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## Introduction

Sociology has attempted to affect the therapeutic community in two ways. The first of these consists of our criticisms of both theory and practice because of the degree to which these do not fit the known epidemiology of phenomena known variously as mental illness and personal problems. The second attempt to influence has come from the philosophical stance of sociology: recognition of the relativity of realities. Although this paper addresses the second of these sources of influence, a few comments about the former first need to be made because of its effect on the latter.

## Background

Sociology, and increasingly, psychology and social work, have come to concentrate on the distribution of events. This is an attempt to overcome the criticisms most frequently aimed at applied fields such as psychoanalysis, clinical psychology, counseling, and social work. The first of these criticisms is the tendency to ignore complexity in favor of a single cause explanation--usually psychogenic not environmental. Second, inconsistency in prediction, identification, and cure has been noted. The third points to the reason for making the first and second criticisms, i.e., clinical research does not meet the minimal standards required by the scientific method.

Each of the named criticisms stems from a lack of attention to the distribution of events. An obvious first step in understanding the nature and cause of behavior or mental states would be to check for patterns, i.e., are there consistencies in the kinds of people who have more experiences of a type. For example, that women, Blacks, and the poor have higher official rates may be a clue to understanding that which we call mental illness. The logical demand then is that one must be able to account for patterning; explanation needs to take into account any distinctive differences in rates of occurrence. There appear to be two probable models of explanation which would take epidemiology into account and remain within the deterministic framework of sciences. The first would assume that a particular category of persons with rates of, for instance, mental illness higher than the rates of other categories experiences more of the cause. The second model posits that gatekeepers are more willing to label certain kinds of people mentally ill. The first of these assumes that there are variations in stress, learning, opportunity, self concept and so on which result in rate differences. The second assumes that the standards or perceptions of agents of control tend them to interpret certain kinds of people in a way resulting in a higher incidence of the phenomenon in question. It is likely that these explanatory models are not mutually exclusive, rather, both life experience and labeling practices are not randomly distributed. Because the focus of most literature has been on

etiology or cause of the behavior rather than the diagnostic decisions made, we will leave the former and concentrate on the latter. This interpretive or labeling model of explanation rests on the assumption that humans are not passive observers, rather, they take an active part in the outcome of interaction, largely by imposing interpretations as a basis for action (Blumer, 1969).

## The Interpretive Model

There is a possibility that all fields of the social and behavioral sciences need to go back to their philosophical roots and examine basic assumptions. From a philosophical point of view, one of the few truths is that truth is relative. Cultural and moral relativity is one of the most important principles in the social sciences. This principle is taken from the more extensive concept of a socially constructed reality (Berger and Luckmann, 1967). This refers to the idea that there is no such thing as a single objective definition of reality. There are only various and sometimes competing realities each of which is defined by a different group. It is obvious, even to laypersons, that the same empirical data can be used to support a variety of conceptions of reality--physical as well as social. What we do is to impose a pattern (or meaning) on "facts" (events, etc.) which in and of themselves, have no meaning. We continue to believe (a subjective phenomenon) that something is real, in an objective appearing sense, because the people we know believe so. In other words, there is some degree of consensus. Consensual validation is the sociological jargon for this. In addition, we hold on to beliefs, which may not be true, because they work, i.e., they make the world explainable and predictable. As long as the theory or definition of reality works and is supported by significant others, we will regard it as true.

Whether or not consensual reality is true in some objective sense does not really matter. To paraphrase W. I. Thomas (1937:42), whatever people believe to be real will be real in its consequences. When I see something, I must interpret it, give it meaning. If one believes in witches, they behave as though witches exist: they take protective measures, explain events in terms of witchcraft, and might even execute witches. Nonbelievers, on the other hand, may choose to execute witches because of their presumed heresy or to institutionalize them because they are crazy. Consensual reality, therefore, is extremely important socially and psychologically because it is the only operative reality that most people have. That is, most of us believe and act upon whatever we have learned to be true. That is what is meant by a social definition of reality. Like any social definition, consensual reality varies by time and place. The case examined here, voodoo, presents an interesting epistemological question: what happens when the realities of therapist or representative of a social agency and client differ? It is assumed that the interpretive or labeling model may account for the outcome.

