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ORIGINAL PAPER

Falling, Dying Sheep, and the Divine: Notes on Thick Therapeutics in Peri-Urban Senegal

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Abstract Peri-urban Senegal lies outside the influence of both the nation's historic public mental health model and contemporary global mental health. This paper examines how cultural logics in this underserved region spill over from social domains to widen the therapeutic sphere of psychoses and epilepsy. Observations and 60 carer and/or patient interviews concerning 36 patients afflicted by one or both conditions illustrate how the "crisis of the uncanny", a spectacular eruption of psychoses and seizures into the everyday, triggers trajectories across these domains. To resolve the crisis, patients and carers mobilize debts and obligations of extended kin and community, as well as a gift economy among strangers. The therapeutic and non-therapeutic are further linked through the semantics of falling, which associates this local term for the crisis with divine ecstasy and the slide from human to non-human forms of life. We introduce the concept of thick therapeutics to capture how the logics of sheep- other animal-human relationality, secular-divine politics of giving, and payment/sacrifice for healing imbue a therapeutic assemblage continually constructed through actions of patients, carers and healers. We ask what implications therapeutic thickening might have for mental health futures, such as monetized payment under global mental health.

Keywords Psychosis · Epilepsy · Eruption of the uncanny · Thick therapeutics · Senegal

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Introduction

"Faty gets medicine at the clinic, because epilepsy is in the brain". The elderly man, comfortably dressed in a boubou, and I[1] sit on plastic chairs beneath the baobab tree, surrounded by the tin-roofed structures of his family compound. It is shortly past noon, and the sweltering heat of this Senegalese desert town oppresses even in the shade. The community volunteer (*bàjjenu gox)* who directed me here has already briefed me on Faty's affliction. Thanks to her, the man, Faty's grandfather, has been expecting me, the researcher. For now, he is my sole interlocutor; Faty is off playing soccer and his mother at the market.

Faty's seizures come and go. During his frequent falls, he hallucinates, becomes oddly agitated and folds himself into his mother. Seizures bring on skin conditions so severe that "the boy's head turns white". And though medication at first stopped the seizures, it "pumped up" Faty's body into a grotesque shape. Even now, Gardenal (phenobarbital) can make him dizzy, agitated, or cause vomiting. Endless visits to renowned healers, and later the clinic, have consumed his mother's hard-earned money from her food stand and his father's remittances sent from his job in Ivory Coast.

Our chat is interrupted when the seven-year old boy arrives, energetic and all smiles. A throng of kids in shorts and tee-shirts follows.

The grandfather returns to our conversation: "Epilepsy is in the brain". But it is a marabout, he continues, his family's spiritual guide, who finally clarified the difficulty with the boy's case. His intractable epilepsy, *the marabout* has told the grandfather, stems from powerful *jinne* [demonic spirits] coming from India who possess little children:

> The *jinne* were chased out of India, and they migrated to Senegal. Here they intimidated dignitaries and adults – but in vain. That is when they turned to little children, leaving them handicapped … These *jinne* are the reason for the remarkable increase in seizures [*kiriss*] in Senegal today. And few healers have the knowledge to confront those *jinne*. Those *jinne* have even knocked less experienced marabouts to the ground!

Indian popular culture penetrated Senegal beginning in the 1950s (Vander Steene 2008). But what matters here to the grandfather's spiritual guide is the coupling of foreignness and indomitable force these demons exude. Only a great marabout can heal the severe epilepsy inflicted by powerful transnational Islamic spirits. The grandfather's narration of his spiritual leader's reasoning conveys a popular epidemiology of the incurability of convulsive epilepsy and severe mental disorders, echoed by patients, carers and sometimes health workers in areas like this one, untouched by either global mental health or Senegal's own public mental health model. And it metaphorizes fears of globalization more generally.

This paper develops the notion of thick therapeutics to capture the complexity and contexts of trajectories such of patients like Faty, whose affliction is at once "in

[1] "I" refers to P.M. Diagne, who conducted this interview. In this paper, "we" refers to A.M. Lovell and Diagne. All non-researcher names are aliases except for historical figures.

the brain" and the work of malevolent intruders from India. The spectacular eruption of psychoses and seizures into the everyday, a phenomenon we term the "crisis of the uncanny", links numerous material and symbolic domains. Like Faty and his grandfather, patients and carers seek to resolve such crises by weaving between vernacular healing or what they call *faju Wolof*; and vehicular Euro-American, imported treatment, or *faju toubab*. To explain, tame, treat and contain the affliction at hand, their actions modify, refute and recombine a number of cultural logics underlying social forms beyond the strictly therapeutic. Reconfiguring interpretative anthropology (Geertz 1973) within the practical norms perspective of French Africanist anthropology (Olivier de Sardan 2014), we apply the idea of thickness to crisscrossing interpretive contexts as well as to the shifting ways in which economic, social, political and other circumstances shape therapeutics through those contexts. Globalizing processes weigh directly on the therapeutics directed at the resolution of crises (e.g. through the flow of commodities like Faty's anti-seizure medication) and indirectly on social formations outside healing processes (e.g. through dispersal of family members like Faty's father, a manual laborer in Ivory Coast on whose remittances Faty's treatments depend).

Using observations and 60 interviews with patients and carers concerning 36 patients in underserved peri-urban areas of Senegal, we focus on two social forms—animal-human-divine relationships and secular-divine gifts—whose underlying logics also affect the therapeutic realm. The semantics of "crisis" and "falling" reinforces the associations that link these forms to healing, thus thickening the therapeutics. Finally, we argue for the relevance of thick therapeutics for imagining mental health futures where global mental health has yet to penetrate. At stake is whether global mental health acknowledges or ignores the questions posed by thick therapeutics, including the extent to which components of vernacular healing can actually be extracted and made commensurable with the vehicular.

Study Background, Theoretical and Methodological Considerations

From Fann to Global Mental Health

Post-Independence Senegal historically stood as an intellectual and cultural center and exemplar of democracy for newly independent Francophone West African nation-states (Cooper 2014). The Fann School, a unique ethno-psychiatric model named after a neighborhood in Dakar, Senegal's capital, sought to reconcile socially re-integrative values of indigenous healers with French clinical approaches to neurosis and psychopathology (Diagne and Lovell 2019). Founded in the 1950s by a French military doctor, Henri Collomb, Fann furthered France's institutional strategy of maintaining ties to a decolonizing region. Fann's proponents identified its ethno-psychiatric public health project as African-centered and disseminated its principles to other Francophone African countries (Collignon 2015), although Senegalese psychiatrists and intellectuals eventually challenged the model's colonial roots and culturalism (D'Almeida 1997). Despite the intellectual richness of this illustrious but complicated past (Diagne 2015; Kilroy-Marac 2010), Fann-

inflected psychiatry has mostly disappeared, except for its still-functioning clinic in Dakar. Elsewhere in Senegal, Fann's influence is barely felt (Diagne and Lovell 2019) and public mental health remains rare (Tine 2015).

