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“L'heure de Dieu est toujours la meilleure”

A Puggy

ABSTRACT

A Catholic Association is opening up new psychiatric centres in Benin. Its aim is not only to take care of the mentally ill people, often abandoned in the streets or shackled, but to radically transform local perceptions about madness. This ethnography examines how mental illness is conceived as embodied, that is, as a physical condition rather than a mere mental state. Moreover, it analyses how the Association's discourse is rendered effective through the transformation of the mentally ill's bodies and the construction of new social subjects. Five months of fieldwork research in one of its new centres allowed me to investigate its members' perception about mental illness and the ways they make their new belief system effective in changing cultural conceptions about madness. Considering that the 'madmen' are culturally categorised by particular body aesthetics, the conscious transformation of their bodies has an impact on local understandings. Embodiment and practice theory are useful approaches to analyse how cultural conceptions are modified through the introduction of new practices toward the mentally ill and a discourse that sustains them, using the body as the ground for transforming local perceptions. Methodology included interviews with staff members and patients, and participation in the Centre's everyday practices.

Keywords: mental illness, body, madness, Benin, practice theory, embodiment

> "I was hungry and you gave me food, I was thirsty and you gave me drink, I was a stranger and you welcomed me; I was naked and you clothed me, I was sick and you visited me, I was in prison and you came to me."
>
> Gospel of Matthew, 25: 35-36

Introduction

I am crossing the corridor of the administration building when the nurse stops me. She is speaking to patients' relatives before starting with consultations. She interrupts her talk and says she wants me to take a picture. She points to a girl curled up on the floor and states that she is chained. When the nurse finishes her conversation she explains that the girl's relatives went to look for the key, and that it would be me taking her chains off. The girl is looking around with a bewildered and frightening face, moving her feet within the chains, sometimes moaning with a low voice. While she is touching her feet with a trembling hand, she says it hurts.

Chaining mentally ill people is common practice in Benin, and in West Africa in general. Many patients asserted that they had experienced this condition during their life. Usually priests or traditional healers utilise this practice: the mentally ill are attached to a tree with a one meter chain fastened to their ankle, or their arms or legs are imprisoned into a log, similar to Tall's (1992: 77-79) description of a healing centre in Benin. Madmen can be restricted in this way for months, years, or their entire life. All the people I saw being liberated wore some iron cuffs around their ankles, which restrained their movements. Others roam like invisible entities throughout the streets. Often naked, they look for food in the rubbish.

When the key arrived the girl was immediately let free. The Association Saint Camille de Lellis "Oasis d'Amour" strictly rejects any physical means to contain patients. It was founded in Bouaké

(Ivory Coast) in 1983 by Grégoire to take care of the mentally ill abandoned in the streets, and to free the ones kept in chains in the villages, *les oubliés des oubliés* (the forgotten of the forgotten) as he calls them. Grégoire was a tire mechanic. On the edge of committing suicide God stopped him: something like a current passed through his arms and made him drop the pills and the glass of water he was holding in his hands, while he heard a voice telling him "The life you've got inside isn't yours, you don't have the right to extinguish it". After a pilgrimage to Jerusalem a sentence in a priest's sermon astonished him and changed his life: "what stone are you carrying to build Christ's Church?". Back in Bouaké he halted for the first time to look at a naked madman delving into the rubbish to find some food. He had seen many people like him before, but this was the first time he recognised Christ himself in that ill body, because Jesus had indeed identified himself with ill, poor and abandoned people. While at the beginning he was going to the streets to give those people some bread, he soon understood that something more should be done for them and he built the first Association's psychiatric centre in 1992. From that year many others were constructed in Ivory Coast and Benin, due to the incredible therapeutic success and the free of charge treatment. Western medicines are utilised in addition to prayers and education, as it will be explained in the ethnography.

The Association's mission is not limited to the care of the mentally ill, but strives to change people's mentality about madness and the practices associated with it. It explains to the public that the mentally ill are not dangerous and are not mad, but that they only have an illness like many ordinary people. Moreover, they state patients are not bewitched or possessed by spirits in opposition to local understandings of madness.

The following ethnography examines how cultural conceptions about madness can change in Benin thanks to a complete transformation of the mentally ill body and a new way of having contact with the 'madmen'. The new discourse the Association is spreading becomes increasingly influential precisely because it is embodied in everyday practices and patients' bodies. This is possible because madness is immediately perceived through body aesthetics, in particular matted hair, dirty torn clothes, and long nails. I will analyse mental illness only from its bodily expression, stating that it is a disorder of the body as much as it is of the mind.

Since the publication of Benedict's (1934) article on abnormality, many anthropological studies have investigated the relation between mental illness and society (Scheper-Huges 1979), and examined the field of ethnopsychiatry (Kleinman and Good 1985). Moreover, there exist many works on healing practices (Prince 1974; Abdou 2007), the impact of modernity on medical knowledge and traditional practices (Janes 1995; Leslie 1977), and on changing conceptions about mental illness (Narter 2006; Wagner et al. 1999). For example, Abdou (2007: 37) analyses a healing cult in Benin and the ways it is efficient, having consequences not only on physical pain "but also on emotional and psychic conditions". My aim is not so much to describe how the curative process works in accordance to cultural understandings, but rather to understand how a new discourse can change cultural conceptions thanks to its embodiment in everyday practices and in patients' bodies, through the creation of new social subjects.

The Association's mission enlightens some issues about cultural change, because medicine should indeed be conceived "as a cultural system, a system of symbolic meaning anchored in particular arrangements of social institutions and patterns of interpersonal interaction" (Kleinman 1980: 24). Introducing a new kind of medical system has implications on the ways illness is perceived, because clinical practice "creates particular social worlds", of which beliefs about sickness are one aspect (Kleinman 1980: 38). The idea of mental illness is indeed a belief system used to explain deviant behaviours, of the same kind of the belief system that implies witchcraft as cause of madness (Szasz 1960), explanation widely diffused in West Africa (Ahyi 1997; Iroegbu 2005 ; Prince 1964, 1974). Having the Association introduced a new system of thought in Benin

with a different terminology, I will use the words madness and mad as neutral terms which enclose both the traditional term *folie* (and *fou*) and the Association's notion of mental illness, which are contrasted one to the other by the Association's discourse.

The new belief system spread by the Association goes much beyond mere linguistic expression because it is embodied in the new way patients are made social subjects. While people are used to seeing a mad person as dirty and uncured, the transformation of his body deletes the expected image, and instead portrays one of a sick person. New patients are indeed shaved, washed, and dressed up with clean clothes. A completely different appearance is the ground to eliminate the label of *fou*, while supplying the meaning gap with the new notion of mentally ill. In fact, because aesthetics is an important tool to socially define somebody (Turner 1980), reshaping the mentally ill's physical appearance has a great impact on changing people's way of thinking. This change is apparent in staff members, all of them former patients, because of the importance of new everyday practices, and a different experience of the mentally ill to change cultural conceptions.

This thesis is structured as follows in order to analyse how this new medical discourse produces new conceptions about madness rejecting traditional explanations that understand madness as the result of witchcraft. In the next section, a theoretical discussion on embodiment and on the transformation of cultural conceptions will be made to show how this ethnography is located in contemporary anthropological debates and which contribution it brings to them. Then, the ethnography is divided in two parts. The first part shows how madness is culturally categorised by the physical appearance of the *fous*. I will then analyse how mental illness is conceived as embodied by my informants. Moreover, the difference between spiritual and physical illness will be examined to claim that refusing witchcraft as causal explanation shifts mental illness from the spiritual realm of illness to the physical one like every other bodily diseases. The second part of the ethnography analyses the way the Association is changing local conceptions about madness through the transformation of patients' bodies. Following Ortner's (1989) idea of cultural change, I show how a transformation of cultural conceptions can be brought through the introduction of new practices sustained by a discourse. In particular, the discourse is not only embodied in those practices, but also in the mentally ill body. A radical change in its physical appearance renders the person not immediately perceived as a *fou*, leaving a meaning gap that can be filled through discourse, constructing a new social subject: the mentally ill person.