## Voodoo in a Deep-South City

The study is part of ongoing research. As is frequently the case, it began serendipitously. The author is a rape counselor as well as sociologist. In the course of counseling rape victims, she ran across a number of instances in which voodoo was mentioned as central or peripheral to the rape. From some of the rape

victims, it became apparent that they had encountered difficulties in dealing with police and hospital personnel because of their beliefs. Initial interviews with people in some official position such as nurse or psychiatric social worker lent credence to the victims' observations that officials did not believe in voodoo and further, felt that believers were "weird" or in some other way not in touch with reality. As a consequence, most believers do not reveal the nature of their view of the world to outsiders (Webb, 1971). Further examination of a variety of believers and nonbelievers uncovered more specific patterns.

Researchers of voodoo have treated it in various ways including as an alternative medical system (Snow, 1974; Webb, 1971), a religion (Williams, 1979), and a subculture (Benyon, 1938; Snow, 1973). The inclusiveness of the concept of subculture seems to come closer to the adherents' beliefs than the other two which, logically could be subsumed under the more general.

Believers in voodoo in the area studied are not equally committed to or knowledgeable about the belief system. Variation runs from knowing that one can be hexed, that there are voodoo men, use of phrases, to the use of complex rituals and life involvement. All shades of voodoo systems take a deterministic stance; there is cause and effect with the source in the supernatural. Further, the system is based on the belief that humans, with certain skills or determination, can influence events over which the supernatural has control. Thus, birth, death, sickness, falling in love, jealousy, and success can all be seen as part of an order amenable to influence.

Because of this context, voodoo believers can use voodoo as a means of determining events. Mary, a relatively young mother, knew that her husband had become an active participant in voodoo rituals and somewhat of a pupil of a local voodoo practitioner. His new interest became the source of much dissension between them. Jack insisted that Mary, too, become involved; but she held to her disbelief. His attempts at dominating her became more frequent and insistent. All of this time, Jack's public presentation of self was that of a traditional young man and good husband. As is so often the case, the bonds of loyalty kept Mary quiet about what was happening in their home. In addition, she felt that Jack's conventional appearance and behavior would make others think that she lied. While cleaning out a closet, Mary found a shoe box containing a "voodoo doll" with pins stuck in it. The doll, with bits of Mary's hair sprinkled with salt, was wrapped in her underwear. Almost immediately Mary left her husband and children. She reasoned that if he was crazy enough to do "that", then he was crazy enough to kill her outright. She did not fear for the lives of her sons, but did plan to get custody of them as soon as she found a job. Jack's exact intentions are unknown, but it is clear that he was attempting to do something to Mary or that he wanted something to happen to her. The ritual use of the doll indicates that he tried to cause illness or death. In anthropological literature there is documentation of death by voodoo (Cannon, 1942; Lester, 1972; Clune, 1973; Lex, 1974), thus, there is clear indication of an effective reliance upon voodoo for causing certain outcomes. Thus, the most general parameter of voodoo is validated by proof of the senses (ritual causes death), ancedotes of what has happened to others, and consensual reality--the bulk of the evidence to which one is exposed tends to a certain conclusion: it works.

A more specific example of how voodoo "works" for insiders is to note that it

can be used as an explanatory framework of an unusual event. Yvonne, a college student with a young child, was having all kinds of interpersonal difficulties including an ex-boyfriend who kept shooting at her. She was in college against the wishes of her parents who thought she should find a good man and stay home where she belonged. They thought that if Yvonne did not straighten up that their granddaughter should come to live with them. The conflict between Yvonne and her parents escalated into overt hostility and they began using voodoo to manipulate her. For instance, inside her locked apartment some spirit had poured soap powder on the floor. Footprints were in the middle of the powder but not on the edges. Her car had been moved from one parking space to another. She finally became convinced that her parents would try to kill her through voodoo if she did not acquiesce. She was able to make sense of unusual events by explaining them as the result of voodoo.

