

THE CULTURAL CONSTRUCTION OF ILLNESS  
The Case of Mukund Among the Lele of Zaire\*

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The purpose of this paper is to examine a healing institution, *Mukund*, among the Lele of Zaire. The Lele, matrilineal and agriculturalist, are best known through the excellent works of Mary Douglas (1963; 1966) and the discussions provoked by her detailed descriptions and fine analysis in the field of kinship, symbolism and economics (e.g., de Heusch, 1971; Levi-Strauss, 1973; Sahlins, 1972). Although one can find some health-related information scattered in Douglas's discussions of Lele religion, there is no study dealing specifically with any aspect of Lele medical system. And though Mary Douglas herself notes that "the idiom of medicine so dominated their religious forms that it was often hard to distinguish two separate spheres of action" (1963: 205), she focused her interest on the religious sphere; her only paper pertaining directly on Lele ethnomedicine is a very short description of the treatment of leprosy (1954).

This paper has three parts: in the first, I will discuss two presuppositions which might orient the examination of *Mukund*; in the second, I will describe elements of Lele medical system serving as context to *Mukund*; in the third part, I will examine the *Mukund* itself.

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## RELIGION AND THE CULTURAL CONSTRUCTION OF MEDICAL REALITY

For the purpose of this paper, two fundamental assumptions can be distinguished in medical anthropology: first, that non-Western medical systems are dominated by religious beliefs and practices, or at least are closely associated with them; second, that illness is culturally constructed. Both of these assumptions can be traced back to the "founding fathers" of the subdiscipline.

The dominance of religion in ethnomedical systems is clearly stated in Rivers's pioneering book, significantly entitled *Medicine, Magic, and Religion* (1927) and generally considered as his "primary legacy to medical anthropology" (Wellin, 1978: 25) or as a "symbolic totem" of the subdiscipline (Landy, 1977: 4). Similarly, Ackerknecht writes: "I have insisted very strongly on the *magic character of primitive medicine*" (1971: 14; emphasis in original) and notes repeatedly: "I think it is safe to state... that [primitive medicine] is *primarily magico-religious, utilizing a few rational elements*, while our medicine is predominantly rational and scientific, employing a few magic elements: (1971: 15, 21, 121, 135). Speaking of the Azande, Evans-Pritchard notes that they "attribute sickness, whatever its nature, to witchcraft and sorcery" (1937: 479). A corollary of this orientation is the assumption linking the dominance of religion to anxiety and uncertainty resulting from technological inferiority or inefficiency and lack of scientific and rational knowledge (e.g. Alland, 1970; Fox, 1976: 104; Jaspán, 1976: 227-237; Lewis, 1975: 199; Rivers, 1927: 31, 34).

The *idealistic* orientation of the anthropological tradition and particularly the interest in *cognition* can partially account for the privileged position of religion in the comparative study of medical systems. It can also be understood as resulting from a pervading double dichotomy: on the one hand, the West vs. the Rest, to use Sahlins's rhyming phrase, and on the other hand, science vs. religion.<sup>1</sup> In other words, having assumed that the Rest is fundamentally different from the West, and that only the West possesses scientific knowledge, the anthropological discourse logically emphasizes the "engulfment" of the Rest in religion.

This prevalence of religion in the earlier writings on ethnomedical systems as well as the *ethnocentric* and *scientist* biases which found them epistemologically are still present in medical anthropology, partly because

they are closely linked to Western conceptualizations of religion and science. They are well evidenced in studies of "dual use" of medical resources, where traditional beliefs of causation and treatments are very often examined as factors in the underutilization of services. They also appear in queries about the efficacy of non-Western medical systems, and in the now controversial but ever present divide between ethnomedicine and biomedicine (Press, 1980: 45-46). The persistence of this line of reasoning is also well illustrated in the general consensus that "supernatural" diseases are those whose characteristics (duration, frequency, prevalence etc.) cannot be accounted for by natural causation and for which "ordinary" treatment actions are ineffective.

