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Intimate Hierarchies and Qur'anic Saliva (*Tëfli*): Textuality in a Senegalese Ethnomedical Encounter

This article examines the multimodal textuality of a videotaped ethnomedical encounter between a Senegalese healer and his patient and considers these findings in light of metadiscourses on healing that were collected in interviews. The article demonstrates how a cultural figure of the healing process is precipitated out of patterns of co-occurrence (or "textures") of linguistic, paralinguistic, and nonlinguistic semiotic devices and suggests that this approach is well equipped to illuminate ethnomedical practice in Senegal and elsewhere.

While Senegalese in West Africa speak of "natural" causes of misfortune and disease, they sometimes ascribe illness, hardship, and other negative occurrences to malevolent spirits (in Wolof, *jinne*), or even to Satan himself. When this latter class of disturbances occurs, Senegalese often seek the help of healers, or *sérīñs*. The figure of the *sérīñ*, who is typically male, is of considerable importance in Senegal because of his ability to perform highly prized healing rituals, although he also fills a wide range of other roles, including that of Islamic priest, judge, and instructor of the Qur'an (Copans 1988; Cruise O'Brien 1971; Cruise O'Brien and Coulon 1988).

In this article, I analyze an encounter between a *sérīñ* and a patient that I video-recorded in Senegal during fieldwork in the summer of 2000 and consider these findings in light of metadiscourses on healing that were collected in interview contexts.¹ Following Good's (1994) recommendation for a broader semiotic approach to ethnomedical practices, I examine the interaction of linguistic, paralinguistic, and nonlinguistic forms of semiosis in the encounter rather than privileging the linguistic

track, as prior studies of doctor–patient interaction have too often done (Ong et al. 1995:908). I opt, in other words, for an analysis of what Duranti (1992:660) has referred to as the “multichannel architecture” of the event. Duranti uses this term with regard to the study of greetings, and indeed the greeting phase of the ethnomedical encounter I analyze here is, semiotically speaking, extremely dense and significant. It thus receives special attention in this article.

After introducing Senegalese ethnomedicine and the *sériñs*, I describe the setting in which the encounter occurred. With the setting clarified, I turn to the notion of multimodal textuality, which serves as a framework for the subsequent analysis and which provides one way to construe Duranti’s call for the study of multichannel architecture. I alternate between an analysis of the encounter itself and a consideration of metadiscursive remarks made about the encounter and about ethnomedicine in general, which were gleaned from interviews with Senegalese informants. It is suggested that an alternation between these two types of data is critical for understanding the cultural significance of event-internal multimodal textuality. In the following analysis, two main multimodal “textures” (i.e., patterns of token co-occurrence) are shown to be salient in the encounter. These textures project distinct semiotic effects, namely, intimacy and asymmetry. Finally, I discuss the practice of casting Qur’anic saliva (in Wolof, *tëfli*), in which the healer invests his saliva with Qur’anic verses and then casts them on the patient. It is argued that *tëfli* encapsulates these two textually produced effects and is of special ritual importance in the encounter. As I suggest, this blend of intimacy and asymmetry in Senegalese ethnomedical encounters serves as a cultural figure for how healing itself is imagined to operate. The figure for healing described herein consists of invoking a transcendent power in a setting where the social distance between the patient and the *sériñ* is effaced on the one hand, yet reinforced on the other. This figure of the healing process is precipitated out of multimodal textures, but its significance is given a higher degree of coherence by circulating metadiscourses, which must therefore serve as important data points alongside the primary video data. To recognize how healing practices are semiotically constituted here and elsewhere, attention to multimodal textuality and to circulating metadiscourses is thus shown to be indispensable.

The *Sériñs* and the Sūfī Brotherhoods

Senegal, the Westernmost country of Africa, became an independent republic in 1960 after more than a century of French domination. Wolof is the predominant language and belongs to the Atlantic linguistic group within the Niger–Congo language phylum. Since France’s colonization of Senegal in the 19th century, however, French has been used alongside Wolof, particularly in urban areas (Diouf and Yaguello 1991:9) (for recent work on the status of Wolof vis-à-vis French see Swigart 2000 and McLaughlin 2001).

The title *sériñ*, or *marabout* in French, is used to refer to a large number of high-status religious personages within the Sūfī brotherhoods that dominate Senegal’s Islamic landscape. Among the Sūfī brotherhoods in Senegal, a country whose population is now nearly 95 percent Muslim, the Qādiriyya (founded in 12th-century Baghdad) and the Tijāniyya (founded in 18th-century Morocco) were introduced in the 18th and 19th centuries respectively (Cruise O’Brien 1971:27). In the late 19th century, just as French colonial rule began to solidify, the Senegalese Mouride brotherhood

emerged as a branch of the Qādiriyya and grew exponentially in subsequent decades under the leadership of the brotherhood's founder, Cheikh Amadou Bamba (Cruise O'Brien 1971:37).

Although pre-Islamic elements have persisted amid Islamization, it should come as no surprise that ethnomedicine in Senegal draws centrally upon, and is rationalized in terms of, Islamic doctrine. For *sérīns*, their patients, and indeed most Senegalese, the Qur'an is considered an (often *the*) authoritative and comprehensive book of medical knowledge.² As with Sūfī brotherhoods elsewhere in the Islamic world, the *sérīns*, or *marabouts*, are positioned as intermediaries who offer their followers access to Allah. In Senegal, this mediating role includes the capacity to communicate with various classes of spirits and to control them through propitiation. As I suggest below, healing is also a process in which the *sérīn* occupies a mediating role that is higher than the patient and closer to the transcendent, yet that is also said to require "intimacy." It is intimacy with the patient that is said to facilitate the hierarchical transfer of healing power. I show that the multimodal textuality in the encounter is best understood in light not only of the general position of *sérīns* as privileged spiritual intermediaries, but also of metadiscourses about healing that emphasize the need for healer/patient intimacy.

Setting and Methodology

The interaction analyzed below is between a traditional healer, Sérīn Siñaañ, and one of his patients, Djafara Fofana. (I use the actual names of the speech participants and informants rather than pseudonyms, since all of them agreed to be audio- and videotaped and agreed to have their names included in seminar papers, conference presentations, and publications.) The encounter took place in June 2000 in Koungeul, a village located 336 kilometers from Dakar in east-central Senegal. Koungeul was founded in the 15th century by the Camara family, who belonged to the Manding ethnic group, which in turn came originally from Siby, a region of the Empire of Mali (N'Diaye 2000:17–18). At present, the village of Koungeul and the surrounding areas contain about 15,000 inhabitants comprising a wide variety of ethnic groups, including the Wolof, the Manding, the Bambara, the Soninke, the Pulaar, the Sereer, the Diola, and some members of the Koñagi.

The *sérīn* in this interaction rarely moved outside his own village of Koungeul. He belonged to the Tijāniyya brotherhood and specialized in curing stomachaches, migraines, malaria, sexual diseases, sterility, devil possession, *anthropophagie*, love problems, and job troubles.³ Further, like many other Senegalese traditional healers, Sérīn Siñaañ specialized in the preparation of amulets, including both a type of amulet that affords protection against thieves and also the *gris-gris*, which are believed to protect one against a variety of negative forces and to grant one's wishes (Cruise O'Brien 1971:24; Gamble 1957; Kalis 1997:167–168). Sérīn Siñaañ typically created his remedies through the use of medicinal herbs, roots, and flowers consecrated through prayers and rituals that draw extensively on the Qur'an.

In contrast to the relatively sedentary life of Sérīn Siñaañ, the patient of this encounter, Djafara Fofana, travels more widely within Senegal. During the dry season, he usually lives in Koungeul. During the rainy season, he often resides in Dakar, where he looks for temporary employment to help maintain his extended family. He is in his thirties, and the day I met him he did not feel well and so decided to visit

Sérñ Siñaan. The interaction took place in the healer's hut, where his patients typically visited him.

Encounters between *sérñs* and patients in Senegal, as well as in West Africa more generally, are not considered to be public events; rather, they are extremely private interactions analogous to interactions between doctors and patients in countries like the United States. Although the act of videotaping these healing encounters might thus be considered invasive, I secured permission beforehand and videotaped the encounter only after lengthy interviews with the *sérñ*. He asked me, however, to respect certain rules of decency during my videotaping. Specifically, he asked me not to use my camcorder if the patients needed to remove their clothes. During the interviews that I conducted earlier on the day of this encounter—which amounted to roughly four and a half hours—Sérñ Siñaan allowed me to use the videocamera, and he thus became quite comfortable with the camera long before the arrival of the patient.

Multimodal Textuality

In what follows, I analyze the textuality of a *sérñ*–patient interaction. As Barber states, African oral texts “often already contain the germs of a theory of themselves” (1989:13). Her point can be taken to mean that texts possess an internal structure or “text structure” (Agha 1996) that offers interactants, and later analysts, clues as to how to interpret the signs found therein. Critical here is Jakobson’s work on the poetic function, whose central aspect is parallelism (Caton 1987:223–260; Jakobson 1960:368). Jakobson’s concept of parallelism is not limited to familiar varieties of meter and rhyme. The poetic function refers to the patterned co-occurrence (or *texture*) of linearly unfolding semiotic tokens at any level—phonological, prosodic, morphological, syntactic, lexico-semantic, and even, one might argue, nonlinguistic semiotic (kinesics, gaze behavior, etc.). In his analysis of Shokleng myths, for example, Urban (1991) showed how agent- and patient-centricity is conveyed through grammatical parallelism. Through the repeated positioning of the topic—e.g., the noun phrase ‘beehive’—as the object of a transitive clause (i.e., as patient) across lines of the myth, the objectness of the hive, its status as something acted upon, is foregrounded (Urban 1991:34–35). Other Shokleng myths foreground agency by repeatedly positioning the topical noun phrase as the subject rather than the object of a transitive clause. The use of parallelism makes certain signs comparable with one another and at the same time makes them stand out as different from their cotext. In this way, parallelism helps create an elementary kind of textuality, which I distinguish henceforth as *texture*. And as work in ethnopoeitics has illustrated (Hymes 1981; Tedlock 1983; Woodbury 1985), the semiotic resources for creating textures through parallelism is vast. As Silverstein writes, “As structures of cohesion, texts are nothing more than by-degrees complex and multiply overlaid patterns of *co-occurrence* of (token) sign-forms one with respect to another” (1997:270). When talking about the cohesiveness of textuality, that is, how signs seem to fall together into distinct co-occurrence patterns (e.g., through parallelism)—I use the term *texture*.⁴ When discussing the coherence aspect of textuality—that is, the significance that such token co-occurrence patterns come to have for interactants—I use the term *text*.

