakes up? How are things with your wife? Yes, there are no problems. There is an issue with the prescription. He must keep the date of his injections of Modecate, in order to monitor his use of the medication. And above all, he must remain compliant.

After the patient exits, Ghalib begins to grill me. He asks for the umpteenth time why I chose to do my research in Senegal. I explain the choice was initiated in prep school when I studied the Negritude poets and more specifically Senghor. He says that last time I had responded that my motivation was because my mother was a psychiatric nurse. I explain it is both, an admixture of the two motivations. Is he trying to catch me in a falsehood? The conversation continues: He asks if I am metisse. I explain that I have a lot of “white blood” and he seems to understand. The next question is of note: it is the question of children. I explain that at this juncture we cannot afford children, especially just having purchased our first home. He then asks –skeptically?—how I finance my education. He asks about my wife, whose name he knows, and whether she works. I explain that she is a doctoral candidate. He wants to know if we work to finance our educations. I explain that we take out loans in order to supplement our income, as well as using the money to subsist. I then attempt to turn the tables and I ask him about the notions of sexuality and the presence of discourses of race, given his question about my own racial background and his questions of patient four around his relations with his wife.
He simply grumbles, “we have no racism here…” and he attempts to shuffle me out of the office mumbling something about talking next week about this stuff if we have time.

He stops himself at the door, places his hand on my forearm and asks if I have training in psychiatry. He asks if I haven’t ever studied as a psychiatrist. I explain that no I haven’t. He blows this off and returns to questioning my motivations for doing my research. I mention my own experiences as a clinician in Denver. But I am driven by a need to refocus the conversation towards an examination of his own motivations and experiences as a therapist. Given the tug-of-war, I again attempt to pull him in the direction of self-disclosure. I manage to get out a few questions on the topic of his vacation. He spent it with his family in Congo. He has 3 children, 2 boys and a girl. He played with them. He was gone for 2 months. He said he came back and has been back for 3 weeks. He says one must finish one’s studies, as if to counsel me, and then abruptly waves me off as he closes the consultation room door.

Ghalib’ efforts to control the therapeutic environment and somehow make himself an ideal observing agent positioned to analyze all –even me—in that environment speak in part to the power differentials present in the therapeutic encounter. His discussion of the patient’s experience on the drugs speaks to at once his commitment to a drug regimen, but also more favorably to his concern for his patients. That said, it was my observation that Ghalib took a humorous timbre to his work. Consistent with Freudian theories of joking behaviors, I would argue that Ghalib used humor to somehow distance himself from his patients and maintain a professional demeanor; according to Freud’s hydraulic model of humor in which laughter serves as a release valve to pent up anxiety, Ghalib monitored and/or modulated his own therapeutic role via laughter.7

7 Freud’s model is discussed in The Joke and its Relation to the Unconscious (2002).
I would argue additionally that Ghalib’ questioning of me exceeded maintaining the therapeutic environment. It broadened his intervention into one in which he saw his role as a professional to be paramount. His role can be construed in terms of the impression he was trying to give. He questioned me then and my motivations because he wanted to exhibit mastery over my role at the clinic. His questioning speaks to a need to position me within a regime of surveillance and monitoring in the consultation. These concerns highlighted his ego-formation as a psychiatric professional within the context of my lack of professionalism. In transerferential terms, he was able to assume a role that defined his own in an act of recognition that was unilateral and yet dialogical. Via language, through the intervention of talking, he placed me in a paradigmatic relationship to the articulation of his own professional subjectivity.

There is a significant aspect of the transerferential economy that I have left aside until now. I have left this feature of the transerferential economy out until now because it implicates my own supposed lack of professionalism as perceived by the clinicians. So, what I turn to now is my role in the transference/countertransference that occurred with my presence in the consultations.

*My Role in The Transreferential Economy*

In the Patient Four vignette my presence is all but ignored. There are two ideas that this fact initiates. First, there is the issue of confidentiality; second, there is the issue of professionalism and my lack of professionalism as perceived by the clinicians. My role in the transreferential economy was defined by a disregard for patient confidentiality. This can be explained in the following ways: first, the clinicians sought to provide freedom for me to do my work, a factor that we might see in terms of a hosting relationship; second, they felt that their patients did not need to have confidentiality because I was cast in terms of being a professional;
or third, everyone at the clinic was deemed a possible source for healing, as Collomb taught. I would say that my presence then was cast in terms of all three of these ideas. So, first, the clinicians were being good hosts in allowing me to conduct my research. Second, as a professional in my own right, I was considered as a necessary part of the therapeutic encounter, or at least a neutral party in that encounter. Which leads to the third, I was considered in my role to be as much a part of the therapeutic intervention as anyone else on the ward.

The transference that implicated my role can be understood in terms of these issues of confidentiality and in the accompanying ideals of professionalism. There was a problem though. I was not considered a professional or at least not all the time. Because my open-ended interviewing technique—the person centered ethnographic technique that I mention in the methodology section of the Introduction—gave the impression at times that I did not know what I was doing. I was hence not professional in my demeanor or in the impression I was giving. This analysis of my behavior was confirmed for me by the repeated references Ghalib makes in his questioning to my training and in the repeated questions other clinicians asked me about my agenda. On numerous occasions clinicians would ask me, “but what do you want to know?” Given my emphasis upon observation as a part of my methodology, I did not always have a satisfying answer to that question. This perspective was confirmed in the following vignette:

The last day of my research I attended a conference at L’Hopital Principale de Thiaroye. The conference was devoted to training clinicians on how to treat child patients who were transitioning to adulthood.

During the lunch hour, a discussion was struck up about Saint-Exupery’s book *The Little Prince*. One of the clinicians asserted that the little prince of the title is transitioning from childhood to adulthood. A second clinician disagreed and said the real story is how the little
prince is stuck in childhood. I chimed in at this point. I said the little prince uses both the informal “tu” form of “you” and the formal “vous” form in the same sentence. The use of the “tu” form is a feature of adulthood as children refer to all adults in the ‘vous’ form. I argued that this play of language casts the little prince as being in the throes of a transition from childhood to adulthood. Crucial for our purposes was the response to my assertion on the part of the second dissenting clinician. He turned away from me and said to all gathered, “Well, among we professionals, we know that he is still a child no matter what he says or how he says it…” I was seen as lacking the necessary professionalism to both venture a comment not to mention hold an opinion that diverged from his position as a psychiatrist.

But I was not a clinician. Therefore it could also be said that I was not a professional in the sense of being a clinician. This returns us to the discussion of transference. My role in the transferential economy can be understood in relationship to their perception of my role. According to this perception I was at once a neutral party and at the same time a contributor to the transference going on. It was precisely my role as a non-professional – frequently questioned by Ghalib and others—that allowed my hosts to receive me as a guest, and yet according to the doctors’ training in Collomb’s work, participate in the patients’ healing. These facts could be seen in relationship to the access across boundaries of confidentiality that I was given. Having situated myself in the context of the consultations, I want to turn to an account of the rotations of one of the clinicians, Fareed. I do so in an effort to describe his bodily hexis. I look at his consultations as well in order to connect his behavior with our earlier discussion of some of the other clinicians.

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8 The sentence in question is, “s’il vous plait, dessine-moi un mouton” with the vous form accompanying the imperative that is in the “tu” form. The sentence translates as, “if you please, draw a sheep for me”.

159
Rotations and Consultations with Fareed

I am here at 9:30 am or so. I go to the library to drop off my computer and then I venture into the clinic looking for Fareed whom I have planned to follow for the day. He is not here yet (or I learn later is in another part of the clinic unawares) and so I wait. There are patients on the benches awaiting sessions with nurse, Madame Diop. I wait.

After a while, perhaps fifteen or twenty minutes I round a corner coming from the exterior of the inner-clinic suite of rooms and consultation room, and there is Fareed standing with a patient discussing his treatment.

We enter the room to talk to his first patient. She is immobile on the bed, stretched out, her legs stiff. Fareed says,

FA: The last time I saw you, you refused to talk. Can you tell me why?

She does not respond, continuing to lie on the bed. Her brother (BR) and mother occupy the room along with her. They are seated on chairs.

FA: Tu as pris des medicaments? Tu refuse de parler. [Have you taken your medication? You wont speak.]

The brother chimes in at this point after Fareed has asked how the night passed,

BR: It was Mother who passed the night with her.

They then begin to discuss in earnest. This conversation is in Puular. Eventually Fareed leaves the room accompanied by the brother. The brother complains in French that she has not eaten in five days (he counts down the days, “Sun., Mon. . . .”). He says deeply concerned,

BR: She’s gotta’ eat…
FA (reassuringly): With the medication she’ll eat.

Fareed shifts in conversation and reassures but also challenges the brother by saying,

FA: Everyone is involved in the treatment.

This woman looked depressed almost to the point of catatonia. It is clear from the brother’s treatment of the doctor and his codeswitch to French that he deeply respects the doctor and he concludes their interaction with many, “Merci docteur. Merci…). This code-switching is compelling additionally because, having spoken in Puular, the use of French exposes the degree to which deferential linguistic codes are couched in terms of the language of the doctor or the medical professional. So the brother is ratifying Fareed’s position as the medical professional.

The space in which this interaction occurred is also worthy of note. The scene unfolds in the patient’s room. This is a private space nested within a highly public one --the clinic—and the turn to Puular is a gesture of reinforcement of confidentiality⁹; the return to French places them again within the spatial configuration of a clinic: Fareed is no longer a fellow immigrant, but re-enters the space of hierarchy and difference. He is moved or placed back into the public, and the incumbent public personae emerges. The use of the Puular speaks to the globalizing forces at play in the clinical setting. This is a world, not unlike the clinical world in the US and with the advent of refugee status, and immigration into Europe, the Western milieu, that features an international (see Chapter Four) or between-nations, set of relations. This inter-national set of circumstances allows Fareed to be at once a professional, and yet within an economy of transference, to emerge as an intimate. This cosmopolitan space in part allows for this set of

⁹ The patients’ notions of confidentiality are contrasted with those of Ghalib in the earlier vignette for precisely the reasons stated above. These include the relationship my presence had to both hosting economies and professionalism or my lack thereof.
circumstances to arise. It is an intimate space that is nested within a public. The use of Puular becomes a metaphor for the relationship between this public and private tension. It is a room for sleeping and eating, and domestic acts performed in the language of home, or at least homeland. Hence, it is a private space. Therefore this space seems to be outside of the realm of influence that is the public invocation of the Senegalese national language of French. Yet in terms of the clinic hierarchy and professional commitments to drug regimens it is highly public, with public reading along a trajectory of citizenship in terms of immigrant status.

There is additionally an implicit assumption that Fareed makes here; specifically, he contends that drugs work. Their efficacy is tied to his understanding of illness and in Kleinman’s terms disease. According to Kleinman, in *Patients and Healers in the Context of Culture* (1980), ‘disease’ is the biological experience and subsequent epistemological, and ontological biomedical construct for understanding compromised health. As for ‘illness’, it is the understanding of the social and/or cultural construct around compromised health. The presence of a global normative regime around which these ideas of good and bad health are constructed demands that we add an additional term that speaks to the increasingly globalized ideas about what forms good health, and moreover what constitutes good preventative and ameliorative care. And for the sake of discussion it allows us to begin to more specifically address what illness/disease mean in a global arena. The term I employ to speak to these global ideas of what constitutes both illness and disease is the erstwhile ‘medicoscape[s]’. The clinicians are trained to recognize these global ideas of disease and illness. And as we will see in the next chapter it is the biomedical model along with Islam (see Chapter Two) that sutures their training coming as they do from various points on the globe.
There are many significant behaviors that express the medicoscape. It is to the bodily hexis of Fareed that I now turn in an effort to describe these behaviors.

*Fareed and the Physicians’ Bodily Hexis*

A significant behavior I witnessed in my work among the clinicians was the gesture of stamping. The use of stamps in Senegal is ubiquitous and is designed to convey the notion of the ‘officially ratified’ to a given set of behaviors and/or interactions; most of which occur within a hierarchical register. Part of the doctors’ -- and indeed all those providing clinical care-- inhabitation of the consultation chamber is to stamp a patient’s prescription, which is written in chicken-scratch that is to the layman’s eye almost illegible. Each doctor, however, develops a distinctive way of stamping, some roll the stamp, while others make a brusque go of slamming the stamp onto the prescription paper.

There are other noteworthy expressions of the professional’s bodily hexis, such as the way charting is done, and the way the doctor sits at the consultation desk. So, that, for example Ghalib would at times rest his feet on the desk and push his back against the wall behind the desk; for his part Adil did not even sit at the desk, preferring the examination and resting bed; and finally, Fareed, in an expression of his rather quiet and precise negotiation of the physician’s habitus, would sit at the desk ram-rod straight.

It was the stamping however that speaks the most to the global regime of pharmaceuticals. The doctors were trained with an eye towards ratifying the global regime of medications. This can be seen in their use of the Physician’s Desk Reference (PDR) manual that was housed in the clinic’s archives. On many occasions I saw the physicians consulting this manual. When asked why they would invariably respond something along the lines of, “It helps to understand what I’m prescribing and what dosages I should use.” The use of the stamp reflects
upon the use of the PDR. The stamp places the use of the medication within the professional framework. The stamps highlight the doctors’ attachment and deployment of the officially ratified technology of pharmaceuticals. They were placing the clinic’s stamp of approval not just on the slip of paper that symbolized the efficacy of medication, but also attributing a certain magical power to the totem of the prescription. This fact outlines the significance of the biomedical model in determining each clinician’s unique expression of their professionalism.

Additionally, by stamping they were engaging the patient in a social contract that said, [1] I will follow my doctor’s orders; [2] I will comply with my course of treatment; and [3] I am aware of my sickness and the need to cure it, having given it a name i.e. diagnosis.

In the following ethnographic vignette we see several of the ways the body is implicated in the therapeutic encounter. Note here however the way that the bodily hexis mediates an uncomfortable situation in which Fareed as an unmarried man, moves about the room in order to give the impression of professional behavior, while clearly being ill-at-ease with the probings of a woman in a society which we have seen is very focused on children. He is able to turn the

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10 It is also curious from an anthropological perspective that the overriding metaphor used to speak about pharmaceuticals in a clinical context is a kinship one. Medications are known as members of ‘families’ of drugs. This model would seem to indicate the degree to which drugs are said to have generalizable properties. In other words, they form families because they speak to general symptomology. This collectivist orientation to the discourse on drugs implicates the role of statistical science in medical practice. Statistics are used to determine efficacy. A family of drugs, then, is said to address general trends in efficacy. So for example MAO Inhibitors is a family of drugs used to treat mood disorders that are connected to Serotonin uptake in the brain. Leaving the science aside we can see how the notion of family as used in this instance speaks to the generalizable relationship the family has with treating the same or similar disorders. They function scientifically the same way and are therefore seen to treat a certain collective body of patients. This body of patients’ reaction to the drugs is measured in studies that are then correlated statistically. It is then with regard to the collective body of patients and the measurement of their interaction with the drugs that we can see the development of the family metaphor. Similar discourse is generated around ethnographic ideas of kinshipology. According to the latter form of ethnographic analysis, the idea of culture itself is measured in terms of generalizable data with regard to the relationship that family structure has with a culture.

11 Doctors frequently failed to share the diagnosis with their patients. That said, I think this speaks to the talismanic nature of the medications that were prescribed to treat most diagnoses. The patients, then, were left in the dark, partly to promote the professional stature of the doctor (e.g. I alone know and understand what is wrong). Of equal significance, however, is the concern the doctors had for communicating with their patients in the language or semiotic field that would most reach them. Diagnosis, then, was for professionals, sickness was for patients.
tables on the woman, in their power negotiation, by lying or using indirection, but also by making recourse to the various technologies of professionalism available to him, including *inter alia*, charting; scheduling; and stamping:

The patient enters. She asks of Fareed’s wife. He lies about his bachelorhood by saying, “she is not coming today”. Fareed takes a moment and looks for his stamps. He cannot find them. He finally crosses to the metal bookshelf next to the door where he reaches into his bag and finds the stamps there.

The patient claims that her husband is in Kaolak. She says she must find her mother because her husband does “savage” things. She says she does all the cooking but he is unappreciative. Sometimes he says for her to stay with him and other times he says for her to go. She says she thinks the problem is she has no children with him. He is divorced and had children with his first wife.

She tells Fareed that she is 27 and Fareed says she should have children. She says her illness does not invite having children. Her concern is that she will have young girls who will end up in the street. She says she is going to divorce her husband. Fareed continues with this line of argument with, “One should have children.” The conversation seems to drop at that.