A second general assumption in medical anthropology is that illness is culturally constructed.<sup>2</sup> The founding fathers of medical anthropology were concerned implicitly, and sometimes quite explicitly, with the cultural construction of medical reality, although they did not use that phrase. This is evident in Rivers's plea to elicit the relationships of medicine to "other recognized social processes" (1927: 9) and in his statement: "medicine is a social institution" (1926: 61). In a similar vein, Ackerknecht insists that "*what is mental, and even bodily disease is primarily defined not by nature but by society*" (1971: 141, emphasis in original). Evans-Pritchard's analysis of Azande data can be seen as eliciting the social conditions of the production of everyday reality (Douglas, 1980). In spite of this awareness of the constructed nature of medical reality, the founding fathers erred, however, in considering this constructedness to be characteristics of "primitive" societies only and to operate mainly through magic and religion.

The premise of the cultural construction of illness is apparent in the distinction disease/illness, widespread but problematical (Frankenberg, 1980; Young, 1981), in the distinction between a popular and professional sector of health care systems (Kleinman, 1980), in the notions of lay referral structure (Freidson, 1970) and therapy managing group (Janzen, 1978), and in the labeling theory of mental illness etc. Folk illnesses, such as *susto*, are well-known largely because they illustrate the work of cultural beliefs and social roles in the definition and management of illness (Rubel, 1964; Uzzell, 1974). This general premise of the constructedness of illness is congruent with the core concept of *culture* (D'Andrade, 1973; Fabrega, 1979; Frake, 1980; Kleinman, Eisenberg and Good, 1978).

My analysis of *Mukund*, a cult of affliction, is not intended at illustrating any dominance of religion in Lele medicine; rather it is an attempt

1 See Paul Jorion and Genevieve Dolbos (1980) for a critical analysis of the place of "magic" in this problematical polarization within the anthropological discourse. It is also significant that Horton, after trying to bridge the gap between African thought and Western Science details eleven points of differentiation (1967).

2 The cultural constructedness of illness does not necessarily negate certain universals of disease, some of them biologically rooted. Jane Murphy (1976) has shown, for example, that "symptoms of mental illness are manifestations of a type of affliction shared by virtually all mankind" (p. 1027).

at understanding the cultural construction of Lele medical reality, process in which religion as component of the ideological superstructure might be a part, although not necessarily dominant. The idea that illness is culturally constructed has the merit of being crossculturally applicable, and thus, escapes the narrow *ethnocentrism* and *scientism* which are inherent in the assumption that non-Western medical systems are dominated by religion. Furthermore, instead of assuming this dominance of religion, it considers it, along with other institutions, as parts of the process of the construction of medical reality, and as being culturally constructed itself.

## ELEMENTS OF LELE MEDICAL SYSTEM

### Disease Etiology

The Lele distinguish "natural" diseases from non-natural ones, a distinction which is common in most Central African cultures (Bibeau, 1979; Janzen, 1978). Natural diseases are in the normal order of natural things. They are often called diseases of God. This is less because they are caused by God as because they operate within the order of things designed and ultimately controlled by God. The Lele often say that they are "God's slaves" (Douglas, 1963: 204) or "God's chickens." Diseases of the elderly are natural in that they are expected outcomes of human development. As a matter of fact, when a very old person dies, there is no mourning. Instead public dancing takes place to celebrate, an honour usually reserved to members of the aristocratic clan or to polyandrous wives.

The Lele also know that the dry season which is cold brings naturally man diseases. Mary Douglas, describing the climate in the Lele area during the dry season writes about the Lele:

"... they dread the months of June, July and August... All weak things, women, children, young animals, are thought to be vulnerable, and likely to die in this season ... At other times a man has no scruple about beating his wife, but boys are taught never to strike a woman in the dry season, lest she crumple up and collapse. Coughing and pulmonary diseases, which account for the majority of deaths in the Congo, are certainly rife, for the air is full of irritants and this is the season of epidemics." (p. 20)

The Lele are well aware of these environmental conditions which may bring natural diseases. A good example is *makongu*, a disease characterized by a sensation of openness, especially of the anus, which may be itchy and have scratches. There is also uneasiness when sitting, and frequent high fever and general weakness. Although the Lele know that certain natural conditions may provoke diseases, there is the ever present fear that malignant sorcerers might take advantage of these conditions to harm people.

In brief, the category of natural diseases includes all diseases which are believed to be congruent with the normal and natural order of things. Natural diseases are those which pose no problem of understanding, for their meaning seems self-evident. They are immediately understood as fitting in the normal course of human experience (aging, seasonal variation ...). Put differently, natural diseases are those which are not *cognitively puzzling* because their causes are known as natural. Conversely, non-natural illnesses are cognitively *problematical* by definition, and most likely to be constructed through religious beliefs, in accordance with the interpretive function of religion as providing meanings to individual and social existence.