Silverstein (1997) usefully distinguishes “interactional” from “denotational” text (see also Wortham 2001), where the former refers to coherence in terms not of

reference and predication about states of affairs, but of recognizable social action. In other words, he distinguishes token co-occurrence patterns that help create coherence about states of affairs (in the case of denotational text) from token co-occurrence patterns that help convey interactional moves (in the case of interactional text). In the latter case, token co-occurrence patterns can help give coherence to the pragmatics of an interaction and therefore serve metapragmatic functions (Silverstein 1984). They can help interactants inhabit culturally recognizable roles and perform culturally recognizable acts (Agha 1996), as I try to demonstrate below.

Silverstein's analyses of textuality are based on linguistic data, with a limited number of paralinguistic accompaniments. In this article, I extend the analysis to multimodal textuality, following Agha's (1996:469) important suggestion that textuality, as token co-occurrence, is in principle multimodal in nature: It includes both linguistic and nonlinguistic signs. In this way, I offer a means to operationalize Duranti's recommendation for linguistic anthropologists to study events vis-à-vis their multichannel architecture.

By identifying textures of semiotic tokens, whether linguistic, paralinguistic, or nonlinguistic, and by considering these patterns in relation to each other (see Agha 1996:470), I thus seek to identify event-internal evidence as to the interaction's overall coherence, its textlike quality. Doing so is an act of entextualization—the process(es) whereby texts emerge—in the sense that it makes the cohesiveness of textures into the coherence of a text. Those who have investigated entextualization have most often been interested in how signs cohere to such a degree that they become detachable from their co(n)text and hence recontextualizable (see Bauman and Briggs 1990; Silverstein and Urban 1996), as in the case of a surgical report (Kuipers 1989; Pettinari 1988). This type of interest in entextualization appears to be rooted in a concern for discourse circulation, through which entextualization is followed by recontextualization on subsequent occasions (e.g., Mehan 1996; Mertz 1996). Parallelism can help discourse “call attention to itself,” and through so doing it can help make it “memorable, repeatable, decontextualizable” (Wilce 2001:191). The concern in this article, however, is with entextualization at a different scale. I am concerned with how token co-occurrence patterns, which are projected within and across semiotic modalities, can help yield a coherent text about healing in the first place. Methodologically, I do this by attending to two kinds of data: transcribed video data in which event-internal multimodal textures are discerned, and metapragmatic discourse about ethnomedicine, which I glean from interviews. As Hanks writes, “While formal and functional connectivity can provide a scaffolding for a text's meaning, it is only in union with the sociocultural world outside that it becomes whole” (1989:104). In this respect, the metadiscourses that I draw from interview settings reveal cultural presuppositions that help give the event-internal textures a higher degree of determinacy. That is, they help entextualize them more strongly as instances of a coherent and culturally recognizable interactional text, in this case about healing.

Metadiscourse on Intimacy and Greetings in Ethnomedical Contexts

In a follow-up interview that I conducted with Djafara Fofana immediately after his meeting with Sérîñ Siñaañ, I asked him how he would have felt if the greeting with the *sérîñ* had not gone well at the beginning of the encounter. He responded as follows:

Avec ce *sérîñ*-là, je me sens très proche de lui, et cela a commencé avec les salutations initiales. Au début, u::h quand moi et le *sérîñ* on a commencé à se saluer, nous, on n'a pas seulement établi une relation étroite entre nous, mais aussi une relation avec les ancêtres. Mes ancêtres peuvent être contactés à travers le voisinage du *sérîñ* e::t je peux mieux les ressentir, quoi. Donc, au Sénégal, une thérapie médicale ne peut pas fonctionner sans les salutations, quoi. Elles doivent être très affectonnées et tu dois te sentir comme si le *sérîñ* était un membre très proche de ta famille, quoi. Tu dois te sentir très à l'aise avec ton *sérîñ*, sinon la thérapie ne peut pas marcher, puisque le *sérîñ* ne peut pas entrer ton esprit et le mettre en contact avec les ancêtres et avec son propre esprit aussi. Les salutations sont normales au Sénégal. Je ne peux même pas penser de commencer à parler avec une personne sans avant tout la saluer. Je sais bien que pour vous, u::h les *tubaabs*, c'est différent. Les *tubaabs* ne saluent jamais bien. Et quand ils saluent, ils ne peuvent pas saluer bien, quoi. En effet, leurs salutations sont très brèves. Les docteurs *tubaabs* ne saluent pas bien aussi, u::h (0.6). Comment est-ce que les thérapies peuvent marcher de cette façon là?

With this *sérîñ*, I felt very close to him, and this immediately started with the initial greetings. In the beginning, u::h when the *sérîñ* and I exchanged the greetings, we not only established a close relationship between us, but also with the ancestors. My ancestors can be contacted through closeness with the *sérîñ*, a::nd I can better feel them. So, in Senegal, a medical therapy cannot really work without these greetings. They have to be very affectionate and you have to feel as if the *sérîñ* were a close member of your family, so to speak. You have to feel very comfortable with your *sérîñ*, otherwise the therapy cannot work, since the *sérîñ* cannot enter your spirit and put it in contact with the ancestors and with his own spirit as well. Greetings are normal in Senegal. I cannot even think of starting to speak with a person without greeting him or her. I know that for you, u::h *tubaabs* ['white people'], it is different. The *tubaabs* never greet properly. And when they greet they cannot really greet properly. Their greetings are very short indeed. *Tubaab* doctors do not greet properly either u::h (0.6). How then can treatment work?

These metadiscursive remarks address the issue of the relationship between intimacy and ritual efficacy in ethnomedical encounters. Many of my informants repeatedly pointed out that the initial greeting phase is critical for a successful meeting with a *sérîñ*. In Dakar, for example, I interviewed a journalist, Marc Ndome, who argued that in Senegal it is central to put oneself in an "open" position in the presence of a *sérîñ*. In his words, "S'il n'y a pas de salutations, les thérapies ne seront pas efficaces. Ça c'est sûr, Sabina, n'est-ce pas? U::h donc, il faut être très ouverts quand on se rend auprès d'un marabout" ('If there are no greetings, the therapies will not be efficacious. This is certain, Sabina, isn't it? U::h, so, one needs to be very open when one goes to the *marabout*'). In short, if the initial interaction does not go well, it is said that it is highly likely that the subsequent medical treatment will fail. Whether the performance of intimacy in ethnomedical encounters is actually as efficacious as this informant suggests is not an issue that I attempt to address. My concern here is only to show that multimodal textures that project intimacy in ethnomedical encounters are invested with specific cultural value—that is, intimacy is said to be integral to the healing process itself, as I describe in more detail below. Minimally, these metadiscursive remarks offer the analyst (at least partial) evidence as to the significance that intimacy has for participants in ethnomedical encounters. In what follows, I turn from these metadiscursive remarks on the role of intimacy in ethnomedical encounters to a consideration of implicit textures in the encounter itself that these metadiscourses seek to invest with cultural significance.

The Encounter between the *Sérīn* and the Patient

The ethnomedical encounter analyzed below took place in Sérin̄ Sīnaañ's modest hut. Before the interaction began, Sérin̄ Sīnaañ assigned me a seat from which to videotape, a soft mattress on a rickety wooden frame which he used at night as his bed. I was instructed not to move from this spot when people arrived. Not long after I sat down, a patient knocked on the door, having removed his shoes. In the village of Koungeul, as well as in the other Senegalese villages that I have visited, hut doors are usually left open, and people come and go constantly. But at a sérin̄'s hut, people tended to announce their arrival by knocking on the door, even if it was not closed. If there was no door, they would rap their knuckles on a wall or another available surface.

A total of five speech participants took part in the encounter, four of whom were copresent for the entire duration of the event: Sérin Siñaan; the patient, Djafara Fofana; Sérin Siñaan's son Ousmane, who was his father's apprentice; and myself with the camcorder. The sérin's other son, Mariama, made a brief appearance for 17 seconds.

The total length of the healing encounter was 20 minutes and 15 seconds, much of which (around 14.5 minutes) was taken up by a break in which the *sérin* prepared the medicine for the patient. Because of space constraints, the break segment in which the medicine was prepared is not analyzed here. As indicated in Table 1, for explanatory purposes the transcript can be decomposed into an array of textually distinct phases.

The first phase of the interaction, the *initial greetings* phase, which stretches from lines 1 to 66, is extremely dense and important in terms of sign behavior. From lines 67 to 84, during the phase that I am simply labeling *prelude*, the patient apologizes for not having visited the healer earlier. He then recounts how he has finally come to visit this *sérīn*. Throughout the entire section, the *sérīn* simply listens and offers minimal responses such as *waaw* ('yes') and *dëgg laa* ('right'/'I understand'). At the conclusion of this section, at line 85, the patient suddenly reinitiates the greetings

Table 1
Synopsis of the ethnomedical encounter.

[illegible]

phase by calling out the last name of the *sérîñ*, Siñaañ. This kind of reinitiated greetings phase is common in Wolof greetings in general and distinguishes them from the Western folk conception of greetings as mere conversational openers that are highly bounded.

Finally, starting at line 95, the patient starts to disclose his symptoms to the *sérîñ*. He describes two problems. The first is stomach pain that he has been having for some time. The second is related to his job. After this *disclosure of symptoms* phase, the patient becomes more passive, in that he talks less.

With the disclosure-of-symptoms sequence completed at line 141, Sérîñ Siñaañ sets out to identify the ailment through the use of divination. He casts saliva on his rosary (a practice described later) and asks his patient to choose one of its beads, which the patient promptly does. The *sérîñ* then counts back the beads leading up to the chosen bead. While doing so, he tries to gain contact with one or more spirits in an effort to identify both the ailment and the relevant verses from the Hadith and the Qur'an which will provide the cure.⁵ After some seconds of clicking through the rosary while murmuring an inaudible incantation, Sérîñ Siñaañ finds the right verse from the Hadith, that is to say, the verse that begins with *ba bu salaasa*. He announces it at line 143b and then proceeds to the therapy phase. In a follow-up interview, I was told by Sérîñ Siñaañ that it was during this divinatory moment that he identified the Qur'anic verse that he would recite later in the encounter (line 180c).