He asks, “you’re sleeping well?” She responds that yes she is sleeping well. She takes her pills: one at night and one in the morning.

Fareed takes notes on the green and yellow *affiche de controle* (charts that are kept in grocer paper envelopes). He looks at her meds that she has brought in in a small, plastic bag and has dumped unceremoniously on the table. She says, “when I go on a trip I take money to eat, look around and I buy clothes with the rest of it…” Fareed asks, well who buys the meds? She laughs and concedes that it is her husband who buys the meds. Fareed has observed that she
dresses well. Fareed writes another prescription and he stamps it two times. He goes back to the metal bookshelf. He retrieves his date book and sets the 5th of March for their next session.

I would argue that each moment in this vignette was to some extent choreographed. So that, for example, retrieving the date book while casual enough actually allowed Fareed to create a crucial pause or interruption in his administration of care. He could very easily have written the date down in the chart where it would normally have been noted. Instead, he chose to get up, revealing his full height, cross the space and engage in a behavior that while compromising his appearance as a fully-prepared professional reinforced his capacity to govern the therapeutic space.

Equally as significant was the choice to stamp the prescription twice, indicating the full weight of what he was performing. His peregrinations, then, around the consultation room, coupled with his ‘stage business’ of stamping reveal the degree to which he wanted to provide an impression of professionalism that belied his own transference issues as an unmarried man in a Muslim high birth-rate inflected society.

**Summary and Return to Lacan**

The emphasis placed upon medications in these consultations and rotations would seem to be in conflict with the role of the collective defined as the family nucleus, as in the case of Fareed’s observation that it takes everyone to give proper treatment. By way of summary, though, I want to argue that individualistic therapy was present. Lacan was present, in a metaphoric sense. Indeed, it is the semiosis of Lacanian techniques of the psyche that is of significance; for, the clinicians utilize in almost all of these cases a certain didacticism that speaks to a parental role playing. Given the dictates of Islam, the clinicians take on a role of marabout, who has the role of gentle guiding parent in the Sufi Islam practice of Senegal. The
clinicians, then, interpret the mirror stage and Fourre’s notions of the role of the parent to call for a type of therapy that seeks to foster a relationship with the patient that is more as teacher and parent than it is impartial observer. While this flies in the face of Freudian role playing, it seems to speak to the specific cultural milieu of the unique Senegalese presence within the medicoscape. The doctors then interpret Lacanian psychoanalysis in such a way as to tailor it to the situation on the ground. I asked the clinicians many times why they felt the need to tell the patients what to do. Their response invariably was, ‘because I am the doctor.’ The role of physician then is one that as Fatou explained and Ghalib echoed was as clinician, not as theorist. As Ghalib insisted at one point, “what we are trained to do is clinical…” The focus on clinical practice demands an emergent ego on the part of the clinician as well such that the practitioner places an emphasis on what works. In as much as the medications seem to bring relief, they are more clinically operative than the theoretical constructs that the clinicians learn in the staff meetings. As Agathe put it, in speaking of Capote, “I just didn’t get it…” This again speaks to the indeterminancy of the medicoscape. It is by no means completely worked through; it is at once local, and global; and it is non-static, because as we saw in Chapter One there was such an emphasis on the social, and today that emphasis is being downplayed in favor of that which is perceived to be universal. The notion is that psychiatry is meant to treat the body –by biomedical definition thought to be a universal—and therefore the mind; techniques of the psyche, then, are

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12 My discussion of the disparities between clinical practice and theoretical constructs is not designed to be a novel part of my thesis. I understood the role of the clinicians to be largely one of treatment. What I am proposing here then is to connect the continuing presence of theories of for example social psychiatry to clinical practice. I seek to highlight here the degree to which therapeutic practices in the current moment are not designed to incorporate theory alongside technique or treatment. Rather with the ascendency and maintenance of the biomedical model there has been a deterioration of the application of theory. That said, I return to my metaphor of oscillation. Theory and practice can be said more aptly to be oscillating. The doctors are trained in global ideas of practice along with historically ratified—in terms of Collomb’s continuing influence upon the operation of the clinic—theories. And while the two are never reconciled the use of the ego-centered models speaks to the encroaching forces of modernity. I characterize the latter in terms of the false binary of modern individualism as contrasted with received ideas about collectivism. This essentially is a re-articulation of one aspect of the project’s thesis.
subject to the dictates of a science that treats the body as inseparable from the mind. Constructions, then, of illness, as the normative structure surrounding notions of disease, lead directly from diagnosis—the manifestation of bodily experience of illness or disease—and flow on down to medical technologies. The doctor qua doctor, is the doctor qua professional healer. That which separates the physician from the traditional healer—or guerisseur which comprises notions of tradition alongside the nominalization of medical practicing—is his or her access to professional habitus. I am a doctor, therefore, signifies, ‘I am a member of a cadre of individuals who dress a certain way, speak a certain way, perform clinical tasks a certain way, and ultimately occupy space a certain way.’ The Reunion or staff meeting is the site where the doctors rehearse their performances of professionalism; much as the penc is where patients rehearse their adequacy as normative agents. Let us turn, then, to the Renuion.

**La Reunion: Technology, Education, and Hierarchy**

When this project began towards the end of 2003, I attended a staff meeting at the clinic. It was then as now known as *La Reunion*, but it was vastly different. The chairs formed a ring, or oval shape, with clinicians, researchers, students, and apprentices all seated roughly as equals around a non-existent focal point. The space in the center was empty; this speaks metaphorically to the egalitarian focus of the meeting. The meeting was also designed to be much more apprenticeship oriented; hence, there were no lessons as such, only discussion of clinical cases. Patients on the ward, their progress, their medication regimens, observations of their clinical behavior, and discussions that clinicians may have had with the patient, ruled the day. This was not a classroom as such but Western medical teaching institutions both in the operative sense,
and in the sense of edifices, were or at least seemed to be the model. In other words, the doctors were being taught through practice rather than through didacticism.

Today, there has been a complete transformation. Clinical case studies are presented but they are done so completely in the abstract; that is to say, the patients discussed are not those on the ward, at least contemporaneously speaking. There is much more technology present; where in the first meeting, clinical cases were presented verbally, an appeal is now made to not just auditory forms of learning, but to the visual. Along these lines, Power Point presentations are de rigueur. Gone are whispering nurses, replaced by frequently ringing cell phones with highly personalized ring tones. I noted in my time spent in over 35 meetings I attended, I never seemed to hear the same ring tone. Each individual had chosen their own favorite 50 Cent song (“Go Shorty, it’s your birthday…”) or Jay Z song; most were of American rap or R & B artists, and most were contemporary. But I never seemed to hear the same ones.

There were the erstwhile and ubiquitous PCs, with the latter crowding out the tables in the clinic’s archives. There were new-fangled mechanical pencils and fancy MontBlanc pens; there were iPods, playing everything from Seal to Phil Collins, in brief moments of loneliness, when no one was around except for researchers like myself; and there were laser beam pointers; and there was a DVD/VCR player and a large 32” television that was rolled out to watch movies, when these weren’t played by projection from the PC hooked up to a projection device.

In my visits to L’Hopital Principale, a military hospital near downtown Dakar, I was struck by how less technologically advanced it seemed by comparison. But the general sensation that biomedicine was coming to the fore holds up. They had a row of patient suites along a sewage drain, and a phalanx of offices for physicians. In the center of their enclave there was a painting of Freud alongside Collomb, the latter being honored though he never worked officially
at that hospital, as the father of Senegalese psychiatry. That said, the offices of the doctors, were where the real story was to be told. Here, there were scales of the highest and most up-to-date quality. And the desks, unlike those at the clinic, were shiny and well-kempt. There were chairs that looked brand new for patients’ sessions. And the windows looked out onto immaculately groomed gardens.

The disparity had to do with funding. L’Hopital Principale is a hospital that caters to military personnel. It is a wealthier hospital because it responds to the needs of former and current state employees including veterans most of whom are well-compensated for their services and have pensions when they end their conscriptions. Clinique Moussa Diop, as I explained in the introduction, is a semi-private institution that caters in part to those who cannot afford to pay for treatment. So it is a poorer institution. So, how to explain the disparity between the presentation of wealth at the Reunion and the impoverished and crimped quarters of the clinic itself.

Though it is located in a private within a public –the Children’s House-, this space is the clinic’s public face. That is to say, this is the space that other professionals visit when they come to the clinic, many in order to participate in the colloquia delivered for the day. This liminal space, then, becomes a site for a presentation of self that is highly modulated. In other words it is the space where resident clinicians put on their best presentations. Not unlike the mirror stage as discussed within its four walls, it is a space in which the inchoate ego of the institution is invested with pomp and circumstance. It is the space of developing professionalism, and as such and tautologically, it is the space for professionals.

How are we, then, to understand the clinic as a site for training? Let me turn to the educational structure of the clinic.
**Education**

The students at the clinic are trained in large lecture halls. They take, as Ghalib said, courses designed to familiarize them with psycho-biology and therapeutic modalities in their first couple of years. So, Ghalib took his exams on the 7th of June, 2007, in “Therapy: Physiological and Neurological”; “Psychiatric Semiology”; and “Psychiatric Pathologies”.

Adil, who was writing his third year thesis on the history of the clinic, explained the educational structure as follows:

- 6 years of primary school
- 4 years of secondary school (our middle school)
- 3 years of high school
- University (Med school is lumped in) with 5 years of theory; 2 of clinical training; and 2 years to do the doctoral thesis. In the end one is a general practitioner.
- In Senegal, one does a Certificate of Specialized Training.
  - Year 1: Probationary year: do you have what it takes to be a psychiatrist?
  - Year 2, 3 & 4: Years for Psychiatric Dissertation.
- After the probationary period, one can elect to do an entrance exam and be an intern for 4 years. Adil opted to do the dissertation.

Adil gets paid 300 million CFA a month, which while we were there was roughly 3,000 dollars. Fatou explains that the doctors are paid, with most of them recruited at the University of Dakar. They are paid by three organs: [1] the National Ministry of Education; [2] the Health Ministry; and [3] a small sum from the clinic itself. There are those who receive a small sum from all three sources, while others are paid by only one or the other. And these are the scholarships which she was counting among the remuneration received from the clinic. Tuition is 600,000 CFA per month, and the typical clinic-based scholarship is for 150,000 CFA. This breaks down to 600 dollars per month with roughly a third of that or 200 dollars paid by the clinic. All the doctors are expected to spend some time in France, though the length of residency varies. Roughly 1 to 3 years may be spent abroad.
The rigorous training, Fatou went on to say, is designed to weed out those who are not fit for the life of the psychiatrist: a certain life of the mind that is revealed in the writing of the dissertation. In fact, both Fatou, and the head of the clinic, Momar Gueye, are professors, splitting their duties at the clinic with time in the classroom and lecturing abroad. Psychiatry, then, counts as an intellectual pursuit as much as a medical one. And yet, despite the emphasis in training upon theory, most if not all of the doctors would self-designate as clinicians first; theorists second. Why the disparity? In part because of the growing emphasis upon pharmaceuticals. Most of the abstract case studies done at the Reunion resorted to some discussion of the appropriate medications to subscribe in any given instance. The doctors, then, are trained with an eye towards what is perceived to be a culturally unmediated efficacy. If it works, use it. Medications it seems are beyond the grimy grasp of culture. So, how do the doctors review their cases? Beyond just the medication assessments and learning the intricate details of psychopharmacology, there is a consistent use of the DSM-IV, and a neurology-slanted discourse that emerges in the case studies. That is however not all that is discussed, as we found with Capote. Two typical Reunion emerge with one being devoted to theoretical concerns, and the other to clinical concerns. Let’s look at two such examples.

*La Reunion and Theories of Liberty*

On the 23rd of March, 2007, the Reunion was held in the Conference Room of the clinic. On this day the speaker was Dr. P. Gasmer, a French philospher who had arrived to discuss the concept of liberty, in part addressing Collomb’s ideas and ideals around his definition of the therapeutic encounter as one in which the patient is *liberated*, and as institutionalized, by the practice of allowing patients to come and go at will during their hospitalizations.
Gasmer initiated the discussion by defining the antonym of his term of liberty. He sought to define non-liberty as the conditions of possibility for the emergence of a theory of liberty. He characterized non-liberty in terms of unrealized passion. Everyone, then, has a passion or a certain capacity for the pursuit of a passion in life. Non-liberty then is the compromising of the full realization of that passion. He calls this compromising: victimization. Everyone is a victim. He parsed this into victimization at the hands of oneself. There then was the dialectical presence of victimization at the hands of others. He introduced two terms at this juncture: first, the notion of responsibility such that clinicians take on the responsibility towards their patients to care for the victim of oneself; second, the notion of the natural victim. With the latter he spoke to victimization that is of a sort that stems from biological antecedents. In terms of these biological forces the doctor at once takes responsibility for the patient but also becomes a source of victimization. Drugs have no victims but because they are given by another they can become a source of victimization precisely because they limit the full expression of the aforementioned passion, as well as denying the validity of the natural expression of self. While, then, nature can victimize it is the clinician’s responsibility to liberate the natural self with in this case the use of drug regimens. There is the dialectic between liberty and non-liberty that emerges. That dialectic is formed around the possibility that these regimens will render the patient denaturalized and therefore unliberated (non-libre). It is with this regard that the prescribing of medications is a social act. This social act reinforces and gives a standard interpretation to norms production. By the same token it confers upon the patient a sense of self that while mediated –via the drugs— provides for a sense of liberation. This sense of liberation can cause the patient to take on the responsibility for care of the self, which had previously been the responsibility of the physician. To come and go at free will at the clinic, then, becomes a method of re-inscribing upon the
patient the full responsibility for liberty. While we are all victims we also validate ourselves by taking responsibility for our own welfare within the dialectic of victimization and liberation.

Standing back from the thesis and analysis of the conditions of possibility for liberty, in an ethnographic move, we find two crucial points. First, the difficulty to follow the theorization; and second, the emphasis historical in precedent upon the method of freedom to come and go at will during hospitalization.

In terms of the former, I would argue that this type of rather circuitous logic, comes from a Continental philosophical tradition that places emphasis on the difficulty to parse. Notions of the [de]naturalization of subjectivity; and the difficulty defining such terms as ‘liberty’ and ‘responsibility’ make this material difficult to grasp. I would argue that this discussion really is a discussion of the responsibility clinicians take on in the formation of the successfully integrated *citizen*, with liberty understood in terms of the capacity to participate in the political economy of the *natural* State of Man. Lest I slip into the circuity that I here critique let me make the simple point that the philosophy engaged by Gasmer falls within an historical trajectory of Enlightenment definitions and continuous –and unresolved—arguments about the nature of the political animal in relationship to the biological animal. Drugs emerge as a site for the exploration of notions of citizenship that are themselves to be understood in terms of the negotiation of the limits of what Agamben would describe as *zoe* (or biological life).\(^{13}\)

The historical trajectory of the development of the man of history in terms of the individuated ego of the clinician is to be found in the work or theorization of Collomb. While insisting on the cultural mediation of psychiatry, he sought to create a therapeutic space that worked. Anthropology deals with efficacy with a good deal of awkwardness. What are we to do

\(^{13}\) See Agamben’s *Homo Sacer*. 
when what we observe in the therapeutic encounter with the use of pharmaceuticals works? Most recent anthropology of pharmaceuticals insists on not addressing the issue of what works. For Collomb this was a central concern and perhaps because I do not have the requisite training to speak of efficacy with any reassuring precision, I would be remiss if I did not mention that it was a part of the discourse generated at the clinic around the topic of professionalization. While it was implicit, it remained a central concern for the cultural field of psychiatric praxis and practice. Would a given therapy work was the measure of one’s effectiveness as a therapist.

What worked for Collomb was the French-derived ideals of liberty, more specifically the liberation of the patient. So that while the patient was not free, s/he was liberated by the institution with the come-and-go policy. He was less concerned with drug therapy and it is part of the emerging medicscape that this commitment to drugs has itself gained ascendancy at the clinic. But at base the concern for efficacious treatment remains the most pressing issue for these professionals. Training, then, in theory is not enough. Training that increases clinical aptitude must accompany any and every instance of theoretical discussion, implementation, and development. Let me then turn to a typical clinical discussion during the Reunion.

*La Reunion and a Clinical Case*

There was an early March Reunion that encompasses the oscillation between theory and practice. Professor Gueye, the head of the clinic, on a rare day present, was the instructor for the day. Dressed in an expensive suit, and sporting his stylish eyeglasses, Gueye argued in his presentation to the students that the definition of depression needed to be expanded to include not just the biological features of the disease but also the social etiology of its presentation. He admonished the staff to “set their eyes on the mission of curing”. Curing for Gueye, as a sort of disciple and within a loose kinship lexicon, the ‘son’ of the ‘Father’ of Senegalese psychiatry,
Collomb, could not be developed, promoted, or secured outside of social issues. While he, then, couched his discussion in terms of social interventions, his talk nevertheless was devoted to describing the disease of depression *clinically* and therefore largely in terms of the DSM-IV descriptions of the disease.