Today, Senegal, like most Francophone African nations, lies outside the sphere of global mental health endeavors. Francophone African organizations and psychiatrists tend not to belong to the Movement for Global Mental Health (Lovell, et al. 2019) and global mental health policy bodies, and they rarely participate in regional (non-Francophone) international psychiatry events.[2] European countries and faith-based organizations unilaterally provide training and funding for Senegal's psychiatric clinics, a throwback to earlier international health and development. Unlike the HIV and malaria fields in Senegal (Eboko 2015; Tichenor 2016), global funding flows and global health programs rarely reach mental health services in Senegal. Even aspirational "global mental health talk" proved scarce in our conversations with Senegalese psychiatrists, mental health administrators and public health workers,[3] with two exceptions. The Senegalese military collaborates with the US military on PTSD training and techniques typical of global mental health.[4] And in Senegal's Casamance region, where ongoing armed conflict has continued on and off since 1982, the International Red Cross provided PTSD training, and USAID rebuilt post-conflict child mental health facilities.[5]

This historical background clarifies the difference between the vernacular and the vehicular. By analogy with architecture, vernacular healing implies "local" or "traditional" therapeutics shaped by local imaginaries, in response to local needs and with the materials at hand. By analogy with linguistics, the vernacular can become vehicular. Vernacular languages (local dialects, English when spoken in predominantly Anglophone countries) contrast with vehicular ones (e.g. Swahili, spoken throughout East Africa as a second language; the English of international

[2] Including the World Psychiatric Association's Sub-Saharan Region activities, as was pointed out at the plenary level at the 2018 WPA regional conference in Addis Ababa (Ethiopia). (Ursula Read, personal communication, January 3, 2018). A former WHO Division of Mental Health Director highlighted the Anglophone bias of global mental health commissions which fail to "open avenues of different thinking about the practice of psychiatry" (Sartorius 2017). His examples, however, concerned French (not African) treatment modalities.

[3] We found no global mental health projects among the submissions to the Comité national d'éthique de recherche en santé (CNERS). Our interviews and conversations (2015–2017) with the Director of the Division of Mental Health of the Ministry of Health and Social Welfare; public health professors, senior and junior psychiatrists and other mental health professionals, indicated little awareness of global mental health, funding sources and notions (e.g. the global burden of disease (GBD), the mental health treatment gap) or claims (e.g. the high prevalence of depression worldwide). Senegalese epilepsy specialists do participate in global endeavours, but the few mental health aid projects in Senegal resemble more those of the international health and development era (e.g. bi-lateral rather than multi-lateral, small donors) rather than large global health-identified philanthropists and other organizations). Senegal and other Francophone African countries are not linked to the complex assemblage and particular ideologies of global mental health (Lovell, et al. 2019).

[4] J.A.D. Tine, psychiatrist with the Senegalese Military forces, personal communication, March 22, 2017)

[5] Ba 2015; interview with J.-P. Diallo, Deputy District Medical Chief, by A.M. Lovell and P.M. Diagne, May 15, 2017.

commerce).[6] Global mental health, a vehicular system, contains different standards, tools, and practices (Lovell, et al. 2019) from French-influenced psychiatric and psychological practices brought to Senegal under Dr. Collomb. The Fann model of ethno-psychiatry differs from how patients use vernacular-vehicular healing today, just as French-inflected "vehicular healing", founded on a more psychoanalytically-inflected tradition of psychiatry than, say, U.S. biomedical psychiatry, differs from what global mental health might bring.

Key Theoretical Premises and Concepts

According to a recent review, anthropologists of global health in Africa increasingly site their research in Euro-American clinics, from where they observe health in communities through a biomedical lens (Scherz 2018).[7] Such a perpective may inform global health endeavors about some community-level needs, but not without limitations. First, it risks reproducing the binary that pits the rationality of evidence-based biomedicine against supernatural, religious, plant-based and other local practices. Such rigid divisions mask the political and social labor that produces forms of healing, black-boxing if not burying traditional ways of knowing (Cooper 2016). Second, clinically-sited studies confine therapeutics to a narrow domain within the larger, more ambiguous context that historian Nancy Rose Hunt calls "therapeutics writ large" (Hunt 2015: 11–12).

To break conceptually with binarization and adequately restitute the complexity of our observations, we introduce, first, the concept of "thick therapeutics", of which circumscribed biomedical treatment and local healing constitute but a small component. The qualifier "thick" brings to mind Geertz's distinction, borrowed from ordinary language philosophy, between capturing social phenomena as if through precise "I-am-a-camera" observation and interpreting them. The latter move situates events within interacting systems of signs in larger structural contexts through which action and behavior are produced, perceived and interpreted (Geertz 1973). In this paper, thickness signals an ensemble of overlapping affective, moral, social, symbolic, material and other domains within which the expression of altered states and responses they elicit are embedded. The resolution of crises engendered by these states engages actors—and the anthropologist who observes and listens—in broader webs of meaning.

Rather than conceptualizing social forms within a "stratified hierarchy", as Geertz did, we theorize them in terms of the ensemble, or assemblage, they attach to. Unlike the closed system of Parsonian functionalist sociology into which Geertz fit "culture", assemblages better allow for the fragility, resilience and changeability of social formations. Components of assemblages include, as we see below, the human and non-human (e.g. sheep), material (e.g. medicines) and non-material (e.g.

[6] The etymology of the vernacular (the informal, the non-standard, the "native", from the Latin *vernaculus*: "domestic, slave, or home-born") suggests a subordination to the cosmopolitan dominant of the vehicular.

[7] Kilroy-Marac, however, pays careful attention to the vernacular in her ethnography of Fann clinic (Kilroy-Marac 2010, 2014, 2019). Read, in Ghana, also interviewed and observed people with mental illnesses outside the clinic (Read, this issue; Read, et al. 2009).

jinne), each mutually affected in interaction with the other (DeLanda 2019). Within mental health, we thus extend the relevance of assemblage theory from earlier studies of family recovery in mental illness (Price-Robertson, et al. 2017) and addiction (Lovell 2013), to broader therapeutics around psychoses and seizures erupting as a crisis of the uncanny.