Before the *sérîñ* can continue, however, his younger son, Mariama—who, incidentally, is not his apprentice—enters the hut with another child, interrupting him. Not only does the healer leave the orbit of the ethnomedical encounter to speak with his son, but he also breaks register in the process. There is a high frequency of imperatives, which were completely absent in the earlier stretch of discourse with his patient. Further, there is a noticeable rise in relative volume, especially during the healer's first line, as well as direct eye contact. During this interaction, Sérîñ Siñaañ does not try to broadcast his public persona as a healer. Instead, he appears to take on the role of the stern father, although he maintains a faint smile during much of this sequence, which seems to temper his otherwise stern and disciplinary voice.

After a short exchange of words with his son, which lasts from lines 145 to 156, the *sérîñ* resumes his interaction with the patient and thus launches into the *recitation of the Hadith* phase, which lasts from line 157c to line 160m. The Hadith is believed to have derived from the teachings of Mohammed. While it is felt that the Qur'an cannot be translated, and in this sense is like a transcendent text that directly acts upon the patient, the Hadith is recontextualizable. Since it is an interpretation of the Prophet, it can be refitted into new contexts. In this phase of the interaction, each line starts with words in Arabic from the Hadith, which I preserve in italics both in the interlinear gloss and in the translation below it. After the original Arabic is presented, the *sérîñ* exegetically glosses these lines in Wolof for the patient.

With the recitation of the Hadith finished, the *sérîñ* then starts to prepare the medical remedy, which takes around 14.5 minutes. Two separate remedies are prepared: The first is composed of seven roots from seven different plants whose origins are not disclosed to the patient nor to other speech participants (myself included). The patient is told to put the ingredients in boiling water, to let them steep for half an hour, and then to drink this solution twice daily for five days. The second herbal remedy is used to "chase away" the negative influences that are disturbing the patient

at his workplace. For this, the patient is instructed to infuse a variety of herbs in boiling water and drink the solution daily for ten days. From lines 161 to 172 the *sérîñ* offers the medicine to the patient, and then in the *offering of thanks* phase from lines 173 to 180b, the patient expresses his profound gratitude to the *sérîñ* for his assistance and requests his help and protection.

The last major phase of this encounter, stretching from lines 180c to 184c, is the *recitation of the Qur'anic verse*, which was identified during the divination phase as uniquely relevant to the patient's ailment: Sura 48:1–3, whose title is 'Victory' (Arberry 1976:225). Unlike the recitation of the Hadith (starting with *ba bu salaasa* at line 157c), which is glossed in Wolof by the *sérîñ*, the Qur'anic verse is recited only in Arabic. This verse extols Allah's grandeur and His power to triumph over all obstacles and opponents. At the conclusion of this verse at line 184c, the *sérîñ* casts his saliva on the patient, although he also includes himself in the scope of this act. The saliva is believed to be the physical carrier of the Qur'anic verse itself. The casting of saliva (in Wolof, *tëfli*)—which is an extremely widespread and important practice among Senegalese *sérîñs*—is in certain ways a "eucharistic" climax of the encounter, as I describe in more detail later. The final phase is the *farewell*, in which the patient takes leave, a phase that stretches from lines 185 to 191.

The Multimodal Texture of Intimacy in the Greeting Phase

In Senegal, as in many other parts of the globe, greetings help serve to establish, define, and maintain social relationships. Wolof speakers typically do not meet or initiate a conversation without first exchanging elaborate greetings. Although Irvine's (1974) study of Wolof greetings found considerable evidence of interactional asymmetry, in Senegalese ethnomedical greetings asymmetry, though undeniable, is tempered by a texture that projects intimacy, evidence of which I present below.

Discourse-Level Evidence

Immediately apparent from the data transcribed in the first phase of this ethnomedical event, the initial greetings, is the high frequency of latching, that is to say, cross-turn contiguity of utterances less than one-tenth of a second apart. I concern myself only with cross-turn latching rather than turn-internal latching. The former is able to help project intimacy between the two speech participants, as argued below.

Initial greetings

In addition to latching, a high frequency of overlap, initiated by both the *sérîñ* and the patient, is also evident in the transcript below.⁶ As indicated in Table 2 below, latching and overlap together constitute 92.6 percent of the 66 turns during the greeting phase. While their frequency decreases, they remain very high during nearly all subsequent interactional phases. Considered as a whole, overlap and latching constitute 74.5 percent of turn boundaries and are thus highly recurrent features of the interaction. Further, the *sérîñ* and the patient initiate latching and overlap in a nearly symmetrical fashion over the course of the encounter. During the greeting phase, for instance, the *sérîñ* initiates latching 17 times, while the patient initiates it 18 times. Similarly, the *sérîñ* initiates overlap 15 times, while the patient initiates it 12 times. In cases of simultaneous overlap (which were relatively few in this

Figure 1

Initial Greetings Phase, lines 11–12 (see transcription below). From the left: Sérin Sinaañ, Djafara Fofana (image extracted from original video footage).

encounter), I have counted both interactants as initiators (e.g., lines 20b–21 in the transcribed segment presented below).

What significance might such discourse-level patterns have here? I suggest that the recurrent latching and overlap create the impression of a seamless dialogue between the voices. The relative lack of temporal separation between the turns comes to signify a relative lack of interpersonal separation between the speech participants; that is, this pattern helps project a sense of interpersonal intimacy. It is unlikely, however, that this texture of latching and overlap alone is able to signify intimacy with any determinacy. Rather, it is when this texture co-occurs with mutually supportive textures—such as the deictic patterns considered below—that intimacy appears a more likely construal.⁷ Further, publicly circulating metadiscourses, cited earlier, that stress the need for intimacy between healer and patient also help interactants discover the cultural coherence of these event-internal textures.

Deictically Projected Intimacy: The Wolof Proximal Deictic Stem -i-

If one attends to grammaticalized indexical devices, specifically to the proximal-to-speaker Wolof deictic stem *-i-*, one finds further evidence that a texture of intimacy is in play. This deictic stem, on which various classifier prefixes are added, occurs throughout the encounter, but is used in a marked fashion relative to nonethnomedical contexts.⁸ Of the eight questions that the patient poses to the *sérin* during the greeting phase, seven contain the proximal deictic stem *-i-*.⁹ Upon examining other ethnomedical encounters in my corpus, I detected a similar use of this deictic stem during the initial

TRANSCRIPT

Participants:	Top: Wolof Speech Event Middle: Interlinear Gloss Bottom: English Translation	(Kinesics) [[Transcriber's Comments]]
PATIENT: 1	<i>Salaam Maalekum!</i> Peace be upon you 'Peace be upon you!'	{WITH HIS SHOES REMOVED, THE PATIENT KNOCKS ON THE EDGE OF THE DOOR, THEN ENTERS THE HUT BAREFOOT. HE APPROACHES THE <i>SÉRIN</i> , WHO IS SEATED ON THE FLOOR; THE <i>SÉRIN</i> , IN TURN, GLANCES UP}
		[[Arabic expression]]
<i>SÉRIN</i> : 2a	(0.22) <i>Maalekum Salaam!</i> Upon you be peace '(0.22) Upon you be peace!'	{THE <i>SÉRIN</i> 'S GAZE RETURNS TO THE PAGES OF THE BOOK ON HIS LAP AS HE UTTERS THIS ARABIC EXPRESSION}
	2b (0.99) <i>Bissimillah!</i> Blessed be Allah '(0.99) Welcome!'	[[Arabic expressions]]
PATIENT: 3	(0.44) Ah- gó- góor gi! Ah, ma- man the-CLSF-SG-PROX '(0.44) Ah, nice to see you here!'	
<i>SÉRIN</i> : 4	(0.31) Waaw = Yes '(0.31) Yes ='	{THE <i>SÉRIN</i> GAZES UP AGAIN AT THE PATIENT AND THEN RETURNS HIS GAZE DOWNWARD A MOMENT LATER}
PATIENT: 5	= Siñaafi waay = Siñaafi-LST NM but-INTNS '= Oh, Siñaafi ='	[[Siñaafi is the last name of the traditional healer]]
		{HAVING COME CLOSE TO THE <i>SÉRIN</i> , THE PATIENT EXTENDS HIS RIGHT ARM. HIS LEFT ARM IS KEPT CLOSE TO HIS BODY, ITS PALM FACING DOWN ON HIS RIGHT ARM. HE SHAKES THE HEALER'S HAND (SEE FIGURE 1)}
<i>SÉRIN</i> : 6	= Na nga def? How you-AUX.SUBJ do '= How are you doing?'	
PATIENT: 7	[Siñaafi Siñaafi-LST NM 'Siñaafi'	
<i>SÉRIN</i> : 8	[Sa yaram jamm Your health peace 'Peace be upon your health'	[

TRANSCRIPT

Participants:	Top: Wolof Speech Event	{Kinesics}
	Middle: Interlinear Gloss	
	Bottom: English Translation	[[Transcriber's Comments]]

(Cont.)