Embodiment and the transformation of cultural conceptions: a theoretical discussion

Embodiment

Since the 1970s there has been a growing attention to the body in anthropology. Many analyses emphasised its social character and its continuous transformations and redefinition (Csordas 1994; Taylor 2005). The body became a social reality that can enlighten about cultural and social conceptions (Turner 1980). Douglas described it as a “microcosm of society” (Douglas 1973: 101), claiming that “the social body constrains the way the physical body is perceived. The physical experience of the body, always modified by the social categories through which it is known, sustains a particular view of society. There is a continual exchange of meanings between the two kinds of bodily experience so that each reinforces the categories of the other” (Douglas 1973: 93).

Since the mid-1980s the Western duality mind-body has resulted problematic for anthropologists, and has been considered ethnocentric because many societies do not make this distinction (Scheper-Hughes and Lock 1987, Kohrt and Harper 2008: 465). Since then, many attempts have been made to overcome the dichotomy: from the concept of “the mindful body” by

Schepher-Huges and Lock (1987), through "the body in the mind" by Thompson (Strathern 1996), to the notion of "embodiment" by Csordas (1990, 1994, 1999). While the last approach seems to be the most used, Ots (1994) criticises the term because it implies a superiority of the mind over the body, which is perceived only in Western countries (Ots 1990: 26). He hence introduces the German term "Leib", which reflects the unity between the two realities. Notwithstanding, I prefer to use the notion of embodiment because it can be applied to other concepts, for example an embodied discourse. To stress the unity of mind and body I will sometimes refer to the mentally ill body, a term that implies embodiment without the mind prevailing over the body, and renders the illness an attribute of both mind and body.

Csordas's approach is also useful for my analysis because it positions culture within the body. The idea of "the body as the ground for culture" (Csordas 1990) is fundamental to understand how the Association strives to change cultural conceptions about madness in Benin. The transformation of the mentally ill body is indeed used as the ground for changing cultural understandings. The body is no longer just an object in relation to culture, but is the subject of culture (Csordas 1990: 5). Csordas (1990) uses the notion of embodiment to explain how the practice of glossolalia (speaking in tongues), used for healing in a Pentecostal movement, brings together language, gesture and emotion, thus creating a unity of mind and body. In a similar vein, Dein (2002) analyses how there is a close connection between the physical and the spiritual, and between religious words and body during healing sessions in a Jewish community. The concept of embodiment is useful for my case study, because mental illness is not only strongly reflected in physical appearance, but it was also perceived as a bodily condition among my informants.

Practices, embodied discourse and cultural change

Since the 1970s practice theory had tried to describe how cultural and social change occurs. According to Ortner (2006: 18), a cultural transformation takes place when the "*schemas* through which people *see* and *act* upon the world [my emphasis]" are broken. In my case the Association's discourse is powerful because it changes the way the world is perceived, creating a new belief system that is assimilated by members while experiencing it. I talk about powerful discourses in line with Foucault's assertion that discourse, power and the production of truth are strongly interconnected, because "relations of power cannot themselves be established, consolidated nor implemented without the production, accumulation, circulation and functioning of a discourse", a discourse based on the production of truth (Foucault and Gordon 1980: 93).

To analyse social transformations Bourdieu stated that the habitus, conceived as "a subjective but not individual system of *internalized structures, schemes of perception, conception, and action* common to all members of the same group or class" (Bourdieu 2006: 414, my emphasis), is not only produced by the structure (in my case old conceptions about madness), but also "by different *modes of generation*, that is, by conditions of existence which […] cause one group to experience as natural or reasonable practices or aspirations which another group finds unthinkable or scandalous, and vice versa" (Bourdieu 2006: 409, author's emphasis). That is to say, a different way of having contact with the mentally ill can change perceptions about madness and hence the behaviours and practices toward the madmen. However, Ortner (1989) finds that practices alone are not enough for changing "culture". She argues that a change can occur only if new ordinary practices come with a new ideological system, which plays an important role in shaping consciousness (Ortner 1989: 207). In other words, new practices must be supported by discourse to produce change. Instead of keeping this sharp distinction between the two aspects, my analysis will show how Ortner's ideology is actually embodied and is expressed through practices, in line with Comaroff's (1985: 5) idea of rethinking "the relationship between ideology as explicit discourse and as lived experience". A similar analysis was made by Wade (2011), who explains how gender equality is achieved

through learning dance in an ideologically committed community. The discourse spread by the Association is indeed embodied in practices and expressed through the body and its governance.

Moreover, in contemporary debates anthropologists are trying to overcome the separation between knowledge and bodily practices (Lock 1993:136). The following ethnography responds to the need for more research on the topic. This need results from the great transformations in the medical discourse in Third World countries which have "important implications for the organization and understanding of the body and its position in the social order" (Kuipers 1989: 105).

Fieldwork setting and methods

The Centre where I lived for almost five months was the third centre opened in the country by the Association and the first one in the North of Benin, a region where Western psychiatric knowledge has not arrived yet. It was inaugurated during my stay. A few days after my arrival the first mentally ill people were collected (*ramassés*) from the streets, and others were brought by their relatives. When this psychiatric hospital was officially inaugurated one month later, there were already 118 interned patients, and 106 living with their families but coming once a month to take pills and some of them an injection. When I left the field, they added up respectively to 204 and 221. The hospital was designed to host around 200 people, but Association's centres are usually overcrowded. The mental illnesses that were diagnosed during my stay included schizophrenia, various kinds of psychosis, neurosis, depression, epilepsy.

This was the first hospital where staff was exclusively composed of ex-mentally ill people (about 35 members) still under medical treatment, with the exception of the nurse who had nonetheless suffered of mental illness in the past. Patients can easily become staff members when they start helping in the everyday duties, such as cooking, washing clothes, cleaning, taking care of the others. It was through these informants that I could notice a far-reaching change in madness conceptions. This change was possible thanks to participation in the Centre's activities, while experiencing and learning daily practices through the abounding relations with patients. Living on an everyday basis with the mentally ill not only allows staff members to have a different view on their disorder, but it is a platform for building up and assimilating new conceptions.

Staff was divided in two groups: the community (*communauté*), which was exclusively composed of six girls, some of them nuns, including the nurse that was also the Centre's director. The community resides in a particular building, different from the two quarters for the mentally ill (separated by gender), with the privileges of having a toilet in the room, and eating different food from patients. Community members have at the same time more responsibilities, being in charge of the pharmacy, the cash box and of going to the market. Every member of the personnel (*personnel*) is instead responsible for one room and of the mentally ill sleeping there. Their duties are cleaning the Centre, doing the laundry, check if each patient has eaten and taken his pills twice a day, preparing food, organise prayers, and so on.

My residence in the Centre enabled me to participate in the everyday practices and community life with the mentally ill. I was not only listening to the nurse and the founder's discourses repeated over and over again, but I could talk and interview staff members and patients. Participant observation was hence a method utilised on an everyday basis by helping staff in their duties. I was also following and doing myself consultations with new or external patients, which was important to learn which kind of behaviours are clinically considered abnormal. Open ended interviews and informal conversation with staff members and patients concerned mostly their stories and understandings of their and others' illnesses. Unfortunately the nurse, the only owner of authoritative knowledge in the Centre, was always too busy to have a formal interview with me. Nonetheless we became close friends and many informal conversations were held. In particular, our night conversations before going to sleep often yielded to precious information about the Centre's

problems and people's health. Being her confidante, I was always abreast of what was going on.

Before starting the ethnographic analysis, it is crucial to note the importance of Catholicism in the Association's new belief system. Religion plays indeed a central role in the way members' worldview is shaped, as will be evident in the following ethnography. Every conversation (everyday informal conversations as well as interviews) was full of religious references, and very often they answered to my questions mentioning the Bible. The great majority of my informants were deeply religious and dedicated to prayers, and many of them undertook an ecclesiastical education to become nuns, monks, or pastors before getting mentally ill. Moreover, the Association and its mission is recognised by the Vatican as part of the Catholic Church. The founder and the nurse always claim to be mere instruments of God: his hands and his feet.