He began by noting that the regulation of mood implicates the diencephalic system. Therefore, depressive states and manic states form two poles. He cautioned that there are along the continuum between these two poles important variations in symptomology according to the intensity of the syndrome—as experienced by the patient—and the predominant mental or physical factors. With regard to the latter, he was distinguishing between mood and/or emotional factors as opposed to or at times in conjunction with or at times parallel with somatic factors.

He went on to describe what he called an EDM or major depressive episode as follows:

1. sadness of mood
2. diminishment of interest or pleasure in routine activities
3. loss of appetite and so loss of weight or weight gain
4. insomnia or hypersomnia.

As far as the mental states or emotional states he described were what he termed in a classic Freudian move, guilty ideations. Next, he looked at the criteria used to measure severity:

1. the number of symptoms; 2. the duration of symptoms with the preferred presence of a certain chronicity (for, as Luhrmann has so effectively communicated, we all get depressed at some point).

There are several types of depression, including paranoiac depression and generalized anxiety depression. There is also post-traumatic stress disorder which Gueye subsumed under the
rubric of depression. Biologically speaking there are also organic causes of the illness that once again implicate the diencephalic system.

Curing should proceed by [1] naming the disease i.e. diagnosis; [2] encouraging the patient to come to some sort of resolution to seek and follow treatment all of their own accord; [3] cessation of work for a short period, because it takes most drugs at least 8 days to take effect and begin to perform adequately; [4] orient the patient with a psychiatrist thereby establishing a therapeutic and transfential economy that will also bring healing. Relatedly, crucial to treatment are the consultation process, diagnosis, suggestion of compliance and follow-up regimens, and accompaniment of the patient to the clinic for the hospitalization. In terms of successful treatment that may take anywhere from four to eight weeks and if there is only partial success the dosage of the medication –he encouraged the use of Effexor—would have to be altered. Med compliance is difficult for many patients because they cannot afford drugs, but if the patient can buy the meds it is worth the effort. He said, too, at one point, that the psychiatrist can “damn” the patient with the diagnosis of depression to the realm of a chronic disease. The depression in fact may be attributable to external and social causes that need addressing perhaps more than the actual symptomology itself. This final point returned us to the beginning theme of the talk, that the definition of depression needed to be expanded to include the social elements and descriptors of social etiology for the disease. This final point reflected the influence of Collomb.

In Collomb’s day there was less of a moral economy I found at the clinic in terms of what is considered consistent with Islamic tenets. We return then to Adil’s admonition to go and do what Allah wants and have babies. The notion that appropriate social behavior should be responsive to and reflective of a commitment to the dictates of the faith of the Book reveals
illness as not just disease but as implicated in terms of morality and liturgical practice. Honoring Allah by exhibiting certain behaviors or the failure to exhibit certain behaviors implicates Kleinman’s notion of illness. Defined as the social aspect of disease illnesses such as depression place the patient in a regime of norms production that is based upon not internationally ratified notions of healthy behavior but very local grappling with and understandings of successful integration into the social body.

By way of summary then we see the degree to which the subject formation is committed in the theory based Reunion to a political social self – read: liberated self. In the clinically based case there is a commitment to the socially mediated self as expressive of the relationship between nature –i.e. biology—and sociality. The two were not discrete just as Collomb would have it in his brand of ethnopsychiatry. That is to say, sociality and mental health are always mediated culturally. But in more recent years the argument has been more forceful that biology is less socially and culturally mediated. Diagnosis for example does not in part emerge along a continuum from identified moral illness or sickness on to the act of interpolating the illness. Rather it is understood in terms of statistical evidence describing biological malfunctioning. In the Senegalese case, as Mamadou put it, “illness is God. So you pray.” So, in the case of Dakarois psychiatry there can be no naming of the disease without a recognition of social or moral failure; there can be no diagnosis without sociality and that sociality is frequently couched in terms of Sufi Islam; hence, the presence of the Islam inflected penc.

The Reunion, while evacuating Islam, has its own moral economy: let’s set our eyes on healing, Gueye admonishes the young professionals in training. What becomes paramount for these students is a consistent negotiation of their own role as both social, political and ultimately moral agents alongside their function as agents of biological intervention.
Where anthropology might struggle to identify efficacy as a landmark upon the landscape of the cultural field of the biomedical model, clinical psychiatry is not so limited. In part because of the history of cultural psychiatry at the clinic or at least of what Collomb called *social* psychiatry. If it works, it works because it treats the patient as both a social agent, as well as a biological one. For our purposes what is interesting is the tension and emerging ascendancy of the biomedical model as the chief arbiter of sound mental health. This implicates the clinicians in the emerging medicoscape such that their commitments to biomedicine are formulated along an additional continuum flowing from Islam in a global context to pharmaceuticals in a global context. We would do well, however, to remember that in their efforts to cure both illness, and disease, by applying the biomedical model, they are chiefly concerned with providing care. In short, the doctors and other clinicians do not take on the habitus of medical professional in a manipulative sense but rather as an avenue towards cooperation in encouraging their patients to take responsibility for their own care and ultimately their self-liberation from their diseases. This cooperation between clinicians and patients allows us to see that the doctors care. In fact, the doctors give care, because they care.

The sign at the front gate to the clinic that reads, “Every man is his brother’s keeper” speaks to this caring ethos that in part brings together the clinicians who come from many different regions of the world, on common ground. In the next chapter I examine the way the idea of medicoscapes can be placed in dialogue with this caring ethos.
Chapter Four

The Medicscape as ‘My Brother’s Keeper’

Wednesday the 16th of January, 2007. 9:30 am. The archives of Clinique Moussa Diop.

Today is the day for the staff meeting for the journal, Psychopathologie Africaine.
Attending are Professors Momar Gueye and Fatou. Jeanne (Clinic Archivist) and myself. Fatou arrives 20-25 minutes late. Gueye says, “let’s go over what’s going to be put [in the next issue] of the journal.” So, they begin to sort through copies of drafts of articles. They vote on what goes in not formally but by simple expression of opinion. Gueye takes each opinion into consideration and makes the final decision.

On this day they are reviewing an article from Cote d’Ivoire. They sort through big stacks of articles all stapled together. These are the articles that have passed muster and will be included in the next issue. Most of these articles are sent in from places as diverse as France, Spain, Haiti, and all over the continent of Africa (e.g. South Africa, Nigeria, Upper Volta, Libya, Liberia, Sudan, and on and on). The articles are collated and placed in a large brown three ring binder, from whence they will next be sent to the printers.

They search for the article from Cote d’Ivoire in order to study and vote on its inclusion in the next issue. The Professor (Gueye) wants it included. It is decided ultimately that it will get in.

“The journal is very scientific,” the Professor explains. He goes on to say that they receive over 1500 letters and articles per volume. Jeanne, the archivist, explains that the journal costs 15,000 CFA (or 150 French Francs) for an African individual; 25,000 CFA (250 FF) for
those coming from “other continents”. For African institutions it costs 24,000 CFA (240 FF) and for those coming from other places in the world, 36,000 CFA (360 FF). The price for past volumes is 12,000 CFA (120 FF) in Africa; and 18,000 CFA (180 FF) for those reading from other continents. Volumes that are available are 1970-1999, not including the present volumes.

I ask what is the mission for the journal? What is its organizing principle? I am told by the Professor and the others agree that the journal’s credo is to provide a scientific perspective on African and diasporic psychiatry. The professor’s conversation shifts after my question. They pull out a map and attempt to find Dar El-Salaam on its glossy surface.

On another day some four weeks later, I am seated at the main table in the archive. It is 8:30 and Rene Collignon enters carrying a large stack of newspapers and articles coming from all around the continent of Africa but principally from Senegalese sources. He is the journal and clinic’s resident historian. He can be found at the clinic for 6-8 week stints in the winter and in the summer. After an hour or so of him clipping out articles from these journals, he turns to me and asks how I am doing. He asks how my research is going. He then returns to his work and just before he does I schedule an interview for lunch that afternoon.

The afternoon rolls around and we go over to La Provençale for lunch and pastries. We speak of the clinic, its history, its journal, and his presence there as a Belgian historian. His presence speaks to the continuing influence of the historical development of Senegalese psychiatry upon the contemporary moment, as well as the international feel of that historical trajectory. He expresses many complaints about the contemporary moment and thinks the clinic is less assertive in its approach to publishing the journal; in its approach to the penc; and in its commitments to training doctors thoroughly in both Collomb’s theories and in terms of African
psychiatry. In the interview conducted with him in February of 2007, he explains that for him, the clinic is “less rigorous” (moins sérieux) than it used to be.

The Anthropology of Psychiatry’s Problem with Analyzing Diversity in Localized Settings

Both historically and contemporaneously the doctors at Clinique Moussa Diop hail from many different parts of the continent of Africa and diverse portions of Western and Eastern Europe. There are doctors and other practitioners from Djibouti, Morocco, Democratic Republic of Congo, Guinea-Bissau, Ukraine, Russia, and France. Flying in the face of such diversity, frequently in both the anthropology of psychology and psychiatry, sites for the production of research protocols are treated as discrete and sealed. Furthermore, those among whom we work are viewed as constituting essentially homogenous communities with little to no variation in regional affiliation or derivation (see O’Nell 1996, Scheper-Hughes 2001). What happens when the clinicians, among whom we study—in the various hospitals and clinics that we choose as sites for research—come from different regions of the world? If we concede that the fact of diverse regional affiliation means there are a plethora of approaches found in these sites, we must equally search for the epistemological glue that produces effective therapy. I argue that in the present moment that glue is the biomedical model, An additional factor is Islam. And likewise as we see with the journal, there is a perceived focus on the African experience as related to global forces.

However, rather than see biomedicine as a monolithic and hegemonic force—and likewise Islam, for that matter, as I will demonstrate in this chapter—as do many others in the social sciences, I propose that we think of biomedicine as both a local and global phenomena that is constantly negotiated. The journal with its *scientific* (read: biomedical) credo exemplifies the
negotiation of the local and the global. An analysis of biomedicine in the African context demands that we recognize the functioning of biomedicine as a global flow of medical knowledge-production, which I have termed throughout as a “medicoscape.” As Appadurai would characterize these global flows, forces that are international and/or global in operation engender novel sets of relationships that are local in orientation.

By utilizing Appadurai’s concept of –scapes we can discern the process by which the clinic has emerged onto the international psychiatric scene. The notion of a medicscape as a descriptor for the burgeoning process by which the clinic [re]produces and interprets the biomedical model, forces us to contend with the persistent fluctuation, dissolution, and resuscitation of the boundaries that shape the contours of an international and global positivistic oriented medical epistemology.

With a history of generating theory and clinical practice via the journal *Psychopathologie Africaine*, the clinic has a long-standing presence on the international psychiatric stage. ‘International’ will be clarified shortly. For now, I am referencing the presence of doctors from the various regions of the world as well as the way these doctors are trained in these regions. There are additionally many approaches to the therapeutic process that are themselves related to the international presence at the clinic. It is this heterogeneous approach to therapies, Islam (as we saw in the previous chapter), and the presence of trainees from France, as well as the resulting diversity in orientations to the rubrics of science and faith, that lead me to call this a cosmopolitan space. If we concede that part of what defines this cosmopolitanism is the fact of the clinicians’ inhabiting the role of ‘citizen of the world’ (see Appiah 2006; Nussbaum 1996), then we can begin to tackle the question of how the universal discourse of biomedicine is counterpoised against its particular manifestations at the clinic. Having established the
international/local aspects of the observance of Islam in the second chapter, I turn now to the international understandings of and local applications of the model of biomedicine. But I return to the sign at the fork in the road at the clinic: *Every man is his brother’s keeper.* We find in its articulation the presence of a moral and/or ethical regime that will receive interrogation in this chapter. Ultimately we can see the *sacralization* of the public sphere. It is my intention when I conclude this book to argue that it is in an ethnographic instance, the role of the social scientist to take a stance vis a vis his/her interlocutors that finds a way to respect this sacralization. We can no longer afford to analyze the neoliberal state in terms of secularism but rather must think in terms of a daily negotiating or *oscillation* between the sacred and secular. It is my contention to reiterate that this oscillation best describes the Senegalese process of norms production seen metonymically in the therapeutic encounters at Clinique Moussa Diop. That this norms production deploys idea[l]s of collectivism and individualism provides a lens by which to see the defining relationship between universal idea[l]s and particularistic idea[l]s that are subsumed under the notion of the cosmopolitan.

The clinic with its international group of clinicians therefore appears as at once a participant in the erstwhile medicoscape, while also occupying a position as a negotiator of its parameters, dictates, and ultimately, knowledge-production. Inflected by the presence of Islam, part of the clinical ethos that unites the practitioners at the clinic, is a desire to instantiate and argue for, then, the universal applicability of the biomedical model. Within the interplay of collectivist oriented modalities (e.g. the *penc*) alongside ego-centered modalities (e.g. Lacanian psychoanalysis), we can see the *local* interpretation of that biomedical model. That model is defined by psychopharmacology and “talk” therapy that form the crux of a clinical practice that derives its orientation from the Western tradition of psychiatry while resolutely couched in
indigenous forms of therapy. What emerges is a hybrid form of treatment that mingle the local and the international; the modern and the traditional; and the rural and urban. By considering the Western and the indigenous aspects of treatment at the clinic I will demonstrate that Senegalese psychiatry negotiates a complex and at times contradictory relationship with pan-African typifications of the therapeutic encounter (collectivist in orientation) with modern talk therapies that are ego centered and largely Western derived.

I want to begin then with defining what I mean by ‘international’/‘global’ and then proceed to describing the international scene within a Senegalese context; I then will look at the psychiatric scene as a local phenomena, proceed to working out a definition of the modern as well as the traditional within this context that is linked to the erstwhile rural/urban divide. It should be clear ultimately that rather than binary these classifications or ideal types serve to only highlight the analytical background while what emerges in the field’s foreground is an oscillation (Amselle 1998) or symbiotic relationship between each of these divergent currents. I begin each section of the chapter with an ethnographic vignette or interview that helps situate the ensuing discussion.

*Dr. Adil*

Dr. Adil, as I mentioned in the introduction, hails from Djibouti in Eastern Africa(bordered by Ethiopia, Somalia and Eritrea); he observed that, “ it is necessary in my mind to compare many models of therapy in order to be positively certain one has understood, thoroughly, clinical practice.”

In terms of that clinical practice, and the many models of therapy, Adil explained further in an interview he understands these models as falling under two rubrics or two approaches: psychopharmacological and psychotherapeutic. For Adil psychopharmacology is only the
beginning of treatment; “medications render the patient lucid enough to engage in conversation and therefore to be treated.” It would seem that Adil looks to “talking cures” more than psychopharmacology. But he sees the notion of the separation of the two, as, he says, having its limits as well, because for him they are to be effectively mingled or blended. For Adil this mingling defines the biomedical model.

We can see in Adil’s comments the very process of the implanting of the medicoscope, with its focus on the biomedical model. However, in his deployment of the models of therapy that influence his practice—psychopharmacological alongside “talk therapy” —we find the incursion and recourse to a set of principles that are at once local and global. The two oscillate however. On the one hand, medications are global. On the other hand conversations and their meaning are socioculturally specific, and are therefore localized. But Tanya Luhrmann’s work (2000) exposes the degree to which both models of meds use and some form of “talk therapy” form the cutting-edge of therapy today in Western contexts. So the presence of the two is at once both a global and local interpretation of the biomedical model.

Adil has a highly local interpretation of the way to practice “talk therapy” as well. So for example, speaking of his training in Tunisia, he was most impressed by one professor (whom he describes as more a researcher than a doctor). This instructor introduced Adil to ‘difference’. Adil tells the story:

“He asked me what I thought life was. I was at a loss for words and the professor continued. He said life is simply oxygen but the force that animates life is difference. We need information about those who are unfamiliar in order to construct models of rapport. In the moment of recognizing this need to understand, ‘we’ and ‘they’ both are equally vulnerable. So by appreciating difference and understanding the possibility of being vulnerable one can begin to dispel prejudices.”
Adil concluded that when one applies oneself to the patient there obtains an exchange such that the patient has a *need* and the doctor has a *need to* understand what the patient needs and it is within this liminal and circular space that equality is born.