Second, we bring the theoretical-methodological perspective of "practical norms" to the interpretive work of actors. French anthropologist Olivier de Sardan (2014) originated this epistemology for development studies in Africa. Like Bourdieu's practice theory, it captures how social actors bend, modify and reject norms, simultaneously following logics underlying one domain (such as solidarity) within another domain or combining separate logics (as when kinship logic applied to government bureaucracies results in clientelism). In other words, culturally-embedded logics of action share a "family resemblance" (Wittgenstein 2009), are relatively flexible and crisscross domains, rather than obeying a monolithic, overarching culturalist principle.

Finally, to identify crisscrossing logics that thicken therapeutics, we follow, by virtue of our interview narratives and observations, the trajectories put into motion when consequences of psychotic and epileptic crises ricochet across life domains. Anselm Strauss and his colleagues defined the illness trajectory as the "total organization of work done over the course of [a] disease" through the actions, skills, resources of numerous social actors, from professionals to patients to the entourage (cited in Baszanger 1998: 364). More recently, anthropological studies of addiction conceptualize trajectories of the afflicted as forged through the movement *between* treatment and non-treatment spaces (Lovell 2013). Thick therapeutics extends this idea by recalling the social domains traversed and uncovering crisscrossing logics between domains, made visible through movement and agency.

Among the questions this paper raises is whether the characteristics of vehicular therapeutics of global mental health and "thick" vernacular therapeutics—a therapeutics writ large—can be commensurated with the other; that is, rendered similar, comparable, or measurable by the same standard. Modified Geertzian hermeneutics, practical norms and trajectories reveal the inter-relationships between the vernacular and the vehicular woven by the actions and reactions of patients and carers to the crisis of the uncanny.

Setting and Methodology

We conducted our eighteen-month (2015–2017) study in Thiès and Diourbel, two cities underserved by public and global mental health, and focused on one health district in each. Thiès (pop. 668,000) a regional center and transportation hub, functions as a dormitory city for workers in Dakar, 65 kilometres west. It houses a private, faith-based psychiatric clinic and is connected by national highway to Dakar's Fann psychiatric clinic and to the National Psychiatric Hospital Center (CHNPT), in Thiaroye, near Dakar. Diourbel (pop. 268,000), a Mouride holy city in the desert east of Thiès, depends economically on groundnut and millet cultivation. Diourbel lacks public and private mental health clinics. Neither city has community-based mental health services.

We examined psychotic conditions and epilepsy together because of their frequent co-occurrence, similar popular etiologies,[8] long-term management and, occasionally, treatment in the same service in Senegal. Most Senegalese epileptologists are psychiatrists, and about half of children and adolescents hospitalized at Thiaroye's CHNPT receive diagnoses of epilepsy.[9] International health agencies, global partnerships, and global mental health organizations classify psychoses and epilepsy under "mental, neurological and substance use related disorders" (MNS) (Collins, et al. 2011), and the WHO mental health treatment gap (mhGAP) tools used in the South place epilepsy under common mental disorders. In short, as major global mental health researchers note, "the distinction between mental and neurological disorders has little relevance for many low-income countries […]"(Whiteford, et al. 2016: 412).

To avoid bias due to clinic-specific attitudes to healers (e.g. tolerance, prohibition, etc.), we developed a systematized non-clinical convenience sample according to our previously-developed methodology (Diagne 2015; Lovell 1997). People suffering from chronic psychotic disorders and/or epilepsy (defined by interviewee or referral source) were located through ethnographic methods: observation on streets, in marketplaces and other public spaces; conversations with community agents (*bàjjen gox*)[10] and leaders; and word-of-mouth. We defined chronic as a duration of 1 year or more. Patients and carers confirmed a psychotic or epileptic condition, showed us medication for those indications or provided descriptions which allowed the project's psychiatrist[11] to confirm the condition.

We conducted semi-structured interviews about 36 persons afflicted with psychotic conditions, convulsive epilepsy or both. 24 interviews were with their carers. We define the latter as the principle person who makes medical, social and other decisions related to the patient's crisis; provides material, informational and psychological support; assures responses to basic needs like housing and food; and accompanies the patient in therapeutic endeavors. We re-interviewed 12 patients, selected for heterogeneity, at least once after 1 year.

Interviews covered patient demographics, education and work history; household/family compound structure; kin structure; amount and sources of household income; interviewee's illness history, therapeutic itinerary, including cost, payments and their sources; care (kin or non-kin) involvement (financial, decision-making, healing, care, etc.). Interviews usually took place in the extended family compound and in the presence of several family members.[12] Interviews were conducted in Wolof, occasionally in French and once in Seréer. All were audio-recorded, transcribed and translated when necessary into French. We re-examined Wolof

[8] For many people, no firm distinction exists between the origins of epilepsy and psychiatric illnesses, as both are supposedly caused by the same spiritual forces (Franklin, et al. 1996:133).

[9] J.A.D. Tine, personal communication, December 2015.

[10] These female volunteers, usually respected local figures, provide health education, interpret government policies for community members, refer people to services, and mediate between citizens and government representatives.

[11] J.A.D. Tine.

[12] As was culturally appropriate and met CNERS guidelines.

versions for recurring terminology. Field notes were kept of informal conversations and observations.[13]

Patients were aged 6 to 50. Half (18) suffered from psychoses, 11 from epilepsy and 7 from both conditions. Just under two-thirds were men. Duration of illness varied from five to 34 years, depending on age. Two attended school. One worked as a mechanic, another sold fish, and two begged. No others had occupations. Carers included a parent, grandparent, older sibling, childhood friend, neighbour and stranger. Two-thirds were women. Carer occupations ranged from manual jobs (carpenter, mason) to white collar ones (civil servant, assistant pharmacist). Most female carers were home-makers who also worked outside the home (e.g. fruit vendor, praise-singer).

To understand the social cartography of treatment modalities, we conducted an additional 24 semi-structured interviews concerning the health care system in Senegal, available treatment, and treatment needs for psychoses and epilepsy with physicians, nurses, social workers, other health agents and healers. These took place in the two health districts and in a Casamance district with charismatic healers mentioned in patient interviews. The present paper does not focus on those data.

The Crisis of the Uncanny and Its Moral Consequences

A Rupture in Everyday Life

Patients' trajectories begin following the eruption of an altered state of psychosis or seizure in everyday life. We illustrate the uncanny and its consequences through two patients: Omar, an adolescent; and Awa, a mother.

Omar

Our exchanges with eighteen-year-old Omar and his cousin Sebene begin under the acacia tree of a family compound in Thiès. Sebene, a well-dressed man in his mid-thirties, excuses Omar's lateness. These are the final weeks of the baccalaureate, the national high school exams. Omar is presenting for the most difficult one, the *Bac-S* (Sciences). Coming through the compound gate, in neat jeans, short-sleeved shirt, NY Yankees cap, a backpack slung over his shoulder, Omar resembles a typical Thiès high-schooler.