The mentally ill body

There were five people in the blue pick-up truck. The founder was driving very slowly and I was sitting next to him. He was attentively watching around with a sharp look to find the mentally ill. He seemed to me like a predator searching for the next quarry. When I turned back I saw the nurse doing exactly the same: we were hunting. Suddenly the vehicle slowed down and pulled over. The founder took down my window and said to a dirty and dusty man walking in the street "Good morning! What's your name? Come with us!". One of the two guys on the back of the pick-up held out his hand. The man said his name, took the hand and jumped on the vehicle. We had arrived to the new Centre only two days before and it was the first time we were collecting (*ramasser*) a group of mentally ill people from the streets. When they arrived at the Centre they were shaved, washed, their nails were cut, clean clothes given, and they were given an injection without a previous consultation to state their mental health: physical appearance was enough to understand that they were ill. The Centre was still not officially inaugurated, but many persons came in the following days to bring their mentally ill relatives.

It was in general easy for the Association's members to identify mentally ill people in town. They roam around in dirty and torn clothes, if not naked, often with uncured matted hair, and long nails. According to Turner the body is treated "as the frontier of the social self" (1980: 112) and the cultural categorisation of the mad person in Benin strongly follows aesthetic lines. Asking an informant how he could tell whether a person was mad, his answer concerned the patient's physical appearance: "have you seen how his hair was? He doesn't wash himself, and his shirt was completely torn. *C'est un fou ça*. (This is a mad person)". Common reference was made to nudity (even if I did not see any case during my 5-month stay) and long matted hair. It has been argued that sociocultural values are most clearly expressed through embodiment, thus inscribed in the body (Strathern 1996: 197; Becker 1994: 100). In particular, the body can express "deviation from cultural norms" (Becker 1994: 112).

The arrival of a 'visionary' in the Centre is an exemplary case to illustrate that physical appearance and bodily behaviours are fundamental to detect mental illness. When I saw him the first time he was waiting in the hall with his hands tied on the back by a rope whose end was held by a relative. He had very long nails, dirty clothes, and his hair was completely matted forming a unique dense mass of knots with some disordered locks dangling from his head and chin. We untied him. I took him by the hand and we went to the showers. On the way he explained to us that God gave him a vision, but his family says he is mad and nobody listens to him. The striking thing was that in the consultation with his mother, no mention was made to what he claimed, neither to the question "Does he sometimes say I'm the president! It's me the...something he's not.

Does he sometimes say I'm that I'm that?", whose answer was negative. They said the reason why they brought him was that he wanders a lot, laughs alone, and beats people, which represent more bodily signs instead than the context of his talking. As Strathern (1996: 3-4) points out, mental illness could not be studied if its expression would be only 'mental', but it concerns "some bodily states that [are] indubitably 'there'". And in this case they were much more important as characteristics of mental illness than the way his mind works. In other words, it was not so much the content of his speech that made his being perceived as *fou*, rather other bodily behaviours, including the slightly aggressive way with which he was recounting his enlightening. For staff members his vision actually made lots of sense.

However, there were some cases were disagreement arose concerning who should be taken from the streets. Once, two staff members got out of the pick-up truck and came back supporting a very dirty woman that could not walk well. When they came closer the founder stated: "Is she [mentally] ill? She's a disabled person. Leave her there. Leave her there", he said with a low pitch, "beggars aren't [mentally] ill people". Beggars are indeed dirty and uncured, but they do not roam aimless through the city, and they usually have a small plate in front of them to collect money. Moreover, the founder explained to me that, in case of doubt, talking to them would clarify if the person is ill or not. Yet, I never witnessed a situation like this during my stay, because physical appearance was always enough to understand the mental health of the individual.

It is worthwhile to note that the *fous*' physical appearance differs depending on gender. Still, when asking how to recognise a mad person, staff members always referred to male individuals. In particular, the word *fou*, masculine in French, is used for both genders and I rarely heard the word *folle*, the equivalent for females. My informants stated that when cured you become human again. That is to say that the *fous* are not considered as human in all respects, and gender does not matter so much. Nevertheless, mentally ill women can be recognised from their uncured and dirty state too; hair does not form locks as for men but are usually untidy, while regular women braid their hair.

Embodied mental illness

Since the mid-1980s anthropological attention has focused on the difficulty of maintaining the separation between mind and body, a Western distinction inherited from Cartesian philosophy. Descartes sharply distinguished the body as *res extensa*, implying its physical and spatial existence, from the mind which is instead immaterial (Strathern 1996: 3). It has been noted that the sharp Western distinction between mind and body is not present everywhere in the world (Scheper-Hughes and Lock 1987, Kohrt and Harper 2008: 465), and should hence be overcome from an analytical point of view. As seen in the theoretical discussion, there has been various ways to deal with such dichotomy to emphasise the integration of the two aspects. To show this unity, my analysis on mental illness takes into consideration only the physical dimension of the disorder, while such illnesses is usually implicated in the mind.

Yet, Lambek (2006) made an interesting point in the discussion. While anthropologists look at other cultures to overcome the Western dichotomy mind-body, this distinction is widely present around the world but not in the same form as in our culture, that is, the way the relation mind-body is conceptualised varies from society to society (Lambek 2006: 425). In my case, the distinction between the concepts of mind and body existed among my informants. Following the Catholic differentiation among body (*corps*), soul (*âme*) and mind (*esprit*), on which Descartes drew his philosophy by collapsing the soul in the mind (Strathern 1996: 41), they stated that there are two dimensions in mental illness, spiritual and physical, which are strongly interconnected and interdependent. The fact is that when they talked about the spiritual they never conceptualised it as

what we mean with mind.

Spiritual versus physical illness

In West Africa madness is generally perceived as the result of witchcraft or spirit possession (Ahyi 1997; Iroegbu 2005; Prince 1964, 1974). According to the Catholic perspective the only means for recovering from such attacks is by praying. Part of the Association's commitment is to spread the idea that there is neither witchcraft nor possession in mental illness. The impossibility of demoniac presence within its centres is proved by the existence of a chapel in every hospital and the practice of praying every day, which should keep away evil actions such as witchcraft. Their assertion that there is no witchcraft in mental illness was often accepted because the Centre was perceived as God's house (*la maison de Dieu*), where the Devil is not powerful enough to penetrate.

In Benin not every illness is attributed to witchcraft. A sharp distinction is indeed traced between natural and spiritual illness. While the former derives from natural causes, the latter is provoked by witchcraft. Spiritual illnesses are invisible and cannot be explained through Western medical examination, e.g. X-ray. If you have recurrent headaches it is very likely that you have been bewitched. The same if you have some strong pains but medical tests indicate that everything is fine. Traditional healers are hence consulted to find the cause and a treatment. They are able to understand the source of the problem through their clairvoyance, and can provide the person with the right infusion. Some exorcists are instead able to extract the invisible source of pain from the person's body through praying. These objects, which become visible after having been extracted, vary from needles, to entire snakes or fishes (Fanou 2008). According to the Catholic point of view, spiritual illnesses can be cured only through prayers, while medicines are needed for physical ones. While spirit possession is considered therapeutic for mental illness by some traditional healers in Benin and Nigeria (see respectively Abdou 2007; Prince 1974; Strathern 1996, ch.7 for others accounts in the world), it was considered an evil manifestation within the Centre and absolutely different from mental illness.