The effort on the part of Adil to grapple with prejudice and his efforts to understand issues of difference forcefully argue for a certain empathy and additionally, a sense of setting aside one’s preconceived notions that according to Adil’s professor, by definition allows one to better treat patients. The implicit argument is for drawing closer to the patient’s experience and offering treatment that appreciates difference (vis à vis treating, for example, immigrants; ethnic groups that within the broader context are thought to pose a threat to one’s national patrimony; as well as those who have completely different worldviews e.g. Christians in a predominantly Muslim country such as Djibouti.)

*Adil, Papa Noel, and Islam as Complicating the Biomedical Model*

It is in fact with regard to different worldviews that Adil gets anxious in terms of his own complicated relationship with Senegal. In an earlier interview, I referenced, Adil described the Mouride Sufi Islam brotherhood and its annual pilgrimage to Touba in the North of Senegal, as akin to the belief in Papa Noel among Christians. As I discuss in Chapter Two, the Mouride are one of the three main Sufi Islamic brotherhoods (Qadiriyya, Tijani, and Mouride) in Senegal. Started by Cheikh Amadu Bamba in the early portions of the 20th century, the brotherhood is centered in Touba, Senegal. Every year Sufi adherents and faithful take a “pilgrimage” to Touba in honor of the Bamba legacy.

Adil said, “It is inappropriate to say this is not the true Islam. That said, there are those things in the Islam here in Senegal that remind me of the relationship to religion that those in the “Occidental” countries of the world, have with their religion. “For example, “Papa Noel.” He
never existed. This is only business. By the same token the pilgrimage and the focus on Touba here in Senegal is also business. The adherents think of Touba as the pilgrimage to Mecca. Touba does not have the same religious value for other Muslims as it does here in Senegal; once again, it never existed as a religious conviction, it is only business.”

With this regard we have the observation that Senegalese psychiatry through the *penc*, is characterized as an Islam inflected practice (see Chapter One) that resonates with the preeminence of Islam in the country. Islam is an international faith. But Adil associates Islam as *practiced in Senegal* with business. But given the world-wide entrepreneurialism of the Mouride, calling the practice of this brotherhood, *business*, is at once a characterization of local phenomena set in the context of global market relationships. And yet because we are speaking of Islam we are also talking about global symbolic and religious economies. There obtains an interplay between the global sense of Islam and its local manifestation.1 As I described earlier, during the *penc*, some of the doctors and other health care professionals can be seen praying along with their patients at the beginning and end of each meeting. They are directed to do so by the *penc* leader Mamadou. These clinicians as I mentioned come from many different places on the globe. What unites them is Islam. But Islamic practice as we see here is both local and global. Again, the practice oscillates between a practice that unites and at the same time separates.

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1 While Sheldon Gellar’s insights into the relationship between the ascendency of Islam in Senegal are somewhat dated, it is worth noting that the imposition of Muslim clerical leaders truly intensified during the Senghor presidency (1960-1981). Gellar observes speaking of the postcolonial state: “The recent resurgence of Islam in Senegal and the growing dissatisfaction of Muslim leaders with what they consider to be the deterioration of traditional Islamic values… led the government to place a much greater stress on Islamic values. With Senghor’s departure [in 1981], this trend will continue and probably be intensified”; in my work as I reveal below this has indeed been the case (Gellar 1982:35).
Adil has problems with the *penc* because as he says, the group’s charismatic leader “wants to appear as a marabout. This troubles some patients because some have problems with religion or problems of a religious nature”. Adil takes issue to some extent with the principles of the *penc*. He thinks, “prayers are for the mosque.” And moreover, “the majority of the patients do not understand Arabic.”

In Adil’s mind the patients have adopted the colonial model in which religion is really a financial concern. He thinks, “Touba is really a business venture.” He has patients who are Mouride and do not believe that Bamba is dead.

“If one breathes, if one eats these things happen by the grace of Touba or Bamba. To say “merci” or *jerejef* (Wolof term for ‘thanks’) for those who believe in Touba is “merci” to Bamba. One should say thank-you to Allah. Touba is equal to Allah. It’s the same problem with colonialism.” Adil thinks the theological model of the Trinity, in Christianity, is similar to the worship of Touba, Allah, and Bamba. For Adil this replicates the state of affairs under colonialism.

As Adil concludes, however, “one must simply observe and not judge [the *penc*].” Fridays are for the mosque.” So, the *penc* emerges as a treatment modality that while adhering to notions of collectivism—it unites as Collomb would have defined ‘unity’—flies in the face of Adil’s training in the biomedical model along with his faith. The *penc* condenses into a conflict with both his education and his observance. As far as the Islam at the base of the *penc*, Adil thinks they serve the same God but there are problems. And yet as he concludes revealing the oscillation between practice and belief, biomedical and ‘traditional’ (read: Muslim), local and global, and plural or universal and singular manifestations of the faith, “one must be a judge without a verdict.” This returns us to his commitment to “difference”. For Adil this concept of
difference becomes a clinical practice and not just a theoretical construct. –Its use becomes consistent (as discussed in Chapter Three) with their clinical training as well as their training in psychiatric theory. Given the international aspect of Adil’s training in Tunisia and now in Senegal, the concept of difference allows Adil to provide treatment across cultural disparities. It allows him to use the biomedical model while also remaining faithful to the tenets of Islam in a nation whose Islamic practices he doesn’t agree with. The ideals form a feature of the medicoscape, as well as being an exemplar of the notions of professionalism that surround clinical practice at the clinic.

It is clear, then, that for Adil it is psychopharmacology and other features of biomedical regimens for treatment such as “talk therapy”, that make his experience universal. And yet that too does not tell the complete story, because Adil is equally committed to the science of “difference” as captured in his clinical practice as he says in the erstwhile interview. I would argue that we can look to his actual clinical practice to find a resolution to the contradiction.

In a later consultation conducted during the sweltering months of the rainy season in Dakar (roughly July or August through to the first couple of weeks of October), Adil ushered a woman in a wheelchair and her three companions into his consultation room. These chambers are scarce because there are too few rooms for doctors to treat patients. So, this room was set aside specifically for these consultations conducted on every Wednesday of the week. The woman is seated uncomfortably in the wheelchair. She wears a dark blue boubou with matching headwrap. Her daughter who rolls her into the consultation room is wearing a bright yellow dress and her two other companions whose relationship remains unspecified are wearing a deep red
and bluish boubou respectively. The two companions take up their seats in front of Adil who sits behind a large, teacher’s desk, where he writes notes, dispenses prescriptions—replete with the stamping behaviors—and in general conducts the affair of meeting the needs of his patients. His efforts as he understands them are in service to other doctors who “have the nerve to go for holiday” (he said facetiously) for the summer months.

The patient sits by the door to the room and the daughter sits behind Adil off to an angle from his chair. The patient is mumbling loudly in an incoherent language. Adil begins by saying, “what’s going on Aseytu?” Her sister quickly responds, “Her foot is hurting her.” To which Adil points out rather ruefully, “if something is hurting her and she says she is in pain, that’s normal…” They simply grumble and Adil acquiesces and concludes, “if her foot is hurting her I can’t care for her, I’m not a specialist…”

Adil is not a specialist. His concerns with religion and his notions of difference and his clinical practice are all tied together by a sense that he restricts his areas of expertise to the things he knows. He is motivated by the demands of the Hippocratic Oath with the admonition not to “cut for stone” or in other words not to do harm by simply failing to turn the reins of cure over to specialists. Rather than separating him from his patients, biomedicine allows him to appreciate their humanity, and therefore not cast himself in a role that is beyond his professional skill. He treats (within the confines of psychopharmacology wedded to “talk therapy”) the apparent condition in spite of the cultural differences he may encounter. His acknowledgement of his

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2 It is a curious feature of the clinic’s engagement with its patients that patients frequently for their part wear formal clothes for their consultations and medication sessions. This is an ironic reversal of the clinicians’ own practice of wearing casual clothes as discussed in the preceding chapter. The doctors dress down to better establish therapeutic rapport and the patients dress up. Why the disparity? I think it is an example of the impression management on the part of both patients and clinicians that I mention also in Chapter Three. With regard to this, it is the patients desire to be perceived as part of the elite as added to their desire to show respect for the clinician that informs the practice of dressing up. In this respect the patients interpret the forming of rapport with their doctors in terms of smoothing out class—or caste—distinctions, while the clinicians for their part understand the very same process according to international currents and debates.
limitations as a psychiatric specialist allow him to see his patients as just that: patients and not as vessels of foreignness or alterity. He does, not, in other words, experience anomie given his displacement culturally. He does, nevertheless, experience difference and this is resolved—if it is at all—by recourse to adherence to ethical regimes he has garnered from his training. Moreover, these ethical considerations are couched in terms of drawing lines of connection with the umma or community of faithful alongside his faith in biomedicine. He cannot treat her foot but he can advise her where to go to get it treated.

To summarize, the biomedical model as practiced by Adil gets tangled, in a sense, in issues of religious practice inter alia. Where the penc is viewed as an effective form of therapy by his superiors at the clinic, for Adil this treatment regimen conflicts with his own religious convictions. In a larger sense, however, it is the choice of religion itself as found as a part of treatment in a clinical setting that is really the issue. For our purposes we see the interplay of local and global forms of treatment. The medicoscape emerges as indeterminate; as inflected by both local and global understandings of the model of treatment that is said to be applicable to all. Walled away within an Islam that is foreign to him, he experiences a forceful sense of purpose. He is to treat and not as he says, judge. But that sense of foreignness plagues and leaves him caught within the cross-hairs of the demands of a physician and the demands of a faithful adherent of Islam. In the end Adil throws off the mantle of alterity. He discards his own commitments to his faith and opts for the security of a model of therapy that speaks to another economy for him, and that therapy is couched in terms of positivistic science i.e. in this case pharmacology and the role of the medical specialist. In other words, while there is clearly an orientation towards the biomedical for Adil, its manifestation in the use of religious variables mitigates against its full force and application. So, he is left with the ethical principles at the
heart of his clinical practice, to not cut for stone, but to render care as best he can according to a system of treatment in which he has been trained and that finds its antecedents in a colonial regime of training. That training can only be found as implicated by global and/or international forces. It is European in orientation but Adil has found it—reassuringly so—everywhere he has traveled. So, how are we to define the global and the international given the circumstances of a mitigated sense of difference?

**How to Define the International/Global**

For the purposes of this chapter, when I speak of the “international psychiatric community,” I am referring to the highly specific set of relationships that reveal the ascendancy of capitalism and consumer culture and that, rather than defy neoliberal national boundaries, seem to reinforce them. The “International” vector, then, of the medicscape, implicates the operation of world-wide power structures that in the medical realm can be considered representative of geographically disparate regimes of access, control, proliferation, dissemination, and reinforcement of largely the biomedical model.

The notion, then, of an international psychiatric community can be informed by Kamari Clarke’s formulation of transnationalism as articulated in her book, *Mapping Yoruba Networks* (2004). Clarke, while making reference to “globalization,” argues that “things” global are “producing culturally portable practices through which new forms of innovations are being legitimated in new localities using various forms of knowledge” (Clarke 2004). In the case of the clinic the tension between the “local” and the “global” rests uncomfortably upon a crucial bedrock of shared medical knowledge-production circumscribed by local and national boundaries that simultaneously slide into notions of formally recognized, and more importantly,
formally *ratified* medical praxis and clinical practice.\(^3\) These practices are both explicitly and implicitly governed (or at least influenced) by world-wide regulatory agencies such as the World Health Organization and documented in the International Classification of Disease schedule of illnesses.\(^4\)

Clarke’s notion of *transnationalism* helps to situate the therapeutic approach and infrastructural epistemological base in what she terms succinctly as “portable practices.” Where we differ is in the degree to which I want to argue that that knowledge base constructs a web of social and indeed national connections that foreclose and in the same breath reproduce relationships that I characterize as *inter-* national and, therefore, *between* nations versus her emphasis on crossing boundaries and hence *trans-*national.

For the purpose of this chapter, then, *international* refers to the psychiatric/medical knowledge, clinical practices, epistemological orientation, and research modalities that are at the core of biomedicine and its ascendancy in the *international* community of health care systems (Luhrmann 2003, personal communication).\(^5\)

By the same token, I employ the terms *global* and *globalization* to speak largely as a nominalization of the verb ‘to make available to the world.’ In this regard, the erstwhile

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\(^3\) An excellent textbook I use in teaching my Introduction to Anthropology course (see Bibliography for Thomas Hylland Eriksen) uses the term *local* to describe the manner in which people around the world carve out worldviews based upon both local understandings and those deemed global.

\(^4\) The clinical staff employ both the ICD-10 and the DSM IV to make diagnostic decisions and recommendations. Wikepedia provides an excellent overview of the history and current status of the ICD. In its current instantiation the ICD-10 shares by design much of the same diagnostico criteria and nomenclature as the DSM-IV. There are significant differences chief of which is the designation for personality disorders which according to the ICD-10 shares the same axis as other mental illnesses. As of now, the ICD-11 is scheduled for release in 2015 and its psychiatric classifications are being revised by an International Advisory Group. In my experience at the clinic, I saw clinicians use the ICD for statistical information and the DSM-IV more for diagnoses.

\(^5\) As with so many medical and more specifically anthropologists who work on psychiatry as a cultural field in and of itself, I am indebted to Kleinman for the concept of *health care systems*. In the quotation I use to begin this chapter Kleinman offers his definition of what he deems to be health care as a holistic and synergistic part of the patterning of any cultural fabric. The question I seek to pose here is what happens when that cultural fabric extrapolates to the global?
medicoscapes marks what Appadurai directs us to see as the emergence or engendering, as I prefer, of a world stitched together by various media, communication devices, methods of travel, and therapeutic practices, clinical modalities, and finally and most importantly, a shared positivistically oriented epistemology (Appadurai 1996). The case of Dakar’s Clinique Moussa Diop by the same token, reveals competing positions with regard to the biomedical model. So, while participating in a global and international regime of medical power that Fullwiley (2007), following Foucault, would call biopolitical these positions are additionally geopolitical. They draw doctors and researchers from other points around the globe to engender a specific (counter-intuitively) local ethos. This ethos is sui generis and noteworthy in its sensitivity to caring for those living in a city in which unemployment rates and extreme poverty are palpable. In terms of that ethos, as I have mentioned there is that sign at the entrance to Fann Hospital that houses the clinic, that reads, “every man is his brother’s keeper”. So it is that there remains this commitment to care for one’s brother. To call this ethos an exhortation is to use too mild a term. This ethos is a descriptive ethical or moral claim about the nature of God and his relationship to the umma. Only after defining or delimiting a relationship with Allah is it then thrust into the realm of the normative.

And perhaps what I am seeking to sketch out in terms of the normative is nothing short of a political agenda that finds its antecedents in the tumultuous politics and imbroglios at the heart

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6 I utilize ‘engendering’ because while ‘emergence’ captures the burgeoning process by which African psychiatry has begun to infiltrate the political-economic functioning of international psychiatry, ‘emergence’ is undimensional, and linear. The notion of ‘emergence’ carries with it the notion that the historical or teleological dimensions of psychiatry in Africa are static, having a beginning and an end. The term ‘engendering’ provides agency to clinics like Moussa Diop because it is not so much the linear trajectory that provides clues to the received wisdom of the biomedical model but the constant birth process in which the clinic actively engages with international standards of care and devises therapeutic interventions that are unique to the Senegalese context.
of Senegal’s postcolonial history. In this instance I use Ruth Mayer’s formulation of
globalization in which she argues that globalization, “[w]hile it weakens national institutions and
“financializes” politics…does not necessarily weaken the desire for “nation”, “subjecthood”,
“identity”---terms that are “fuzzy” indeed” (Mayer 2002). She continues by observing that
“fuzziness has never stood in the way of political motivation, let alone national commitment…”
(Ibid).

In terms of ‘national commitment’, the story to be told here is in part one of the
manufacturing of a postcolonial sense of ‘nation’. This is a story of implanting a set of norms
that are centered around the presumed effectiveness of the biomedical model. In this context it is
cast in a family idiom—my brothers keeper the sign reads. The model as applied to Senegal then
has aspirations for allowing patients to re-enter the collective. But it also defines the role of the
individual –each man the sign reads in a normative demand placed upon individual sentiments.
The de facto subject formation found with the sign of a collectivist oriented individual is the task
set for this localized version of the biomedical model. But it is my argument that in as much as
these normative structures vary in terms of notions of ’subjecthood’ as applied to local conexts,
so does the biologically based intervention (read: biomedical) get entangled as Fullwiley would
have it in bio-politics (Fullwiley 2004). Furthermore, this renders biomedicine as distinct and
unique as the subjects it produces.

