

Religion, Magic, and Medicine

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DR. GHASSAN HAMADEH (*Third-year Resident in Family Medicine*): Today I will present a patient whose complaint, "pain in the feet and falling-out spells," proved to have more important implications of management than his obvious diabetes mellitus. I will review some of the interpretations and factual background of such complaints common in some black communities, in particular, in the Sea Islands of South Carolina. This presentation will use the Ecological Framework approach¹ as a means for generating hypotheses about the patient's behavior.

CASE PRESENTATION

Mr. W.W. is a 45-year-old black man, the only living child of Ms. E.S. His father died in 1972 of cancer at the age of 59 years. His younger brother also died of cancer in 1968 at the age of 24 years.

Mr. W.W. was first seen by me in the Family Medicine Center in June 1985 with the encouragement of his common-law wife, T.G., who is a patient in the center. At the time he joined the practice, he was a longshoreman earning \$18 an hour. He said he was Methodist. His family is shown in the genogram in Figure 1.

Mr. W.W. was given the diagnosis of diabetes in August 1984, when he presented to the emergency room in hyperosmolar state. He was admitted to the internal medicine service and started on insulin. He was later followed by the outpatient clinic at the Medical University of South Carolina.

In June 1985 he joined the Family Medicine Center (time line of important events and visits, Figure 2). In July 1985, he said, "My problem is my physical illness, which is causing me to lose time from work. I have pain in my feet and I'm having falling-out spells." In the fol-

lowing two months, Mr. W.W. was fired from his job, evicted from his home, and admitted to the hospital for hypoglycemia. He was also started on an antidepressant. His diabetes control did not improve after hospital discharge despite frequent, close follow-up visits. In September 1985, I asked Mr. W.W. to come to the clinic with his family for a "family interview"; he refused and did not show up at the scheduled appointment. He also was not home when I went to see him on a scheduled home visit six months later in March 1986. A member of his community reported that Mr. W.W. was going to "faith healing" services. A telephone call to the patient confirmed this activity. Mr. W.W. said, "The Lord has taken the demon out of my body, and I have never felt better in a long time. I have stopped taking insulin and am going back to my old job next week." The last contact with Mr. W.W. was in September 1986, when he came with his wife to see another physician. He reported he was feeling fine and stated he was not taking insulin. He expressed no interest in returning for further follow-up and said he had no job yet.

Mr. W.W. also has a history of hypertension, hernia repair, and acute pancreatitis due to alcohol. In 1980 he quit alcohol stating, "I have more faith now because back in 1980, when I had trouble with my pancreas because of drinking, I asked the Lord to take that stuff away from me and haven't touched it since."