However, there have been some cases in which the two domains were confused and competition by different actors arose to find a cure. Here are two examples that show how spiritual disorders can be mistaken for mental illness and the other way around. They show that medicines work on mental illness, that is physical, while they do not have any effect on spiritual disorders. The first case regards a young girl brought to the Centre by an exorcist. The night I met her she was sitting on her bed in the darkness screaming and moaning because of her pain. I could see her skinny and naked figure thanks to the candle that was smoothly illuminating the room. Her hand was trembling while caressing her legs which she felt full of bruises and sores. They burn so much that I cannot wash them anymore, she was telling us, there are worms eating my flesh up to my bones, “Ah! My feet! My feet! It hurts! It hurts!”. Sometimes she felt snakes moving inside her chest. The girl was aware that nothing could be seen on her legs, as she could not see anything either, but she was sure that it was her aunt who sent her a spiritual illness through witchcraft. The nurse put her under psychiatric medicines. She responded well to the treatment and pain was diminishing. Suffering of additional physical diseases she was sent to the hospital in front of the Centre to be cured. They made her abandon her psychiatric treatment, in the understanding she was bewitched, and after a week her anguish started again. This was proof that she was suffering of tactile and kinaesthetic hallucinations, instead of a spell by her aunt. Few days later they prescribed her psychiatric medicines again because everybody eventually agreed that her pains were due to kinaesthetic hallucinations and not to invisible spiritual wounds.

The second case is instead of spiritual nature. One of the young nuns working in the Centre was put under pills because of visual and acoustic-verbal hallucinations, and temper troubles. In the past she lived at the place of an exorcist with the hope of ending her suffering, which she explained as attacks by her fetishist sorcerer father. Something happened one night I spent away from the Centre. The nurse was waiting for me in her consultation office the morning after. “Marilyn had a crisis last night. I was praying in front of the Virgin Mary's statue when I heard her screaming 'Leave me! Leave me! Don't kill me!'. I couldn't get in because the door was locked from the inside, so I prayed while walking around her room”. After these words she stood up and invited me to go with her to see how she was. When we arrived the door was open. From the nurse's question “Who opened the door?” I understood that somebody had spiritually entered in the room during the night, and she did not think it was the girl herself to have unlocked it. On the girl's cheeks there were four lines of dry blood and two on the forehead. We could not find anything in the room sharp enough to cut herself in this way. Even her nails were clean.

We called an exorcist we knew well and he demonstrated to all of us the presence of a spirit controlling her body, and stated it was him that had made the scarifications, representing the father's ownership of that body. Scarifications are indeed widely used in Benin as a sign of kinship. An unusual proceeding was undertaken: not only the community and me were called for praying in her room, but all the mentally ill were also assembled for prayer at an atypical hour of the day. The reason is that spiritual attacks can be fought only through God's action. Medicines do not have any effect. Our hospital was not anymore the right place for Marilyn, who was therefore sent to live in a prayer centre.

Moreover, it is important to notice that even if spiritual illness is invisible and immaterial, and conceptually conceived in contrast to physical illness, it was clear for everybody that it is embodied. As Lambek (2006: 425) argued, notwithstanding the distinction in thought, the dualism is “transcended in practice”. It expression cannot go beyond the body of the sufferer. Even if the first case does not concern a spiritual illness, it shows that in local understandings it is felt in the body, as sores, worms, and snakes for example. The same for spirit possession: scarifications, a sign on the body, were provoked by an invisible entity possessing the person. Csordas (1990) analysed how the expulsion of demons resulting from Charismatic healing is expressed through physical manifestation, and are thus always embodied.

In sum, a natural illness differs from a spiritual illness for its origin, symptoms and treatment. While the former derives from natural causes, the latter is provoked by witchcraft. The manifestation of the distress varies as well: while many behaviours of a possessed individual can resemble those of psychiatric patients (like talking a lot or being aggressive), possession is distinguished from mental illness for its rejection of Catholic symbols such as the cross, the holy water and the rosary. In Marilyn's instance, the bloody signs on her face were strictly linked to the work of a voodoo spirit. It represented the scarifications of her family and it was a way her father used to claim his ownership on the girl. Such acts have never been witnessed by the nurse in a mentally ill person. Finally, a way to understand a person's affliction is by the treatment's effectiveness. If medicines do not have any effect on spiritual disorders, they do work on mental and natural illnesses.

Mental illness as a natural and physical disorder

The notion of madness is usually conceived in anthropology as a social construction, because the distinction between what is considered normal and abnormal behaviour is cultural and dictated by society. Apart from this differentiation at the basis of the conceptualisation of madness, culture influences also the expression of deviant behaviour (see Scheper-Hughes 1979: 79-80, Kleinman and Good 1985: 3, Good 1997). Benedict (1934) noticed that some cases which would be judged aberrant in Western countries can be accepted elsewhere and sometimes even considered

honourable. For the Association, the diagnosis of mental illness follows the dichotomy spiritual-natural. This sharp differentiation between the two domains is emphasised by the Association to explain that mental illness has nothing to do with witchcraft. In agreement with the sharp distinction between natural and spiritual, mental illness becomes hence natural just as other general illnesses. Moreover, the term spiritual was not only put in contrast to natural, but also to physical. The result is that mental illness becomes a physical disease. My findings confirm Strathern's (1996: 4) statement that "once we recognize that there is a mental component in all bodily states and, conversely, a physical component in all mental states, the boundary between mental and other illnesses disappears".

The Association very often compares mental illness with general physical illnesses. In particular, a parallel with hypertension and diabetes is made when explaining that mental illness is temporary and can hence be cured. They state that even if the medical treatment will last for the patient's entire life, the person is nonetheless cured: it is like with hypertension or diabetes, if you regularly take your pills you are not ill anymore, but when you stop then you get sick again. Comparison with the same diseases was made too when explaining that medicines are not enough to cure. There is a need of a good atmosphere within the family for the person to recovery:

> It is not only medicines that cure, the same for those who suffer from hypertension. Now, there is a thing, if you know that something you say will make him get upset and every time you keep on saying things that will upset him. Can it work like that? It is the same for dad at home: every time you know that what you say will upset him, and every time you say it. If your dad suffers of hypertension, also if he's taking his pills, his blood pressure will rise! And then he can fall down and become paralysed, and then they will say it was his children that provoked it. It was the children. Is it good like that?

Not only mental illness is compared all the time with other general diseases, but it is considered as a physical illness in every respect. The main point is that it is curable through medicines, that means it is an illness of the body.

Spiritual and physical dimensions in mental illness

Mental illness is perceived as a physical illness by the Association. It is not seen so much as a mental state, but rather as a physical condition. I was told that people become mentally ill when their brain receives a shock, or a hit. Staff members, all of them former patients, understood worries (*soucis*) as the major cause of mental disorders. Worries force you to think and reflect so much that the brain heats up. Reference was often made to the meninges: everybody has some worries, but one becomes mentally ill when the worries pass through the meninges, which happens when somebody has thought a lot. For another informant the meninges mix themselves, with the consequence of being unable to reason anymore correctly, because the brain is not working properly. It is from here that one starts to do abnormal things. Reference was made to the nerves too, stating that the nerves in the brain do not work well anymore after having received a shock.

However, some staff members stated that there are two dimensions in mental illness: physical and spiritual. Even if the two terms are always found in contrast to one another, it is said that mental illness is shaped by both components. They actually use the word *côté* (side) implying that the two dimensions form the two sides of the same coin. Defining what the spiritual context meant for my informants is challenging. They always refer to something immaterial and invisible, in contrast to the physical and natural world. But it was never taken into account as what we conceive as mind. In fact, the spiritual realm does not coincide with our idea of mental states, but transcends it. It is rather a dimension of life regarding religion. Some staff members see the reason of their illness as a consequence of having looked too much for spiritual advancement, that is becoming closer to God, while neglecting their bodies. "We are human beings, so we need to be fed", they once stated. The following excerpt consists in a dialogue between two staff members at the arrival of the visionary:

P: We threw ourselves in the spiritual and we forgot and neglected the body.
S: We forgot we are humans.
P: We forgot we are humans. Thinking about praying, praying, praying, we forgot to feed our body.
S: Yes! It's possible, at least for me. I got ill in 2008. I haven't been eating foooor two weeks, maybe three weeks.
P: Three weeks! Without eating, without drinking.
Me: Three weeks without eating and drinking?!
P: Yes! Yes!
S: At least I was drinking water in the evening.
P: That one [the visionary] said he spent one week without eating.
S: He spent one week without eating.
P: Me too, me too! I spent seven days without drinking and eating.
S: Does it depend on craving for getting spiritually elevated?
P: Yes! That's what I'm saying, we neglected the body.