Invoking Foucault, Fullwiley sets as her task an examination of “the effects…”of the
“holes left in the wake of state biopolitics…” with regard to the moral and ethical landscape of
preventative abortion in the face of sickle cell anemia(Fullwiley 2004: 159). Furthermore, in her

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7 See Gellar’s, Senegal: An African Nation Between Islam and the West for a strong characterization of postcolonial Senegal’s political struggles.
groundbreaking work on testing for the disease in Senegal, she argues that her informants’
“stories illustrate that sickle cell testing is a technology bound to have different effects,
*depending on where it is practiced and why*” (Fullwiley 2004: 186; emphasis mine). The state
politics that she identifies implicate both patients and doctors in webs of meaning and
ontological grounding in terms of legislating and producing funds for a sea change in testing
options for doctors. In addition to testing options for the doctors there are the availability of
testing technologies that would allow patients to make informed decisions about “therapeutic”
abortions given the knowledge of compromised pregnancies. The doctors are “‘resist[ant]’” as
she puts it, perhaps because they fear “that emphasizing genetic testing could potentially divert
attention from more pressing health problems” (Fullwiley 2004: 186). She exposes the patients’
moral and ethical dilemmas. These dilemmas are casts in terms of Islam and cultural mandates
that prohibit abortion alongside the forced acknowledgement of the possibility of producing
children plagued by a disease that has as of yet no known cure. Fullwiley’s work very
significantly places the issues of biopolitics (e.g. legislating funding, training doctors, legal
concerns, cultural practices, and manipulation of hot-button health care issues to promote
political and ideological agendas), in sharp relief. To extend Fullwiley’s analysis I want to add
to this already complex set of variables, the notion of a proliferation of biopolitics that implicates
many regions of the world and witnesses a deflation and resuscitation of geographical
boundedness. Accordingly, biomedicine fosters cooperation while in the same instance giving
birth to conflict. The case of the Ukrainian born, Moscow trained psychologist Katya will go
some way towards characterizing the deflation and resuscitation of this geographical
boundedness. Her case will subsequently reveal the way that the professionals at the clinic think
of biomedicine and its implications within a talk or psychoanalytic therapy/collectivist group therapy oriented matrix.

**Considering the [Un]Boundedness of Biomedicine**

*Katya*

Over the course of the year I spent at the clinic, I met with Katya several times. We met in her office which is tucked back in a corner of the clinic complex. The room is spare with a desk dominating it; placed with its back to a wall to the chamber, it is covered with a few books, not all of which pertain directly to psychiatry or psychology. Her floor was carpeted and the space was expansive. I would sit in a chair facing her desk and our conversations would range over many topics and not unlike the books on her desk they would not all pertain to psychology or psychiatry.

Katya, 39, was born, and spent all of her formative years in the Ukraine. She did her training in Moscow at a Canadian school. She studied a form of therapy called neurolinguistics. Freud was forbidden. After her Moscow experience, she went back to the Ukraine where she worked from 1991 to 2000. During her time in the Ukraine her husband finished his studies (he is Senegalese). She had her first child in the Ukraine and her second in Dakar.

Her experience during her time at the Canadian school in Moscow was marked by learning a form of interviewing technique. She worked with her professors à propos this interviewing technique. After the “lesson” for the day, the students would break up into groups, and they would practice the technique amongst themselves. All the textbooks were in Russian or English. Perhaps because of her interviewing training, Katya prefers working with those, “who have the need to talk” as opposed to clinical cases. She prefers working with outpatients. She
says, “I have concerns around the issue of liberty” by this she means the patients’ ability to come and go as they please. She feels it is good and bad. But in general she thinks it is better than the model of internment that approximates the practice at many hospitals in the West. Her concerns center around her notion that “the atmosphere in which patients ‘talk’ creates avenues for exchange and that promotes health.” So, if patients are free to come and go, the types of necessary exchanges between patient and health care provider are minimized. She thinks also that those accompanying patients should come in the evening during visiting hours. This desire for more control over the intervention and the presence of the family accompaniers recalls Euro-American ideas about those interventions. In other words, visiting hours are a feature of the medicoscape that in this instance is reinterpreted in a highly local manner. That is to say, there are no ‘visiting hours’ at Clinique Moussa Diop in the sense that family members are always present. The presence of the family members goes to the heart of Katya’s conflict over psychotherapy and the collectivist orientation of the clinic, both historically and contemporaneously. She contradicts herself in her efforts to describe the relationship between the two.

In contradiction of her claims to prefer one-to-one therapy she at the same time claims she prefers group settings. Katya feels “that group settings are the most efficacious.” In her mind it is the connections made as a collective that bring healing. It is this unresolved tension that informs our apprehension of the medicoscape as indeterminant. It is very difficult to pinpoint its allegiances. Her training is characterized by unbounded use of materials that come from many different worldwide contexts such as Russia and the English speaking world. For Katya, this

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8Patients are allowed to come and go at will at the clinic. See Chapter One for further discussion of this peculiar psychiatric practice.
global flow of ideas about effective treatment i.e. her training in a highly ego-centered modality, fly in the face of her sense of appropriate and indeed *efficacious* treatment. The treatment in the setting *on the ground* finds her patients responsive to *both* group and individual-centered therapies. In the context of our interview then for her the apparent binary is negotiated clearly and successfully rendering it false. The emphasis she places on both group and individual therapy indicates that the two oscillate or are related symbiotically. I feel certain that in terms of her clinical practice, *group* therapy is an *extension* of ego-centered therapy. Rather than being caught in the two poles of the dialectic her humanistic concerns –moral in nature as we will see—allow her practice to emerge as the synthesis of the two approaches.

Katya’s moral commitments can be seen in part in her thesis topic that she completed in Moscow. Her thesis was devoted to abandoned children. “I wanted to work with children but not in the capacity of a teacher”. In short, she wanted “to help those weakest and most vulnerable in most if not all cultures in the world: children”. Despite her moral commitments Katya has misgivings about religious expression of moral codes and normative structures. Katya thinks, however, religion can be very useful in skilled hands. The notion of belief (*croyant* in French; *talibe* in Wolof, referencing ‘disciple’ or ‘religious adherent’) can facilitate the transference of the patient toward the health care professional. This transference as she understands it can diminish the symptoms of the patient significantly.

On the other hand it has also been her experience that faith can make people less pliant and apt to form rigid personality structures. They think that it is God who will make them better. She thinks that while the Senegalese are not fatalistic – namely in terms of their belief that Allah will render them capable to return to the fold-- their faith makes them more external in their
approach to life’s challenges. By this she means manifestations of moral and ethical normative regimes are directed towards maintaining a theological and liturgical response to their sicknesses. Their prayer at the mosque for example is highly public and this for her signifies that the religion professed in her office every day is focused towards making the correct ritual choices (i.e. eblutions) in a manner that once again reinforces the collective. 10

As Katya sees it, these are the difficulties faced by the psychologist and indeed researchers in general (including myself): differences in exteriority and interiority in a given culture as perceived by the professional offering services to the sick person.

Counter-intuitively, those cultures in which self-expression is deemed the ultimate goal of social reproduction, exchange, and finally, configuration of normative structures, will emphasize internal development of personality structures. Put another way, those cultures who place an emphasis on the experience of self will be more likely to seek to develop that self by looking inward: “what do I like; what are my favorite things to do, etc.” By contrast those cultures where a premium is placed on the expression of the social grouping will accord the greatest availability of resources to those members of the collective whose concern is for the

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9 Katya’s understanding of Senegalese fatalism provides a window into ways that we might render the notion of fatalism less essentializing. Rather than only contradictory to my assertion of the “Senegalese attitude” as documented by both myself and Fulwiley, I would argue this reveals a tension present in the therapists’ own ideas about what characterizes Senegalese culture.

10 A plethora of anthropological material has been generated around issues of collectivity and individualism. I return to Kusserow’s (1999) article, I mentioned in the Introduction, on the manner in which individualism is employed as an ideal type for anthropological investigation, seeks to nuance more effectively the binary of “collectivism” and “individualism.” She argues subsequently that the nodal model of ‘collective’ and ‘individual’ cultural orientations over-simplifies the data. She proposes that we think in terms of a spectrum that allows for an understanding of the two concepts as situational. She believes that people according to, for example, parenting styles and agendas and according to complications derived from norms and moral/ethical foundational structures are likely to mix-up their use of any one type of collectivism and individualism. Her conclusion is nothing short of a call to analyze the way that discrete social groups such as membership in certain class oriented projects demand that social scientists be cognizant of the ever-shifting social terrain that those who are in charge of for example our children but certainly in broader social spheres of influence such as the workplace, etc. are likely to utilize both forms of positioning to their advantage.
functioning of the group and therefore are externally oriented. Katya felt her work with her
Senegalese patients was somewhat “limited by the cultural emphasis on collectivity or family.”
That is to say, she experienced difficulty with their external orientation. This in part was a result
of a Western oriented set of psychiatric practices that are not wholly suited to a more collectivist
orientation, and are therefore internally oriented.

That said, it is unclear to her that her patients necessarily cannot access personal
sentiment and expression. In fact, in an instance of synthesis or as I have said of symbiosis, she
vacillates on whether they can at once access the aforementioned interiority. By the same token
her own commitments seem to be in the direction of exteriority. We must remember that her
main love is for group work.

It comes then as no surprise that Katya has reservations about the over-abundant use of
medications at the hospital. In our interview she said the clinic was much too “medicalisé” or too
oriented toward the biomedical model and its interest in prescribing drugs. And too medicalized
in terms of its focus on treating the individual. For Katya, not unlike for Adil, medications
render the patient lucid enough to conduct conversation. That said, by citing the overly
medicalized environment at the clinic, she clearly has misgivings about the use of these
medications. But unexpectedly and somewhat inconsistently, she objects in terms of religion.
She objects to the local manifestation of the biomedical model in which drugs are used alongside
religious practices such as the penc. At the same time, biomedicine allows for a certain
sanguinity in the clinical encounter. How does she resolve the tension between the interior
oriented set of practices and the exterior? With humor. These difficulties with clinical
interventions aside there are moments of laughter and her own experiences of the “A! Ha!”
moment. She tells a very short and apt story in terms of an encounter with a patient. She finds the
story amusing and full of transferential content. She finds in this story an instance of the reconciliation between an internal set of principles in which she was taught and which are suited to an urban setting in the West e.g. Moscow, alongside local interpretations of both illness and cure, that are said to be collectivist in focus and suited to a postcolonial urban environment in West Africa or Senegal. The humorous anecdote pegs therapy as a form of interaction that is itself fraught with unresolvable and indeterminate understandings of its own function.

Katya and the Moving Car

As Katya narrates the story, “the patient said, “psychology is like a person who takes a car in to see a mechanic when it has been in an accident. The only problem: the mechanic is unable to see the problem unless the car is in motion!” So with psychology and psychiatry: there obtains a sort of homunculus fallacy. How to fix something using the very same something in order to do it? How to understand the functioning of the brain and treat it when the only way to see its function is by using one’s own brain? One can only see the functioning in terms of the operation of one’s own brain. Also, how to see the operation of the brain except by seeing it operate?

My interview with Katya reveals in an obvious sort of way the implications of such a broad array of workers at the clinic, who are all trained in similar models but who have on the ground vastly different experiences of the therapeutic interaction. What they all seem to share is a moral or ethical sense of their practice, united with a conflicting notion of how to realize that agenda. Each man is his brother’s keeper, the sign reads. Her epistemological and perhaps normative agenda would seem to mitigate against any heuristic notion of biomedicine as shared by her colleagues. More subtly though it foregrounds in our discussion the degree to which those who care for the sick are found in a nexus of contrasting training and clinical experience.
and yet find themselves part of a therapeutic team. The team as Agathe tells us in Chapter Two is comprised of everyone in the milieu. What is the conceptual and metaphorical glue that holds their experiences and training together? In the case of Katya it would seem to be a commitment to treating patients despite recognizing the limitations of the psychotherapeutic encounter: that moving car… that said, she also sees the challenges facing the biomedical intervention.

For Katya the hospital is too medicalized. She seeks to make her patients well. But the key is not so much within the biomedical realm for her but in the psychological construction of social relationships. In this respect there is a classically complementary, and yet, conflicting, and indeed competing medical epistemology. Namely, the divide that obtains when one tries to set a therapeutic modality alongside the widespread indeed global emphasis on the use of the biomedical. Again, the medicscape emerges as defined by space, by [un]boundedness. It is also temporally contextualized in terms of quotidian concerns.

To summarize, it is rather ambitious to say that Katya finds biomedicine completely devoid of applicability. In fact, the point is that Katya finds a certain contradiction to its use. For her, on the one hand, the biomedical approach provides the therapist with the tools to begin to speak to the patient. She says the drugs render the patient more lucid and therefore primed for talk. On the other hand, the biomedical model becomes a blanket that covers the therapeutic endeavor with unspecific modulations of care.

Katya has developed her definition of the biomedical model both in the Ukraine and in Senegal. Her experience and her therapeutic approach have developed in an international—that is, between nations—context. Because her approach is internationally ratified and taught we can see the relationship biomedicine has with the medicscape. But her moral commitments place her responses to the global situation in psychiatry in a very local perspective. She balances or
relates her emphasis on individually oriented therapy –her external approach—with group oriented therapy –the internal—by attending herself and encouraging her patients to attend the penc.

Part of placing the biomedical model at the center of my discussion of the international/global situation in psychiatry is to discuss one of the technologies forming the infrastructure of the model. That technology is the diagnostic tool. With diagnostic tools we can see the operation of the biomedical model in terms of the epistemology of science –in this case statistics alongside neuroscience—that unites the clinicians. I want to turn then to the clinicians’ perspectives on the use and utility of these tools. To that end, I return to conversations I had with Adil.

Dr. Adil and the ICD, DSM-IV, and Nosography at Clinique Moussa Diop

I met Dr. Adil and his colleague Dr. Seck on a hot and humid July afternoon, it having rained just hours before, leaving behind grimy, muddy puddles in the pockmarked Rue Cheikh Anta Diop. We ventured into the sea of cabs at the entrance to the clinic, their freshly washed yellow paint coats gleaming in the noon day sunlight that filtered through swiftly graying skies. We were silent. Dr. Seck was a recent graduate of the medical school housed at the University of Dakar. The other name of the school repeats that of the street (University of Cheikh Anta Diop) As we crossed to get to La Provencale horns blared.

After we crossed the street we marched directly past the bakery and entered the passage to the restaurant. Seck and Adil were deep in conversation but I could not make out exactly what they were saying over the din coming from the clogged arteries of the street.
We sit and Adil begins to fiddle with the toothpick container. He is miffed, he says, and then begins to explain why without much more than the most perfunctory prodding from me. He says,

ADIL: I am disturbed there is no nosography in Dakar. I think there needs to be a school of nosography.11

SECK: I think that’s why the penc is no longer effective…

ADIL: Yep, that’s why the penc has changed…

ME: You mean since Collomb’s day?

ADIL: Exactly, when we had a proper diagnostic system –and by that I mean a uniform one—the penc served as the key third part of… with the accompaniers and the hospital staff… the penc helped doctors assess the way that their work was going. I think there need to be discussions between the accompaniers and the hospital staff so that people know what to do once the patient has left the clinic… the only way to make sure patients keep up with their treatment is to have accompaniers know what the diagnosis is and be prepared to support the patient should they need it once they get home.12

SECK: I think accompaniers are best equipped for the longue duree of treatment because they understand aspects of the treatment that others are not prepared for in terms of the family arrangement.

ADIL: There are two types of nosography. The first is Continental nosography that focuses on the disease entity and their conception… or the patient’s conception of their illness. And then

11 ‘Nosography’ is defined as nomenclature for disease entities.
12 See Chapter One for a discussion of the practice of having family accompaniment at the clinic.
there is the Anglo-Saxon nosography, which is pragmatic. I prefer to pose questions with patients and leave the discussion open but that doesn’t mean I don’t have some idea of what I think the patient is dealing with…

ME: So you kinda’ combine the two?

ADIL: I am writing my thesis and in it I say there is no model of diagnosis. I think there are different diagnoses from hospital to hospital. For Thies for example the hospital is Catholic and private and so that’s the approach to nosography.\textsuperscript{13}

ME: I’m not sure I know what you mean?

ADIL: There are no mad people, only those who are ill [Ce n’est pas fou, ils sont malade].

ME: So you’re saying at Thies they treat people like they’re mad?