ASSESSMENT

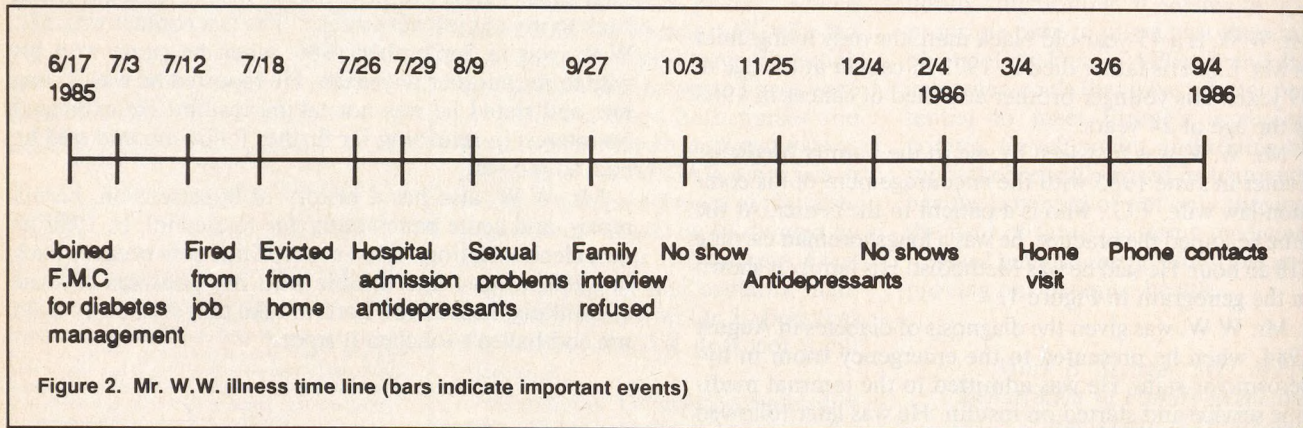
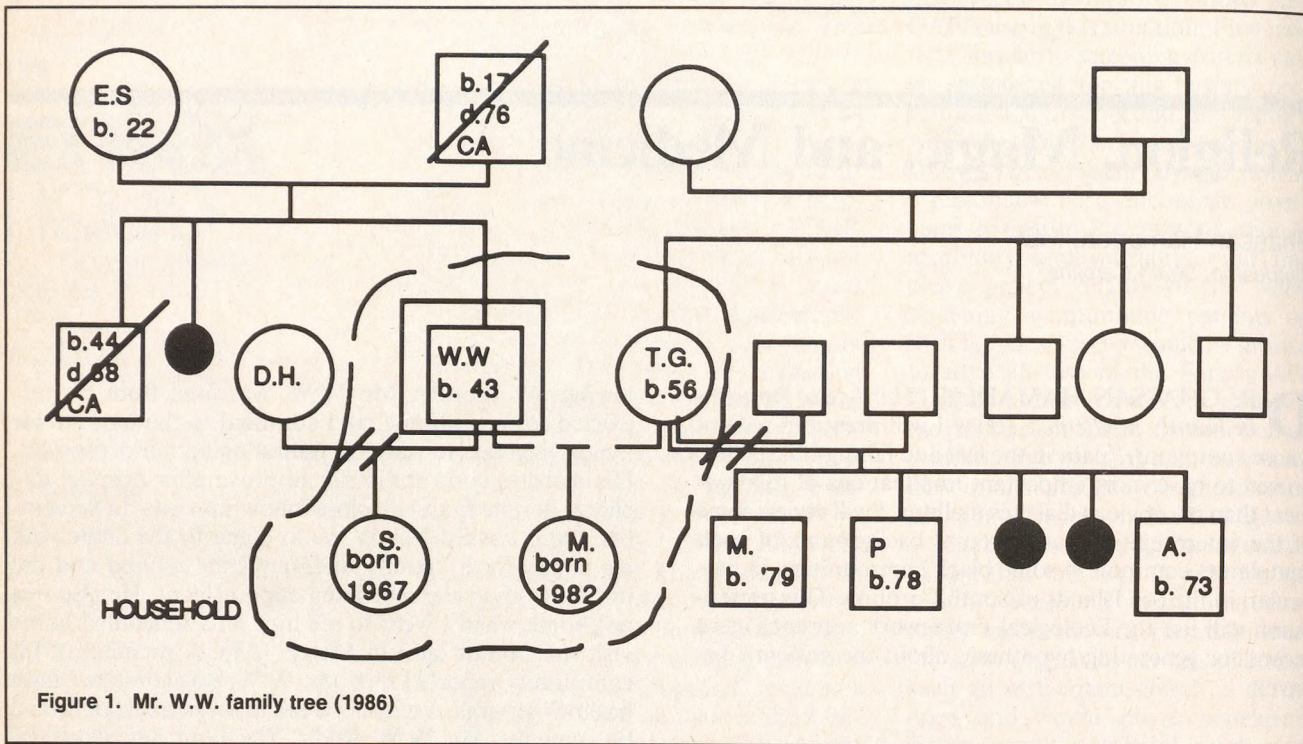
The following concepts from Galazka and Eckert¹ are helpful in analyzing this case: The clinical experience cycle (Figure 3) looks at the physician-patient relationship in the context of an ecosystem (Figure 4). Using these two models, it is possible to identify the stage at which physician-patient communication stopped so as to better understand Mr. W.W.'s case.