			{THE PATIENT STARTS TO ROLL HIS RIGHT HAND BACK TOWARD HIM AND REGRASPS THE HEALER'S HAND BY WRAPPING HIS FINGERS AROUND HIS THUMB AND THE BACK OF THE HEALER'S HAND. THE HEALER FOLLOWS HIS LEAD AND DOES THE SAME}
PATIENT: 9	[Siñaan Siñaan-LST NM 'Siñaan' [		
SÉRIN: 10	Sa yaram jamm Your health peace 'Peace be upon your health' [		
PATIENT: 11	Jamm rekke Siñaan Peace-SUBJ only-ADV Siñaan-LST NM 'Peace be upon you, Siñaan' [		{BOTH THE PATIENT AND THE SÉRIN RECLASP HANDS IN A REGULAR HANDSHAKE FASHION}
SÉRIN: 12	Jamm rekkey = Peace-SUBJ only-ADV 'Peace be upon you ='		
PATIENT: 13	= Naka wa kër gi? How of house-SUBJ the-CLSF-SG-PROX '= How is your household here doing?' [		{THE SÉRIN IS THE FIRST TO WITHDRAW HIS HAND, WHILE THE PATIENT LEAVES HIS HAND OUTSTRETCHED FOR A MOMENT, THEN RETRACTS IT}
SÉRIN: 14	Sa yaram jamm = Your health peace 'Peace be upon your health ='		
PATIENT: 15	= Naka njaboot gi? How family-SUBJ the-CLSF-SG-PROX '= How is your family here?' [		
SÉRIN: 16	Jamm rekke = Peace-SUBJ only-ADV 'Peace be upon you ='		
PATIENT: 17	= Naka xale yi? How children-SUBJ the-CLSF-PL-PROX '= How are your children here?' [		{THE PATIENT STARTS TO KNEEL DOWN ON HIS LEFT KNEE}
SÉRIN: 18	Sa yaram jamm Your health peace 'Peace be upon your health' [		

TRANSCRIPT

Participants:	Top:	Wolof Speech Event	{Kinesics}
	Middle:	Interlinear Gloss	
	Bottom:	English Translation	[[Transcriber's Comments]]
(Cont.)			
PATIENT: 19	[	Jàmm rekke Siñaan Peace-SUBJ only-ADV, Siñaan-LST NM 'Peace be upon you, Siñaan'	
SÉRIN: 20a	[	Jàmm rekkey = Peace-SUBJ only-ADV 'Peace be upon you ='	
20b		= <i>Alxamdullillây</i> Thank Allah '= Thank Allah'	[[Arabic expression]]
PATIENT: 21	[	= <i>Alxamdullillây</i> = Thank Allah '= Thank Allah ='	[[Arabic expression]]
SÉRIN: 22		= Jàmm rekke <i>alxamdullillây</i> Peace-SUBJ only-ADV thank Allah '= Peace be upon you, thank Allah'	[[Arabic expression]]
PATIENT: 23	[	Na nga def ag liggéey bi? How you-SUBJ do with work-iOBJ the-CLSF-SG-PROX 'How is your work going here?'	
SÉRIN: 24	[	Jàmm rekkey = Peace-SUBJ only-ADV 'Peace be upon you ='	
PATIENT: 25		= Jàmm rekke, Siñaan Peace-SUBJ only-ADV, Siñaan-LST NM '= Peace be upon you, Siñaan'	{THE PATIENT GLANCES OVER AT THE VIDEOGRAPHER}
SÉRIN: 26	[	Sa yaram jàmm = Your health peace 'Peace be upon your health ='	
PATIENT: 27		= Na nga def ag coono? How you-AUX.SUBJ do with tiredness-iOBJ '= Are you tired?'	{THE PATIENT GLANCES AT THE SÉRIN QUICKLY, THEN TURNS AWAY}
SÉRIN: 28	[	Jàmm rekke <i>alxamdullillây</i> Peace-SUBJ only-ADV thank Allah 'Peace be upon you, thank Allah'	[[Arabic expression]]
PATIENT: 29	[	Jàmm rekke = Peace-SUBJ only-ADV 'Peace be upon you ='	
SÉRIN: 30		= Jàmm rekke = Peace-SUBJ only-ADV '= Peace be upon you ='	
[...]			

Table 2
Frequency of initiated latching and overlap.

Phase of Encounter	(L)atching		(O)verlap		L + O/ # of Turns	% Total L + O
	<i>Sérññ</i> (%)	Patient (%)	<i>Sérññ</i> (%)	Patient (%)		
1) Initial Greetings	17 (25.8)	18 (27.3)	15 (22.7)	12 (18.2)	62/66	93.9
2) Prelude	6 (33.3)	6 (33.3)	1 (5.6)	1 (5.6)	14/18	77.8
3) Reinitiation of Greetings	4 (40.0)	2 (20.0)	0	2 (20.0)	8/10	80.0
4) Disclosure of Symptoms	14 (30.4)	12 (26.1)	3 (6.5)	4 (8.7)	33/46	71.7
5) Diagnosis and Prescription	0	0	0	0	0/3	0
6) Interruption by Son	2 (15.4)	0	0	0	2/13	15.4
7) Recitation of Hadith	0	0	0	0	0/6	0
8) [Break]						
9) Offering of Medicine	4 (33.3)	6 (50.0)	0	0	10/12	83.3
10) Offering of Thanks	3 (37.5)	3 (37.5)	1 (12.5)	0	7/8	87.5
11) Recitation of Qur'anic Verse	0	0	0	2 (50.0)	2/4	50.0
12) Farewell	2 (33.3)	0	0	3 (50.0)	5/6	83.3
Total	52 (27.1)	47 (24.5)	20 (10.4)	24 (12.5)	143/192	74.5

greeting phases; thus, this pattern appears to be quite common. That the use of the proximal deictic stem is marked here was especially evident from several playback experiments that I conducted with Senegalese speakers. Although my informants found the greeting phase of the ethnomedical encounter “typical” based on the video data, they responded differently when I showed them the transcript. Several informants who scrutinized the grammar in my transcript were surprised by the frequency of the Wolof proximal deictic stem *-i-*. They felt that these must be mistakes. In a situation in which one addresses someone of higher relative status, as the patient was doing to the higher-status *sérññ*, according to my informants, one should use the Wolof distal deictic stem *-a-*, regardless of whether the referents of the noun phrases are nearby. They thus stipulated a standard of appropriate deictic usage for communicating deference to a healer. However, the standard of polite distance created through the use of distal deictic forms was noticeably absent in this ethnomedical encounter. The proximal stems deictically project a different interactional schema, one in which the referent of a noun phrase is proximal to the speaker of the utterance containing the token *-i-*. This schema is shown in the questions that the patient poses to the *sérññ* (Table 3).

In these questions, the referents of the noun phrases ‘your household’, ‘your family’, ‘your children’, ‘your work’, and so forth, are deictically projected as proximal to speaker. This co-occurrence pattern and the latching and overlap texture mentioned above seem to operate together to produce a common effect, an image of intimacy. The high frequency of such proximal deictics has a cumulative effect of projecting an interactional schema in which the speaker of the utterance is close to—intimate with—his referents. This use of deictics thus seems to be another resource for creating the impression of connectedness or intimacy. However, this deictically projected

Table 3
Questions containing the proximal deictic stem *-i-*.

Line	NPs Proximal to speaker
PATIENT: 13 = Naka wa <i>kër gi</i> ? How of <i>house-SUBJ the-CLSF-SG-PROX</i> ‘How is <i>your household here</i> doing?’	<i>your household</i>
PATIENT: 15 = Naka <i>njaboot gi</i> ? How <i>family-SUBJ the-CLSF-SG-PROX</i> ‘How is <i>your family here</i> ?’	<i>your family</i>
PATIENT: 17 = Naka <i>xale yi</i> ? How <i>children-SUBJ the-CLSF-PL-PROX</i> ‘How are <i>your children here</i> ?’	<i>your children</i>
PATIENT: 23 Na nga def ag <i>liggéey bi</i> ? How you-SUBJ do with <i>work-iOBJ the-CLSF-SG-PROX</i> ‘How is <i>your work going here</i> ?’	<i>your work</i>
PATIENT: 31 = Naka <i>soxna si</i> ? How <i>wife the-CLSF-SG-PROX</i> ‘= How is <i>your wife doing here</i> ?’	<i>your wife</i>
PATIENT: 33 = Naka <i>xale yi</i> ? = How <i>children-SUBJ the-CLSF-PL-PROX</i> ‘= How are <i>your children here</i> ? =’	<i>your children</i>
PATIENT: 51 = Naka <i>xale yi</i> ? = How <i>children-SUBJ the-CLSF-PL-PROX</i> ‘= How are <i>your children here</i> ? =’	<i>your children</i>

intimacy differs from the intimacy projected through the texture of latching and overlap in at least one respect: It is the patient who initiates this pattern consistently over the course of the greetings phase, while in the former case the intimacy is symmetrically projected.

During a playback experiment with Mamadou Sow, a Senegalese informant who currently resides in Philadelphia, he commented on the overlap and latching of this initial greetings phase. He remarked that the initial greetings seemed ‘melodious and harmonious’ (Fr., *mélodieuses et harmonieuses*), and added that the greeting event was ‘like a braid’ (Fr., *comme une tresse*), in the sense of braided hair. He stated that this was a “real” encounter between a Senegalese traditional healer and a patient and stressed, like Marc Ndome, quoted above, that greetings must be this way; otherwise, the healing therapy is less likely to be effective.

In short, a high degree of attention and significance is given to the greetings phase of ethnomedical encounters. The capacity to feel closely connected and intimate with the *sérin* is deemed essential. The braidlike quality of the greeting, as Sow put it, increases the efficacy of the subsequent ritual. By contrast, if the greetings do not go well, this is believed to reflect negatively on the relationship between the *sérin* and the patient, which in turn does not bode well for the healing ritual that is soon to follow. In this respect, the multimodal texture described above helps establish for the participants a semiotically palpable sense of connection, without which the healing practice is said to risk failure.

Asymmetry in the Ethnomedical Encounter

Intimacy, however, is not the only textually emergent effect evident in this ethnomedical encounter. Further attention to the greeting phase reveals an additional multimodal texture, one that projects status asymmetry. As Kuipers (1989) remarks, contemporary research on medical discourse between doctors and patients has often been preoccupied with showing how authority and asymmetry are reproduced over the course of the interaction. For instance, in his study of Bangladeshi doctor–patient relationships, Wilce (1997) found that doctors overlapped with the speech of their patients, while patients did not do the same with doctors. This nonreciprocal pattern of overlap was “indicative of an unequal distribution of power” (Wilce 1997:358). Unlike in Wilce’s study, overlap and latching between the *sérîñ* and the patient in the above interaction is highly symmetrical with respect to who initiates these patterns. This symmetry, coupled with publicly circulating metadiscourses on the value of intimacy in ethnomedical encounters, invests overlap and latching with a different significance from the findings of Wilce and many others who have analyzed doctor/patient discourse. Nevertheless, patterns that project asymmetry do co-occur with this intimate texture. As I describe below, during most phases of the ethnomedical encounter the interlocutors create a multilayered text structure in which intimacy and asymmetry are both preserved through distinct co-occurring patterns that are overlaid upon one another. In this case, the exchange of certain semiotic devices preserves status asymmetry, whereas other concurrent patterns, overlaid upon the first, establish a type of intimacy or closeness between the speech participants that is said to be critical to the ethnomedical interactional genre itself. In what follows, I consider six sources of evidence of asymmetry:

1. Asymmetrical patterns of greeting initiation and questioning
2. The patient’s deference toward the *sérîñ* as conveyed through name invocation
3. Relative seating positions
4. Asymmetrical patterns of eye contact and avoidance
5. “Staggered” use of Arabic by the patient
6. Presupposed asymmetry of expertise during the recitation of the Hadith

Asymmetrical Patterns of Greeting Initiation and Questioning

In linguistic-anthropological literature, there is a history of considering asymmetry as frequently invoked and reproduced over the course of greetings. In her classic study of Wolof greetings, Irvine remarks that “ranking is inherent in any [Wolof] greeting no matter how abbreviated, because the mere fact of initiating a greeting is itself a statement of relative status” (1974:175). She demonstrates how age, sex, religious status, and “caste” distinctions are typically marked over the course of Wolof greetings (Irvine 1973). Unlike the greetings of the Baatombu of Benin, where the greeting initiator is the higher-status speech participant (Schottman 1995:492–494), Irvine observes that the initiator of Wolof greetings is usually of lower relative status. It is the lower-status person who normatively takes the role of asking questions, whereas the person of higher relative rank remains the more passive respondent. As Irvine states, “Ideally, one greets ‘up’: it should be the lower-ranking party who greets the higher” (1974:169).