The afternoon has cooled and there is a welcome and soft breeze that blows through the courtyard. Still, the overhead fans at least stir the somewhat stagnant air. The server has come and she takes our orders. Adil orders a salad. I order the lamb chops which are inexpensive in Dakar. Seck also has a salad. She vows to the server that she will have an espresso after eating. Her French indicates she has spent some time in Paris where most young Senegalese psychiatrists are trained. I know this because she punctuates each assertion she makes with the word, “quoi”. An idiomatic usage of the word “what” that is familiar to those who have watched French television coming out of Paris.

Seck turns her attention to Adil who continues:

\textsuperscript{13} Thies is located 70 km (so a little over 43 miles) from Dakar. 1998 population figures place it around 320,000. Thies has a locked psychiatric facility and therefore in many respects more resembles wards in American and European hospitals.
ADIL: So what was I saying?

SECK: You were talking about Thies, right?

ME [I simply nod in agreement and Adil continues].

ADIL: Yeah, to be in an asylum is to eat, drink, and sleep under lock and key. This approach is not operative at all hospitals, for example Fann. I think there should be a uniform approach to therapy. I think Fann has much more of an international approach to therapy…

ME [interrupting]: What does that mean to you?

ADIL: The clinic has a long tradition of bringing in people from all over the world. Plus, I think Professor Gueye tries to go around to different parts of the world to speak about the sorts of therapy being used at the clinic…

ME: Such as?

ADIL: Such as the family members coming in with the patients and the penc: all things that Collomb started…

ME: But is that all you mean by ‘international approach’?

ADIL: No I mean the way that people, I mean professionals, working at the clinic come from different backgrounds and ways of being trained…

ME: So you’re saying that’s why it is so difficult for there to be uniformity in diagnosis?

ADIL: Look, at the level of diagnosis there should be a more uniform structure…I mean there is a risk of ignorance. And what I mean by that is, for example, the doctors don’t use the same meds and so the pharmacies don’t carry the same meds…
SECK: There are also laws that protect the patients. They’re under-utilized. There are laws that say if a patient refuses treatment (shots for example) then they are not to be given. That law is under-used. Actually, many doctors are unaware of the legislation around issues of mental health care.

ADIL: Look, people come to the hospital when things don’t work. But the healers give good medication so why see the doctor? So, they get drugs that don’t work from the hospital and then return to the traditional healer…

SECK: Women in particular suffer because they are asked to work in the house and then work outside of the home as well, whereas the men only do part of the work…

ME: You mean they only work outside of the home…

ADIL: In order for the drugs to work you have to take them; in order to get patients to take them you need family members; in order to get family members to work with patients and doctors is to have some way of telling them, “this is what your brother or sister or son or daughter has”. And in order to do that you need to have a uniform nosography.

ME: But the healers don’t have a uniform nosography either…

ADIL: All the more reason for us to have one…the whole purpose of the penc is so that patients feel like they have a bridge to that traditional world but that only works if you can offer them better treatment. The only way to offer them better treatment is if we can all agree on what the problem is…
ME: But is that possible?

ADIL: Well, at the level of medication it is. I think the pharmacies should have all the meds that patients need but they don’t…

The food arrives and the conversation drops as the afternoon shifts into a lower gear.

*Adil’s ‘International Approach’*

I want to begin with the factors informing my understanding of the ‘international approach’ of which Adil spoke; they are [1] diagnostic tools e.g. the DSM IV and ICD guidelines; [2] psychopharmacological technologies; [3] Examination protocols and other efficacy measuring devices; [4] The dual modalities of “talk therapy” and biomedicine as a combined front against mental pathology; and lastly, [5] doctors’ training both in terms of global educational centers (as measured by the theory generated thereof) and epistemological orientations. Returning to Appadurai’s –scapes we find these medicoscapes defined by not just the biomedical model but also its local manifestation. Additionally, it is within the interplay of the global and local that definitions on the part of clinicians develop around notions of collectivism and individualism. Turning, now, then to a better understanding of ‘traditional’ or in this case indigenous diagnostic tools I demonstrate the degree to which diagnoses hinge on orientations towards global and local understandings of biomedicine and their rapport with Islamic doctrine, law, and quotidian modes of being (dress, gesture, occupation of space, and notions of colleaguality and professionalism; all of which I make discrete only for analytical purposes).

It is not unusual to see a doctor –though it was my observation that it was *only* doctors—consulting either of the diagnostic manuals, the ICD or the DSM-IV. For the uninitiated it is
useful to know that the ICD is in its tenth incarnation. It is comprised of a schedule of illnesses, and statistics having to do with morbidity rates. The ICD is prepared under the auspices of the World Health Organization (WHO) who has overseen its operation since the mid-1940s when it was given advisory power at the International Health Conference in Paris. Although mental health diagnoses and the development of an international nosography came about in the ‘40s, WHO’s real investigation of an appropriate approach to international understandings—and the incumbent generation of a standardized epistemology—began in earnest in the 1960s. This coincided with reform in both the US and as we have seen in Dakar under the tutelage of Collomb.

The DSM-IV likewise is the fourth installment of a schedule of mental illnesses developed in the early 1950s with the first manual produced in 1952. It is interesting to note that it was not until 1980 that the psychodynamic approach was abandoned in favor of the biomedical model.14 The DSM-IV is organized according to a matrix of mental health that is composed of five axis, but it is the first four that are operative for adults. The first axis is comprised of clinical disorders such as depression or bipolar disorders; the second is for so-called personality disorders (a classic example of which is Borderline Personality Disorder); the third is acute medical conditions, an example of which might be a brain injury; and fourth is the axis devoted to environmental or socially related concomitant factors in assessing mental pathology. The fifth and final axis is devoted to outlining and measuring illnesses effecting children and adolescents under the age of 18.

The doctors, then, at Clinique Moussa Diop, such as Adil or Dr. Seck, can be seen regularly consulting these manuals. I would argue that it is precisely the use of two diagnostic

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14 According to Wikipedia, the DSM-V is not scheduled for release until 2010.
manuals that is telling. The two manuals share some points of connection but differ on which axis to place personality disorders with the ICD placing them on the same axis as clinical illnesses. Such discrepancies make for uneven diagnosis and to some extent force the clinicians to conjure up diagnoses that suit the moment. Furthermore, not unlike clinicians in the West, doctors’ use of these diagnostic tools becomes a sort of shorthand such that there obtains no need to “look things up”: doctors are prepared through experience to come up with diagnoses. Finally, in terms of the transreferential economy, the use of the diagnostic tools and the diagnoses that follow, are highly idiosyncratic expressions of ego on the part of the clinicians. Each clinician develops his own style, frequent diagnoses, theories of etiology, disease progression, and applicability of each axis to a given disease. This style speaks at once to local/global; the individual/collectivist orientation of clinicians themselves such that clinicians emerge just as ego-centered in their approach to using the diagnostic tools as the ego-centered modalities they employ. Let me offer now an example of one such personal or idiosyncratic expression of a clinician’s ego.

*An Interview with Fatou*

On a bright and cheery fall/winter day in mid-January, among the first weeks I was at the clinic, I interviewed Dr. Fatou, We enter an office space that she shares with her fellow clinicians. It is directly down the hall from the main entrance and comprises the first suite among the phalanx of offices and consultations rooms in the “right” wing of the clinic (à droit). She ushers me in assuring me that we can talk but unfortunately for only an hour. She asks somewhat suspiciously whether that will be enough time. I assure her it will but that I would appreciate
some more of her time later in my work at the clinic. She smiles and rather cryptically reassures me that she will set aside time for me for future “consultations”.

Fatou did her internship at the clinic. She arrived in 1997 and completed her internship in 2002. She spent one year preparing for her boards, she then took the exams, and spent the rest of her internship at the clinic. She, in part, began her work at the clinic in pursuit of much needed funds to finance her education (that is to say, a scholarship) but the work grew interesting for her and so she remained. For Fatou her interest is fueled by the level of heterogeneity in the daily operation of the clinic. There are always new issues that face both clinicians and the patient population. She enjoys the way the doctors discuss these issues and her role as critic of their responses to the situations that arise. She finds for example a very compelling narrative emerges when she must work with the residents around issues of treatment for patients who are in distress or that “cause problems.” In my experience at the clinic, I never heard mention of axis two diagnoses (or so-called personality disorders). Perhaps, this is an indication of the relationship to diagnostic tools such as the DSM-IV and the ICD-10. Despite having reluctance speaking about the use of these tools, she finds it exhilarating to help the team of doctors come up with a solution to these difficulties. Her duties at the clinic are varied and she gives instruction to nurses as well as working with social workers. During our conversation, which as I say was early on in the research (January), I inquired about the *penc* as a form of traditional psychiatric practice performed at the clinic. She claimed with a smile that there was no ‘traditional’ medicine

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15 It was at times like this that I had the nagging feeling they thought of me as a patient. I could never confirm this opinion of my work but in terms of Pratt Ewing’s notions of a transference/countertransference economy present in all ethnographic work, it is worthy of note albeit somewhat undecipherable. She was fully aware of my interest in becoming more familiar with her work as a professor and clinical specialist. She subsequently extended my wife and I an invitation to her home to meet her husband and child much later in my time at the clinic. Part of the point, though, is that the requisite informant/ethnographer relationship was held at some distance by a certain professionalism. I discuss this impression management in Chapter Three.
practiced at the clinic. According to Fatou, Collomb’s use of the *penc* was to set patients at ease; furthermore, the team he assembled was designed to assist him in constructing, theorizing, maintaining, organizing, and ultimately constructing his therapeutic villages (mentioned in the Introduction). Rather than see the *penc* as a traditional modality, Dr. Fatou views it as a highly modern form of group therapy that masquerades as traditional. It has the structure of the traditional gathering but its content is largely biomedical. This content, however, I have argued speaks to patients in part because of its collectivist orientation (it is after all a *group*), but its content is modeled after group therapy in the West in which there is a highly individualistic component such that each patient is asked to speak and share about their own experience. The clinic since Collomb, however, sought to use the *penc* as a community building activity such that, as I described in Chapter One, everyone is invited and there indeed is an unspoken ethical regime articulated around both its use and the expectations that it can only be efficacious if everyone attends.

But the *penc* has changed in recent years and today it is a site for the negotiation of the development of individual health. There is, then, a tension between its collectivist trappings which I claim are really hold-overs from colonial psychiatry’s claims about the nature of ‘African Culture’ and its current instantiation which sees it employed more to instruct patients in the proper care for themselves and the regimens they will have to maintain in order to promote their own, *personal* health.

Returning to Dr. Fatou, her office itself is somewhat shadowed which gives it a welcome coolness even in the height of the hot winters. She sits at a large desk. The desk has papers on it
that remain mysterious to me as there is discomfort on the part of my interlocutors to explain what they are. There is however a large charting notebook that rests on the desk and it is open.  

There is a book shelf to the right of the desk and there is a small wooden bird that rests here as well as little bric-a-brac on the desk itself. Facing the desk to the right is another chair, presumably for patient accompaniers. Following the requisite greetings in Wolof mixed with French, I begin by asking her what the in-take process is like and how patients are diagnosed. Leaning forward in her seat she explains that family members bring in patients and they are normally seen by Professor Momar Gueye who heads the clinic. I was not allowed to witness these consultations. Next, they are admitted and the doctors consult one another and come up with both a treatment plan as well as a diagnosis at this time. It seems, however, that there are no standardized definitions of illnesses so each clinician operates usually employing the diagnostic tools of the DSM-IV and the ICD-10 to come up with their own diagnoses. So, we return to Adil and his opinion that the patient I have called at her own request, Martine Mendi was not just bipolar but also an hysteric. This latter diagnosis is no longer in vogue but his use of it reveals the degree to which doctors remain ensconced in Freudian oriented diagnostic programs. Furthermore given my observations of the transferentially loaded relationship Adil had with women –staff and patients alike—his use of the diagnosis of hysteria speaks to his own unique

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16 “Charting” is the clinical practice of keeping diagnostic notes as well as progress notes and observations of both behavior, participation in the milieu; eating, sleeping, and bathing/grooming habits; and finally, treatment plan and follow-up plan.

17 I describe the setting in an effort to outline the rather familiar furnishing. I think the presence of the bird for example speaks to a desire to make the patients comfortable in the consultation room. It also speaks to Fatou own idiosyncratic interpretation of what a milieu for therapy should look like.
sense of self in his role as clinician. It speaks to his own ego or at least to his own interpretation of his role.\textsuperscript{18}

According to Fatou, the clinic is just that, a \textit{clinic}; that is to say, it is concerned almost exclusively with \textit{clinical disorders}. So it is that—as discussed in Chapter Three—the doctors use the three diagnoses of depression, bipolar disorder and psychosis most frequently.\textsuperscript{19} That said, the clinic often treats patients with substance abuse issues, as well. And they run aground in their efforts to determine where to place these disorders. Crucial to our understanding of this clinical approach is the idea that doctors are oriented most frequently in relieving what appear to be perpetually acute symptoms. Treatment is meant to solve an \textit{immediate} issue: doctors want to stabilize patients before any discussion of follow-up care can begin. In my observations this is achieved mainly through loose “talk therapy” accompanied by drug prescriptions. I will turn to psychopharmacology directly, but for now allow me to say that there is a consistent balance act between meeting the needs of family members who are frustrated with their ill family members and treating patients in an individual manner; that is, as discrete individuals needing mental health interventions.

\textsuperscript{18}Adil with regard to Martine Mendi spoke in his own terms of the transference/countertransference that was rendering their therapeutic interactions complex. As he related matters, perhaps too complex. So much so, that he turned her care over to another one of the clinicians: Fatou.

\textsuperscript{19}Roughly 75\% of the time in a patient population of no more than 30-40 patients at a time and usually running more along the lines of 20 or 30 depending upon the season; the summer months (August through to October) witness fewer numbers of patients in part because of migrancy patterns, I would argue, with fewer numbers of unemployed poor in the city of Dakar, most having returned to the countryside for the harvest season. These seasonal exoduses are known as \textit{nooraan} which is the time in the fall when villagers go into the cities looking for work; \textit{navetaan} is the time when migrants move from the city back to the village for harvesting the fields and this is during the rainy season or summer.
Interlude: A Consultation with Dr. Fareed

So that, for example, I witnessed the following encounter between an accompanier, a patient, and Dr. Fareed:

The July day was hot with the approach of the rainy season eminent. Fareed enters with a young doctor. We are meeting in a consultation room that forms a sort of quadratic angle with the hallway on the “right” side of the building. It is a cramped space with a desk of cheap wood and an examination space pressed against the far wall. There are chairs in front of the desk; to the left of the desk, and to the right of the desk. I am seated nearest the door in the left hand chair. Fareed conducts the consultations, at least initially, but after a while (30 minutes or so) a young woman takes over. She is also a student doctor I am told.

The fifth consultation of the day occurs in the morning hours around 11 o’clock with lunch not taken until one o’clock in the afternoon. Consultations take on average fifteen minutes with some lasting only ten and others twenty. The longest consultation I observed took forty-five minutes (with Dr. Adil).

Restless because of hunger, I watch relieved as a young man of no more than thirty-five (I guessed) entered wearing a crisp white cotton button down and somewhat wrinkly khaki trousers. He seemed to be medicated that is to say his eyes were a bit bloodshot and he had cotton mouth, with his mouth ringed by swiftly drying spittle that was slightly caked at the creases in his mouth. Despite seeming medicated he was hyper in his speech and bodily movements, gesticulating with his hands animatedly and profusely. His accompanier is his sister. The young male doctor whispers to Fareed, “he seems to be manic.” When asked if he sleeps, it is the sister not the patient who shakes her head vigorously and indicates this is not the case.

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20 One side-effect of psychotropic drugs is cotton mouth.
There is immediate conflict with the patient getting highly upset because his sister is talking preventing him from doing so. She complains, “when he doesn’t take his medication, he eats a lot and [he] doesn’t sleep.” The young female psychiatrist asks if he takes his “shots” i.e. regular injections. He shakes his head in dissent and it is concluded by the staff in the room that the problem is that he is not med compliant. Every time the accompanier speaks he seems to get upset. Crucially, the sister says she wants him to follow his “mood regimen” because she is tired.

The meeting ends with Dr. Fareed setting the 25th of July as their next date for consultation. In the meantime the patient is cautioned to take his meds and to make sure he meets his appointment. The patient says with a smug smile, “I don’t have a problem. I just need a vacation.” After he leaves the doctors look at each other and say almost simultaneously, “he seems manic.”

