Diagnosis and Treatment of the Rootwork Victim

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Over the past two years at Duke Medical Center I have had the opportunity to assess more than 20 patients presenting with various complaints who believed that their symptoms resulted from a form of malevolent magic called rootwork. Rootwork is a system of hexing beliefs which originated among southern blacks, but which is by no means confined to the South. Belief in it has been well documented among blacks and to a lesser extent among other ethnic groups in Tucson, Rochester, San Francisco and numerous other locations. Those who believe in rootwork universally think that it originated in Africa. Most African cultures do, in fact, ascribe to some system of witchcraft beliefs, but it is difficult to trace any specific American belief to any specific African source. No single dominant African culture came to the New World, and American black folk beliefs have, since their beginning, probably been heterogenous and syncretic (i.e., having grown by incorporation of beliefs from various diverse sources). In areas with a high concentration of blacks such as the Mississippi delta or the Sea Islands of South Carolina, beliefs have been relatively more uniform. Voodoo is a term often used by believers to refer to hexing beliefs in the New Orleans area and is used sporadically in other areas, though the terms rootwork, hoodoo, or conjuring, are more widespread designations.

Nowhere in the U.S. do beliefs closely resemble those of Haitian voodoo with its elaborate priesthood, hagiography and possession beliefs, except perhaps in the New Orleans area and in areas where indigenous beliefs have been supplemented by relatively recent imports from the Caribbean. Wherever blacks have had contact with other ethnic groups, there has been some tendency for incorporation of belief from those groups into the existing system.

In spite of the marked variability of beliefs in different areas, there are some elements of form and content that are generally widespread. Wherever people believe in rootwork, there are, in fact, individuals who claim to be rootdoctors and who are willing to take off, and in many cases to put on, hexes. Rootdoctors can be males or females and generally claim some combination of acquired and inborn power. They are secretive, almost always claim some religious stature; and are generally not specialists, but will treat any problem whether the result of natural or supernatural illness. In addition they act as intermediaries for placing a curse, rather than as originators of it.

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Any illness of mind or body may be ascribed to rootwork, though mental and gastrointestinal disturbances tend to be most frequent. "Death roots" are believed to exist, but are far less common than "misery roots." Common methods of putting a hex on someone, usually referred to as "putting something on" or "fixing" or "working a root on" someone include hiding a "rootbag" or "mojo" on a person's property or putting an evil substance into a person's food or in a place where he is sure to walk over it. Rootbags are usually bags of cloth, most often red, containing plant roots and various evil substances such as dust from a graveyard or reptile eggs, which can hatch and give rise to snakes crawling under the skin. Negative roots are most often believed to be worked by people jealous of love or material goods. Positive mojos can also be obtained to protect against harmful magic or to bring luck or romance. There is always a reluctance to talk about rootwork beliefs, and often a feeling that they can affect only individuals who are "weak" or who are not "good Christians."

PROBLEMS OF DIAGNOSIS

From the discussion above, it is apparent that the culturally determined system of rootwork beliefs can give rise to what appear to be bizarre delusions (e.g., animals living under the skin or having one's thoughts or feelings affected magically). It is important to understand that for patients who believe in rootwork, such beliefs may not represent a break with reality, but, instead, may represent an interpretation of reality in accordance with a widely accepted set of beliefs not shared by the physician. A patient and his family may find a diagnosis of "misery root" more understandable as an explanation for his diffuse symptoms than a diagnosis of, say, "sarcoidosis." When confronted with a patient who believes that he is the victim of rootwork the physician must not conclude, on the basis of that evidence alone, that the patient is psychotic.

The opposite sort of error (i.e., assuming that "it's all cultural") is equally dangerous. There is considerable literature demonstrating that the content of paranoid delusions is drawn from a patient's cultural background, so it is not surprising that patients with rootwork backgrounds have rootwork delusions when they are, in fact, psychotic. Diagnosing psychosis in the face of rootwork beliefs can be difficult, but it is usually possible, if attention is paid to associated symptoms (e.g., flat affect or flight of ideas), to associated delusions (e.g., belief that not only is the house rooted, but it is electronically bugged as well), to family perceptions (e.g., Do they believe there is strong evidence of rootwork?), and to form of beliefs (e.g., Does the patient seem to be looking for clues rather than looking for data? Is the group that the patient sees as trying to harm him expanding to include more and more people?).