The Clinical Experience Cycle

In the first phase of the cycle, the patient has a sensation, labels it, comes to the physician, and presents a complaint.

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It is now the physician's turn to become aware of both the patient's real request and understanding of the problem. Failure to differentiate complaint and request leads to a breakdown at this level of interaction. Mr. W.W.'s case will illustrate how ignorance or underestimation of a patient's wider ecosystem (family, community, and culture) leads to a misunderstanding of the presenting complaint and the patient's predicament. If no block is met at this level of interaction and the physician becomes aware of the request, he or she can generate an explanation for the problem and share it with the patient. They come to a certain agreement, and a management plan compat-

ible with both parties' perspectives is implemented. The cycle is complete.

The Ecological Framework for Case Analysis

This framework allows for visualization of the patient's predicament and an understanding of his or her request. The potential for the outer circles to affect the inner ones and modulate the way an individual responds to environmental challenges is depicted in Figure 4. On the other hand, individuals have their own reactions and under-

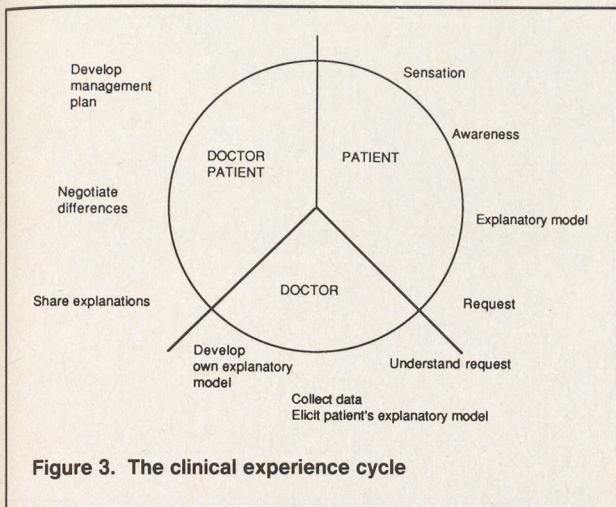


Figure 3. The clinical experience cycle

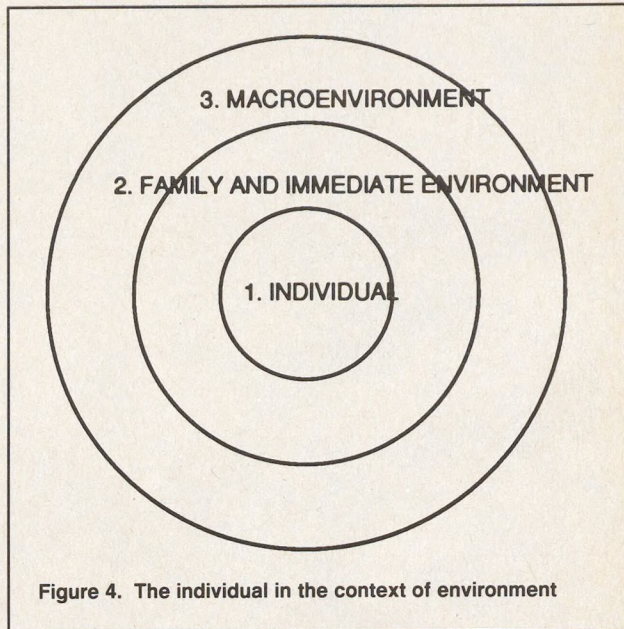


Figure 4. The individual in the context of environment

standing of environmental challenges. These interpretations could be completely different from those of their subculture. Overemphasizing either the cultural component or the individual component of behavior usually leads to bias.

HYPOTHESES

Many hypotheses can be generated to explain Mr. W.W.'s behavior. Using the ecological framework diagram, these hypotheses can be grouped by levels of analysis.

At the individual level, insulin resistance, psychological problems (learned helplessness, secondary gains), stress, depression, all may be contributing factors to poor response. Mr. W.W.'s blood glucose, however, improved in less than 48 hours after he was admitted to the hospital, and treatment of his depression did not alter his poor control (fasting glucose in the 16.65 nmol/L [300 mg/dL] range), making these explanations less likely.