The patterns that Irvine observes are evident in the data that I analyze here. However, it is important to recognize that signs of asymmetry—which were indeed salient—co-occurred with the multimodal texture of intimacy described earlier. Irvine's observation that Senegalese typically "greet 'up'" is evident in this interaction by the very fact that it is the patient that offers the first "*Salaam Maalekum!*," not the healer. Similarly, when the *sériñ*'s younger son, Mariama, interrupts him, he too offers the first "*Salaam Maalekum!*" to his father (line 145). Irvine's remark that the one who asks the questions is construed as lower than the one who responds is supported by comparing the relative frequency of questions posed by the interlocutors (1974:175). Table 4, below, provides a list of all questions and responses in the greetings phase of the interaction. Notice that the patient asks three times as many questions as the healer (nine for the patient, and three for the healer).¹⁰

The Patient's Deference toward the Healer as Conveyed through Name Invocation

Most Wolof greetings, after the exchange in Arabic of *Salaam Maalekum/ Maalekum Salaam*, continue with what one might call a *name invocation sequence* in which one or both participants address alter by last name (LST NM). The vocative use of surnames is widely held by Senegalese to have deferential force (although this is not to suggest that utterances of LST NM vocatives are always taken up as instances of deference). More technically, LST NM address serves as a deference indexical that marks the addressee as having "deference entitlements" (Agha 1998:133; Shils 1982:145–146). In the ethnomedical encounter analyzed here, it is only the patient who addresses the *sériñ* in this way. At the very start of the initial greetings phase the patient utters "Siñaan," the last name of the *sériñ*, four times (lines 5, 7, 9, 19). Further, the reinitiation of the greeting is sparked by the patient, who again addresses the *sériñ* by his last name at line 85. And at the very close of the interaction, a capping name invocation is produced by the patient at lines 190 and 191.

The fact that it is only the patient who performs the name invocation may be explained by assuming that the *sériñ* does not, in fact, know the patient's last name. Nevertheless, the net semiotic effect remains: There is a clear asymmetry in terms of who utters and who receives deference indexicals. It is the patient who conveys deference to the healer through this mode of address, not vice versa.

Asymmetrical Seating Positions

Asymmetry is not only linguistically produced, however; it is also achieved by other means. One of the most obvious nonlinguistic semiotic facts that helps project asymmetry is the seating arrangement of the two speech participants. As soon as the patient enters the hut, instead of sitting on the chair located next to the *sériñ*, he kneels on his left knee and stays (in what must be an uncomfortable posture) in roughly that position for most of the interaction. I observed that this kneeling position was typically adopted by men during their encounters with healers. It is likely that to sit on the chair, and thus to be vertically higher than the *sériñ*, who is seated cross-legged on the ground, would be to declare oneself higher in status than the *sériñ* (cf. Keating 1998:70, 129, et passim). In this way, the patient appears to convey

Table 4
Questions and responses in the greetings phase.

PATIENT [Question]	→	SERIN [Response]
Naka wa kër gi? How of house-SUBJ the-CLSF-SG-PROX 'How is your household here doing?'	→	Sa yaram jàmm Your health peace 'Peace be upon your health'
Naka njaboot gi? How family-SUBJ the-CLSF-SG-PROX 'How is your family here?'	→	Jàmm rekke Peace-SUBJ only-ADV 'Peace be upon you'
Naka xale yi? How children-SUBJ the-CLSF-PL-PROX 'How are your children here?'	→	Sa yaram jàmm Your health peace 'Peace be upon your health'
Na nga def ag liggéey bi? How you-SUBJ do with work-IOBJ the-CLSF-SG-PROX 'How is your work going here?'	→	Jàmm rekkey Peace-SUBJ only-ADV 'Peace be upon you'
Na nga def ag coono? How you-AUX.SUBJ do with tiredness-IOBJ 'Are you tired?'	→	Jàmm rekke <i>alxamdullillàh</i> Peace-SUBJ only-ADV thank Allah 'Peace be upon you, thank Allah'
Naka soxna si? How wife the-CLSF-SG-PROX 'How is your wife doing here?'	→	Mu ngiy fi rekk She here-AUX.SUBJ-SIT-CNTV here-CLSF-SG-PROX only 'She is fine here'
Naka xale yi? How children-SUBJ the-CLSF-PL-PROX 'How are your children here?'	→	Ñu ngiy fi rekk They here-AUX.SUBJ-SIT-CNTV here-CLSF-SG-PROX only 'They are fine here'
Naka xale yi? How children-SUBJ the-CLSF-PL-PROX 'How are your children here?'	→	Jàmm rekke Peace-SUBJ only-ADV 'Peace be upon you'
Naka wa kër ga? How of house-SUBJ the-CLSF-SG-DIST 'How is your household?'	→	Jàmm rekke Peace-SUBJ only-ADV 'Peace be upon you'
[Response]	←	[Question]
Sifaañ Sifaañ-LST NM 'Sifaañ'	←	Na nga def? How you-AUX.SUBJ do? 'How are you doing?'
Ñu nga fa They there-CLSF-SG-DIST 'They are fine'	←	Ana wa Ndakaaru? Where of Dakar? 'How is your family in Dakar?'
Ñu nga fa They-AUX.SUBJ there-CLSF-SG-DIST 'They are fine'	←	An sa wa kër gi? Where your of house-SUBJ the-CLSF-SG-PROX 'How is your family doing here?'

deference by assuming a position that is physically and tropically lower than the *sérîñ*, a kneeling position that is maintained over the course of almost the entire interaction.

Asymmetry in Patterns of Eye Contact and Avoidance

Asymmetry is also achieved through the initiation and avoidance of eye contact. As Heath (1986:21, 177–178) observes in his study of doctor–patient interaction, changes in eye movement are typically accompanied by changes in head orientation. In the encounter analyzed here, while interactants undoubtedly rely upon head movement to infer gaze direction, it seems that eye behavior is felt to be the most socially significant moment in this complex behavioral sequence. If one considers the prohibitions placed on gaze direction at the Qur'anic schools (the *daa'ira* discussed below), it would seem that metasemiotic attention is placed most heavily upon the climax of the gaze behavior—that is, the eye contact itself—even if head movements help supply visual clues as to where the gaze is directed. For these reasons, the transitions (especially head movements) that lead into eye contact are not represented in the figures presented below.

During most of the initial greetings phase, the two speech participants studiously avoid eye contact. When the patient first knocks at the edge of the door, uttering “*Salaam Maalekum*,” *Sérîñ* *Siñaan* glances up quickly, but immediately lets his gaze fall back down upon the pages of a book on his lap. It is only after his eyes return to his lap that he utters the response to the initial “*Salaam Maalekum*” with “*Maalekum Salaam*” (line 2).

There are several occasions during the initial greetings phase in which the patient makes eye contact with the *sérîñ*. At line 40a the *sérîñ* glances up at the patient, and a moment later the patient gazes back at the *sérîñ*, as shown in Figure 2. (The earlier-to-later sequence of gaze behavior and linguistic utterances is to be read left-to-right.)

It is important to observe that the eye contact is initiated by the *sérîñ* and reciprocated by the patient. Further, the patient's eye contact ends sooner than the *sérîñ*'s. Even after the patient returns to his default downward gaze, the *sérîñ* maintains his gaze at the patient. In the series of lines immediately following the above material, we see a roughly similar pattern (Figure 3).

Although the patient initiates eye contact here, a split second later the *sérîñ* reciprocates with eye contact while the patient is still speaking. Noticeable again, however, is the fact that the *sérîñ* maintains eye contact far longer than the patient, who instead

Figure 2
Patterns of eye contact and avoidance in lines 40a–43.

Figure 3
Patterns of eye contact and avoidance in lines 45-50.

casts his eyes down and away. Although the patient quickly reestablishes eye contact with the *sériñ*, once again he does not maintain this eye contact for long. The *sériñ*, however, maintains contact much longer. This pattern is affirmed in the following exchange of turns (Figure 4).

Here again is the identical pattern illustrated in Figure 2 above, in the sense that the *sériñ* initiates eye contact and the patient reciprocates, and the patient quickly breaks off eye contact while the *sériñ* maintains it longer. The same pattern, in fact, appears robustly during subsequent phases of the interaction. Even during the divination phase when the *sériñ* trains his eyes upon the rosary before him, the patient—except for a split-second glance at the very beginning of this phase—does not look at the healer's face. Instead, he keeps his eyes trained on the healer's rosary or simply downward and away. In sum, the *sériñ* tends to initiate eye contact while the patient reciprocates afterward. Further, when the patient does reciprocate he tends to return to a downward gaze sooner than the *sériñ*.

What might be the significance of this pattern of eye-contact initiation and avoidance? Metadiscourses on gaze provide some clues. As many interviewees commented, in Senegal, eye-contact avoidance is important in many forms of interaction, which may be at least partly the result of early socialization at Qur'anic schools. As Cruise O'Brien notes, many Senegalese go to the Qur'anic school, the *daa'ira*, at a young age and usually spend from 15 to more than 20 years there. The instructors and supervisors at these schools are a special category of *sériñs* who usually teach the Qur'an for their entire life (Cruise O'Brien 1971). My informants indicated that one of the rules that students are immediately taught is never to gaze at anyone who is of higher status, nor to gaze at anything that appears attractive or interesting, such as food or objects. For instance, during meals, one is not allowed to gaze at the meal participants nor at the food on the other side of the bowl that is the center of Senegalese meals. In this sense, the avoidance of gaze is explicitly taught to Senegalese who attend the *daa'ira*. In particular, it is likely that the avoidance of eye contact with those of higher status serves as a deference indexical: The absence of eye contact marks the addressee as someone with deference entitlements.