Many patients who believe they are rooted are not psychotic, but do have serious psychopathology which must not be overlooked. When a patient believes that someone he knows has paid a rootdoctor to cause him misery or death, a high degree of intrapsychic stress and interpersonal conflict is present and needs to be carefully assessed. When a patient who has given up rootwork beliefs returns to them under stress, it is reasonable to infer that his previous coping mechanisms have ceased to function adequately. A patient's belief that he is the victim of roots may be the final common pathway by which biological, social or psychological diseases are expressed. Patients who originally presented to us with the belief that they were rooted have subsequently proven to have major affective disorders, schizophrenic disorders, organic brain syndromes, post-traumatic stress disorders, unresolved grief reactions, brief reactive psychoses, marital maladjustment, and a wide variety of other, often treatable, pathologies.

One of the reasons that rootwork beliefs are not better known to physicians is that patients are reluctant to talk about them to physicians, but there are definite advantages to eliciting these beliefs from patients who hold them. It is not uncommon for a patient to be vague and somatically preoccupied before his beliefs are explicitly discussed, but to talk fluently and with feeling when they are out in the open. A further reason to elicit these beliefs is that they represent the patient's fantasies about the origins of his difficulties and, as such, often reflect a great deal of psychological truth. One patient, for example, presented with symptoms similar to those of which her father had recently died. She believed these symptoms were due to roots worked on her by the same enemies who had caused her father's illness. Her rootwork belief was one of the clues that we were dealing with an unresolved grief reaction to the loss of an ambivalently regarded object.
In order to elicit rootwork beliefs, the physician must be aware of them in all black patients who have grown up in a rural or underprivileged environment, even if they are no longer living in such an area. The best approach is to ask for clarification if the patient seems to be implying that there is something unnatural or out of the ordinary happening with his symptoms. If a patient says that he is worried that a certain person may have had something to do with his symptoms, the physician should ask directly: “You mean roots?” or “You think maybe he has put something on you?” Such a question will diminish the fear of ridicule a patient may have and transfer to the physician the burden of having brought up the topic.

The importance of family and, if possible, social network assessment cannot be overstated. The family and friends are the best source for determining how closely a patient’s beliefs match those of his particular community. Furthermore, it is crucial to assess the extent to which family members support the patient’s belief that he is a rootwork victim. Often, the labeling of one family member as rooted and, perhaps, another as having caused it, can represent a form of scapegoating that emerges when other methods of dealing with family conflict have ceased to function.

PROBLEMS OF TREATMENT

The first problem in treating a patient who believes he may be the victim of rootwork is establishing an alliance. These patients always have some ambivalence about seeing a physician and are often in something of a paranoid state. It is no more appropriate to directly challenge their rootwork beliefs than it would be to directly challenge a frank delusional system or a religion.

Alliance with the family is absolutely necessary for successful treatment. A family can reinforce either a patient’s expectation of benefit from therapy or his sense of hopelessness. When scapegoating or other family pathology is present, the family must be actively involved in the treatment process.

Treatment in each case must be based on the careful biopsychosocial diagnosis outlined above. Our most successful treatments have usually been those involving intervention on more than one level (e.g., chemotherapy and individual psychotherapy for depression plus marital therapy to help with direct communication of needs). Many methods of treatment have been proposed for this group of patients: psychotherapy, hypnotherapy, root doctor referral, and ertsatz de-rooting ceremonies. Each of these methods probably has its place, but it is important that therapy be tailored to the individual patient. Many patients with these beliefs are from lower socioeconomic environments and treatment is often complicated by all the problems reported in dealing with such patients. These factors can make a directive approach such as hypnosis desirable, but do not necessarily override its limitations. When possible the individual psychopathology and dysfunctional communications underlying a specific rootwork belief should be dealt with.

