Opening remarks to further the Providence Roundtable discussion of demons and theophanies in the medical clinic
Brown University Faculty Club, November 13, 2017

Roberta E. Goldman, PhD – Clinical Professor of Family Medicine, Alpert Medical School of Brown University; Adjunct Professor of Social and Behavioral Sciences, Harvard Chan School of Public Health
Roberta_Goldman@Brown.edu

I've been a researcher and professor in Brown's Department of Family Medicine for almost 30 years, and like for most of you, I'm guessing, my research and teaching usually address topics that are typically associated with medical research and medical education. As an anthropologist, though, whose discipline explores cross-cultural human experiences, my scope occasionally expands. I'm comfortable with the idea of representations of good and bad spirits in cultures around the world; less so, I recently discovered, on my own turf. I found it interesting how taken I was with the discussion at my table during the last Providence Roundtable dinner, and I've continued to talk about it with family and colleagues. I think the reason is because traditionally in anthropology, despite long-term embeddedness in their communities of study, anthropologists' work has in fact been governed by a strong ethos of scientific detachment, viewing the study population as a distant Other, with a capital O. This goes hand in hand with the anthropologist's historical tendency to produce a static cultural representation of the studied people and locale. Since the late 1980's, however, which happened to coincide with when my husband and I returned from two years of doctoral dissertation field research on relatively isolated Portuguese islands, anthropologists have trended away from this distancing approach. They began incorporating some of the Postmodernist viewpoint that acknowledges, and even embraces, the researcher as affecting and personally affected by the phenomena of study and its representation in academic manuscripts.

Through my subsequent years of working in community-participatory behavior change health research (which in itself is a major departure from the traditional non-interventionist stance of anthropology), I thought I'd dismantled the old notion of myself as detached observer/researcher versus the studied Other. But I've begun to wonder anew about how and when and why my own upbringing, socialization and academic training motivate me to oftentimes seek and find connections with what might initially present to me as an unfamiliar Other, and in different instances I maintain that psychic distance. Specifically, during that table discussion in response to Dr. LaFrance's lecture, I learned that some in academia do reconcile the coexistence of science and demons in our postmodern world, while I considered why, despite being an anthropologist, and maybe because I was brought up Jewish, I have trouble with the seeming inconsistency. As the table discussion evolved about Dr. LaFrance's medical case involving the possibility of an incubus (a word I had to quickly google), I had running thoughts about my upbringing in New York, and it occurred to me that the Devil and demons were entirely absent from my Jewish education and cultural/religious practice. It's not that the Devil or demons were outright debunked as credible entities, just that I had never heard them mentioned. I even talked to my mother about this last week, and she had the same thoughts. So, again turning to google, I looked for information about the Devil in Judaism, and found that Satan, while being a Hebrew word (שָׂטָן), was little mentioned in the Old Testament and, moreover, had a less independent role in that text than in representations in the New Testament.

All of this led me to recall an experience I had early in my career with the Devil and inpatient medicine here in Rhode Island. I was surprised one day at Memorial Hospital of Rhode Island to hear my name overhead paged for a stat consult at the pediatrics inpatient unit. I did not know what stat meant, and

had to be instructed to run immediately over to pediatrics. Bewildered about why the pediatrics unit would be calling urgently for an anthropologist, I ran. When I arrived there, the family medicine resident team introduced me to an expressionless 15 year old Cape Verdean girl who related in a matter of fact tone that she had had a dream the evening before when she was napping alone in her apartment, while her mother and younger brother were out at a Pentecostal service in the next town.

In the dream, the girl's estranged father, who lived in Florida at the time and who she referred to as The Devil, had instructed her to take all of the pills in the bathroom medicine cabinet. Her mother said that after the service she found her daughter unconscious on the apartment floor, and she called an ambulance. The girl was successfully treated at the hospital, and admitted overnight. When I met her and her family that next morning, she was physically fine and expecting to be discharged. The girl's mother told me that she completely agreed with her daughter's interpretation that taking the pills had been ordered by the girl's father, who was The Devil.