For staff members, the causes of their mental disorders are indeed recognised in bodily needs such as lack of sleep, but the mind was never mentioned. These people who wanted to become spiritually closer to God abstained from food and from sleep for long periods in favour of praying, to be able to *voir claire* ("see clearly"), in the footsteps of Jesus who fasted for 40 days.

From a spiritual perspective staff members perceive their suffering as an experience that will allow them to share and understand other people's suffering, and to be able to help them thanks to a new empathy. At the same time the spiritual can refer to mental states such as wrath. But wrath is not spiritual because it concerns the mind, rather because it is connected to the religious sphere. Wrath, like other strong bad emotions, is considered as the influence of an evil spirit animating the body. It is not possessing the body, but it influences it in a negative way. Therefore, there is no need for an exorcist's deliverance, but the person can simply be calmed down by the people surrounding him or the right ambience. A bad emotion cannot come from God, whose Holy Spirit brings enlightenment and wise thoughts, but it is rather the influence of the Devil. Some informants stated that sometimes they can hear two inner voices, one saying "Do that!", the other "Don't do that!"; in this case they need to understand which one comes from the Holy Spirit and which one comes from the Devil. The Devil can hence have a bad influence if the person follows the wrong voice.

It is said that the spirit, holy or evil, animates the person and is strongly connected to the kind of mentality one has at a certain moment. When I asked my main informant from where he thought his illness came, he told me about the eve of the day he became ill:

> Consider that first I was in the rain, then the sun beat down on me. So, there was already a change of temperature. Malaria took hold. This is the physical context. Now, if we take the spiritual context, I was a bit angry. I was asking God why my sister had died. Because she did good things for people. Why did she die?

He asserted in another interview that it was the wrath itself that caused his burnout (*surmenage*), and made him do things he did not do before. From a religious perspective he should have accepted his sister's death because it was God's will. His bad thoughts could only be provoked by an evil influence that made him pose himself too many questions about the matter, and enter into an angry mood. What is interesting here is that despite the fact that wrath belongs to the spiritual realm, it is inseparable from the physical domain in my informant's point of view: blood pressure increases, temperature rises, and insomnia sets in. The two dimensions come together and the dichotomy mind-body cannot be held within my informants understanding of mental illness.

Congruency of the treatment with cultural conceptions of mental illness

Many analyses have been written about the efficacy of healing processes in concordance to cultural understandings (Erinosho 1997: 165; Iroegbu 2005: 78). My case study shows how the treatment given in the Centre is effective because it reflects local views, while dealing with both cultural dimensions of mental illness. It is composed of medicines (*médicaments*), prayer (*prière*), and education (*éducation*). Leaving aside for the moment the aspect of education, the first two components reflect the natural-spiritual elements. The belief that mental illness has to do with the body is confirmed by the acceptance of medicines (pills and injections) as remedies for the illness (Luhrmann 2000: 6), as seen above. Also traditional healers treat madness physically through herbal infusions to drink and to wash with. Experienced staff members found the Centre's healing process effective exactly because it takes care of both dimensions, in contrast for example to priests who treat only the spiritual side. God cures instead both features through the Association's work, acting through medicines. One informant drew a useful metaphor: it is like when a snake bites you. You need to kill the snake and to medicate the injury. If you do not treat the wound, you are going to die. If you only treat the wound the snake will bite you again. This is the reason why if you get cured only through medicines, the illness returns, and you will relapse.

As for other physical diseases, medicines should hence be accompanied by prayers to render the treatment effective: “we only treat the person, but God cures him” was a sentence repeated all the time. This means that the Association only takes care of the mentally ill, in particular by providing Western medicines, but without God's action they are powerless. God cures both illness dimensions, and treats patients' bodies through pills and injections. He is the best doctor, and taught medical knowledge to humans. In fact, God is the author of every recovery, according to the nurse.

Prayers are so important that the community assembles five times a day around the Virgin Mary statue, whereas some staff members responsible of prayers gather the patients in the *apatam* (a circular hut where people can assemble enjoying the shade) at 6 and 18 o'clock after the bell has been rung. Many patients join spontaneously. Many others are brought by hand by the personnel regardless of their religion. Praying is indeed one of the regular routines that must not be neglected. Moreover, a mass is held in the Centre every Wednesday.

The main concern of this first part of the ethnography was to show the unity of mind and body in regard to mental illness through an examination of the mentally ill body in Benin. When referring to the spiritual realm, staff members do not perceive it as our idea of mind, rather as a religious dimension that can bring them to commit wrong actions and thoughts. Moreover, it is fundamental to understand that the Association wants to change local perceptions shifting mental illness from the spiritual realm to the physical and natural one. This move allows them to state that there is no witchcraft influence on mental illness, but it is a natural illness like many others. Furthermore, the importance of body aesthetics to define social subjects (Turner 1980) allows the Association to change cultural conceptions about mental illness through the transformation of the mentally ill body, as I will examine in the next part of this ethnography.

Transforming cultural conceptions about madness through body transformation and embodied discourse

The body as the existential ground for culture

Not only mental illness is perceived by staff members and patients as embodied, but the mad person is categorised mostly through bodily aesthetics. Changing the physical appearance gives a new status to the mentally ill. New patients are shaved, washed, and clean clothes are given upon their arrival. This ritual has a double function. The most discernible reason is to give new dignity and identity to the person as part of the therapeutic process. Body appearance involves indeed the "construction of the subject" (Turner 198: 137), and it is the ground on which the mentally ill acquire a new social identity. From an outcast avoided by people he can become somebody, a regular person. The most hidden concern regards instead the interest in changing traditional perceptions of mental illness. The public's vision of the mentally ill expects dirty and dishevelled people. Showing them as clean and tidy patients has an impact on their cultural conceptions. Douglas (1973: 93) noticed not only that society "constrains the way the physical body is perceived", but social categories can change through "the physical experience of the body". She identifies two kinds of body between which there is a recurrent exchange of meanings, which substantiates cultural categories: the physical body and the social body. This sharp distinction is untenable for many cultures because it follows the nature-culture dichotomy (Csordas 1994: 5) and cannot be used for populations that perceive their individual identity as social (Scheper-Hughes and Lock 1987: 15), and their bodily care involves the "cultivation of social relationships" instead of the individual personal appearance or identity (Becker 1994).

I rather prefer Csordas's (1990) idea of the body as the "existential ground for culture", in which the body is not anymore a cultural object to be analysed but the subject of culture (Csordas 1990: 5). He uses Merleau-Ponty's phenomenology which places the starting point of perception in the body and not in external objects (Csordas 1990: 9). Objects become as such only after have been perceived. They are hence the result of perception and are not just empirically given. This eventually leads to the incorporation of subject and object. The body of a mentally ill person is immediately recognised to the one of a mad, because of a cultural category inscribed in the body that defines them. In this sense culture is embodied, or in other words the body is the ground for culture, because these social categories shape the way we actually perceive the world. Culture is

found at the basis of perception (Strathern 2006: 37), as the social is inseparably carried within ourselves (Csordas 1990: 10).

In Benin, matted and dirty hair, torn clothes or nudity are culturally decoded and lead the public not only to distinguish the person as mad, but also to behave in a particular way toward him or her. When the visionary was taken to the shower he strongly rejected the idea of being shaved. He stated that he is like Samson, whose power resided in his hair. They finally managed to shave him just by talking to him, without any use of force, even if he was complaining during the procedure and asking them several times to stop. The most relevant point made by a staff member to convince him was that when he would be shaved, people would finally listen to him and be interested in his vision. Being shaved is considered handsome in Benin and many regular men and boys, included patients and staff members, like to keep a hairless head. Some women prefer to have short hair too, and in the Centre they could choose if to be shaved or be braided.