In this vignette we see the conflicts that accompaniers frequently have with their ill relations. And while the patient is seen certainly within the dyad of the sibling relationship it is clear that directions for care and follow-up are given to him and him alone e.g. “take your meds”; “don’t miss your next appointment”. This is balanced however or really is set in tension with the demands of the family unit. The sister is “tired” and so complains in the hopes that her pressure along with the doctors will effect some change in the patient’s behavior. More to the point, that just as Adil frustratingly observed, the diagnosis was kept hidden from both patient and family member. Although there is consensus in terms of the diagnosis it is clear that this is not communicated to the patients nor to his sister. This is an example of a uniform diagnosis but with the failure to communicate it to the accompanier as Adil thinks is necessary the diagnosis loses a significant portion of its efficacious saliency.
Fatou I found, was casual in her attitude towards diagnosis. She felt that diagnoses were not necessarily the only ways to provide care. For her, what mattered was the *clinical* process. In other words, patients were there to be treated not to be interpolated by some disease or another. Hence, Adil’s frustration; Adil felt that without a diagnostic system accurate care would and could not be given. He wanted to tie himself into a global and international set of diagnostic criteria, while Dr. Fatou sharing his adherence to the biomedical model in the sense that she employed psychotropic drugs parted ways with him in the clinical moment or instance in its *local* context. For her what was needed was a *local* interpretation of the patient’s condition. For her that’s what made the clinic’s intervention unique and applicable to the patient population they were treating. I would argue Fatou’s perspective is consistent (at least) with so-called traditional animism-based approaches to therapy which privilege individual perceptions of illness naming each illness somewhat specifically to the patient such that, for example, each person has a different animal that must be sacrificed for a cure to be realized. It is with this ‘traditional’ diagnostic system that I now turn after which I will discuss psychopharmacology both traditional and modern.

**The Ndop Ritual in Global Context**

During my pre-field research in 2004, I attended the ancestral worship ritual called *ndop*. 10am. I was living in Professor Momar Gueye’s home where I had secured lodgings at a reasonable rate. Our story begins with me climbing into a taxi on my way to the neighborhood surrounding Fann Hospital in order to meet up with an Italian anthropologist by the name of
Adrianna who had introduced me the week prior to the principle ritual practitioner or *ndopkat* of the *ndop* ritual that takes place in Rufisque, a longish taxi ride away.21

In reading up on the ritual at the Fann Hospital archives, I had learned via the writings of the French anthropologist Andras Zempleni, that *ndop* is a Lebu and Wolof practice performed to treat “les maladies mentaux” or mental illnesses. As Zempleni conceives of matters the ritual evolved from a more archaic ritual process known as the *Lup*, a very private rural ritual that had escaped the incursion of Islam into the region on the part of the Berbers.

Adrianna reminded me that we needed to purchase a gift for the *ndopkat*. We got hung up on the way because our intermediary and translator wasn’t at the gas station where we were supposed to meet. So we waited. And waited and waited. Titzianna noticed a fruit stand with oranges and we decided to purchase some for the *ndopkat*. Produce is not expensive in Senegal and yet the oranges would communicate our gratitude for allowing us to observe the ritual. Just as we were buying the oranges our interpreter arrived amidst a profusion of apologies.

We climbed back into our taxi and headed out: supremely confident that what we were about to witness would change our lives. We drove over the pitted roads rutted by years old mud and finally turned into the unpaved road leading to the domicile of our principle interlocutor: Madame Yaay Leck the current *ndopkat*. A woman of, I would guess—though she never intimated—of at least seventy but more likely, eighty years old. With somewhat rheumy eyes she greeted us as she changed into her ceremonial garb. A traditional Senegalese robe with a head wrap: all in purple: a color presumably of some ritual significance. So many details and I wasn’t getting them down quickly enough!

21 *-kat* is the suffix attached to words to indicate specialization; so that, for example, the verb *jang* which means to ‘learn’ is attached to the suffix *-kat* to render the term for ‘teacher’ as *jangelekat*. In the same way, then, *ndop-kat* signifies ‘expert’ or ‘specialist’ in *ndop*. 

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We were left with her eldest son, a young, tall man of simple speech who explained that the sacrificial animal central to the ritual proceedings was being purchased: a goat; more specifically a white goat: again of some ritual significance (I thought of Turner’s color classifications among the Ndembu of Zambia).

We waited. Conversation drifted onto George Bush. I expressed my dismay that he would probably win the next election again. My hosts seemed dumbfounded. Why would we want to re-elect a leader who had led us into a stupid war over oil? I attempted to explain that Mr. Bush wasn’t the sharpest tool in the shed but to no avail. They seemed convinced that the American populace was deluded and had been duped into following the lead of a man whose principle concern was for money. Their President Wade was only a little better. He flew around the world all the time in his plane and did little to nothing for the Senegalese. But there was his work campaign and though it was a failed effort with unemployment rates at an all-time high his work with international forces was compelling for my hosts. We settled in for a longer wait.

At some point with her son’s sporadic comings and goings I got the overwhelming sensation that I had passed some test. George Bush had been helpful after all. My vociferous critique of his administration had earned me the respect of my compatriots that sweltering winter day. Suddenly things swung into motion. The ndopkat returned and ushered us into her car and we drove to the ritual site.

Ndop as it is practiced today occurs in a courtyard. Surrounded by yellowed rust stained walls the courtyard opens up onto a path easily entered by guests and patients. The back portion of the courtyard is cluttered with blood splattered urns called ‘altars’ by the faithful. Allah is the purveyor of all that passes here and his sovereignty is represented by a tree that divides the
courtyard from ritual space to altar space. We were directed to sit on a bench and again wait.\footnote{Waiting is a form of social leveling and indeed \textit{leavening}: it allows for at once the establishment of social registers while by the same token it forces people to slow down and practice patience; this last allows the channels of communication to open, such that time spent waiting is frequently the time in which the parties waiting are able to talk about daily concerns. It is unfortunate when one waits alone, however, this conveys more of a direct power play. Luckily, I had Adrianna to talk to.} The \textit{ndopkat} and her assistants began moving about doing various ceremonal activities such as preparing the ground for the gathering of blood from the sacrificial animal. And then the animal was brought in. He was a small white goat with horns barely showing. He was tugging at his tether and he was bleeting.

Finally the patients entered. Two gentlemen in their early twenties. Both dressed in sweats. The one wearing a knit stocking cap. He refused to look up and engage in eye contact. He appeared to almost drool and rather unkempt he seemed somewhat unaware of himself. The other chap seemed better put together. But he too seldom smiled and seemed very concerned about what was going to happen. Then the others came: A heavy set woman I had seen give the \textit{ndopkat} a wad of money in a tightly clinched fist. And children. Children gathered hanging over the walls peering in laughing and smiling and generally enjoying the preparations for the ritual. These people some of them presumably family members some just casual observers in addition to the assistants and Tizianna and myself were there to watch: we were all, in a sense, an audience.

The ritual began. The goat’s legs were strapped and he was laid on his side. His mouth was opened and the more despondent youth was directed to whisper into his mouth all that he desired of Allah. The rab or ancestral spirits would hear his prayers and carry them to Allah.\footnote{As I say, the \textit{rab} are ancestral spirits, figures of long-deceased family members of the person presenting with an illness.} When he was finished he was directed to rise and stand back. One of the \textit{ndopkat’s} assistants, a
young man with an Afro, was directed to then kill the goat. He took out a large knife and amidst the feverish pleas of the goat he began to saw its throat. Time seemed compressed. The goat struggled and then lapsed into death. By the time of his demise his throat had been sawed to such an extent that his head barely connected to his body.

Next the goat was strung up and was butchered for the ceremonial feast on the morrow to which we had not been invited. Cats were everywhere attempting to catch a bit of discarded meat or intestine. At one point during this portion of the ceremony a large rat scampered through the proceedings and was summarily thwacked on the hindquarters with the blade of the ndopkat’s assistant. The dropcloth underneath the animal was taken up and removed. We then watched as the ndopkat took the hand of the patient and moved him into the middle of the ritual circle. Taking a sort of rug she then gathered some gris-gris or ritual roots and held them in the rug while the patient whispered his prayers to the rab. She passed the rug over his legs and body seven times. She had him sit down and repeated the same process.

The heat was compelling by this point. Significantly, at the various intervals in the proceedings the ndopkat had us participate in the praying. The guests nodded approvingly and the children gathered to watch giggled and squirmed to get a better view. The guests of the patient seemed enthralled and many of them swayed and prayed along with the patient.

During the course of these portions of the ceremony the ndopkat told stories. Many of them funny anecdotes about other patients and her success at healing them. The griot told stories as well one about a trip to the United States in which she fell asleep during the ritual: a long eight day affair involving singing and drumming and much larger gatherings of spectators. This

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24 The event in question held in Gullah Country off the coast of North Carolina was called Coumba Lamba ’96 and featured hundreds of devotees seeking healing for both mental and physical ailments. Maam Yaay Leck had presided over this event and had on her wall in Rufisque an eagle’s feather given to her by a Native American group.
affair may be called the engendering of a medicoscape in as much as it involved a world wide group of practitioners who shared a similar epistemological orientation to medical practices.

For now though, I want to return to the ritual. Finally, the ritual meal was prepared and all who had come to watch were invited to eat along with the patient and all the practitioners. We ate fried fish and rice that day in traditional Senegalese fashion sitting “Indian style” on a rug and rolling the morsels into balls that we then popped into our mouths.

After the meal we took up our audience member positions on the bench as the roots were taken into the rear of the courtyard. A hole was dug and the roots were placed in it. Swathed in curdled milk and blood from the scapegoat, an urn or altar was then placed over the buried roots or gris-gris. This is the altar to the rab: uniting earth and fecundity with life’s source or blood. The prayers of the patient could be heard by the rab only with daily or weekly sometimes monthly payments to the ndopkat and prayers said upon this altar. Allah is Supreme over all but prayers come to his ears only through the whispers of the ancestors.

Next, quietly, the patient was asked to strip and bathe in the blood of the animal. He did so carefully and with great respect. And curiously enough he had begun to smile. At several points by this juncture he was seen to be conversing with the other patient or taking the heavyset woman aside and conversing softly with her. At these moments the ndopkat would dish out hugs and grasping of hands. Everyone was involved every one was crucial to the unfolding drama.

After bathing, the tripe of the goat was placed on the patient’s head presumably to heal his fevered mind. He put his knit cap back on and shook hands with those gathered to watch. Nearly nude by this juncture he allowed the intestines of the animal to be strapped to his body.

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Attending this convening of doctors and patients were practitioners from places as diverse as Bermuda, the Netherlands, and various portions of the US.
They were to remain there for the duration of his life. Luckily enough I imagine, despite his belief in the ritual efficacy of the agents of the ritual, he could wash the blood off after sunset the next day. The remaining gris-gris could be placed in the ocean to thank the spirits gathered to watch the ceremony. The ritual was over at least until the morrow.

**Indigenous/Rural Nosography**

The crucial diagnostic tool in the ‘traditional’ or ‘indigenous’ nosography are the gris-gris. The use of gris-gris has its historical development in rural regions. Its use in the city of Rufisque, therefore, indexes a past that saw a larger part of the population living in rural settings. In terms of the use of the gris-gris for diagnosis, I offer the following description: One day, during my pre-field research, in the height of the late December warmish sun I watched as the ndopkat took a bowl of gris-gris and tossing them around in a whicker basket rubbing her hands over their surface. She then would look at their arrangement and decide which sacrificial animal needed to be purchased and therefore what ailed the patient.

Zempleni, writing in *Psychopathologie Africaine* in 1966 gives a divergent account of clinical diagnosis at the hospital that mingle[s] the ‘traditional’ and the ‘modern’ by bringing together the traditional notions of spirit possession and modern examination techniques. He, thus, describes the moment of diagnosis more in terms of a psychiatric and therefore medical examination:

The privileged relationship between a crisis of acute anguish and the interpretation of sorcery is a constant in the clinical experience at Fann Hospital. Also, some therapists affirm that they are able to identify the work of [ancestral spirits] by these clinical signs: “The patient trembles and if I touch him on the chest, he breathes loudly and rapidly… There is a lump between the heart and the lungs: he cannot take his medicalation, he vomits immediately.” In a more general manner, acute symptoms are related to the digestive tract and have the appearance
of respiratory conditions, which leads the therapists to envisage the intervention of a sorcerer (Zempleni 1966:321).

Significantly, Zempleni heavily theorizes the diagnostic process (invoking Levi-Strauss and shamanism) with the ndop ritual but actually fails to describe it; he instead focuses on the blended therapy at the clinic. With this focus, I believe, Zempleni connected the practice of the clinic at once with a broader, global and international readership, while in the same instance giving a local spin on it. The biomedical model emerges then as not monolithic in its applicability but as implicated within a broader spectrum of available clinical approaches that were Senegalese in perspective and operated according to a highly local set of ideas about what constitutes or is the nature of mental illness. The rural setting in which the indigenous nosography develops its meaning is to be contrasted with the urban setting in which “clinical signs” are the focus. The observation of clinical signs as Zempleni calls them is cast in the idiom of an urban positivism in as much as it is set amidst the clinical techniques of Fann Hospital. The fact that this nosography is indigenous means it is rural. Turning, then, to the urban, clinical naming of disease seems to be the necessary next step in our analysis.

Psychopharmacology in Global and Local Perspective

Among the technologies available to doctors (and which place them in a global and international biomedical economy) are psychotropic drugs. Those used principally at the clinic include: Effexor (to treat depression, anxiety and panic attacks); Tegratal (to treat bipolar disorder and schizophrenia); Largactil (antipsychotic used to treat mania, bipolar disorder, and schizophrenia); and Haldol. Medical supervision sessions are not just “talk therapy” session. They also feature drug prescribing. A typical interaction between doctor and patient might go as follows:
An older man in a rose boubou arrives to speak with Dr. Fareed on a July day. Rather than initiate a discussion with the patient about his illness, Fareed asks about his drug regimen. This is not unusual even in the West—and more than likely was the approach he was taught during his training in France—with the doctor taking on less the role of therapist and more the role of clinician. The patient is taking Largactil and he is experiencing severe side effects including dry mouth, constipation, and extreme drowsiness. Fareed decides on the spot to switch him to Tegratal, an anti-convulsant and mood stabilizer.

That same day, Fareed will prescribe, Haldol, as well. He will consult the PDR and will thereby connect the patient to a standardization of practice that is medical in nature and less psychological in orientation. The use of the PDR connects him at least with Western medical practice and while not a diagnostic tool, certainly is a feature of biomedical technology that is international in implication and application. He is a doctor first, a psychiatrist second.

On average Fareed schedules patients to return in four to six months. Adil’s frustration over developing a universal nosography to be utilized in clinics in Dakar is aptly illustrated in this encounter. Patients and those with whom they share their own care are frequently limited in terms of the information that is provided to them. It is, however, an indication of the degree to which psychiatry in Senegal remains a rather obscure or shadowy medical science, that patients frequently are uninformed by their physicians. It is also due to the ‘traditional’ and rural ideas of

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25 The Physician Desk Reference is a massive compendium of descriptions of medications and includes pictures of the different dosages and/or other methods of administration. So that, for example, the Largactil whose clinical name is Chlorpromazine Hydrochloride can be administered anywhere from 25-75 mg dosages (for mild cases of psychosis) to anywhere from 75-150 (for more severe cases). The injections are not standard however as they cause pain and can cause abscessing at the sight of injection.
psychopharmacology and the expected behavior of practitioners. Physicians are expected to have a rather arcane knowledge just as are the mysterious tradipractitioners.  

*Drug Salesmen and the International Traffic in Pharmaceuticals*

The rainy season arrived late in 2007. So when I arrived at the clinic one day in August running a bit late, it was very hot and muggy but the rains had not really begun in earnest. I came into the clinic and crossed over to the right side of the building. There I found Adil ensconced in the main consultation room. He was toying with a mauve folder with laminated pages that were ads for drugs. Seated in front of him was a young pharmaceutical salesman. He was accompanied by a younger fellow salesman.

They are selling Microflox which comes in 250 and 500 mg tabs and is used as an anti-infection agent. The drugs clinical name is Ciprofloxacine and it costs 4200 CFA. They are also selling an anti-malarial drug, Lufanter. Finally, they are hawking Lorinol which is an anti-allergy medication. It seems strange that they would be selling drugs that are not psychotropic in nature. And indeed, as in the story I have already recounted, this was the very day that Adil admitted that he was not an orthopedic specialist and would be unable to treat a woman with foot pain. It was a curiously fortuitous moment because it was as if Adil were saying, “I am a psychiatrist, not a general practitioner”. But that is in fact the paradox of the entire scene because as a medical professional as with traditional healers the expectation of healing professionals is that they will be able to treat any illness. So much so that in terms of market relationships the salesmen who

26 The term in Wolof for a medical practitioner who specializes in drugs is jabarkat. And while they are beyond the scope of the present it is curious to note that as I mentioned earlier the suffix –kat is applied to those with a specific specialization and so, in this case, it is the word jabar that become so salient as it is the term for wife. There can be a lot of conjecture on this and there were no explanations offered conclusively in the field except some musing that perhaps the connection is really the act of mixing and preparing that both do.
were selling drugs mainly with their international trade names Adil was brought into a web of *international* biomedical treatment regimens but in such a way as to be responsive to and responsible for the local situation. In other words, in the *local* worldview in Senegal, a doctor is a doctor and this influenced the application of the biomedical model in terms of the drugs that were presented to Adil to administer care.