Non-natural illnesses are those caused by spirits (of nature or of ancestors), fetishes, sorcerers. Concerning the spirits of nature, Mary Douglas writes: "They could make all women or individual women barren, all the men or individual hunters fail, as punishment for individual or collective transgressions" (Douglas, 1963: 207). As a cause of illness or misfortune in general, spirits of nature intervene mainly to punish transgressions of social norms related to village unity, and breaking of prohibitions related to spirits. This contrasts with spirits of ancestors which, quite logically punish transgressions of norms related to clans for which they are ancestors. Illness can also be caused by living representative of ancestors, that is, persons holding positions in the structure of authority of a clan, a lineage, or a family. Uncles and fathers, for example, can punish by inflicting all kinds of misfortune (bad luck, accidents, impotence...).

Sorcerers are obviously one of the main causes of illness. Not only can they use the mystical powers of fetishes to harm people, not only can they manipulate and trigger other causes of illnesses, but they can also hide their intervention under the mask of naturally caused or spirits caused illnesses. This greatly complicates diagnosis and therapy.

Symptoms are not the only determinant of etiology. As a matter of fact, similar symptoms can be indicative of different etiologies, e.g., when a sorcerer takes advantage of natural conditions to inflict an illness whose symptoms are similar to the expected illness resulting from these conditions. An important implication of this consideration is the imperative to consider natural and non-natural causes of illnesses as overlapping categories in some instances, and not as rigid and exclusive ones (Janzen, 1978: 190-191). In fact, the insertion of a specific illness episode or segment in one or the

other of these categories depends upon social circumstances and is often negotiated within the lay referral network.

### Diagnosis and Treatment

The lay referral group plays a very important role in the definition and assessment of symptoms. Symptoms are articulated in relation to parts of the body, to organic functions, or to subjective sensations, e.g., pain in the neck, pain in the "internal things", heat in the heart, cold in the body, crossed ribs, dizziness etc. There is not a one to one correspondence between symptoms and illnesses; dizziness and pain in the "internal things" for example can indicate different illnesses. Consequently, for severe and complicated illnesses, only a constellation of symptoms can really be meaningful. Such cases must be deciphered by a specialist, a diviner.

Among the Lele, diviners are selected by ancestors spirits through possession (see Ngokwey, 1980). There are no female diviners among the Lele. This contrasts with the Zulu, another Bantu-speaking group, where diviners are usually women (Ngubane, 1977: 102). Divination usually takes place at the diviner's house and village, unless the diviner is consulted while on a trip. Special precautions such as cleaning and protecting the divination space must be taken to prevent the interference of sorcerers in the divination process. Environmental conditions can also intervene. Too much sun, for example, will cause the divination to "err"; in this case, the seance is postponed till favorable environmental conditions are met.

Lele divinatory techniques are well described by Douglas: "The rubbing oracle, *Itumbwa*, was the commonest, but there was also a whistling bag oracle, *kapulu* (...), a horn oracle *kahei*, a sniffing bag oracle, and others more mysterious, said to involve use of skulls of sorcerers'victims" (Douglas, 1963: 224-225).

Among the Lele, a diviner can ask questions of his consultees; they can provide various information and let him know if they think he is headed in what they consider to be the right direction, or if they disagree. This stands in sharp contrast with the practice among the Xhosa of southern Africa, as reported by Jansen. "Interviewing is unknown in tribal medicine... When the diviner starts the consultation, he begins by guessing. He is not supposed to take 'the medical history' by interviewing the patient and/or his relatives. On the contrary, he is the one who has to give answers to all the questions about the patient and the causes of his disease" (in Foster/Anderson, 1978: 119). Although similar cases can be found among the Lele, they are rather rare, for the patient and his group have a more active participation. Here divination is a real communicative and interactional process.

The diagnosis offered by a diviner is not absolutely authoritative. It is also negotiated within the managing group. If, for some reason, the group or one faction questions the validity of a diviner's diagnosis, it can always look for another one. However, confidence in the diviner's competence will usually result in the trust of his diagnosis, especially if it makes sense for the consultees.