Earlier that afternoon, Sebene described to us how Omar's affliction appeared suddenly, a year ago:

> Omar started to have seizures [*kiriss*]. Then he went a long time without them. Now they're back. When he's about to have a crisis, his words, his gestures become aggressive. He talks back to me – no respect. He even insults his father! It's not like him. He breaks furniture. He speaks loudly and frightens the kids. And he cannot hear what we are saying! He is in another world. He

[13] Diagne conducted most patient and carer interviews alone and a few with Lovell. Diagne is fluent in Wolof and French. Lovell is fluent in French, with beginner-level Wolof.

> tries to leave the house, but pays no attention to the cars. We have to hold him back for his own safety. But even six tough men can't hold him down. [By then] he has the strength of a lion.

We term what erupts in moments like those Sebene described as the "crisis of the uncanny", a sudden transformation of someone familiar into someone strange and unrecognizable. This sense of the *unheimlich* (literally, "un-homelike") is the crux of the uncanny and the dread it arouses in onlookers.[14] Omar metamorphoses into (an)other than his ordinary self, at once physically present yet not in the familiar person of Omar. This perception in the onlooker generates an inarticulateness, expressed in piecemeal descriptions: the "not quite", other, animal-like.

Hierarchically, although Sebene is not Omar's biological sibling, his age-class membership classifies him as Omar's *grand frère* (older brother), a status commanding respect. Hence Sebene's and the family's shock at Omar's insults. Physically, as he stands next to us, Omar does not look big for his age, so the evocation of his lion's strength surprises us as it did the male relatives pinning him to the floor. Omar's otherness comes through also in Sebene's disorientation to characteristics no longer resembling his younger, afflicted cousin, who suddenly speaks in a raised voice not "his".

But Omar, too, relates a self-shock at the crisis of his affliction. He communicates his own sense of uncanniness when he tells us, after listening to Sebene describe him: "I was in another world".

The uncanny otherness (*étrangeîté*, at once strange and foreign) ricochets through actions the devastated family take to resolve the crisis. The most recent eruption, a few weeks before our encounter, pushed Sebene over the threshold of shocked passivity. A neighbor with a relative suffering an affliction similar to Omar's directed Sebene to a woman reputed for resolving such crises. As Omar's father lacked the money, Sebene came up with most of the 100,000 FCFA (almost $180, over twice the average monthly salary in Senegal) the healer demanded. At the subsequent three-day healing ritual attended by Omar's entire extended family, the violence of the ancestral *rab* talking through the foreign sounds Omar emitted matched only the fierceness with which the healer beat the spirit out of the boy's body. A scene, Sebene remarked, so painful even the men present cried.

Awa

In a similar way, Awa's multiple crises uncannily produce a stranger. When we meet Awa, she is singing in her mother's courtyard. She sings not only in French and Wolof, her mother tells us, but in Bambara and Spanish, although she doesn't "know" those languages. Awa once worked as a housekeeper for a famous marabout's wife, who appreciated her ability to prepare "white" people's cuisine like creamed dishes and *crudités.* Awa left to rear her children. She kept her home tidy and her children clean and meticulously dressed. Affliction struck Awa well

[14] Although Freud developed a psychanalytic theory of the uncanny (Freud 1919), our analysis of the phenomenon as an experience of horror and dread before the familiar-become-unfamiliar does not require that framework.

into her twenties, after an accident, just as it had struck a maternal aunt and paternal relative in later adult life, proof to her mother that a *rab* [ancestral spirit] wanders, displaced, in both families.

The uncanny erupted repeatedly in a liminal space separating the two Awas. Pre-affliction Awa had married the descendant of a village chief with whom her own family is allied. That Awa was "our adorable older sister", siblings tell us: excellent cook, organizer of family ceremonies, beautifully-voiced praise-singer. The later Awa wanders at night, entering neighbors' houses, opens their faucets and urinates on their kitchenware. In one crisis, Awa tried to smother her sleeping mother, as if, a sister remarks, "the *rab* had guided her there and told her to kill her." Still another time, the mother catches Awa threatening the children with a knife. During these states, Awa babbles senselessly or echoes the words others pronounce. Some nights, she screams into the darkness, awakening the entire village.

In these and other situations, the uncanny prevails over distinctions between a psychotic episode, seizure, or even possession state. Whether crises are erupting a first time (Omar's description) or successively (Faty's grotesquely swollen body and white head; Awa's murderous gestures), they trigger a search wrapped in uncertainty.

Navigating Vernacular and Vehicular Therapeutics

All patients and/or their carers embarked on trajectories punctuated by consultations with local healers and bio-medically-oriented services. Patients and carers distinguish *faju Wolof* (Wolof medicine) from *faju tubaab* (Euro-American medicine), paradoxically reproducing the binary that anthropologists critique (Cooper 2016). *Faj* means to cure, treat, heal, but also to resolve. (Carers also used the Wolof term *garab*: medicine, tree).

So-called *faju Wolof*, however, incorporates mores than the illness categories and rituals Fann researchers described for the Wolof ethnic group (Zempleni 1968). It includes a range of vernacular healing practices not confined to Wolof culture, as when a mother called highly acclaimed root-based (*reen*) remedies of her Seréer[15] healer *faju Wolof*. Also included under *faju Wolof* are herbalist remedies based on bark, leaves and herbs; gris–gris fabricated for protection by so-called fetishists; animal horns and concoctions purchased in markets to improve strength and other qualities; Islamic divination and prayer; Christian exorcism; diagnosis, divining and demon eviction practiced by *marabouts*; collective healing rituals led by priests and priestesses of ancestral cults. (*Ndëpp* ceremonies, well-known to anthropologists (Ndoye 2010), were not mentioned in our interviews). Practices and techniques can traverse different healing modalities. Thus, herbalists might use Q'ranic verses (*soura*) or marabouts prescribe plant-based bath preparations (*sangat*). *Faju Wolof* also includes the work of itinerant healers, like Hausa from Nigeria, who set up temporary shop and advertise on TV, radio, and visiting cards. Qualifying a healing practice as Wolof thus parallels the invented tradition of "Wolof clothes", including

[15] The third largest ethnic group in Senegal.

the boubou worn by Faty's grandfather (*yére Wolof*).[16] "Wolof" here indexes Senegal's ruling group and dominant (national) language rather than artifacts or practices specific to Wolof people.