Figure 4
Patterns of eye contact and avoidance in lines 62-66.

Although the default interactional mode may be for both the patient and the *sérīñ* to avoid eye contact and thus to mutually express deference toward each other in a manner consistent with behavior prescribed by teachers in the Qur'anic schools (and possibly elsewhere), the patterns of eye-contact avoidance and exchange in this interaction instead reveal asymmetry. As I have stated earlier, the patient tends to make eye contact only in response to eye contact initiated by the *sérīñ*. By contrast, the patient appears more likely to initiate eye contact avoidance. The fact that the higher-status *sérīñ* initiates eye contact can be seen as a kind of "dispensation" to suspend a standard of behavior that would ordinarily be maintained (cf. Ervin-Tripp 1973). This view is analogous to Paulston's (1976) discussion of pronominal address in Swedish. In her analysis, it is the higher-status speaker who has the right to "put the titles away" and initiate a switch from asymmetrical T/V pronominal address to symmetrical T/T address (1976:367).

"Staggered" Use of Arabic by the Patient

Wolof greetings in ethnomedical contexts contain a number of Arabic words and expressions. In this encounter, the Arabic words that appear with great frequency are *bissimillah* ('Thank Allah'), *alxamdullillà* ('Blessed be Allah'), and *tubaarikall* ('Blessed be Allah'). There is a significant discrepancy in the number of these token Arabic words in the speech of the two participants: 18 of such terms are used by the *sérīñ*, whereas only eight are used by the patient. But far more revealing than the absolute frequency is the sequencing of these terms. In almost every case the patient does not initiate the use of Arabic terms; he appears to be reluctant to utter Arabic terms that have not already been introduced by the *sérīñ*. In all but two of the eight cases the patient merely echoes what has already been uttered in the immediately prior turn by the *sérīñ*, replicating the exact same word. What is one to make of this asymmetry in the use of Arabic terms? The answer may lie in their denotational content. As Caton (1986:294) suggests for Yemeni greetings, Arabic words and expressions in this interactional genre communicate praise for Allah and thus have a clear religious content. He argues that they mark the utterer as being a particular kind of person, that is, one who is humble and submits himself before Allah. In this light, it seems here that the patient would not dare be so presumptuous as to mark himself as a religious person relative to the *sérīñ*, because by default it is the *sérīñ* who should be more religious than himself. In other words, by initiating the use of these Arabic terms, and by using them more frequently, the *sérīñ* inhabits the cultural persona of the healer. By echoing the *sérīñ* and by using Arabic terms with less frequency, the patient marks himself as lower in his degree of religiosity. The asymmetry of Arabic usage thus marks a divide in religious authority between the high-status, religious *sérīñ* and the patient who humbly seeks his expertise.

Presupposed Asymmetry of Expertise during the Recitation of the Ḥadīth

In examining the use of Arabic between the speech participants, one should also consider the *sérīñ*'s recitation of the Ḥadīth. In this phase, stretching from line 157c to line 160m, the *sérīñ* recites the Ḥadīth in Arabic and provides a Wolof gloss. Each line begins with an Arabic word or phrase from the Ḥadīth, which is exegetically

unpacked immediately afterward in Wolof, as illustrated in the following lines (*italics* below indicate Arabic; the nonitalicized material is Wolof):

- 157j (0.50) *Wa ma Kountoume tahmalouna* ci mbir
Wa ma Kountoume tahmalouna in fact-CLSF-SG-PROX
 '(0.50) *Wa ma Kountoume tahmalouna* as for the problem'
- 157k (0.69) *Wa anta* naka yow
Wa anta how you-AUX.EMPH.SG
 '(0.69) *Wa anta* as far as your need is concerned'
- 157l (0.73) *Minal ahli xayri* (0.41) Yàlla dina la jox aw yiwu
Minal ahli xayri Allah it-AUX.FUT give benefit
 '(0.73) *Minal ahli xayri* (0.41) Allah will honor you with a benefit'
- 157m (0.58) *Wa sadatane* ak téxé
Wa sadatane and save
 '(0.58) *Wa sadatane* and He will relieve you of your problem'

The fact that the healer glosses the passages from the Hadīth for the patient in Wolof implies a difference in relative expertise between them. It is presupposed that the patient lacks both knowledge of the Arabic used in the Hadīth and knowledge of the Hadīth more generally and therefore needs the healer to gloss it for him in Wolof. In short, the *sérīñ* once again initiates patterns that index his discursive self-positioning with respect to an authoritative, transcendent realm. He implicitly brings the patient into contact with this realm through his mediating role as exegete.

The six independent yet overlapping textures described above can be seen as part of Duranti's multichannel architecture. As Duranti aptly writes with respect to greetings:

In fact, it is misleading to think of greetings either as linguistic or as nonlinguistic acts. They are, rather, complex cultural practices that exploit a number of semiotic (e.g., speech, gaze, posture) and material (e.g., the physical properties of the locale in which the encounter takes place) resources toward the goal of the constitution of actors vis-à-vis a context for their social existence. [1992:660]

In the ethnomedical interaction analyzed here, patterns of eye contact and avoidance, use of Arabic terms, and other resources help project a similar effect, and when these textures are related to one another they become mutually reinforcing (see Agha 1996:470). It is important to bear in mind that in this Senegalese ethnomedical encounter the effect of asymmetry is combined with the effect of intimacy, which is a hierarchy-flattening effect. Duranti's (1997a) findings on polyphonic, overlapping discourse in Samoan ceremonial greetings are germane here. He observes how patterns involving speech overlap project sameness and difference and signify a figure of sociopolitical individuality within a collectivity. Evidence for the cultural significance of the composite text structure in this case can be found by attending to metadiscourses that suggest that what is being projected is a figure of the healing process itself, a point that I return to later. As I discuss next, *tēfli*, that is, the casting of Qur'anic saliva, encapsulates even more vividly the way in which intimacy and asymmetry are interwoven in Senegalese ethnomedical encounters.

The Casting of Qur'anic Saliva (Tëfli)

In many ways, the recitation of the Qur'anic verse, and perhaps the entire ethnomedical encounter itself, reaches a climax when the patient is ritually blessed through the final *tëfli* by the *sériñ*. *Tëfli*, a Wolof metapragmatic term that we might gloss as 'to cast Qur'anic saliva', is considered vital in Senegalese ethnomedical encounters.¹¹ *Tëfli* is used in myriad ways. During fieldwork in rural areas, about half of the approximately 45 *sériñs* whom I met cast Qur'anic saliva upon me as an act of purification as soon as I entered their hut. Further, I witnessed *sériñs* spit upon the broken bones of a patient and ritually massage them back into place. I saw *sériñs* spit upon the heads of people who suffered from headaches, on the injured arm of a baby, on bloodied feet. I saw *sériñs* spit upon the ground as they walked away from their huts.

The location of the *tëfli* in the ethnomedical encounter reveals something about its significance. In this interaction, there are three occurrences of *tëfli*. The first is done to consecrate the rosary in preparation for the *sériñ*'s divination of the patient's illnesses. The second *tëfli* occurs during the medicine-preparation phase in order to 'charge' (Fr., *charger*), as one informant put it, the medicine that the *sériñ* has prepared. And the third instance, which is arguably the most ritually significant, occurs when the *sériñ* casts saliva upon the patient and himself at the very end of the ethnomedical encounter, at line 184c. This third instance deserves further attention. The left and right hands of the patient and the *sériñ* remain extended with fingers slightly interlocked while the *sériñ* recites the Qur'anic verse (Sura 48:1–3). At the conclusion of the recitation of the Qur'anic verse, while their hands are still outstretched, palms facing up (see Figure 5 below), the *sériñ* casts saliva in three short bursts, to the left, to the right, and straight ahead. Some of the particles of saliva undoubtedly reach their open palms. They then both bring their palms up and wipe their own faces. With that, the ritual portion of the encounter is concluded. Only the farewell remains.

Metapragmatic discourse on *tëfli* provides some of the best evidence as to its significance. According to some of my informants, one of the reasons that Senegalese are reluctant to use Western biomedicine is due to the fact that it is not properly blessed through *tëfli*. One informant, Mamoudou Sèygne Diagne from Kounghoul, said the following during an interview:

Tous les *sériñs* ici u:h au Sénégal font le *tëfli*. Les *tubaabs* n'aiment pas ça, je le sais, quoi [. . .]. Vous savez, le *tëfli* est plein de versets Coraniques qui peuvent passer du *sériñ* à la partie du corps du patient qui doit être traitée, ou bien au traitement médical que le *sériñ* prépare pour son patient. Moi, je ne me sentirais pas traité sans le *tëfli*, quoi. La thérapie et la rencontre seraient u:h incomplètes (0.3) uhm, tu dois me croire. Mais, en Italie, ils ont le *tëfli*, n'est-ce pas?

Tëfli is performed by all the *sériñs* u:h in Senegal. The *tubaabs* don't do that, I know it. [. . .] You know, the *tëfli* is full of Qur'anic verses that can pass from the *sériñ* to the body part of the patient that has to be healed, or to the medicine that the *sériñ* prepares for his patient. So, I wouldn't feel healed without the *tëfli*. The therapy and the encounter would be u:h totally incomplete (0.3) uhm, believe me. But, in Italy, they have *tëfli*, right?

Figure 5

Casting Qur'anic Saliva upon the Patient. From line 184c of the Recitation of Qur'anic Verse with *Tēfli* phase (image extracted from original video footage).