The primary role of a diviner is to specify the nature and cause of all illness. Usually, a diviner also indicates the appropriate course of treatment or specific types of healers to visit. Some diviners are at the same time healers, in which case they can treat the sickness.

Every adult has a minimal knowledge of medical properties of some plants, which permits self-medication, especially for minor ailments. But Lele do recognize a special category of professional practitioners, especially for serious diseases. The demarcation between healers and lay persons is not arbitrary: it is socially validated because of the training of healers, because of the variety and importance of their knowledge and techniques, and because of the special powers they have.

Apart from being distinct from lay persons (*professionalization*), healers can also be distinguished among themselves, according to diseases for which they are competent, or to techniques in which they are more efficient (*specialization*). Hence, there are specialists in sterility, impotence, headaches, as well as in blood letting, massages, and so on.

Therapy among the Lele involves *interactional* processes within the managing group including the patient, his friends, and relatives, as well as the healer. This implies exchanges of information, services, and goods. Most healers are herbalists in that they make frequent use of plants in general, roots, leaves, fruits, seeds etc. These are rubbed or applied on the ailing parts of the body. They are also used as basic ingredients of eye drops, nose drops, steam baths, potions, and purges.

### MUKUND: A CULT OF AFFLICTION

Lele say that the *Mukund* is not a cult of *Woto*, the mythical figure who is the hero, ancestor, and founder of the Lele group. By this they mean that it is a foreign cult. They report that it comes from their neighbors *Ambuun* and *Wongo* of the Bandundu region. The introduction of this cult among the Lele is relatively recent. As a matter of fact, Mary Douglas who lived among the Lele in 1949-1959 and in 1953 does not mention it. Further, I verified in 1976 that the Lele villages which are the most distant from the reported geographical origin of the cult not only do not practice it, but they do not even know it. The history of this cult remains to be done. It would

certainly illuminate the important question of intertribal contacts and exchanges.

According to one Lele narrative concerning the historical origins of *Mukund*, the cult was founded by a woman who dies, was actually buried, but rose from the dead a few days later. Through this experience, she was endowed by spirits with a special knowledge and exceptional powers. She introduced this therapeutic institution to cure those who presented similar symptoms to the ones she had herself. Brief as it is, this story nevertheless contains four basic elements of this cult, namely, the dominance of women, the reference to spirits, the therapeutic dimension, and the selection of healers through illness. In the following pages, I will examine first the etiology and diagnosis of the illness; second, the therapeutic process of the cult of affliction itself.

#### Etiology and Diagnosis

The illness treated through the institution of *Mukund* is, as the Lele put it, "an illness of the whole body". This expression refers to the diffuseness of the illness afflicting the whole person, the body as well as the "head and thoughts". The syndrome includes: disturbance of the alimentary and digestive functions, hallucinations and nightmares, depression, general fatigue and weakness, thinning, symptoms which are also associated with other illnesses. When someone has these symptoms and when treatment does not cure, the illness managing group consults a diviner, for spiritual affliction is suspected. The diviner usually confirms the group diagnosis; further, he specifies the name of the afflicting ancestor and the reason for his anger.

The illness is a sanction that follows social misconduct or breach of rules of solidarity which are supposed to regulate relations among living as well as dead members of a clan or lineage. The ancestor can be unhappy for not having been mourned enough or in the proper way; he can also be discontent for not having a baby named after him, which indicates that his fellow clansmen neglect or forget him. The illness can also express the anger of the ancestor, if he died of sorcery, to see his clansmen in friendly relationships with those who killed him, instead of avenging him. It can also punish any behavior which threatens solidarity among the living members of the clan: selfishness, misplaced envy, irresponsible actions, tensions, quarrels, conflicts. In all instances, the affliction is interpreted as a punishment for social deviance.

This illness is a good example of non-natural and/or mystically caused illness. Such a diffuse illness cannot be part of the normal human condition, particularly if it resists any treatment. These puzzling characteristics

(diffuseness and resistance to cure) do not belong to the natural order of human experience. They are interpreted through the idiom of religion, and thus become meaningful and manageable.

This cultural meaning is related to the social functions of the illness. Indeed if the illness is perceived as a punishment for deviance, its importance for social control is evident. It helps define the norms and values of solidarity and the corresponding behavior. Consequently, it helps prevent and regulate deviance. Another social function of this illness is that it reinforces social solidarity: first as a sanction to any breaking of the rules which regulate social behavior within the group; second as a concern for the whole group. The individual illness is just a symptom of a social illness (Zempleni, 1966: 348).