At the family level (group of people living together, not necessarily related by blood or marriage but committed to live and care for one another over time),² the factors affecting Mr. W.W.'s illness include family myths and beliefs about diabetes and the family experience with the medical profession.

One example of family myths and beliefs is the belief that contact with physicians means death. Some blacks of the Sea Islands in South Carolina have a belief that going to the hospital means the end of their life; seeing the physician means that one is close to death.³ In the mind of the mother, and probably Mr. W.W., therefore, it could very well be an established belief that his hospitalization and worsening condition were ominous signs and that no help was really possible. No such belief could be elicited from the mother at the time of the home visit, however.

At the cultural level, factors affecting illness behavior may be absolutely unclear to the physician unless he or she is aware of the larger context of the patient's background. This background includes knowledge about the economic, social, and religious factors affecting a patient's life. In the present case, for example, unemployment may explain some of the patient's attitude and feelings.

Another cultural explanation of Mr. W.W.'s behavior, in particular his procrastination about returning to work, reluctance in following dietary advice or in taking insulin on time, may be found in the black male stereotype often described in the literature as having low self-esteem and poor coping strategies. Such a hypothesis, which assumes that Mr. W.W. "gave up" and was "helpless" when he was confronted by illness and economical stress, is strongly debatable and is an illustration of how exaggerating cultural variables may lead to ethnic bias.

The following is a review of the beliefs some black Americans hold about health. This review could clarify Mr. W.W.'s present complaint and explain his behavior using the ecological model of thinking.

Mr. W.W. had a good job and was functioning adequately until he got sick. He dealt with a previous health problem (alcoholism) through faith healing. Knowledge of this should have elicited an investigation about his perception of the present illness. The report that he was Methodist distracted his caretakers. Had we been aware of the meaning of his complaints set in the dynamics of Southern black culture and of the availability of other health care delivery systems, however, the problem could have been dealt with differently.

Of course, not all black Americans share the same religious beliefs. One should be cautious not to generalize

continued on page 566

INDICATIONS AND USAGE: HALCION Tablets are indicated in the short-term management of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings, and/or early morning awakenings.

It is recommended that HALCION not be prescribed in quantities exceeding a one-month supply.

CONTRAINDICATIONS: Patients with known hypersensitivity to this drug or other benzodiazepines.

HALCION is contraindicated in pregnant women due to potential fetal damage. Patients likely to become pregnant while receiving HALCION should be warned of the potential risk to the fetus.

WARNINGS: Overdosage may occur at four times the maximum recommended therapeutic dose. Patients should be cautioned not to exceed prescribed dosage.

Because of its depressant CNS effects, patients should be cautioned against engaging in hazardous occupations requiring complete mental alertness and also about the simultaneous ingestion of alcohol and other CNS depressant drugs.

Anterograde amnesia and paradoxical reactions have been reported with HALCION and some other benzodiazepines.

PRECAUTIONS: General: In elderly and/or debilitated patients, treatment should be initiated at 0.125 mg to decrease the possibility of development of oversedation, dizziness, or impaired coordination. Caution should be exercised in patients with signs or symptoms of depression which could be intensified by hypnotic drugs. Suicidal tendencies and intentional overdosage is more common in these patients. The usual precautions should be observed in patients with impaired renal or hepatic function and chronic pulmonary insufficiency. *Information for Patients:* Alert patients about: (a) consumption of alcohol and drugs, (b) possible fetal abnormalities, (c) operating machinery or driving, (d) not increasing prescribed dosage, (e) possible worsening of sleep after discontinuing HALCION. *Laboratory Tests:* Not ordinarily required in otherwise healthy patients. *Drug Interactions:* Additive CNS depressant effects with other psychotropics, anticonvulsants, antihistaminics, ethanol, and other CNS depressants. Pharmacokinetic interactions of benzodiazepines with other drugs have been reported, e.g., coadministration with either cimetidine or erythromycin reduced clearance, prolonged elimination half-life, and approximately doubled plasma levels of triazolam, hence increased clinical observation and consideration of dosage reduction may be appropriate. *Carcinogenesis, Mutagenesis, Impairment of Fertility:* No evidence of carcinogenic potential was observed in mice during a 24-month study with HALCION in doses up to 4000 times the human dose. *Pregnancy:* Benzodiazepines may cause fetal damage if administered during pregnancy. The child born of a mother who is on benzodiazepines may be at some risk for withdrawal symptoms and neonatal flaccidity during the postnatal period.