The reason I was called stat by the residents that morning was because the attending psychiatrist who examined the patient told them that the girl's case was "a cultural thing", and there was no more that the medical team could do for her so she should be discharged. The residents were concerned about this plan, or I should say, lack of plan, and so they brought me in, hoping I could provide information that would help them forestall discharge until a plan was made. I had already advised many residents about cultural issues in their patients' care, but even though I had been doing qualitative research and community youth programming in the local Cape Verdean communities, I had never heard anyone talk about encounters with the Devil. I knew we needed community help to assist the patient in disconnecting from The Devil, this dangerous Other, and to devise appropriate next steps.

There was at that time very little published about Cape Verdean culture, so to get information I telephoned a number of Cape Verdean locals who I knew well. But in call after call, no one claimed any familiarity with the Devil in Cape Verdean cultural beliefs, let alone how to deal with extricating oneself from the Devil's grasp. Eventually, the non-Cape Verdean husband of a woman I was speaking with got on the phone to tell me that in his experience in the community, Cape Verdeans are reluctant to admit to outsiders that they know anything about this concept, but that he had over the years heard people speaking about the Devil and witchcraft, *bruxeria*. He advised that the patient undergo an exorcism. I couldn't imagine how I would explain this plan to the medical team and where I could find an exorcist, but he next told me that I just had to call the Catholic Diocese of Providence for a referral.

Up to the point of my call to the Catholic Diocese, my association with exorcism had been limited to what I'd heard friends tell me about a famous horror movie that I never saw and I'm sure you know of, that was released when I was a teenager. So I was surprised to find out that arranging an exorcism was easily done, as the Catholic Diocese directed me to a priest from a nearby Pawtucket church who agreed to come to the pediatrics unit that very afternoon to perform the ritual. Earlier I had checked with the inpatient team who said that they were willing to have the priest come, though they were skeptical about the efficacy. And I met with the patient and her mother about whether they wanted to try an exorcism with a Catholic priest – particularly since the mother was no longer a practicing Catholic. Mother and daughter agreed to the exorcism, and the mother added that since this happened while she herself was at church, she felt that she was clearly at the wrong church, and so would be going back to Catholic mass. After the exorcism that took place behind the closed door of the patient's room, the priest and girl sat together for a while longer, quietly talking. And I was beginning to think that the notion of the Devil was not quite as distant an "Other" for me as I had assumed it to be.

Although the girl and her mother appeared to be satisfied with the exorcism "treatment", after talking further with them questions remained for the family medicine residents, and for me, *and for the priest as well*. Was the exorcism enough? Had we done all that was necessary to keep the teenager safe and help her heal? None of us thought so, and before discharge the following day we arranged weekly counseling sessions with the same priest who, we were pleased to find out, was a counselor at a nearby youth agency. I was concerned about the girl's lack of friendships and her isolation at home every day after school, so I suggested that she volunteer at a Cape Verdean community program that my husband and I had helped found in Pawtucket, and she said she'd give it a try. She began to work with the younger girls every afternoon, and soon began teaching them traditional *funaná* and *batuque* dance, and formed a performance group. Between the exorcism, the counseling, and the community reintegration activities that cultures world-wide deem necessary to improving mental health, this teenaged patient seemed to gradually find her footing in this world, with increasing self-confidence and happiness through her high school years, and I can only hope, beyond.

So, in the days after our last Providence Roundtable, I found myself going over in my mind how my worldview about these issues had been formed, and where it stands now. We as scientists are observers, and in anthropology it's accepted that contextual circumstances generate multiple truths and realities. I have seen this in my research in Portugual, Latin America and the US, even on the topic of spiritual conundrums and miracles. But this acceptance of multiple realities, in effect, *promotes maintenance* of a stance of researcher versus the studied Other. And yet, when this occurs in the context of medical care, engagement with and understanding of the Other, whether the Other is a patient or the patient's Devil, are essential in order to take appropriate action to support healing for that individual. This was evident in the different reactions to the patient's explanation of why she took the pills, and our Roundtable discussion was a reminder to me that who we've learned to be from the various influences in our lives, and the changing nature of who we've become over the years, even as we are scientists, undergirds all we understand and that we do.

So I leave you with some questions for your table discussions: What do you think about this?

- Getting back to Dr. LaFrance's talk, what is the intersection for <u>you</u> of faith and physical functioning of the brain, within the evolving contexts of culture?
- How and when do you integrate and/or separate the various components that make up who you are today, as you go about your work in science or other professions?