Physical aspect plays an important role in the way people approach and act towards a mentally ill person. However, what is pointed out is not simply that culture is inscribed in the body of the patient through particular signs, rather that everybody immediately perceives through some cultural categories the person as mad. Without those signs, madmen cannot immediately perceived as such. Another exemplary case to understand the impact of perception in the shaping of practices toward the mentally ill concerns a patient who arrived with his hands tightly tied behind his back by a rope and having the typical physical aspect described above. He was a good and quiet fellow when in the Centre and a personnel member was spending lots of time with him. One day I showed the staff member the pictures I had taken at the Centre. When we reached his friend's pictures he could not believe that he had arrived in those conditions. If he would still have those long hair, he would be scared and never approach him.

In addition to the cleaning rituals held at the new patients' arrival, there is a need to keep them in decent conditions during their stay in the hospital. The nurse prompts staff members every day to keep the Centre clean and patients proper. Showers are taken every morning at 6.15. While it is unusual that every patient showers every day, the nurse went sometimes herself to check that everybody has been taken from the room and washed. This happened regularly for important events such as the Centre's inauguration or Christmas when a mass was held in the Centre's church, with the invitation of the population at large.

Filling a meaning gap through a powerful discourse

Changing the physical appearance removes the social signs of madness and leaves a meaning gap that must be supplied. In fact, physical transformation is not enough to change local perceptions about madness. The meaning gap must be filled in some ways. There is a need of ideology, in Ortner's conceptualisation “as public and inflected culture” (1989: 200). She nicely showed how cultural and social change cannot take place only through the imposition of new practices, because there are situations in which they acquire new meanings in accordance to old understandings. She made a comparison between two Sherpa populations living in different regions of Nepal, where in only one case new practices brought structural transformations, that is when these new practices were supported by an ideology. I will use Ortner's conceptualisation of ideology as “public symbolic forms and public definitions of reality” (1989: 201) as an alternative term for powerful discourse. As a matter of fact, ideology always entails power (Comaroff and Comaroff 2006). Power can be analysed as the “capacity of human beings to shape the actions and perceptions of others by exercising control over the production, circulation, and consumption of signs and objects, over the making of both subjectivities and realities” (Comaroff and Comaroff 2006: 387). The Association's discourse is powerful because it consists of a struggle over knowledge with the aim of becoming the hegemonic system of thought in regard to mental illness. This battle is pursued also

through the modification of physical appearance and becomes part of what Scheper-Hughes and Lock (1987) envision as body politics.

Describing body politics as "the regulation, surveillance, and control of bodies" (Scheper-Hughes and Lock 1987: 7), which involves power and control (1987: 23), the body is taken as a passive object. Lyon and Barbalet (1994: 49) argued that notwithstanding the interest of social sciences in the body since the mid-1980s, the body was considered only as the outcome of social processes which the individual cannot control. Thus, the body was never examined as a social agent. This seems the case of the Association I was studying, which transforms the *fou* body in the body of a mentally ill person, often without the patient's consent. Yet, the same body has an active role that cannot be neglected. Its transformation is not only the ground for changing madness conceptions, as we have seen above, but produces a new social subject. Physical transformation is not enough to make the change effective, but social subjects are produced through practice (Ortner 2006: 16), and in my case by a new way of experiencing and approaching the mentally ill. Foucault (1982: 208) outlined three different modes in which "human beings are made subjects". One of those is of interest here, that is the division from others, for example through the construction of a sharp separation between the notions of mad and sane. As for the opposition spiritual-natural, the Association stresses indeed another dichotomy: ill-cured.

When talking to relatives the Association emphasises that when patients are dismissed they are cured, and they will be as long as they regularly take their pills and the monthly injection. It is perceived as an on-off state: or you are ill or you are cured, but you can never be both. Behaviours are always indicators of the person's mental state, ill or cured. Moreover, there is always an emphasis on previous behaviours, giving to 'cured' a relational meaning. The label 'cured' concerns hence former and current behaviours. In contrast to the nurse affirmation that when somebody becomes part of the staff is cured, an informant stated that she could not tell if some staff members had actually recovered because she did not know how the illness started with them, and how they behaved before the medical treatment.

Being mentally ill is always perceived as a state which has a beginning and, in the majority of cases, an end. Parents and the nurse always refer to when the person got sick (*tomber malade*) as something that happened and marked a change in the individual. Recovering is a process and the nurse asserts that "a bit [of the illness] still remains" ("*ça reste encore un peu*") until the person can be considered cured.

The ill-cured distinction follows again some aesthetic criteria. The physical transformation of madmen is not enough to render them cured, but it change the image of a *fou* in the one of a mentally ill. Notwithstanding the attention to cleanness and everyday hygiene, the mentally ill in the Centre were often rendering their clothes dirty or torn, wearing many pieces of clothing at the same time despite the heat, walking around slowly and some of them all day long. But there are other elements that distinguish a cured person from a patient, as shown by this excerpt registered during a consultation between the nurse, the visionary and his wife while announcing that he would be released few weeks after in order to check how he would feel after an injection:

> Have you noticed that sometimes when you speak saliva comes out of your mouth? So, we are going to adjust this first. Because while you are talking to your children you shouldn't dribble. Mmh? So, we're going to adjust all that. […] We need to manage to adjust it, by the grace of God, to adjust all that first. Because I don't want to see you talking at your children, and then saliva comes out of your mouth. You speak and your hand starts trembling. Mmh? That's not good. Then [when we'll have adjusted it] you'll go home. […] And if she [your wife] tells you something, that she has seen something and she corrects you, there is no reason to get upset. You need to accept it and change. 'Ah! You're walking but your arm doesn't swing well'. You've to swing your arms as I balance my arms. You've to listen to her for your own good.

In another occasion, when the nurse made the monthly health check of every interned patient, she asked a man if he had washed himself that morning. At his positive answer she questioned why he did not change his clothes: “Look at them! They're dirty”. She continued stating that if he kept himself so dirty she could not let him go home. It is evident that physical appearance plays a great role in the definition of being cured.

Staff members often claimed their own cured state in opposition to patients. They usually did it in relation to some privileges they felt entitled to. For example, they usually claimed it when asking for better food and not the same of the mentally ill: “je suis pas malade!” (*I'm not ill!*). Worthwhile to note is a situation when the nurse told a new staff member that he should cut his hair, which were not much longer than how many men keep them in Benin. “But I'm not *fou*!” he answered. That shows again a correlation between physical traits and the dichotomy ill-cured. In this case a new staff members refused to be shaved, as new patients are, because he wanted to distinguish himself from the mentally ill.

In Benin, *folie* is traditionally considered incurable. This does not mean that treatment by healers does not have any effect on the mentally ill's suffering. Most patients have recurred to traditional healing practices, and some were satisfied. But the problem always arose again after some time, often with worse symptoms. Instead, God cures in the Centre, and forever if medicines are taken. As seen in the first part, it is essential to take pills for one's entire life to keep healthy and do not suffer from a relapse. But when is somebody considered cured? When a new concept was introduced through the establishment of the Association's system of thought, there existed a great discrepancy among my informants' understandings. Only time can tell us if this multivocality is just a step in a process of complete homogenisation or if it is the beginning of a syncretism of strikingly different worldviews. Cultural change is indeed not immediate, but it often takes long time (Ortner 2006: 9). Some staff members judge somebody cured only when the person can abandon medicines altogether. This hence excludes staff members from this category. Others perceive as cured whoever stops to present abnormal behaviours, manifesting only good ones. Another informant, confirming the multivocality, perceived a distinction between the terms cured and *retabli* (recovered), concepts that are by others taken as synonyms. A *retabli*, she stated, is somebody who is still not cured; there are still some secondary effects as his eyes rise at determined moments, he dribbles, his neck is wrung.