Nursing Mothers: Administration to nursing mothers is not recommended. *Pediatric Use:* Safety and efficacy in children below the age of 18 have not been established.

ADVERSE REACTIONS: During placebo-controlled clinical studies in which 1003 patients received HALCION Tablets, the most troublesome side effects were extensions of the pharmacologic activity of HALCION, e.g. drowsiness, dizziness, or lightheadedness.

	HALCION	Placebo
Number of Patients	1003	997
% of Patients Reporting:		
Central Nervous System		
Drowsiness	14.0	6.4
Headache	9.7	8.4
Dizziness	7.8	3.1
Nervousness	5.2	4.5
Lightheadedness	4.9	0.9
Coordination Disorder/Ataxia	4.6	0.8
Gastrointestinal		
Nausea/Vomiting	4.6	3.7

In addition, the following adverse events have been reported less frequently (i.e., 0.9-0.5%): euphoria, tachycardia, tiredness, confusional states/memory impairment, cramps/pain, depression, visual disturbances.

Rare (i.e., less than 0.5%) adverse reactions included constipation, taste alterations, diarrhea, dry mouth, dermatitis/allergy, dreaming/nightmares, insomnia, paresthesia, tinnitus, dysesthesia, weakness, congestion, death from hepatic failure in a patient also receiving diuretic drugs.

The following adverse events have been reported in association with the use of benzodiazepines: dystonia, irritability, anorexia, fatigue, sedation, slurred speech, jaundice, pruritus, dysarthria, changes in libido, menstrual irregularities, incontinence and urinary retention.

As with all benzodiazepines, paradoxical reactions such as stimulation, agitation, increased muscle spasticity, sleep disturbances, hallucinations and other adverse behavioral effects may occur rarely and in a random fashion. Should these occur, use of the drug should be discontinued.

No laboratory changes were considered to be of physiological significance.

When treatment is protracted, periodic blood counts, urinalysis and blood chemistry analyses are advisable.

Minor changes in EEG patterns, usually low-voltage fast activity have been observed in patients during HALCION therapy and are of no known significance.

DRUG ABUSE AND DEPENDENCE: Controlled Substance: HALCION Tablets are a Controlled Substance in Schedule IV. *Abuse and Dependence:* Withdrawal symptoms have occurred following abrupt discontinuance of benzodiazepines. Patients with a history of seizures are at particular risk. Addiction-prone patients should be closely monitored. Repeat prescriptions should be limited to those under medical supervision.

OVERDOSAGE: Because of the potency of triazolam, overdosage may occur at 2 mg, four times the maximum recommended therapeutic dose (0.5 mg). Manifestations of overdosage include somnolence, confusion, impaired coordination, slurred speech, and ultimately, coma. Respiration, pulse, and blood pressure should be monitored and supported by general measure when necessary. Immediate gastric lavage should be performed. Multiple agents may have been ingested.

Store at controlled room temperature 15°-30°C (59°-86°F).

Caution: Federal law prohibits dispensing without prescription.

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continued from page 563

and fall into ethnic bias; individuals may have beliefs very different from their own subculture.⁴ Following is a classification of illness and healers in some of the black communities. It draws heavily on the work of Baer⁵ and on the 1979 College of Charleston Symposium on Culture and Health.³

Classification of Illness

The Sea Islands black population has a system for classifying illness.³ A natural illness is called an ailment. It is caused by forces of nature or punishment from God and a regular physician can help. An unnatural illness, on the other hand, is called a condition. It is caused by the devil, evil, or witchcraft, and one needs a spiritual advisor.