Another instance in which meaning of events was established through the voodoo perspective involved Tweetie, a woman in her 60's, who had been brought to the emergency room by the police. She was, for the third time, a victim of forced cunnilingus perpetrated by her neighbor who was known to have gone to Sister Landor (a palmist, a Christian preacher with a radio show, and a voodoo leader) and bought powers. Tweetie didn't blame Sister Landor--who, after all, had to make a living--rather she blamed the man for misusing the powers to harass and attack her. He was able to get into her locked house and to commit mischief such as stealing money and spilling milk. When he abused her physically, he appeared as a spirit. This vague shadow either forced her to drink a drug or otherwise rendered her motionless: she had no control. She was very aware that the police and nurses did not believe her but would not deviate from her explanation. She reconciled the abuse she received and her assaulter's liberty by appeals to Jesus who would make sure each got her or his just rewards. Regardless of her faith that justice would prevail, she was suffering all the classic symptoms of the rape trauma syndrone.

One last example conveying the "real" nature of voodoo to believers involves Betty and Monica. Both are in the 7th grade, come from poor families, and are not well supervised. Each earns spending money by working as prostitutes for Mammy Belch. Regardless of the economic motive, their values, and what to them, is the excitement of being "working girls," both Betty and Monica explain their involvement through voodoo. Mammy Belch runs a combined "voodoo parlor" and house of prostitution in a rundown residential neighborhood. Clients can buy herbs, cures, potions, powers, and sexual services all under one roof. The girls claim that Mammy Belch puts a hex on them--by giving them the evil eye--in order to make them prostitute themselves and, not incidentally, takes most of the money for their services. It is not so much a matter of making them perform sexually as it is fear of what will happen if they don't. It is said this entrepreneur controls the neighborhood because of her voodoo ability. People are afraid that if they don't shape up in the direction Mammy Belch wants them to, they will be the recipients of the supernatural funneled through her.

Reactions

Many of us dismiss voodoo as a scam or con game. Although we don't know whether or not all voodoo practitioners are sincere, most assume that they are

not. In part, this is sheer ethnocentrism. In addition, most of us are not knowledgeable enough about another belief system to see how one event might fit into an entire system of thought. Leesa, partly as a lark, partly serious, went to have her palm read. Sister Turin mentioned a number of possible interpretations of Leesa's future. Because the palmist had been so accurate about her past, she was willing to believe that the predictions of the future had the same probability of veracity. Because some of the possibilities involved misfortune, Leesa became very concerned. Sister Turin told her that she could have some control over future events--that they were not inevitable. One alternative mentioned was the buying of powers which Leesa could use to protect herself. Being very concerned about what might happen, Leesa wrote a check for $150.00. A little distance and kidding from her mother and friends made Leesa conclude that she had been had. She put a stop order on her check and felt lucky to have escaped the clutches of this scheming woman who was willing to take her money and obviously was unable to give her anything in return. She was outraged that she almost had been conned (and possibly a little sheepish that she had allowed things to go so far).

Leesa's interpretation of voodoo is probably not that different from those in positions requiring them to deal with voodoo believers: basically, they don't believe in it. This fact is well known by believers who are, consequently, unwilling to reveal the real situation. Mary, anticipating reactions of police, religious counselors, welfare counselors, and abortion counselors did not mention voodoo in her contacts with various agencies. It was not until she was asked about her own emotional well-being that she felt free enough to reveal what had made her leave home and end as a rape victim.

Yvonne had approached two separate college counselors with the bare bones of her problems with her family and their effect of her finances and ability to concentrate. Both of the counselors, in making personal referrals to another agency described her as bizarre; there were gaps in her story which was interspersed with events which they assumed indicated she was unstable or lying.