Contrast this with a sunny afternoon in March during which two Effexor salespersons attended the main staff meeting/training lecture (*la Reunion*). They carried glossy, plastic Effexor advertisements with the name of the drug printed in white across a blue background and criss-crossed at the edges with orange and fuchsia bold bands or stripes. They explained its use claiming it treated depression more effectively than other drugs because it could address variations in symptomology. That is to say, it could be better tailored to each individual case.

There are then two trajectories with regards to these two scenes implicating the global trafficking in pharmaceuticals and they seem to converge. First, there is the *local/global* phenomena which witnesses the formation or engendering of a medicoscape; but additionally, there is the individual/collectivist concern as the professionalism of the doctors implicates in a complex web of transference/countertransference their own egos vis a vis their patients. With this regard, the drugs become a way of reaching out to individual patients – using drugs to tailor a treatment regimen for each patient—while also connecting to a biomedical tradition that is both global and international and yet local and tied to local ideas of what constitutes a genuine healer and healing transaction. It is part of the collectivist mythos in Senegal –and ratified by colonial psychiatrists who as we have seen sought to define and describe the ‘African Mind’ *sui generis*—that a doctor treats all ailments. Recall that Fareed thinks of himself as a doctor first and a psychiatrist second. This is the case because doctors like their traditional counterparts function as cogs in a group
wheel. They serve to meet the needs of all patients not just those seeking a specific specialization. But with Zempleni writing in the 1960s we see the beginning of the deterioration of conceptions of the collectivist oriented tradipractitioner. Or at least a tension is revealed such that the clinicians working at Fann Hospital begin to bring to their traditional notions of sorcery, for example, a methodology that is biomedical in orientation and uniquely suited to meet the needs of individual patients. We also see the shift that led Adil to claim he was not a specialist in orthopedics. The psychiatrists are concerned principally with their specialty. Additionally, once again, the concerns of the clinicians themselves were to make their practice as cutting-edge as possible. In their minds this involved utilizing the most current drugs e.g. Effexor and yet as we have seen with Adil this was a fraught process in no small measure because of traditional expectations of their roles. As Adil put it, “Je ne peux pas soigner” which is literally, “I cannot care” for the patient with an illness outside my specialty.

If then –by way of conclusion—part of what mediated the therapeutic intervention for the clinicians was the notion of not cutting for stone, then what was the epistemological regime that made their practice possible? It is the biomedical model itself I have argued here and more specifically international ideas of what constitutes appropriate psychiatric care. So, where the ndopkat was a specialist –the suffix –kat meaning ‘specialist’ –the psychiatrist too is a professional and therefore specialist. But the role of the ndopkat is to be contrasted with that of the psychiatric specialist, in part because of the rural/urban divide. Within the international call to treat as a specialist, the clinicians at Clinique Moussa Diop emerge against the backdrop of the medicoscape. Theirs is a local practice caught in tension with globally ratified forces found within a postcolonial, urban landscape. And though as we have seen there are competing notions of what constitutes therapy both in terms of collectivism –the penc group therapy—and ego-
centered psychoanalysis—Lacan—but also in terms of psychopharmacology and diagnosis, the clinicians are united by a measurable commitment to biomedicine. They are also in most instances united by Islam. But this Islam is also in tension both with other belief systems and also as a political force against which the nation is developing a sense of itself as a secular body politic.
Conclusion

Anthropology and Psychiatry: Conflicted and Cooperative Bedfellows or The Penc and
Models of Oscillation in Global Relationships

...[I]n order to keep misunderstandings from extending, notably with regard to the
modalities based upon the construction of the person and his insertion into groups, and thus
taking up the conceptions of illness and the techniques for its effective treatment according to
which the patient generally made recourse before his hospitalization, the doctor, Henri Collomb,
solicited a collaboration of anthropologists and psychologists in order to form a working team
associated with the clinicians who were devoted to research and constituted a cadre of
individuals devoted to the training of African psychiatrists (Collignon 2000: 285).

Part of the historical story of Clinique Moussa Diop is one of the relationship that
anthropology can have with medical practice; and more specifically psychiatric practice. But
what of the contemporary moment? Where have the anthropologists gone?

In the contemporary moment the absence of anthropologists is a testament to a sea
change in the therapy pursued at the clinic. Forty or fifty years ago, Henri Collomb reasoned that
anthropologists could work alongside clinicians. He thought anthropologists and ethnographers
could help create a therapeutic context that was culturally sensitive at the clinic. Opening in
1956, by the mid-1960s Collomb had gathered his team. Among them was the anthropologist
Andras Zempleni. Andras Zempleni’s work on the rural, ritual ndop was incorporated at the
clinic. His analysis helped the clinicians see what they perceived to be the emphasis in
Senegalese culture –conceptualized as Pan-African—on the collective. His analysis helped the
clinicians see the role of the patient as a member of a collective. There was a tension, however, even in those days between the presence of the collective and the individual expression of illnesses. Even in the ritual patients were required to engage in practices such as diagnosis that were designed to treat their own experience of their illness. By favoring the role of the collective in Senegalese culture, the clinicians effectively ignored the tension between individual experience of illness and collective demands placed upon the patient. How to explain that ignoring of the co-presence of individual concerns alongside collectivist normative claims?

The answer to the conundrum had to do with colonial stereotypification of The African Mind and subsequently of so-called African Culture. These stereotypes were inherited from the work of earlier colonial ethnopsychiatrists. But Collomb with his team of anthropologists posited a different ideal of ethnopsychiatry and though it still maintained that Africans were collectivist in orientation, he also saw the value in using indigenous categories and understandings of mental illness (Fogelson personal communication). Additionally, he saw the value of employing treatment modalities steeped in indigenous lore. His perception of the collectivist orientation, then led to two features of his therapy: the practice of having family members accompany patients for their hospital stays; and the use of a group therapy that he called the penc in deference to the rural practice of meeting under a large tree at the edge of the village to discuss the issues facing the whole village (that is to say, the collective).

But there was a problem. Senegalese culture in the urban context of Dakar was changing. It was becoming more individualistic in orientation. So it was that after Collomb left the helm the clinic increasingly began to use treatment modalities that spoke to the patient as an individual. Family accompaniment took on a new form with the family members silenced during both the penc and in the consultation chamber. To be sure they were still present. But their
presence had diminished. The *penc* also took on a different role. It became a group designed to exhort individual patients to follow their treatment regimens. It became didactic. The increasing emphasis on the individual at the clinic demanded new treatment modalities. Perhaps more aptly this emphasis demanded a re-engagement with Western models. Collomb had critiqued these models and had eschewed them in favor of the more culturally sensitive approach that he garnered from his team of anthropologists working alongside the clinicians. But they became more salient as Dakar developed into a large metropolis. These Western models had themselves featured a tension between the science of the individual and the social matrix of the collective in which illness gained its meaning.

In the present moment, then, the science of the individual has begun to take precedence over the construction of the social. The science of the individual is increasingly felt by clinicians to be a global science especially in terms of their training. The science of the individual as practiced in psychiatry and globally ratified and used in training physicians for the psychiatric specialty is defined as the biomedical model. It features the use of pharmaceuticals principally, but also treatment modalities formulated in psychiatry’s psychodynamic past. This past saw the use of ‘talk therapy’ as a necessary part of treatment. It is the blended model then of drugs and ‘talk therapy’ that has gained ascendancy the world over. This defines the biomedical model in its use in the West. Because the Senegalese psychiatric community as led by Clinique Moussa Diop –it is the oldest such clinic—is both a participant in the shaping of the biomedical model and a recipient of its ideals, it assumes membership in the international psychiatric community. This can be seen in the presence of clinicians from many different parts of the world at the clinic. It can also be seen in the way the clinicians are trained in both theory and clinical practice. This training is couched in terms of global ideas of what constitutes professional training and
professional behavior on the part of clinicians. These notions of professionalism can be seen in the use of cutting-edge technologies, sartorial codes, use of consultation space, and ultimately in the reference to notions of transference and countertransference. Transference and countertransference are features of the ego-centered psychodynamic definitions of the therapeutic dyad. According to these ideals, the ego of the clinician is just as implicated in that dyad as that of the patient. So the ideals of professionalism are seen to be expressions or interpretations of the global standards for treatment that become highly idiosyncratic. That is to say, we can see in the use of the ego-centered treatment modalities the emergence of an individualistic oriented ego that features a unique expression of the use of the technologies, sartorial codes, and behavior within the consultation space –the bodily hexis of the clinicians. We can see then in the clinicians’ exhibition of professionalism vis a vis their use of ego centered therapies the sea change in Senegalese culture. Or at least we can see the dynamic interplay between individual expressiveness and collectivist ideals. This dynamic has always been present so much so that we can speak in terms of stereotypes of so-called African Culture as collectivist. But it has accelerated in recent years. So that, collectivist ideals are losing ground to individual expressiveness or expressions of ego. It is my hypothesis and conclusion that the use of ego centered therapies mean the presence of unique egos on the part of clinicians and patients. And because these treatments are viewed to be the most efficacious in the present moment, designed to treat the urban population, the broader culture can be said to be expressing greater individualism. We are led to conclude that Senegalese urban culture is no more nor less collectivist in orientation than any other city in the world.

The eroding of collectivist ideals can be seen in the loss of the anthropologist’s role at the clinic. Ideas about social constraints are becoming less and less salient. Or are they? The penc
remains operative. Family accompaniment persists. So it is that we can only speak in terms of an interplay between collectivism and individualism that renders the latter two ideal types a false dichotomy. The two are present in a type of symbiotic or oscillating relationship. It is to theories of oscillation that I want to turn by way of concluding.

The social sciences have dealt with notions of oscillating, of originary stories of mixing and commingling rather insufficiently. This has made for a situation in which anthropological knowledge has proven to be ineffective in describing the urban, postcolonial set of social relations. These social relations are slippery. They are global. They demand new terminology.

I have introduced here one new term that is in dialogue with Angelika’s Wolf work. Her term and it is one I use in this book is ‘medicoscapes.’ For Wolf et. al. the term signifies global medical regimes of knowledge-production that make recourse to what Appadurai –the real source for the term both in her usage and mine—calls global flows. For me the term signifies the resuscitation, the collapsing, the interrogation, and the reinforcement of boundedness and unboundedness between nations. The notion of inter-national is crucial here, for it is between nations that medicoscapes really gains its flexibility as an analytical descriptor. This oscillation, this originary tale of mixing has perhaps always obtained. We can see its traces historically as in the work on the American century by Arrighi. But it is not static, nevertheless. And as Appadurai tells us it has accelerated in recent years. But I would argue it has accelerated, yes, but toward what end? I do not think there is an end. There is no telos to the oscillation. There subsequently will never come a day when the tension between for example collectivism and individualism will ever be resolved. Tensions between such ideal types will always be present. Hegel was wrong. There is no end to history; no end to our ever evolving set of social relations such that we might speak of the Hegelian overcoming. There is nothing in terms of global social relations other than
oscillation. This is my ambitious assertion that demands further investigation. In the end though it means there is a place for anthropology after all. So it is that I as an anthropologist arrived in December of 2006 at the doors of Clinique Moussa Diop. My role there speaks to the enduring need on the part of the clinicians to understand their own role. I will share this manuscript with them in the hopes that it will shed light on their practices. It is with this regard that I take up the role of anthropologist there, now over half a century old. And it is in these terms that I am certain we will have a role there in the next fifty years.

It has been my thesis throughout this dissertation that the collectivist/individualist dynamic can be a lens by which to view debates within cosmolopolitanism over universality and particularity. Allow me to characterize that debate by offering a definition of the universal and the particular in the context of Clinique Moussa Diop. In the end we will return to the dichotomous paradigms that form the substance of the dynamic as viewed by such scholars as Nussbaum, Appiah, and Bhabha. Ultimately, I argue that rather than the secularization of the public sphere as the horizon of possible engagements in the realm of the social, we can see with the norms production at Clinique Moussa Diop a possible avenue for the sacralization of the public sphere. I do not want to suggest that we depart from the secular nation-state. I suggest rather that we see citizenship—a citizenship of the world—in terms of an oscillation between faith and the secular principles that inform the organization of that nation-state. Clinique Moussa Diop becomes a metonym by which to view the norms production that goes to the heart of the neoliberal project. But in as much as that project is sliding into global relationships or systems, we might prefer to identify the project with a broader set of variables; variables that I would call cosmolopolitan, with the term acting as both a descriptive analytic as well as a normative or ethical force for change. The question I pose in looking at psychiatry in Dakar is, in
what ways can the cosmopolitan space of Clinique Moussa Diop and the actors that animate it
force us to grapple with notions of faith both in terms of global/local interpretations of the role of
religion but also in terms of the role of science. In terms of these constructions of sociality there
are no universals, there is no particular: only a constant negotiation between the two ideal types;
an oscillation as I say that both describes Dakar in the postcolonial moment and at the same time
is a clarion call for a re-investigation of the role that faith can play in forming ethical regimes
that allow us to care for one another. The sign at the fork in the road at Fann Hospital where the
clinic is housed reads: Every man is his brother’s keeper. The question is how can we encourage
a citizenry to live according to this maxim? I do not presume to have the answer but here I have
offered a description of the way that the clinicians at Clinique Moussa Diop negotiate the
dynamics inherent in fostering the maxim’s sociality. And I argue that it is anthropology’s role to
pose the question.

That that question implicates notions of how we are to define sociality is self-evident. For
many scholars arguing both in a descriptive way for a cosmopolitan understanding of the current
global situation, as well as for an “ethics in a world of strangers” there is an inherent dynamic
that is posited between the universal and the particular. The universal is understood as a
discourse generated from the Stoics on to the European Enlightenment that argues as we have
seen with J.C. Carothers and other ethnopsychiatrists that African culture is collectivist in
orientation; is static; and is morally compromised by the inferiority of African’s mental faculties
Along came Henri Collomb who posited that a more effective brand of ethnopsychiatry would
privilege the social over the scientific or claims that ethnopsychiatrists made using a purported
science that denigrated Africans and relegated them to the sub-human. The universalizing
discourse identified here was in terms of science and it was opposed to faith –because not so
much that scientists like Carothers were not *croyant* but because Western faith systems were reasonable in a Lockean sense and therefore to be juxtaposed with African religious sentiments which were morally compromised and ultimately unreasonable. The notion of the particular as found among cosmopolitan arguments seeks to define the dynamic relationship that the local and the contingent has with that universalizing discourse. It is conceived in terms of a discourse of difference construed in terms of bounded notions of what constitutes for example a body politic. As the aforementioned three theorists argue we can no longer afford to think in terms of either that universalizing discourse with its inherent ethnocentrism and Eurocentricity; we must begin to define the postcolonial condition in terms of a multiple belongingness. And we as Amselle tells us as social scientist must pay attention to the dynamic sets of relationships that foster that multiple belongingness.

But the anthropologists are absent at Clinique Moussa Diop in the sense of shaping therapeutic interventions. There is with this regard the old universalism in new clothes with a view of those interventions in terms of a biomedical science that once again argues that we are all the same at least at the level of medicine. Working among the clinicians at the clinic has shown me how the intimate relationship between culture and biology and its inherent biopolitics in fact means we are very different. Or are we? Pharmaceuticals work. Moreover, individual interpretations of that universalizing, biomedical model on the part of the clinicians and within a transfential economy argue for a non-monolithic view of science oriented interventions. We cannot then see fit to posit a linear understanding of the dynamic. Our analysis is faced with a three dimensionality that is as spherical in its indictment of the local and the global as the globe itself. How are we to live in this three dimensional world? How are we to study and describe it? We are left bereft of any connections that are less than recursive and circular. We are left bereft
of linearity. Ultimately, we must extend our analysis beyond flows even and speak rather in
terms of gravitational pulls as bodies revolve around one another drawing one another into novel
and ancient configurations. And it is in these terms that I offer that while we can never reconcile
the particular and the universal; the global and the local; the scientific with faith; we can at least
recognize the false binaries at the heart of their deployment as ideal types. With this regard
‘citizen of the world’ becomes ‘citizen of worlds.’
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