As this statement reveals, the medicine is felt to be activated only after it has been invested with the words of the Qur'an through the medium of saliva. The *sérin*'s saliva thus becomes sacred and potent for healing, as indicated also by Djafara Fofana, the patient in the above encounter, in a follow-up interview:

Le *tēfli* est essentiel pour l'efficacité de la thérapie, puisque les versets Coraniques peuvent être vraiment efficaces. Tu sais, les versets Coraniques ne peuvent pas rester dans l'air après que le *sérin* les a dits, quoi. Ils doivent donc u:h être crachés sur le patient et même sur le médicament que le *sérin* prépare pour le patient. Le médicament peut fonctionner seulement avec les versets Coraniques qui vont dans la salive et puis sur le patient. U:h ça c'est très important. Je le sais, les docteurs *tubaabs* ne crachent pas sur leurs patients et ça c'est très important pour les Sénégalais, tu sais (0.5). U:h. Le *sérin* peut cracher quand il se sent, mais il y a des moments spéciaux où il est comme forcé à cracher les versets Coraniques, c'est-à-dire, quand le médicament est prêt et quand il transmet sa connaissance thérapeutique, le *xam-xam*, en Wolof, comme tu sais u:h à son patient. C'est la seule façon d'être guéri pour le patient.

Tēfli is essential for the efficacy of the therapy, since the Qur'anic verses are really effective. You know, the Qur'anic verses cannot stay in the air after the *sérin* has uttered them. Rather, they have to be u:h spit upon the patient and upon the medicine that the *sérin* prepares for the patient. The medicine can work only with the Qur'anic verses which go into the saliva and then upon the patient. U:h this is very important. I know, the *tubaab* doctors do not spit on their patients, and this is a problem for Senegalese people, you know (0.5). U:h. The *sérin* can spit whenever he feels like it, but there are special moments in which he is forced to spit the Qur'anic verses, that is to say, when the medicine is ready and when he transmits his therapeutic knowledge, the *xam-xam* in Wolof, as you know u:h to his patient. This is the only way for the patient to be healed.

Saliva, in short, has become a carrier of sorts for the Qur'anic verse. Through investing his saliva with the Qur'anic verse, the healer as mediator is able to channel and transmit the Qur'an's healing power to the patient. At the end of the Qur'anic recitation, the *sérin* spits out the Qur'anic verse, as it were, in order to offer all its healing properties in palpable form—that is, the very drops of saliva—to the sick and needy patient. It is crucial to observe that in all cases, *tēfli* is preceded by the production of a stretch of language—for example, the Qur'anic verse Sura 48:1–3. This is the transcendent semiotic material of the Qur'an. Although not deemed translatable, it is nevertheless transmittable through a variety of vehicles, including saliva.¹²

Although *tēfli* does not have a complex internal semiotic structure in the way that language does, it does have indexical properties created by metapragmatic discourses about *tēfli*. Specifically, the act of casting saliva on an addressee implicitly invokes a diachronic schema, or what Agha (in press) has described as a "speech chain structure" (Figure 6).

Agha defines the notion of the speech chain as "a historical series of speech events, linked together by the permutation of individuals across speech act roles in the following way: The hearer of the (n)th speech event is the speaker of the (n+1)th event" (1999b:7). He argues that speech-chain structures link together individuals through activities of speaking, reading, writing, and so forth.

The links that comprised the speech chain in Figure 6, however, are not valorized identically. Rather, they are hierarchically organized, in the sense that Allah's communication to Mohammed is a speech event of a higher order than the speech event of the present, in which the *sérin* casts saliva upon the patient. To capture the hierarchical valorization of the links in the speech chain, I use vertical lines, rather than horizontal ones, to show role permutations. Each permutation of role involves a step

¹² The role permutation from the Qur'an-as-text-artifact to the Qur'an-as-speaker is achieved through the trope of personification. The numbering of the speech events (1°–4°) indicates degrees of remove from the original speech event between Allah and Mohammed.

Figure 6
Implicit speech-chain structure of *Tēfli*.

down, as it were, from the elevated encounter between Allah and Mohammed to the here-and-now of the ethnomedical encounter in contemporary Senegal.

To sum up, *tëfli* is an aspect of this ethnomedical encounter that is not linguistic, but is certainly meaningful. Metadiscourses about *tëfli* suggest that it projects a speech-chain structure that links the present speech event with a past series of events that lead back to Allah's original communication with Mohammed. This speech chain renders immanent the original speech event of Allah's communicating with Mohammed and helps transmit Qur'anic verses to the patient via saliva. This saliva in turn does considerable ritual work in ethnomedical contexts: It consecrates rosaries, activates medicine, blesses, purifies, protects, and heals. In certain respects, *tëfli* in the encounter is reminiscent of the Eucharist rite, especially as interpreted by Lutheranism. The Lutheran doctrine of consubstantiation asserts that the body and blood of Christ are copresent "in, with, and under" the substances of bread and wine (in contrast to the Roman Catholic doctrine of transubstantiation, in which the underlying substances themselves change). Here, the substance of the saliva does not itself become the verses. Rather, the saliva serves as a carrier or vessel in which the phonated Qur'anic verses can be placed, verses that can then bring the patient into communicative contact with the transcendent power of Allah.

Conclusion

In this article, I have discussed various ways in which the sign behavior in Senegalese ethnomedical encounters is marked off from "normal" interaction, including the use of lexical items such as Arabic terms, discourse-level patterns of overlap and latching, and the practice of *tëfli*. Considerable time was spent analyzing the greeting phases of the interaction since these phases were shown to be extremely dense and significant. In this encounter, I suggested, two internally complex multimodal textures are salient: one that projected intimacy and another that projected asymmetry. The textures and their semiotic effects can now be summarized as follows (Table 5):

Table 5
Summary of textures in the ethnomedical encounter.

Participants	Multimodal Textures	Semiotic Effects	
<i>Sérif</i>	Initiates and maintains eye contact	Offers "dispensation" to maintain eye contact	Intimacy ₁
Patient	Initiates marked proximal deictic pattern	Invocation of closeness	Intimacy ₂
Both	Initiate overlap and latching	Symmetric invocation of closeness	Intimacy ₃
Patient	Reciprocates eye contact, yet gazes away sooner than <i>sérif</i> Sits lower Invokes last name of <i>sérif</i> Poses more questions (about family, health, etc.)	Patient initiates self-lowering and other-raising that maintains deference entitlements toward <i>sérif</i>	Asymmetry
<i>Sérif</i>	Offers blessings Uses Arabic expressions Recites <i>l'adith</i> Casts Qur'anic saliva	<i>Sérif</i> initiates patterns that index his higher discursive self-positioning with respect to an authoritative transcendent realm	Asymmetry

The effects of intimacy and asymmetry are created by independent yet co-occurring linguistic and nonlinguistic textures. Intimacy is metapragmatically characterized in interview contexts as a crucial facet of *sérîñ*-patient interaction, without which there is said to be no spiritual connection and consequently no healing. As summarized in Table 5, three types of intimacy can be distinguished.¹³ Although all three textures project closeness between interlocutors, they differ with respect to who initiates the pattern. Intimacy₁ and intimacy₂ are asymmetrically invoked (by the healer and patient, respectively), whereas intimacy₃ is symmetrically invoked by both speech participants. The asymmetrical patterning of types 1 and 2 projects a status asymmetry between the healer and patient, which is reinforced by other patterns of status marking. As summarized in Table 5, this status marking is produced by a wide variety of semiotic resources, some strictly linguistic, others not. *Tēfli* is an important nonlinguistic practice that encapsulates the effects of both intimacy and asymmetry. On the basis both of its location in the ethnomedical encounter and of metapragmatic discourse about it produced in interview settings, I argued that an implicit hierarchical speech-chain structure is invoked with every token usage.

In short, this Senegalese ethnomedical encounter involves a mixture of two salient textually emergent effects. On the one hand, status marking is robust, in the sense that the *sérîñ* is clearly elevated before the patient while the patient lowers himself before the *sérîñ*. On the other hand, there are undeniable signs of intimacy, which informants state is necessary for healing rituals to work. This blend of intimacy and asymmetry can be seen, in turn, as a figure for how healing itself is imagined to operate: The patient contacts the healing power of Allah through the medium of the Qur'an, yet this contact, crucially, is further mediated by the *sérîñ*. It is thus through a hierarchical relay of spiritual power—from Allah to the Qur'an, from the Qur'an to the healer, and from the healer to the patient—that healing is enacted.

"Multichannel architecture," as Duranti has evocatively phrased it, has thus been approached in this article in terms of multimodal textuality. It has been suggested that emergent textures, which consist of overlaid patterns of token co-occurrence in various modalities, help social actors construe what kind of action is under way, thus serving metapragmatic functions. By itself, the pattern of Wolof proximal deictic usage described earlier in this article does not project a determinate effect of intimacy, yet when layered together with other patterns in various modalities and when contextualized in light of presupposed metadiscourses on healing and healer-patient relationships, a more determinate effect of intimacy is achieved. Writers who appreciate the importance of studying doctor-patient interaction have realized the need for a multimodal approach to medical encounters that does not attend only to the linguistic track (Frankel 1993; Friedman 1979; Heath 1986; Ong 1995). The multimodal study of doctor-patient interaction (and other genres of interaction) has been challenged, however, not only by the problem of how best to code and transcribe nonlinguistic behavior (see Birdwhistell 1970; Duranti 1997a:144; Ehlich 1993; Goodwin 1981, 1993; Heath 1986), but also by the problem of how to integrate data on gesture, gaze, seating positions, and so forth within one's broader analysis of discourse. A notion like textuality may be useful in this respect, for it provides a method and rationale for integrating various types of data. These data range from implicit multimodal textures (like the pattern of eye contact and avoidance or the proximal deictic pattern) to denotationally explicit metapragmatic discourse (like remarks about the need to be intimate with healers) that tries to formulate and more strongly entextualize the

cultural significance of these patterns. Denotationally explicit metadiscourses provide analysts with clues as to how interactants move from texture(s) to text, not only after the fact in interview contexts, but during the original event itself, insofar as the metadiscursive remarks expressed in interviews reflect presuppositions that were operative when the event originally occurred. By considering these different forms of data together, then, this article reconstructs how social actors themselves—in this case, a Senegalese healer and his patient—gave cultural coherence to their interaction at the time the video was originally filmed.

Notes

Acknowledgments. Sérin Siñaan, the traditional healer in the encounter that I analyze in this article, tragically passed away in January 2001. This article is dedicated to his memory. I am indebted to Dr. Asif Agha for theoretical and methodological guidance which he graciously provided during many phases of this project. Dr. Alessandro Duranti offered helpful advice on a previous draft, for which I am also thankful. I am grateful to Mamadou Sow and Djafara Fofana, who proofread my transcriptions of Wolof, to Hanaa Kilani for help with the transcription of Arabic, and to Michael Lempert for editorial feedback on the final draft. Finally, I wish to thank three anonymous reviewers together with the coeditor of the *Journal of Linguistic Anthropology*, Dr. Mary Bucholtz, for their astute comments and criticism. Any mistakes are my own.