Once the diviner has confirmed that it is an ancestral affliction and specified what triggered it, the illness managing group contacts a healer specialized in *Mukund* affliction (*Ngang Mukund*), former patient of this affliction himself. The choice of a *Ngang Mukund* among other types of healers is a crucial phase in the illness management process. It implies consensus upon the pathogenic agent (an ancestor), it determines a particular distribution of roles, and it sets and legitimizes a specific therapeutic course.

#### Therapy

The *Ngang Mukund*'s first step in the therapeutic process is to ask for a piece of blessed white clay (*peembe*) from the lineage or clan of the sick person. Given to the healer, the white clay *peembe* symbolizes the clansmen's good disposition towards the patient and among themselves. Without good relationships, the door is open to possible sorcery interventions, which can impede the success of the therapy.

The second episode in the therapy is the reclusion of the patient in a hut surrounded by palm branches. The whole treatment takes place in the reclusion hut. It includes purges, massages, steam baths and inhalation, incisions, potions, prayers. The healer uses different plants which must come from the savannah, not the forest.<sup>3</sup> I would suggest, given the fact that women are the most afflicted by this illness, that this has to do with the general symbolic association between women and savannah (Douglas, 1975).

3 The plants used are: *ihenene*, *matondungolu*, *mueci*, *bukodiya*, *ntoci*, *okoko*, *ilenlandjoku*, *ilulumbi*, *ikundu*, *ntungu*, *mipope*. I cannot identify their botanical names.

## Do Not Produce, Just Consume

Numerous prohibitions regulate the therapeutic process in the reclusion hut. For example:

- . The patient may not drink water; she can only drink palm wine.
- . The patient may not go out the reclusion hut, except to satisfy urgent physiological needs.
- . The patient may not work under any circumstances.
- . The reclusion hut cannot be cleaned; instead, the ordures are stacked progressively in a corner.
- . Nobody can talk to the patient without giving her some money, a piece of raffia cloth or a token.
- . The patient must eat a lot of food.
- . Only the curer can enter the reclusion hut.

These regulations can be interpreted differently. For example, not cleaning the house and stacking the garbage can be understood as the typical positive utilization of the negative or the unclean (see Douglas, 1966). Instead of trying to interpret all these regulations, I will focus only on two of them, namely the prohibition to work and the obligation to overeat.

What makes these two regulations interesting is that, although in most illness cases, the sick persons are advised to rest and to eat well, in this specific *Mukund* case, these considerations are not only institutionalized and ritualized as part of the therapy, but they are also pushed to their extremes: absolute rest and overeating.

The comparison of these two regulations reveals some basic mechanisms of the cultural definition of an illness and its behavioral correlates. Indeed when these two regulations are put together, they convey this message to the patient: do not produce, just consume. This indicates that one basic and inherent aspect of the Lele construct of illness is that it is an *interruption* of the patient's productive activities, which ultimately amounts to an interruption of his daily experience of social life. This is also shown in that she drinks only wine, she cannot be freely spoken to, and she eats alone etc.

Why is production (work) prohibited but consumption (eating) encouraged? What can be the logical structure of these regulations? A useful perspective from which to examine these questions is to consider the systems of *interaction* and *interdependence* between the patient and the therapy managing group at large. Indeed, if an illness interrupts the patient's ordinary social life, the illness managing group must intervene to maintain his activities, or to compensate for the behavioral disruptions associated with illness. But if the members of the illness managing group can work for the patient,

obviously they cannot eat for him. In other words, disruptions in the socially vital productive activities of the patient can be easily compensated by members of the illness managing group; hence, the prohibition to work. Conversely, the impossibility for the members of the supportive group to compensate for his biologically vital consumption needs result in the emphasis on eating. But why overeating and not just eating? This is another part of the Lele construct of an illness according to which "thinning" indicates disease; consequently, gaining weight through overeating indicates good health or recovery.

The previous paragraphs suggest that there are cultural premises and behavioral patterns constituting a specific construct of an illness. Cultural premises about illnesses are of two types: indicative and imperative. By indicative premises I mean the descriptive aspect of the definition of an illness. Imperative premises refer to its normative or regulated aspect. As for behavioral adaptations, they can be considered from two points of view: the individual (patient) and the communal (illness managing group).