The idea of mental illness as an on-off state concerns relapses too. When somebody has a relapse the person falls again in the status of ill, and this move is usually evident from his body. I remember noticing patients or staff members having a relapse from the way they were moving their eyes: or constantly watching upward even while talking to somebody, or staring at a certain point for few second changing gaze to look at another spot in the same way. Those were things they had stopped doing in the Centre. An exemplary case to show that physical appearance can be more relevant than other behaviours to recognise a relapse concerns a staff member caught in washing one pair of trousers over and over again in the middle of darkness, without answering to our calls. The following morning I was stupefied that he could remember the happening and stated that he wanted to wear those trousers the next day. I asked to the nurse if she was sure he actually had a relapse. The answer was: “Haven't you seen he was naked?!”. This shows again the prominence of his physical appearance over the apparently illogical act.

Yet, in which ways does body transformation play an active role as the ground for changing cultural conceptions about madness? And how is the meaning gap filled through an embodied discourse? From an ideological perspective, the Association is very strict about clarifying that patients are not mad, but ill. Whenever somebody talks about a relative in terms of *folie* it is immediately corrected, often also in a rude way, saying "we don't want to hear anymore that he's *fou*, he's mentally ill!". This emphasis is used in a twofold way. First, while the term *fou* is culturally connected to witchcraft, the concept of mentally ill enters in the category of general illnesses, as we have seen in the first part of this ethnography. Second, the term mentally ill provides a new category to portray this population, creating a new group of social subjects. Ideology provides a category with which to fill the gap of meaning left by the transformation of the mentally ill body, while embodying the Association's discourse. We usually tend to connect knowledge to language "but knowledge is not only coded in linguistic systems" (Crick 1982: 300), being in this case transmitted through physical expression.

As the new concept of being cured is reinterpreted in various ways, the same applies for the new notion of mentally ill. In the case of changing the perception of a *fou* to the one of a mentally ill person, there remains still uncertainty about the assumptions of the term *fou*. That means that not all new categories were yet assimilated, leading to multivocality. Let me sum up these multi-voiced positions: first, somebody sees mental illness as a concept to be substituted for *folie*; it is just a different label given to the same population, which for new patients does not exclude witchcraft causation of the disorder. They are aware that it is just the same body but transformed. Second, *folie* is perceived as the last stage of mental illness, the worst stage; in this case the traditional conception that madness cannot be cured stands only for the *fous*. Patients' bodies are an indicator: those persons are not able to take care of themselves, e.g. keep clean just after showers. Third, *folie* exists, but cannot be found in the Association's centres; the traditional understanding of *folie* as been caused by witchcraft and been incurable is thus accepted, but it is something completely different from mental illness.

Change in cultural conceptions about madness through a new experience of the mentally ill

As seen above, the Association's discourse aims at changing cultural perceptions and understandings surrounding madness. There is at stake some "cultural politics in which people struggle over 'ideology' - public symbolic forms and public definitions of reality" (Ortner 1989: 201). Not only ideology inscribes the body, attributing to certain physical characteristics a meaning, but it becomes embodied in practices. In other words, ideology not only gives meaning to the transformed body of the mentally ill distinguishing it from the *fou* body, but such discourse, apart from being spoken and repeated over and over again, is transmitted through a new set of practices toward the mentally ill person. According to Taylor (2005: 746), discourse involves the cultural construction of bodies through practice within specific social relations.

In one of his visits, the founder gave a talk to staff members as usual. His speeches were not only impressive for the way they encouraged the personnel to work harder for a really small "wage", but also for spreading personal conceptions. He repeated many times that "*il faut briser le mur de la peur*" (it is needed to break the wall of fear), explaining that there is the necessity of making people understand that they do not have to fear the mentally ill. He continued stating that people expect to hear screams and shouts when passing in front of the Centre. That they expect the mentally ill to have fights all the time. Staff should not quarrel or the public would say: ah, this is the *fous*' house! If we wouldn't be here there would be nobody to help these persons. Because nobody approaches them. "I was like them too, I was afraid. Everybody was scared of fou people before getting [mentally] ill. And now, are you afraid? [Staff members answer "no!" in unison] So we need to break the wall of fear! Fulvia was scared too before coming here, right? Do you think she'd have stayed if she'd still be afraid?"

What is striking about this talk is the fact that the Centre needs to give an impression completely different from what the public expects from madmen to change people's minds. The most fruitful way to change perceptions happens indeed through close relations to the mentally ill, but of a different type than those with the *fous*. This confirms Jackson's assumption that "the habitual or 'set' relations between ideas, experiences and body practices may be broken. Thus altered patterns of body use may induce new experiences and provoke new ideas" (2006: 327). New practices and new experiences are in my case facilitated by the transformation of patients' bodies.

Bourdieu's (2006) approach has been criticised for hardly taking social change into account (Strathern 2006: 28), being "the practices produced by the habitus […], always tending to reproduce the objective structures of which they are the product" (Bourdieu 2006: 407). Nevertheless, what remains interesting in his approach for explaining social transformation is the impact of experiences, which "produce the structures of the habitus which become in turn the basis of perception and appreciation of all subsequent experience."(Bourdieu 2006: 409). Experiences are strictly linked to the production of shared and approved meanings over practices (Bourdieu 2006: 410). That is to say, a different way of having contact with the mentally ill can easily change perceptions on the matter, and hence behaviours and practices toward the mentally ill. For this purpose the transformation of the *fou* body into the one of a mentally ill person is fundamental, because previous experiences with the *fous* are not immediately connected with the one of the mentally ill.

Change in cultural conceptions about madness occurs mostly through close contact with the Association's techniques and practices which go much beyond the mere linguistic expression. Discourse is not only embodied through the transformation of patients' bodies, but also through practices. To begin with, the Association emphasises that it is not the illness itself that renders them dangerous, but it is the way we approach them. Such approach entails physical contact besides verbal expression, as shown below. According to the nurse, if people use the right approach there is no danger, the mentally ill would not get violent. In a talk with relatives before starting with consultations, she stated:

> [When there are mentally ill people in the street] we see them and we avoid them. [We think] they're aggressive, they're violent. They aren't violent. They avoid coming closer. From the smile you're gonna give them, the food you're gonna pay for them […], by dint of speaking, talking to them in that moment it's[the danger] ended. You're not gonna be aware about when they'll give themselves to you, because they'll start to have confidence in you, and when you'll tell them to get on your motorbike, they'll get on and then you can drive them until here. […] I know it's not easy, but if you approach them you'll see how everything becomes easy. Do you understand?

Therefore, they should be listened to, kindly approached, be talked to, and they will not be in anyway aggressive. "We say they're violent but it is us who render them violent. It's ourselves that render them violent" she concluded in another talk after stating that even if a mentally ill person lifts a knife, if we gently talk to him he will unknowingly put it down.

Staff members practices are representative of what the right approach entails. When the 'madmen' are collected from the streets by the Association or at their arrival at the Centre they are approached with a smile: "*Bonjour ma sœur/mon frère!*" (Good morning my sister/brother!). They hold out their hand and ask "how are you?" while shaking hands. I always noticed surprise in the mentally ill eyes: this is the way people greet in Benin, but people usually do not go closer to the *fous* nor greet them. At their arrival at the Centre they are taken by hand or arm and slowly accompanied to the showers. The cleaning rituals are pursued without the need of force, as seen for the visionary case. If the new patient refuses, they first try to convince him by dint of talking and offering him food. It sometimes happened that the patient got violent and needed to be calmed down through an injection that made him sleep. If this was the case, he would be washed and shaved when he wakes up. The Centre's atmosphere is most of the time quiet and relaxed. Patients sit down under the trees or under the shadowy *apatam*, some of them alone, others talking in group and playing traditional games.