1. This article is based on eight months of fieldwork in Senegal conducted during three summer trips, and it has benefited from work with Senegalese informants in Philadelphia and Italy as well. For two of the three summers (1999, 2001), I participated in the Dual Intellectual Citizenship (DICSS) program in Dakar coordinated by the African Studies Center at the University of Pennsylvania. In addition to the DICSS program, I received summer predissertation field funds from Penn's Department of Anthropology (2000) and an Africa Health Practicum award (2001) for research on ethnomedical centers in Senegal. In 2000, a Salvatori award enabled me to begin studying the transnational movement of Senegalese ethnomedicine to Italy. While in Senegal, I met with a total of 71 Senegalese traditional healers in rural and urban areas, with a number of their patients, and with many Western biomedical doctors and medical students in the region. The corpus of video data that I collected amounts to 53 hours, and the audio data amounts to roughly 200 hours. The Wolof and French data that are cited in this article were first transcribed by me and were then proofread by Mamadou Sow and Djafara Fofana. Orthographic conventions from three sources were used to transcribe Wolof: Fal et al. (1990); N'Diaye (1995); and Munro and Gaye (1997). Translations from Wolof and French into English, as well the interlinear glosses, are my own.

2. Although it is beyond the scope of this article to consider the diversity of ethnomedicine in Senegal, it is important to note that not all healers ground their practice in Islam to the same degree, nor are all healers Muslim (although the majority of them are). The encounter analyzed herein is a rather typical example of Muslim healer–patient encounters that I witnessed in Senegal. However, starting in the 1980s, several ethnomedical centers have arisen in Senegal that have sought to sever the link between ethnomedicine and Islam. These foreign-funded centers, which constitute a central aspect of my ongoing research, seek to secularize ethnomedicine by removing its Islamic underpinnings and to scientize it by creating laboratory-style facilities where herbal medicine is well “tested.” The use of divination and *tëfli* in such settings is thus often (at least officially) discouraged. The encounter analyzed here thus differs from encounters at these centers, although I am currently investigating the nature and extent of this variation.

3. *Anthropophagie* is not a disease per se; rather, according to my Senegalese informants, it is a condition that human beings experience if negative spiritual entities act against them. More specifically, if someone is “chased” by a spiritual entity, he or she can suddenly disappear

and rematerialize far away from the locale where he or she lives. This creates psychological disturbances for the displaced person (D'Almeida et al. 1997:238–239).

4. My use of the term *texture* is not intended to conform to Halliday and Hasan's usage, in which texture refers simply to the "property of 'being a text'" (1976:2). As they write, "A text has texture" in the sense that it "functions as a unity with respect to its environment" (1976:2). They proceed to examine grammatical devices in English that serve as "resources" for the creation of denotational textual cohesion (e.g., anaphoric coreference).

5. In interviews, informants (including the patient of this encounter) indicated that ancestors (Fr., *les ancêtres*) are often contacted, that is, beings who have some genealogical relation to the patient or to the healer. Other classes of spirits—namely, the *jinne* or *rab*—may instead be contacted (see Kalis 1997:199). *Sériñs* are typically secretive about which spirits they contact and precisely how they contact them. For linguistic-anthropological reflections on divination more generally, see especially Du Bois (1992) and Wilce (2001).

6. My choice of transcription format is motivated by my wish to display, in a readable fashion, several concurrent facts about the interaction that play an important role in my analysis: Discourse-level patterns of latching and overlap, relevant nonlinguistic acts grouped under the "kinesics" column, and patterns of proximal deictic usage displayed in the interlinear glosses. By positioning the kinesics category to the right in my transcript, and by confining it to a smaller column, I do not mean to suggest that this aspect of the interaction is less important, but only that it is less relevant to the immediate point that I wish to make here. Later, when I highlight patterns of eye contact and avoidance, I utilize a very different transcription format in order to foreground gaze behavior. Abbreviations used in grammatical glosses are as follows: ADV—adverb; AUX—auxiliary verb; CLSF—classifier stem; CNTV—continuative suffix; DIST—distal deictic stem; EMPH—emphatic marker; FUT—future prefix for auxiliary verbs; IMP—imperative; INTNS—intensifier; LST NM—last name; NEG—negative stem; DOBJ—direct object; IOBJ—indirect object; PL—plural; PROX—proximal deictic stem; PAST—Past tense; SG—singular; SIT—situative infix; SUBJ—subject.

7. I have observed similar patterns of latching and overlap in nonethnomedical greetings as well, and thus I do not wish to argue that these patterns are unique to ethnomedical encounters. My claim is only that the significance that these patterns have contrasts with nonethnomedical greetings. Specifically, metadiscourses that stress the importance of intimacy in healing encounters have invested the intimacy projected by the texture of latching and overlap with cultural meaning that differs from these other settings. Additionally, when this texture is considered together with other co-occurring textures in the ethnomedical encounter, including the *tëfli*, the intimacy projected by the texture of latching and overlap becomes more strongly contextualized as therapeutic.

8. Although the use of the proximal deictic *-i-* appears to be marked relative to deictic usage in nonethnomedical greetings, the denotational content of the questions is not. Questions about family, health, and work are commonplace in Wolof greetings. Further, the evidence that I rely upon for my argument about the markedness of such proximal deictic usage in this genre is primarily from native informant commentary. Specifically, I relied upon playback experiments in which I sought both feedback on audio and video data from the encounter and commentary on the transcript of the event. The nature and degree of variation in deictic usage across actual Wolof greetings, however, is beyond the scope of this article. Therefore, the question of how distinctive this deictic pattern is to ethnomedical genres of greeting cannot be fully resolved here.

9. The only question that does not receive the proximal deictic is the following:

PATIENT: 27 = Na nga def ag coono?

How you-AUX.SUBJ do with tiredness-IOBJ

'= Are you tired?'

When compared to the other seven questions (see Table 3), this one differs in at least two respects: First, it is a yes/no question rather than a *wh*-question. Second, the Wolof term *coono* ('tiredness') denotes a negatively valued state. The latter fact in particular may help explain why it does not receive the proximal deictic. As I argue below for the other questions, the speaker uses the proximal deictic form to help project himself as close to or intimate with the healer, his family, his health, and so forth. Unlike the other constructions, the healer's tiredness may not be something to which patients normatively should demonstrate intimacy.

10. This asymmetrical pattern of questioning is not specific to ethnomedical greetings, but can be found in many settings in which there is an independently presupposed status asymmetry between the speech participants (e.g., in terms of age, religious standing, caste, and so forth). Irvine's (1985, 1990) work on *griot* and noble speech registers is relevant here. Irvine observes how cultural ideologies about high-ranking nobles and low-ranking *griots* in Senegal relate to characteristics of the speech registers—noble speech (*waxu géér*) and *griot* speech (*waxu gewel*) (1985:575)—associated with these types of persons. The registers themselves are shown to differ prosodically, although lexical and morphosyntactic differences are also evident. The *griot* register, in contrast to the noble register, is felt to be more active and affectively "hyperbolic." Importantly, Irvine observes that nobles sometimes use the *griot* speech register, for example, when making a request to a fellow noble (1985:576, 1990:136). These registers do not therefore simply index or reflect different stratified social groups as classic Labovian sociolinguistics would assume. Rather, they are registers that both nobles and *griots* can utilize and that can help shape social relations (see Agha 1994, 1999a). As two anonymous reviewers suggested, it may be that the patient's posing of more questions, his initiation of the greeting—in short, his more "active" role—may be a way to perform deference that is tropically *griotlike*.

11. By using the term *metapragmatic* here, I do not wish to suggest that the domain of pragmatics (which the term *metapragmatics* implies) necessarily involves linguistic modes of action. Spitting is itself not an act of language use. Still, it is an act that is capable of conveying social meaning. In semiotic terms, this act of spitting is indexically capable of invoking certain contextual facts; specifically, it can invoke a diachronic schema or speech chain of discourse transmission, as I describe below. I thus approach pragmatics broadly here and do not take linguistic utterances as the basic units of analysis. That said, the indexical meaning of casting saliva, as I argue, is created partly by metapragmatic discourse about this act, and thus language does play an important role in establishing the significance of what is essentially a nonlinguistic act. Additionally, the cotextuality of the saliva—that is, the multimodal patterns of token co-occurrence that surround and encompass the act of casting saliva—also helps interactants and analysts reach an interpretation about what kind of action is occurring.

12. Further, in Senegal, I noticed other ethnomedical practices through which the Qur'anic verses are ritually transmitted. I witnessed a common therapy in which the *sérîñ* uses a black pen, a white piece of paper, and water. Once the *sérîñ* has identified the Qur'anic verse that is capable of healing the disease, he starts inscribing it on the paper with the pen. When he finishes writing down the selected verse, he puts the paper in a small container—a bottle, a mug, or a small bucket—that has previously been filled with water. He then mixes the paper with the water until the paper's ink diffuses into the water. It is at this point that the solution, known in Wolof as *saafara*, becomes efficacious for healing. After this phase is complete, the *sérîñ* may ask the patient to drink this solution, bathe with it, or apply it to ailing parts of his or her body. Analogous practices exist in other parts of the globe. Wilce, for instance, observes that "Suyé curing songs are viewed as substances blown and rubbed into patients' bodies" (1999:97).

13. I am grateful to Dr. Asif Agha for helping distinguish varieties of the intimacy effect in this encounter.

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Appendix: Transcription Symbols and Abbreviations (based in part on Duranti 1992; Jefferson 1979; and Schiffrin 1994).

[[Utterances starting simultaneously.

[Overlapping utterances.

= Latching, or contiguous utterances, with an interval of less than one-tenth of a second between lines.

(00.00) Time intervals within and between utterances (length of pauses in seconds, tenths, and hundredths of seconds).

:: Syllable lengthening (more colons indicate greater length).

. Falling intonation.

, Continuing intonation.

? Rising intonation.

! Animated tone.

[. . .] Three dots between square brackets indicate that some material of the original transcript has been omitted.

{ TEXT } The material in small capitals and inside curly brackets indicates speech participants' kinesic behavior.

[[]] The material inside double square brackets indicates transcriber's comments.