In the case under consideration, one indicative premise is that a sick person cannot work. Inability to work is indeed an important part of the description of an illness. This becomes an imperative premise when it actually forbids the sick person, turned patient, to work. The individual behavioral response to this is rest, while the group is expected to work for the patient. Another indicative premise is that a sick person loses his appetite; he cannot eat. But since gaining weight or at least maintaining weight is part of the Lele cure, the imperative premise here is to encourage eating. This results in the group providing food to the patient and his overeating. All this can be represented in the following table:

Premises		Behavioral Adaptations	
Indicative	Imperative	Individual	Group
A sick person cannot work	A patient should not work	Total rest	Work
A sick person cannot eat	A patient should eat	Overeating	Provision of food

Fig. 1. Cultural premises and behavioral adaptations in an illness event.

The model represented above discloses some aspects of the complex logical structure of regulations imposed upon the patient as well as the social functions of these regulations. This indicates how fruitful such an

analysis could be if applied in a systematic and rigorous manner to all regulations imposed not only upon the patient but also upon the whole group. Indeed, such an analysis discloses specific mechanisms of the social construction of an illness and reveals the *processual* nature of this construction. We can see how cultural premises, both indicative and imperative, define an illness and how this definition correlates with actual behavioral patterns and interactional processes. What is more, it shows how ritual regulations as symbols are both meaningful and cognitive. Meaningful, they function in social communication; cognitive, they function in the construction of knowledge, in this case of medical knowledge (see Sperber, 1977 for a cognitive approach of symbolism).

The regulation to drink only palm wine can be understood against this background of social harmony and solidarity. Indeed wine is distributed according to obligations of kinship. Among the Lele, many quarrels within clans arise about the distribution of drinks (Douglas, 1963: 32). Luc de Heusch, the Belgian ethnologist, using a structuralist analysis of numerous Bantu myths and rituals has shown that palm wine, when not shared, is a major source of social disorder (1977: 217-221). By forcing the patient to drink only palm wine, this regulation forces him to enter, in an extreme manner, the sharing networks of his clan. Palm wine sharing is thus an expression and reaffirmation of solidarity, which is indeed what the clan needs to cope with the threat of disruption represented by the illness.

The recovery and the end of the treatment are ritualized. The healer invites other *Ngang Mukund* of his village or neighboring villages. The evening before the discharge, the healers receive a chicken from the sick person's clan. They eat together, then sing and dance all night long with the patient. In the early morning, when the village is still quiet, they run to the river where the convalescent takes a cold bath and is purified. Then they come back to the central place of the village. The convalescent is covered with a white piece of cloth. Relatives and friends bring gifts. People gather in the central place of the village. The convalescent is unveiled and his new name divulged. Among the most common new names given are:

*Imanbangang* (literally the-one-who-finished-healers, an allusion to the resistance of the illness to previous treatments);

*Imanmbong* (literally the-one-who-finished-wealth, an allusion to the costs related to the illness); *Minengu* (medicines, fetishes). The healers plant a banana tree beside the seclusion hut, using the garbage of the hut as a fertilizer. The more the tree grows, the faster the convalescent recovers. If it dies, a relapse is likely. Later, the ex-patient will be initiated to become a healer himself. All this ritualization of the discharge (purification, change of name etc.) expresses and legitimizes the return to "normal" life of the ex-patient.

## Analysis and Interpretation

The prevalence of women in *Mukund* can be interpreted in terms of their position in the social structure. This phenomenon, observed in many other societies (Althabe, 1969; Monfouga-Nicolas, 1972), has led social scientists to consider female cults of possession as disguised protest movements against male domination (Lewis, 1971: 31). Needless to say, this functionalist interpretation does not exhaust the richness of the *Mukund* institution. Many other questions, such as those relating to the structure and history of the institution itself, remain unasked and unanswered. Furthermore, as an explanatory matrix, the war between sexes, is unable to account for many episodes any symbols of this therapeutic ritual. Let me briefly examine a) the *symbolic* uses of the white clay in the first episode, and of the banana tree in the last one; b) the processes of interaction occurring in the management of this illness.