Faju tubaab, by contrast, broadly designates Euro-American "white" medicine. (*Tubaab:* foreigner [usually European]; the color white). This category includes biomedical and psychodynamic treatment provided public and private facilities but also pharmaceuticals and, less commonly, seclusion and instruments like electro-encephalograms and scanners. *Faju tubaab* constitutes imported, vehicular medicine in relation to the homegrown vernacular, *faju Wolof.*

Obligations and Gifts

Resolution of the crisis requires the mobilization of kin, family and sometimes community. Even non-indigent families eventually struggle to meet the costs of resolving the crisis. Sebene, a municipal employee with an electronics side-business, drummed up the money Omar's father lacked. But Awa's family struggled and fell into economic ruin (*ruiné*) over time. Although Awa's mother had consulted healers, Awa became increasingly violent towards her. Awa's brother brought his sister to the public hospital in Thiaroye to have her involuntarily committed. But psychiatric treatment in Senegal (and the global South generally) requires the ongoing presence a family companion (*accompagnant*) throughout the hospitalization to feed and clean the patient, monitor medication and keep the patient calm. Family members therefore sacrifice employment or subsistence work (Awa's brother quit his security guard job) and stretch the unpaid labor of social reproduction to its limits. Alternately, kin hire an unskilled informal worker acknowledged but not regulated by the hospital as a companion (Diagne and Lovell 2019; Kilroy-Marac 2014).

Over time, competing kinship demands (children's education, a member's transnational migration for work, another's illness) dwindle resources needed to buy medicines and access treatment. Or patients stop medicines when side-effects become intolerable—Faty's grotesque appearance led his grandfather to halt the anti-epileptics—or when the delivery chain between the national pharmacy and local ones is ruptured. Crises of the uncanny resurge, rekindling trajectories and further mobilizing debts and duties in the moral economy of family and community, following the logics of what anthropologists call "Wolof solidarity" (Moya 2015) and (less felicitously) "African solidarity".[17] Thus, when carers like Awa's mother

[16] Wolof and non-Wolof, Muslim and non-Muslim Senegalese men wear fine boubous and babouche slippers and women dress in elaborate brocade, lace, *wax* (batiked) attire on Fridays, formal occasions and at gatherings of national pride. *Yére* [clothes] *Wolof* are commonly tailored from imported cloth, principally Dutch-manufactured wax prints, thus complicating the "ethnic" designation.

[17] Overlapping economic, social and historical processes, including the decline of post-Independence grand development projects; planned and unplanned urbanization; the consequences of SAPs imposed by the International Monetary Fund (IMF) and World Bank (WB); the related suppression of national health protection and state-financed medicines following the Bamako Initiative in the 1980s; and the effect of recent global economic crises on a nation-state highly dependent on remittances from those out-migrating have aggravated local scarcity (Buggenhagen 2012; Collignon 1984; Diouf 1992). Moral economy disturbances parallel the negative effect of broader processes on the economic transformation of public

state that the family member's illness "… has ruined us", they bring into play resources spent, debts solicited for repayment or newly incurred, and a large fabric of relationality frayed.[18]

The long illness of Awa's father ended her family's steady income flow. Awa's mother used up her money from *naat*, grass-roots rotating savings and credit associations common in Senegal that provide crucial insurance in a State where most citizens lack health or welfare coverage (Buggenhagen 2012). *Naat* members initially allowed Awa's mother to receive disbursements out of turn, despite the highly-regulated order of payees.[19] Finally, Awa's mother could longer pay the required weekly *naat* contribution. In the end, Awa's sisters declared, the illness ruined them, too. They, their husbands, their brothers all pooled money to find a cure. The extended family sold sheep, gifted them to marabouts, and provided goats for sacrifice. Having no more animals or money, Awa's mother traded the gold jewelry inherited from her own mother. Awa's sisters finally sold the gold heirlooms they received at marriage.

The flip-side of scarcity concerns gifts from non-kin and strangers. Successful athletes living abroad financed the treatment of some patients and donated money to one charismatic healer to support his patients. Mosque-goers gave money to the afflicted stationed in front of places of worship. One grandmother too feeble to cultivate her plot begged in the streets to help her afflicted, orphaned granddaughter.

For donors, larger donations and alms fulfil an obligation of religious charity. Though rarely enforced in Muslim countries (Bondaz and Bonhomme 2014), annual giving based on a percentage of one's wealth—*zakat* (Arabic); *asaka* (Wolof)—constitutes one of the five pillars of Islam. Most gifts we learned of constituted supererogatory charity, occasional payments that contribute to salvation beyond that legally decreed by Islamic scriptures. In some theological interpretations, divine reward even increases multi-fold when the recipient is infirm ((Bondaz and Bonhomme 2014: 356–357, 359), which may explain why strangers purchased medicines for or gave alms to patients we interviewed.

Thus, the moral and spiritual logic of alms and donations penetrate the realm of the strictly therapeutic. We now turn to other domains, which, reinforced by semantic networks in which the crisis is embedded, thicken therapeutics.

Footnote 17 continued
goods, such as now impoverished (or absent) public mental health services, especially beyond Dakar (Diagne and Lovell 2019).

[18] "*Feebaram bi daf ño daanel*": his illness made us fall into ruin. Some interviewees use the French, *ruiné*, implying financial deterioration and loss of health and energy. In Ghana, ruin can refer to the family's reputation because of non-marriageability of the afflicted member (U. Read, personal communication).

[19] Hospital care and transport for treatment constituted emergencies for which women solicited their rotating credit association in Dakar (Buggenhagen 2012).

Thickening the Therapeutics

The Semantics of Falling

The uncanny is interconnected with the divine, animals and gifts through the semantics of falling. Fann researchers noted the polysemy of the Wolofized term, *kiriss*, used interchangeably to designate epileptic seizures, psychomotor crises, spirit possession, acute anxiety of witchcraft victims and the "rage of manic-depression". Historian René Collignon asserts that Wolof people are concerned with causality rather than simply pragmatics of healing or cure in which uncertainty dwarfs the search for causes.[20] "In keeping with [Wolof] etiological reasoning", he writes, "[…] these crises are not seen in terms of sets of nosographic signs but rather […] of causal categories of interpretation that constitute the real principles of classification of disorders". (Collignon 2015: 164).