However, there are situations, and in particular some practices, which at a first sight seem to be incongruent with the Association's discourse. What happens when a patient has a crisis and violently throws rocks at people around him? Or she or he directly beats staff members and other patients? The smily, gentle and talkative approach is not used: the patient is knocked down, blocked, then injected. This practice is called *terrasser* (to knock down) and it is so common, that it is part of everyday practices. It is always used when a patient refuses to eat or taking pills. Five or six staff members, less if the patient is quiet, lay the person on the ground. Some of them keep head, legs and arms still. The mouth is opened with force through a spoon. Then, liquid food or pills with water are inserted while patient's nostrils are blocked, and the person has no choice other than to swallow. While this practice disconcerted me for the first month, I understood later on that it was part of education. As mentioned previously, medicines, prayers and education form the core of the Centre's therapeutic process. Education entails all the everyday practices of staff members toward the mentally ill that aim to correct abnormal behaviours. For example, teaching patients that they should not sit at the table where the community eats. Every time they do, they are taken by hand and brought outside if they are quiet, or with force if they refuse. Often orders are given, such as "wear well your shoes!". Many people stated it is like with children, you have to teach them everything. Most of those practices are embodied, that means they aim to correct some physical behaviours, e.g. walking around the Centre completely naked. In contrast, patients stating they were the Beninese president were never corrected in their wrong thoughts and were actually called by everybody with such appellative. They would realise they were wrong on their own while recovering, sometimes neither remembering they used to say so. The main concern of education thus regards the care of body.

While the Association strictly rejects any means to restrain patients the violent practice of *terrasser* is considered necessary and unavoidable. If somebody refuses to eat, they cannot let him starve. Moreover, patients start eating and taking pills voluntary after few times they have been knocked down. The therapeutic process never terminates before patients eat and take their pills spontaneously. The same for showering: patients are taken by force and washed until they start to do it on their own.

I cannot actually tell what the impact on the population at large was and if the work of the Saint Camille effectively managed to change people's conceptions about madness, but it had an enormous impact on staff members' understandings, on which I focused my research. This was not only due to their mental illness experience, but also through the everyday contacts with patients. The founder's wish is to employ only former patients in his centres because they are *dans l'esprit de la Saint Camille* (in the Saint Camille's spirit), that is they have a new conception of mental illness, which refuses witchcraft explanations of madness. Moreover, they have more empathy with patients having learnt to take care of the mentally ill in the same way somebody else had taken care of them. While the Association's discourse is assimilated in different ways, as seen for the multivocality surrounding new concepts, the practices that embody it are instead homogeneous.

Ortner (1989: 207) stated that cultural change can occur only if new social practices are accompanied by an ideology that sustains them. Practice alone cannot work, as well as ideology alone cannot work. She argues that new practices alone do not bring cultural transformations because consciousness - "the inner or subjective structures of thought and feeling" (Ortner 1989: 207) - is partly moulded by the ideological system. She explains this stating that the public symbolic order (ideology) "has a certain autonomy because its production and maintenance are to some extent the product of a separate realm of social activity which one may call cultural politics" (Ortner 1989: 200). However, I have shown how the cultural politics, which aims to render new public symbols hegemonic, not only are embodied in the mentally ill body through its transformation from the *fou* body, but become introjected and embodied through practice and the right approach thanks to the new kind of experience people can have of the mentally ill. I hence prefer speaking about a unity of practices and ideology. Even if some practices seem to be in contrast with the discourse (e.g. *terrasser*) they actually are not. They are indeed understood according to the new social subject of the mentally ill: a person that somebody has to take care of until she or he recovers, as for whatever general disease. Separating practices, that is techniques of the body (Csordas 1994: 5), from the ideological system seems to me like suggesting again a sort of dichotomy body-mind. In sum, I prefer to envision a "unitary field of body-mind-habitus" (Jackson 2006: 328) in which ideology is embodied to change cultural conceptions about madness.

Conclusions

This thesis analysed mental illness through its bodily expression. In this way I wanted to show how the dichotomy mind-body should be overcome when anthropologists examine mental illness (Strathern 1996). Moreover, mental illness was conceived by my informants as a bodily condition, where the distinction between the terms mind and body existed conceptually, but was never taken into account in regard to madness and in the everyday practices, confirming Lambek's (2006) study.

Moreover, the Association aims not only at taking care of patients, but also at changing cultural conceptions about madness in Benin and Ivory Coast to stop traditional practices like shackling and abandoning the mentally ill. First, they state there is no witchcraft influence on mental illness. This claim renders it a natural and physical illness like all other bodily diseases, instead of the result of a spell or spirit possession. This shift corresponds to the treatment given which consists of medicines, prayers, and education. Medicines work on physical illnesses but cannot heal spiritual ones. Second, the Association explains that people should not fear the mentally ill because they are not dangerous. In accordance to Bourdieu's (2006) assumption that different experiences are needed to change everyday social practices, the Association provides a completely new experience of the madmen

creating a new social subject: the mentally ill person. To do so, it is necessary first to transform the *fou* body, culturally characterised by matted and dirty hair, torn clothes or nudity, into the mentally ill body, which is shaved and tidily clothed. The new body recalls a sick person to be taken care of, rather than a dangerous person to avoid. This transformation is very important, because previous experiences with the *fous* are not immediately associated with the new body. Moreover, people are encouraged to have a different approach, hence new everyday practices toward the mentally ill. In line with Ortner's (1989) idea that a change in cultural conceptions can occur only if new practices are sustained by an ideology, the discourse spread by the Association is not only reflected in the practices it motivates, but it is also strengthened by the transformation of patients' bodies. However, I objected to Ortner's (1989: 207) statement that the ideological system is in part autonomous from practices. Instead, I encouraged an approach which considers the discourse as embodied both in practices and in the new social subjects it creates. The concept of embodiment (Csordas 1990, 1994, 1999) was indeed useful for the analysis because it allowed not only to examine mental illness through the body, because of its unity with the mind, but also to conceive "the body as the ground of culture" (Csordas 1990), in particular the ground for changing cultural conceptions about madness.

My contribution to the anthropological literature on embodiment opens up new possibilities for future researches on transformation of cultural conception, promoting a unity of mind and body as analytical tool, in particular in regard to mental illness. The body is not anymore only a passive object governed by social processes, but has an active role as the ground for the establishment and spread of new cultural understandings and systems of thought, through the construction of new social subjects.

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Summary

Mentally ill people in Benin are often shackled or abandoned in the streets. They can be easily recognised from their physical appearance, which usually consists of matted and dirty hair, torn clothes or nudity, and long nails. A Catholic Association was born not only to take care of them, but also to change local conceptions about madness. They reject the traditional idea that patients are bewitched, while claiming that they are mentally ill. In this way mental illness is not anymore understood as a spiritual illness that is derived by witchcraft or spirit possession, but rather as a physical illness like all other bodily diseases. In this thesis I analyse how body transformation is used as starting point to change local understandings about madness. This includes an investigation into how staff members conceive mental illness as a physical disorder in which mind and body are understood as united and a distinction between the two is irrelevant. The importance of physical appearance allows the Association to spread its new belief system through the transformation of patients' bodies: if 'madmen' are easy to recognise for their dishevelled physical appearance, a radical aesthetic transformation deletes the cultural label inscribed in their bodies. When patients arrive at the Centre they are washed, their hair and nails cut, and they are given clean clothes. Yet, this is not enough to transform local perceptions, because the Association's discourse is necessary to give a meaning to the new body and encourage new practices toward the mentally ill. While they are often feared and avoided, the Association claims they are not dangerous and should be kindly approached and helped. New social subjects are thus created: the mentally ill become people in need of care, instead of bewitched individuals. The transformation of the body is fundamental to encourage a different approach and new practices toward them, because it deletes the physical signs that categorised them as mad. In sum, patients' bodies become the ground for changing cultural conceptions about madness. While discourse also plays an important role in shaping new understandings, and is embodied in the new approach and practices toward the mentally ill.