This religious dichotomy, as well as faith healing, has its roots in multiple quotations and reports of healing in the Bible. The essential beliefs of religious healing can be summarized as follows^{4,6}:

God should be foremost in your thinking and thanked for all his blessings. He has a plan for you. Put your faith and trust in God and he will not do anything bad but might turn you over to Satan if you are not righteous. The devil will constantly try to tempt you and win control over your soul.

The basic concept is that illness comes from Satan because of some form of misdeed. God works miracles, however, and if you believe, God will heal you. If you do not, He will not do so. When one is sick because of a supernatural cause or demon possession, the sickness may show itself through symptoms such as burning in the feet or "falling-out spells." The logic sometimes touches the realm of magic, charms, and voodoo. Along with this hierarchy of illnesses there is a hierarchy of healers. Simply assigning one healer to conditions and another one to ailments may not be enough; a classification is needed. Baer provides such a typology of folk healers⁵: "There are healers and neighborhood practitioners, root workers, spiritualists, magic vendors and those who use cults. In cults, there is usually a certain ritual, dancing or performing a rite."

Classification of Healers

The independent healer is very much like the neighborhood physician assistant and is called "the old lady" or "granny." Usually a woman, she is a consultant who uses herbs and roots.

The root worker is like the granny but also interprets signs of nature. The root worker can be compared with the family physician because he or she interprets some signs of nature and sees the psychological dimensions of an illness.

The spiritualist does not know how to use herbs. He or she is somewhat similar to a psychotherapist. He or she claims to have had a call from God to help people with personal problems.

The magic vendor is comparable to the pharmacist. This vendor helps the spiritualist and knows everything about herbs. He or she works in a shop called the candlestore.

The faith healer is usually a pastor in a fundamentalist congregation, usually Holiness or Pentecostal. This healer is like the one whom Mr. W.W. was seeing. The faith healer uses praying, laying on of hands, and anointing with holy oil and gives blessed aprons and handkerchiefs. The pastor of Mr. W.W.'s church refused my request to visit him or attend his service. Griffith describes what happens in a healing service⁷.

The service is divided into three sessions: prayer, testimony and pastor finale. During the prayer session, a group leader comes out from the crowd and starts reading the Holy Book. The pastor may intervene every now and then and say a few things. Meanwhile, the crowd repeats loudly, "Amen, yes, Lord," and so on. For the testimony session, members stand up and describe how God has been helpful in their daily lives. They also describe how He cured their illness. The group keeps repeating such phrases as: "Thanks, Jesus," and "Tell it, sister." When asked about their feelings during the ceremony, people said they felt very comfortable about the entire service and that they liked the testimony because it gave them a feeling of warmth and support. Finally, the group gets in a circle, and the pastor performs his methods of healing that include laying his hands on people, anointing them with oil, or blessing them. During the procession some people go into a trance and may start dancing or speaking in tongues.

The voodoo man is both a root worker and a member of voodoo cult. The dangers of voodoo are death and the boomerang principle. Ceremonies are used to cast a hex on enemies. If one talks about the hex or spell, the hex may turn back on him or her.

The spiritual advisor is born with a gift of reading peoples' minds and their future. Usually this gift first shows up as a seizure at an early age.

CONCLUSIONS

The supernatural system is useful for explanation and support. It provides a good coping strategy through the prayer and ceremony. Black church meetings are certainly therapeutic in this sense.⁷

Mr. W.W. presented with a complaint that reflected his belief of the cause of his illness, and he had specific ideas about appropriate management. He was reluctant

to tell me of his beliefs, and I was not aware of them. This lack of communication interrupted the first stage of the clinical experience cycle, and the physician-patient relationship collapsed. At that point, Mr. W.W. felt that illness was beyond the comprehension of the "usual" medical care system and beyond his own control; therefore, he sought help elsewhere, through a system he had successfully used before—faith healing.