Tweetie knew full well, from past experience, that her explanation of forced sexual assault would not be believed by the police, nevertheless, proceeded with calm religious assurance to relate her story to personnel at the hospital emergency room. To her consternation, most of the nurses were not even polite. Police officers and nurses openly exchanged giggles. The physician on duty was so disdainful of her "story" that he dismissed her without even performing the evidentiary examination required by law.

Betty and Monica attended school irregularly and when present were viewed as creators of disturbance in classes and the halls. Officials involved with delinquency cases had written them off incorrigible and assumed they had no decent future. It was not until one teacher, acting on her hunch that fear was central to the problem, approached the girls and uncovered the role of voodoo. Even then, most counselors and police-officers dismissed the girls' report as either false or silly.

Another instance related as typical, was uncovered in the realm of child protection. The case of a young girl, a victim of incest, was under review by a team faced with three alternatives: return the child to the home of victimization; place her in a foster home; or send her to her grandparents; respectable people who had requested custody of their grandchild. The most logical choice, the

latter was rejected because the grand parents believed in protective amulets and spells.

Indepth interviews with a psychiatric social worker who has considerable experience in a range of institutions and agencies and is highly thought of in the local therapeutic community revealed a consistent pattern; client/patients being observed or examined for indications of mental illness were uniformly classified as mentally ill if they expressed a belief in voodoo. In systematic recall, she noted that no other independent means of diagnosing was used. In instances she detailed, belief in voodoo was seen, in the circular manner so often used, as both a symptom and a form of mental illness.

One last example will suffice. The author, upon being invited to attend a meeting of the staff of a local mental health agency, was bombarded with questions requiring that she clearly define the religious parameters of voodoo (and legitimate them) and distinguish them from delusions indicative of mental illness. My rather hurried reply was to use Rosenhan's example of hallucinations.

> Thus, I may hallucinate because I am sleeping, or I may hallucinate because I have ingested a peculiar drug. These are termed sleep induced hallucinations, or dreams, and drug-induced hallucinations, respectively. But when the stimuli to my hallucinations are unknown, that is called craziness, or schizophrenia-- as if that inference were somehow as illuminating as the others. (1973:255).

One cynical member of the staff made the analogy to fundamentalists Christians and the difficulty the staff had in dealing with them when their numbers began to grow. More specifically, I noted the degree to which persons in powerful positions now openly related their conversations with God. In the past, conversing with the supernatural was considered prima facie evidence of mental disturbance, now it is used as the basis for legislation and public policy.

Analysis

The variety of views of voodoo indicated above points to the relativity of reality. Whether or not an event is thought to be true and to what degree is dependent upon the interpretation of the event. There is not an automatic response, rather we are forced to assign some kind of meaning to the event. Attaching the term voodoo to an event allows us to make it understandable. Whether or not our interpretation of an event is valid is irrelevant in the cosmic scheme of things. What is relevant is that we need to comprehend it; to make it fit into our conception of reality. The usefulness of voodoo to its believers is summed up on Malinowsky's words:

> Looking from far and above, from our high places of safety in the developed civilization, it is easy to see all the crudity and irrelevance of magic. But without its power and guidance early man (sic) could not have mastered difficulties as he has done, nor could man have advanced to the higher stages of civilization (1948:70).

The tongue-in-cheek view of nonbelievers is obvious. That definitions of reality are arbitrary and subjective rather than objective observations should be clear at this point: different people viewing the same phenomenon see it as different things. Yet, recognition of relativity is not enough for the researcher, the theoretician, or the practitioner. Given our reliance upon determinism, there must be some order and order which, hopefully, can be perceived. At this point, a reminder of epidemiology as a clue to understanding is relevant. How this relates to voodoo might be better illustrated by analogy than preached.