As we saw, *faju Wolof* includes more than Wolof therapeutics. Patients and carers use the Wolofized *kiriss*, but also a second term, "falling", introducing etiological ambiguity, as the following exchange between one of us (PMD) and Omar's cousin/carer Sebene suggested:

> PMD: *But what is "falling"* [daanu]? *Is it a seizure, a trance?*
> Sebene: [In that state] Omar *becomes agitated when he hears us speak. He doesn't see or hear anything* [that we see and hear]. *You can say he's in another world. And no one can stop him.*
> PMD: *Are these epileptic seizures?*
> Sebene: *No, trances. He is falling from the ancestral spirit* [Day daanu rab]. *You can say the rab is persecuting him.*
> PMD: *What kind of trance is it?*
> Sebene: *He doesn't recognize anything.*

Falling embraces physical, mental, and spiritual understandings of the affliction. Other carers and healers used *daanu,* Wolof for "to fall", to denote epileptic seizures (*day daanu kiriss*: "he fell from a seizure") as well as the eruption of dramatic psychotic symptoms like those Sebene describes above. *Daanu* belongs to the jargon of Senegalese traditional wrestling (*lamb*), and the afflicted's seizure resembles the wrestler's fall to the ground. Falling also indicates, as in the exchange with Sebene, the penetration of the body by a *rab* (*day daanu rab*: "he falls when the *rab* enters him", one carer explains). Omar himself attributed his crisis to a rab that had entered him when he jogged near the bush too close to nightfall.[21] Spirit

[20] This counters recent research in West Africa that suggests recourse to one or another modality takes place for pragmatic reasons, such as when indigenous treatments no longer work or psycho-pharmaceuticals produce side-effects (Read 2012). Furthermore, conjectures rather than convictions about what works and where to seek help shape where families of the mentally ill turn in the face of uncertainty (Read 2017).

[21] Arborio (2009) describes similar beliefs among Bambara communities of Mali.

penetration also happens beyond the therapeutic sphere, as when the divine enters someone during sacred chants (*dafa daanu leer*: "he fell from the sacred light").[22]

Some carers used a second word, *jell*, that translates as falling. It can denote divine penetration, such as of a bystander to a trance. Particular to the Mouride context, *jell* occurred more frequently in interviews in Diourbel, a Mouride holy city. Alternately, *jell* denotes the accident of falling into a cooking or other fire during a seizure: "He sometimes burns himself when he falls" (*su ame ay jell, mën naa am làkk-lakk)*.[23] The resulting burns can stigmatize the afflicted as incurable (Arborio 2009). Some healers told us they will not treat patients burned this way.

The polysemy and interchangeability of *daanu* and *jell* echo the semantic range of *kiriss*. All three terms can reference the "out-of-world" experiences psychiatrists would diagnose as seizures or the depersonalization of psychosis, but also other altered, liminal states of possession—experiences beyond the shared reality of here-and-now.

Dying Sheep and Becoming-Animal

The link between falling and animals heightens the sense of the uncanny generated by psychotic and epileptic crises. Onlookers assimilate the afflicted with dying sheep, describing seizures to us in terms of the sounds, motions and blood of sheep being slaughtered. Crises signal possible biological and social death. A carpenter, whose wife abandoned him to care alone for his nineteen-year-old son, Idrissa, likens his falling to dying sheep. Despite anti-epileptic medications, the boy experiences unpredictable seizures, making it too risky for him to work in manual labor. He suddenly becomes agitated. A force "stronger than me", the boy tells us, propels him into the street, where he runs until he falls. His father describes the scene, with great emotion: "My son's crises [kiriss] are so hard. He starts to breathe like a sheep being slaughtered. It's hard to watch. When he falls, he breathes with difficulty, and he hurts himself. Recently, he split open his head. Blood was everywhere on the street » .

Other carers make similar analogies. Four different patients are described below:

> One night, when we were all sitting in the courtyard, something struck Moussa while he was on the mat with the children. He started to move his arms, his feet and his head, like a sheep being slaughtered [*égorgé*: "its throat slit"]. As if he were dying".
> "Amina falls, she foams at the mouth, moves her arms and legs like a sheep being slaughtered"
> "Khadia's crisis is so strong it's like holding down a sheep [before slaughtering].".

[22] Note the resemblance to transverberation in Catholicism, in which God pierces the heart, establishing a contact between the spiritual and the material; and to ecstasy in other religions.

[23] The flicker of flames may trigger seizures, similar to the effect of flashing lights and high contrasts on photosensitive epilepsy. (We thank Leila Bordreuil for this remark).

> "Sometimes Sokhna's headaches are so strong – it is as if she sees something she must chase away. And then she falls. She tosses and turns on the ground, she struggles like a sheep being slaughtered.".

Healers further blur the line between human and non-human animality, but reverse the direction of the comparison. A marabout reputed for healing epilepsy forbids his patients to eat chicken. "When the chicken is slaughtered [*égorgé*], it struggles just like the epileptic who is falling", he explained to us. Ingestion of chicken meat transforms the afflicted into a headless chicken. Carers follow healers' injunctions. "I was asked to sacrifice so much", one mother complained. "Cows, sheep, goats, roosters, chickens—but on one condition, that [my daughter] not eat grilled meat or anything from a chicken".

The danger of becoming-animal can be thought of as a transgression of consensually created forms of life. Philosopher Stanley Cavell, commenting Wittgenstein, distinguished between horizontal *forms* of life—sociality, language—and vertical forms of *life*—the axis separating human from non-human biology (Cavell 1969). Veena Das, who introduced this aspect of ordinary language philosophy to anthropology (Das 2007), describes how a young Delhi adolescent with schizophrenia slides towards the non-human, becoming, in the eyes of maternal kin, like a monkey: hirsute, growing long arms and sneaking food, rather than eating with the family (Das 2015). Besides dying sheep, falling itself mimics movement along a hierarchy of dignity (Lovell and Barrow 1990), down the vertical axis towards animality. An uncanny becoming-animal is also manifested in other gestures, as when Awa constantly disrobes in the presence of others, crawls on the ground or eats soil. When her family buried the bones of the sheep their healer ordered them to sacrifice for her, Awa crept out after dark to dig up the soil with a spoon. Her ex-husband finally poured concrete over the spot. Awa's crawling rather than walking upright, scavenging in the dirt rather than eating from the family's communal dish, like Omar's sudden lion's strength, intensifies the descent.

For Deleuze and Guattari, becoming-animal disarticulates the subject, dissolving the body into flesh and fluids (Deleuze and Guattari 1988). In contrast to this emancipatory rhetoric, carer and healer imagery we recorded captures a temporary becoming-animal, a liminal state between human membership and complete otherness, painful to patient and carer alike.[24]

"Sheep Obsession" from the Everyday to Vernacular Healing

Analogies with dying sheep symbolically recall payment in animals as such and of animals for sacrifice in vernacular healing. Sheep sacrifice is common to Abrahamic tradition in Islam and to animist sacrifice in *ndëpp* and other *faju Wolof* rites. Goats,

[24] In *ndëpp*, the still-practiced Lebou-Wolof ancestral ceremony that fascinated Fann researchers, the community reintegrates the afflicted through the animal. Assistants tie the animal tie up, stretch it against the body of the afflicted and cover them with cloths (*pagnes)*. This human-animal proximity allows the *rab* to leave the afflicted body and enter the animal's. After the animal sacrifice, the now-healed person once again lies against it, feeling in its convulsive death throes manifestations the transactions undertaken with the *rab*. (Ndoye 2010). We do not have details on non-*ndëpp* rituals, such as that Omar's family participated in.

whose capriciousness, one healer told us, comes from *jinne,* also bear an otherworldly dimension. According to one healer, *jinne* seek the blood of goats, hence sacrifice can appease them. Offering a sheep provides mystical protection, assures healing, or bring good luck. Healers make specific requests, demanding sheep with particular markings, of a certain color, size or sub-species, criteria which may originate in the supernatural as much as in local economy.