Some questions can be always asked when someone is in a new community. These questions may help the physician to understand a patient's predicament and go further in the clinical experience cycle⁸:

1. What is good health in the community's understanding?
2. When is a member considered ill?
3. What are common causal explanations of illness in the community?
4. What are the usual modes of treatment and the "alternative" health care systems available?
5. How much is the patient responsible for illness, cure and prevention?
6. Who is the medical decision maker in the family?
7. What are the attitudes about death and dying?

A better way of understanding patient requests is through empathy, or, as it is described in this Chinese quotation:

Go to the people
live among them,
learn from them,
love them.
Start with what they know,
build on what they have,
but of the best leaders,
when their task is accomplished,
the people all remark,
'We have done it ourselves.'

DR. ARTHUR C. HUTSON (*Professor, Department of Family Medicine*): Were the patient's blood glucose levels checked after he stopped taking insulin?

DR. HAMADEH: No, unfortunately, Mr. W.W. refused to have this blood test.

DR. EMILY TATUM (*Third-year Resident in Family Medicine*): What is the significance of burning feet?

DR. HAMADEH: Burning feet seem to be one of the earliest signs of being possessed. Falling-out spells are a later sign of demon possession. Diabetic or alcoholic neuropathy may be at the root of Mr. W.W.'s complaints, but this is unlikely, as he has had diabetes for only three years, is only 45 years old, and is not malnourished.

DR. STEVE LEVIN (*Second-year Resident in Family Medicine*): How can one use the information you presented, assuming it was known before the patient stopped coming to the clinic, and how can one deal with the patient's belief that his illness is the work of demonic powers?

DR. HAMADEH: This information allows you to understand the patient's request and dilemma (if one exists) when he or she first presents. In Mr. W.W.'s case, knowing about his belief in faith healing may have allowed a "controlled" faith-healing trial, during which I would have discussed his beliefs with him without requiring him to change them, been supportive about going to these sessions, and encouraged him to continue medical follow-up. It might have been possible to show him that the benefits of medical management are complementary to prayer.

DR. ALAN JOHNSON (*Psychologist, Department of Family Medicine*): Dr. Levin's question brings up an important point. Assuming the patient went to a faith-healing service and on follow-up his blood glucose levels remained elevated, would that mean the patient is still in sin or evil? I believe the physician can provide help by separating relief from the symptoms of the illness from their metaphysical or symbolic implications. The physician can treat the symptoms; the faith healer is still necessary in addressing the illness. By appreciating this distinction, the wise physician can help the patient find support and guidance in both systems.

DR. MARY GRAHAM (*Second-year Resident in Family Medicine*): Did Mr. W.W.'s common-law wife share his beliefs and encourage him to go to faith healing sessions?

DR. HAMADEH: Yes. She stopped coming to the clinic. A nurse working in the clinic reported seeing both Mr. W.W. and his wife go to a faith-healing session at a local church. She got in touch with the pastor of that church and told him of my interest in attending one of his ceremonies and discussing Mr. W.'s medical problems with him, but the pastor refused any encounter.

DR. JOHNSON: In Nepal, I was impressed by the remarkable flexibility of people to move between the various kinds of healers available in that culture, and I was wondering whether a medical provider could think about this faith healer in the same manner as he or she would a cardiologist consultant and be able to work with him the same way.

DR. HUTSON: This sounds like a health care supermarket. The consumers enter the supermarket and choose a provider of "care." If dissatisfied, consumers could present their complaints to as many providers as they wish. No additional charge would be made for a single entry into the health care supermarket.

DR. BRYCE DOWNEY (*Psychiatrist, Department of Family Medicine*): Recently, I met a 44-year-old man with chronic abdominal pain and "nervousness" of 22 years' duration. He reported to me that he believed he was hexed. He has never used the help of any local healers and never told any of his physicians about the hex. He felt trapped between believing in the hex and wanting to come to a "modern" physician.

DR. HAMADEH: To close, I will add to Dr. Downey's comment and emphasize the usefulness of the ecological framework in providing a systems orientation to patient care. This orientation allows the family physician to work with individuals of diverse cultural backgrounds without forcing them into the trap of having to choose between a modern physician and a traditional healer.

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