The white clay (*peembe*) which is given to the healer is a dominant religious symbol in many central African cultures. It is so important among the Kuba of Zaire, for example, that in a recent book, Vansina entitles the chapter devoted to Kuba religion "White Porcelain clay"; he presents it as the "epitome of sacredness and religion" (1978: 197). Among the Lele, it is associated with spirits of ancestor and is used in blessings, fertility and funeral rituals. White clay connotes harmony among clansmen and between them and ancestors. This harmony guarantees biological and social reproduction of the clan, that is, fertility and continuity.

The positiveness of white clay stems from its association with ancestors. By which logic is white clay connected with ancestors? This association is a process of *metonymic symbolization*. Indeed, white clay is dug out of rivers and rivers are spirits' location. The contiguity of white clay with spirits is the logical basis for its metonymic representation of ancestors.

The banana tree, as we have seen, is used to express and reinforce the recovery of the patient. It is also used in other medical and ritual contexts: certain antisorcery movements and the treatment of babies' convulsions. In the *Mukund* cult of affliction, the association between the banana tree, recovery and ancestors is metonymic and metaphoric. Metonymic because banana trees are the most common plant of the ancestors' village and the ancestors are the dispensators of good health. Metaphoric because of the fast growing characteristic of the banana tree. These two symbols (white clay and banana tree) evidence metonymic and metaphorical processes of symbolization which characterizes the human mind, and not only the so-called magical thinking of the so-called primitives.

Let us look now at interactional processes. The family involvement in illness management appears throughout all the episodes. The decision to

consult a diviner is negotiated within the family. The acceptance by the family of the diviner's interpretation of an individual illness as an ancestral affliction implies also an acknowledgement that "something is rotten in the clan" and that something has to be one about it collectively. The blessed white clay given to the healer clearly expresses the good disposition of the clansmen toward the patient and among themselves; further, it guarantees the clan protection of the patient from sorcery intervention, as noted above. The clan compensation (provision of food and services) for the behavioral disruptions of the patient indicates a redefinition, if temporary, of roles. All these interactions express, enact reaffirm and reinforce a basic ideal of Lele social experience: solidarity.

Only within this context of social interactions can we understand the relationship between the healer and the patient, which is not dyadic and cannot be reduced to a therapeutic interview. Jean Pouillon (1975) rightly points out that the relationship patient-healer cannot be considered cut off its social context. Unfortunately, by social context, he actually refers to "the *conception* (my emphasis) the society has of the relationships between people..." (my translation; p. 78). Such an intellectualist or idealist concept of social context excludes the actual social experience of these relationships. As a result, Pouillon's basic construct of *triangle thérapeutique*, intended to contextualize the relationship healer/patient does not refer to other social relations, but rather to the mystical etiology of illness. According to Pouillon, the relationship the healer as well as the patient have with the illness determines the relationship between them (pp. 81-82) and constitutes a therapeutic triangle (disease-patient-healer).

In spite of its lack of interactional context, the notion of therapeutic triangle illuminates an important aspect of the relation between the patient and the healer as determined by the illness. In the *Mukund* case, this is well illustrated in that the healer is himself a former patient of the *Mukund* illness and in that the patient will become a healer. The affliction is at the same time a selection. The therapy is at the same time an initiation. As a result, the stratified nature of the relationship between doctor and patient founded upon a competence gap in biomedicine is replaced in the *Mukund* by other types of relationships: the contrast between initiator and adept (during the cure) is progressively reduced and turned into a peer relationship (after the cure).

#### Conclusion

The hyper-religious "primitive" is a myth linked to social cultural, intellectual and historical conditions of the West. It is related to beliefs in the *specificity* of Western culture and *rationality*, and in the radical *rupture*

between science and religion. The uncovering and critique of this myth and of its socio-cultural foundation is not tantamount to ignoring or denying the role of religion, as part of the ideological structure, in a social formation. Rather it is intended at cutting it down to size in order to enable an empirical examination of its relationships to other social processes.

The analysis of Lele material clearly indicates the importance of religion in their medical system. The etiological system, the diagnostic procedures as well as the therapy process are informed by beliefs, values, and cosmology. Yet any reductionism subsuming medicine under religion misses an essential point: *illness is socially constructed*. As well illustrated in the *Mukund* case, it is within the social context and through interactional processes that the articulation of medicine and religion takes place.

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