This divine logic overlaps with a second logic underlying the place of sheep in everyday Senegalese society. Geographer Papa Demba Fall calls this logic, which combines accumulation of prestige and social capital with good luck through sheep, Senegalese society's "sheep" or "*ladoum"* obsession". (*Ladoum* top the elaborate hierarchy of distinction among sub-Saharan sheep). (Brisebarre, et al. 2009; Lewis 2014). Even in urban areas of Senegal, sheep visible on sidewalks, balconies or in restaurant courtyards convey prestige. Sheep hidden behind walls of a home communicate degrees of prestige through their bleating (each breed's sound is identifiable). During Senegal's most important religious festival, the *Tabaski* (Eïd al-Adha), Muslim families slaughter sheep. Owners, family and close friends, including non-Muslim, receive and consume the meat. Other sheep parts are distributed raw to the poor. Sheep are very much alive: they breathe, bleat, bleed, eat, excrete fluids, reproduce, and family members feel affection for the household sheep they raise, even knowing these will be sacrificed.

Onlookers can liken epileptic seizures to dying sheep because of their familiarity with ordinary and ceremonial scenes of animal slaughter. The logic of sheep obsession in the everyday connects to vernacular healing in other ways. Providing sheep (and other animals) for sacrifice combines the logic underlying spiritual and supernatural evocation with the logics of forms of capital (Bourdieu 1977/1972; Bourdieu 2011). To sell, give away or sacrifice a sheep for healing means losing actual and potential wealth (economic capital) and prestige (symbolic capital) as well as the capacity to build and maintain social relations (social capital). Within therapeutics narrowly defined, then, sheep are convertible into gifts to the divine; in everyday life, the same sheep allow owners to amass economic and other forms of wealth.

Secular-Divine Politics of the Gift

We have shown how the semantics of falling links the crisis of the uncanny, social logics and and the divine. Here, we examine a third element that thickens therapeutics, namely transactions whereby treatment, healing or calling upon the divine is exchanged for payment in money or in-kind. The logic of the gift thus enters the domain of vernacular healing.

In both vernacular and vehicular systems, payment for healing involves a three-way exchange between donor, recipient, and reciprocator. In Senegal's vehicular mental health services, the donor (patients, their representatives) hands money over to the recipient (institution, its agent) whose reciprocator (doctor, nurse, other health agent) furnishes treatment in return. In private mental health care, money may be given directly to a clinician (recipient/reciprocator), but we found few such examples.

In *faju Wolof*, however, at least four types of three-way exchange are possible.[25] The simplest type involves money or goods exchanged for treatment, as when a mother (donor) pays a healer (recipient) to fabricate a gris–gris for her son. Although apparently dyadic, the exchange is usually triadic, the reciprocation being enacted through the divine intervention of a virtual actor. God "causes" the illness, the healer "cures" or not; thus the cure almost inevitably involves the work of the divine.[26]

In the second type, the help-seeker (donor) gives alms (*sarax*) to a needy person (recipient) in return for healing interventions. The healer (reciprocator) specifies the category of the recipient. A marabout instructed parents we interviewed to give part of the meat from a sacrifice to an indigent (recipient); in another, they were told to give money to the poor. In Islam and other monotheisms, alms comprise an indirect gift to God. Reciprocation (healing) is again partly realized through divine intervention mediated by the work of the marabout.

In the third exchange process, a healer (reciprocator) instructs the help-seeker (donor) to provide a direct gift to spirits or the divine. Several family members were instructed by marabouts to slaughter a goat, eat it and bury its remains in the family compound, to appease *jinne* (indirect recipient). A "priest" (reciprocator) might order a different offering, such as when one asked a head-of-household to make sacrifices to the spirit of his lineage (*tuur*) in the hopes that the afflicted would be cured. The sacrifice may also be carried out by the healer (recipient/reciprocator), to whom carers (donors) provide sheep, cows, roosters, millet, kola nuts, cloth, or other in-kind gifts for that purpose. The sacred intervention may also be sought directly in prayer.

The final three-way exchange in fact involves a request so unreasonable that healing is deemed unachievable. The impossiblity of complying with the request, which we call the "preposterous gift", communicates to the potential donor that the affliction is incurable. This is illustrated by what the family spiritual guide (*seriñ*) sought from Awa's mother. She despaired of ever seeing Awa cured after the *seriñ* demanded specific numbers of white sheep and of black sheep. Her despair was complete when he then demanded she also gift him a black cow. Notwithstanding the mystical significance of colors, numbers and animal sub-types to which she was hardly privy, Awa's mother lamented:

> In our village, I am the legal representative (*jëwriñ*) of our *seriñ*. He's our spiritual leader. He knows I do not have the means to find a black cow! It means he cannot cure Awa. I am his disciple. Why did he not simply say, 'I have heard your request. I have understood it. But quite frankly I can do little, because my spirits (*rawaan*) are opposed to Awa's spirits.'

[25] This section owes much to Bondaz's and Bonhomme's (2014) analysis of the gift and sacrifice in Senegal.

[26] One healer explained the process to us thusly: the plants he uses and the *soura* applicable to a particular affliction—the "diagnosis"—appear to him during a nocturnal trance. He then prepares a concoction (*sangaat*) from plant powder into which he pours the root-based ink with which he has written the *soura* on a tablet. The afflicted drinks the liquid, which materializes the God's intervention. In other words, healers' medicines are potentiated through the action of spiritual power. They are not mere *materia medica.*

The place of the divine in these four types of exchanges in local healing thickens vernacular therapeutics by tapping a dimension beyond therapeutics narrowly defined. Health providers claim that families *always also* turn to *faju Wolof*, even if mental health services are available, because, in the words of one physician we interviewed, "[the affliction] is of another order" than the diseases of biomedicine. The secular-divine logics of gifts that mark patient trajectories, being of that "other order", or register, radically differentiate the payment transactions in vernacular healing from the monetized payments exchanged for vehicular mental health services.