Most data in the mental field indicate that the poor, minorities, and urban residents have higher rates of psychological problems (Faris and Dunham, 1938; Hollingshead and Redlich, 1958; Rushing, 1964; Srole, et al., 1975). In addition, Blacks have a high incidence of psychoses (Scott, 1958) and women disproportionately experience depression (Redick, 1974; Chesler, 1972). That there are two acceptable models of explanation for distribution has already been noted. The first states that those with high rates experience more of the cause. The reader will have no problem understanding that a belief in voodoo is not evenly spread throughout the population; that one's heritage and environment would be strong influences on belief. However, when we shift focus and remember that a belief in voodoo is often the basis for diagnosing mental illness, the second or interpretive model comes to the fore.

The one pattern noted above which has been most adequately studied is that of women, however, it can be assumed that similar research on other categories would result in findings bolstering the interpretive model. The classic research is that of Broverman, et al (1970) in which clinicians were asked to describe a healthy adult, a healthy male, and a healthy female. There was general agreement among the respondent for all three. Their description of a healthy adult and a healthy male were very similar, however, a healthy female was described in very different terms. It is clear that what occurs is <u>not</u> an objective assessment of one's mental health, rather the process involves interpretation, a subjective phenomenon. The healthy woman or man is expected to be one who fulfills the stereotyped conception of their sex. Healthy women are seen to differ from healthy men by being more submissive, less independent, less adventurous, more easily influenced, less aggressive, less competitive, more excitable in minor crises, having their feelings more easily hurt, being more emotional, more conceited about their appearance, less objective and disliking math and science. Clearly "woman" and "adult" are seen as mutually exclusive. Women are in the position of choosing to exhibit those positive characteristics considered desirable for healthy adults and males and being considered unfeminine and unhealthy, or to behave in a feminine fashiong which might be in conflict with the personalities and personal wishes of many women. This double bind for women might increase the actual rate of mental illness for that category. From the definitional point of view, women who do not exhibit traditional traits are more susceptible to being defined as mentally ill. It follows that defining a person who views the world differently or who does not fulfill the expectations of the diagnostician is likewise susceptible of being categorized as mentally ill.

## Conclusion

Nonbelievers can and often will pass off voodoo as rubbish, foolishness, or

mental illness. For the mental health practicioner, however, the situation is more complicated. A clinician is in a position of authority. At the very least she/he has the power to label one well or ill. At the extreme, a practitioner can influence life events as important as involuntary admission to a mental hospital. It is because of the power of the position that the practitioner must be aware that her or his own view of the world is not the only one and not necessarily the correct one. By putting oneself in the place of the other or by participating in mental relativizing the therapist is better able to be fair to clients.

Recognition of the role of beliefs in cause, cure, and perception of illness is slowly but surely coming about (Press, 1977; Rubel, 1977; Webb, 1971). Religious practitioners from the Caribbean community in Miami are available to help Western physicians in hospitals. Seminars and conferences, though still rare, are more frequently informing mental health practitioners and social service personnel of the strength of belief systems and the degree to which the "establishment" should recognize, rather than dismiss them.

To indicate the existence of multiple realities certainly does not help to solve all problems for mental health and social service practitioners. It may interject a healthy dose of cynicism to realize that one may be as unfair in classifying as mentally ill one who believes in voodoo as one who believes in Christianity. Yet, basic questions remain. My personal choice of professional tactics is to begin by viewing world perspectives or ideologies as irrelevant to a diagnosis. It would appear necessary for a clinician to migrate into the world of the client before diagnosing and developing a direction for therapy. After this migration has taken place, standard criteria can be applied. If my goal as a counselor is to alleviate the pain felt by a client then I will proceed differently than one who feels that their goal is to bring a client into closer touch with reality. The extent to which a client's behavior, as opposed to cognitive structure, is my concern would also determine the use made of knowledge about relative realities. Obviously, the acceptance of the reality, to the holder, of different kinds of knowledge and beliefs is a first step in dealing with many of the philosophical issues confronting professionals.

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