Back to the Future: Thick Therapeutics Meets Global Mental Health

Earlier, we referred to the post-colonial therapeutic imaginary of Fann School ethno-psychiatry, a dream of accommodation through a hybrid formation of French psychoanalytically-informed biomedical psychiatry and vernacular healing anchored in the lineage system of Wolof and Lebou people (Zempleni 1968). Fann's founder, Henri Collomb, even travelled to Ivory Coast, Senegal's non-Wolof Casamance region, and elsewhere, hoping to learn from vernacular healers (Arnaut 2006). Over time, Senegalese psychiatrists replaced Europeans, mostly rejecting the ethno-psychiatric project, and international bodies like the WHO promoted a new cross-cultural psychiatry standardized through Anglo-American psychiatric nosology, epidemiology, tools and treatment (Bullard 2007; Lovell 2014).

Today, Senegal's mental health professionals often assume that families fall into economic ruin from pursuing vernacular healing, when they could pay less for effective mental health services. Were these services and pharmaceuticals readily available and affordable, the *ruiné* argument goes, Euro-American-derived psychiatric and psychological treatment would attract people away from vernacular healing.

On the surface, this position runs counter to global mental health's renewal of interest in healers and its declaration that they provide the major treatment recourse worldwide for severe mental illness. Global mental health objectives include "co-opting [the] penetrance and cultural acceptability and presence of traditional healers to deliver conventional [biomedical] treatment 2000)." (Gureje, et al. 2015: 175). Researchers promote studying collaborations between local and biomedically-based mental health to produce an evidence base about whether cross-referrals allow patients to benefit from each system's effectiveness. These proponents also consider recourse to healers a partial solution to the shortage of mental health personnel in the global South (Nortje, et al. 2016), just as in the 1970s the WHO promoted healers in primary care as a solution to health care scarcity in rural areas. Senegal politicized this issue by developing an exclusive juridical category, the "traditional practitioner" [Collignon 2000; Fassin 2000]).

However, for the "*ruine*" argument to hold, payment/gifts in vernacular healing and pay-for-service vehicular mental health must be commensurable, or comparable according to a common standard or rule. This assumption fails in settings like Dagomba plant-based medicine of Northern Ghana, where "money spoils the

treatment", summarized analogically as *money: non-monetary exchange:* : *immoral : moral* (Bierlich 1999). Such sharp differentiation does not hold for peri-urban Senegal, where paper currency may be exchanged in vernacular healing, just as an animal or produce may be offered (albeit more rarely) to a physician when the family is pleased with the treatment. Generally, though, the vehicular treatment of *faju tubaab* must be paid for in paper currency. Patients refer to this payment metonymically as the *ticket de guichet*, actually a tab provided by the billing service and shown to hospital personnel to access services.

In short, payment-for-service and payments-gifts each belong to different universes of reference. How might they be brought into dialogue with one another? Thinking with concepts of translation and incommensurability offers some light. New ethnography of incommensurability (Mair and Evans 2015) reminds us that values and their communities of origin are historically constituted. Hence, encounters across borders like the vernacular/vehicular divide can result in the more powerful party denying difference or positioning itself as the possessor of superior knowledge and values. In other cases, dialogue proves evanescent, as when bordered worlds remaining "hopelessly trapped in their own symbolic systems and webs of belief" (Mair and Evans 2015: 208).

In peri-urban Senegal, our research suggests, commensurating payment-gifts and payment-for-services would require extracting payment-gifts from the deep relationality of other social formations, such as alms, sacrifice, in-kind gifts, and human-animal relations. An act of comparison might *in*commensurate, reproducing and epistemically-grounded power inequality, were vehicular medicine to fail to acknowledge the moral and other dimensions underlying exchanges for healing by vernacular healers.

Conclusion

In peri-urban Senegal, the crisis of the uncanny signals a far more complex reality than psychotic and/or epileptic conditions alone and their therapeutic management. The spectacularity of the unfamiliar and of what the onlooker perceives as transgression of human forms of life triggers the search for resolution. This in turn mobilizes the moral economy of debts, duties and obligations among kin, household, community, but also the logic of gifts and alms from strangers. The meaning of the crisis emerges through a chain of associations linking multiple social domains, whose logics spill over into the therapeutic sphere. Semantic networks of "crisis" and "falling"; the divine, affect, and relationality imbued in sheep; and the secular and divine logics of gift-giving thicken vernacular therapeutics into an assemblage continuously pieced together through the movement of patients and carers seeking resolution to crises over time.

Thinking about therapeutics writ large in this way, from an anthropological position anchored in everyday life rather than the clinic, can generate insights for mental health futures in areas still untouched by global mental health programs and policies. This paper focused on one component of the assemblage—that which is exchanged for treatment and related interventions—to suggest how vernacular

healing might articulate with the vehicular therapeutics of a global mental health. We selected this component because the *ruiné* argument, a received view among to critics of vernacular healing, assumes that recourse to the vernacular eventually devastates patients and their entourage economically whereas psychiatric and psychological services, if available, would be cost-effective.

Yet monetary and in-kind payments and gifts exchanged in healing transactions cannot be easily monetized in the same terms as the payment-for-services of vehicular therapeutics. Vernacular transactions are shaped by human-animal relations and a politics of gifting and sacrifice non-reducible to monetary value. On the contrary, internationally, policies determine the standardization and monetization of vehicular transactions, which are monitored and evaluated through health economic models using the currency of global donors and global markets. To simply reduce vernacular transactions in these monetary terms risks diluting their therapeutic thickness, one defined by forms of life which the afflicted, their carers and healers experience and reproduce.

How monetary and other norms and standards of vehicular mental health will be perceived by the weaker epistemic community in this story—patients and practitioners of *faju Wolof* who also turn to *faju tubaab*—remains to be seen. But economic anthropology and sociology provide many examples of how social actors in radically different places and times bend and differentiate money, regardless of its source, for new purposes and within reconfigured relationality (Buggenhagen 2012; Hart 2015; Zelizer 1997).

For now, global mental health remains opaque, uncertain and elusive in the overlapping domains of psychotic disorders and epilepsy in Senegal. However, other "globals" are at play, captured in our opening vignette, when Faty's grandfather is told that only a great marabout can treat the stubborn epilepsy inflicted by powerful transnational Islamic spirits. He knows what Indian *jinne* have wrought on weaker healers, stricken to the ground.

So, it is the marabout who falls this time, in a move metaphorically linking opaque globalizing forces with the ongoing uncertainty both biomedical psychiatry and local healing produce when faced with ongoing crises in trajectories of patients with psychoses and/or convulsive epilepsy. The marabout's story encapsulates the power of the "foreign unknown" surrounding uncanny afflictions but perhaps also the unknown of a global mental health to come.

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Compliance with Ethical Standards

Informed Consent Research for this paper was approved by the Comité national d'éthique et de recherche en santé (CNERS) of Senegal. Informed consent was obtained accordingly from all individual participants included in the study.

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