It is often tempting to refer a patient to a rootdoctor, but there are several reasons why such a referral should be approached with caution. Although there have been reports of rootdoctors with some psychotherapeutic skills, there is also ample documentation of very inappropriate and often consciously exploitative “treatment.” In Durham, we have found no rootdoctor whose practices we can condone. A reason commonly cited for recommending treatment by a rootdoctor is belief by patients that “unnatural” illness can be cured only by an unnatural means. Certainly not by a psychiatrist. Many patients say they hold this belief, but do, in fact, prove to be treatable, just as do many patients with psychogenic headache who believe that a psychiatrist cannot help them. There are cases in which a patient or his family will insist on concomitant treatment by a rootdoctor as a condition for staying in therapy, somewhat as the headache patient may demand concomitant treatment by a neurologist. There have been reported cases where such collaboration has been useful although we have not attempted it.

In the presence of a patient’s fixed belief that he is rooted, and in the absence of a good rootdoctor, some physicians have attempted to perform their own de-rooting ceremonies. This practice should be approached with caution for the reasons noted above and also because the patient will generally have tried a rootwork cure before coming to a physician and will generally be looking to the physician for some other form of treatment.

CLINICAL EXAMPLES

Case 1

A 63-year-old black housewife had a chief complaint of bad luck and miseries for five years since jealous relatives had hidden a rootbag in her house. She had been born in eastern North Carolina into a large family which never consulted physicians and which took rootwork for granted. At 17 she moved to New York City, married, and became independent of her family and
her old beliefs. When her husband died 10 years ago, she experienced several months of depression, which resolved spontaneously. She was remarried eight years ago, still in New York City, to a man from a small North Carolina town. Several years later, her husband’s mother died and they inherited his family house. The siblings referred to him as “the prodigal son” who went away and got the fatted calf when he came back home, and they never accepted his wife into the family. After moving into the house, the patient became progressively more suspicious and withdrawn. She developed numerous physical complaints. She initially began to think that the neighbors were talking spitefully about her and were jealous of her inheritance. Later, she began to believe that they were listening in on her telephone conversations, had the house bugged and had put a root on the house. She became agitated and began tearing the house apart in search of bugs and roots. She wanted help from a rootdoctor, but her husband brought her to the hospital instead. She had suffered from terminal insomnia, sleeping 4 to 5 hours a night for several months and had lost about ten pounds. She had no history of medical illness. At admission, she had depressed affect and moderate psychomotor retardation. She had no hallucinations and no delusions except as noted above. She was oriented, but was unable or unwilling to concentrate on sensorium testing.

Physical examination was within normal limits, except for a resting pulse of 110 and a slight fine resting tremor. Routine laboratory work was within normal limits but T4 was 26.6 (n) 4.5 to 11.5. T3 was 65.5% (n) 35% to 45%. Thyroid scan showed diffuse increased uptake.

Discussion

The DSM-III diagnoses for this patient are: Axis I major depressive disorder with melancholia, recurrent; Axis II mild obsessive and over-dependent traits; Axis III hyperthyroidism; Axis IV moderate precipitating stress; and Axis V fair adjustment in preceding year. Patient’s husband and family were familiar with rootwork, but did not think there was any evidence that the patient was suffering from it, though one relative acknowledged that “she was so run down anything could happen to her.” Patient was treated with antipsychotics and with radioactive iodine. She and her husband were seen conjointly, and the patient was able to begin discussing her dissatisfaction and boredom and anger with her family. The in-laws meanwhile became mobilized to make the patient part of the family. The patient improved considerably on all parameters over a three-week hospitalization and eventually concluded that her in-laws were “too nice” to have put anything on her.

Case 2

The patient was a 25-year-old black male from rural North Carolina, admitted with a one-week history of intense anxiety and depression with two suicidal gestures and with the obsessive concern that somebody had “put something on” him. He was the oldest of three sons each with a different father. The patient’s father and one stepfather were physically abusive to his mother, though not to him. After graduation from high school, he served in the air force for three years and was honorably discharged. During the next three years he held a number of unskilled jobs, had a number of short sexual relationships and began to drink increasingly large amounts of alcohol. Three months prior to admission, he met a new woman who “reformed him,” but whose family wanted her to marry another man. At the family’s instigation, the other man had a root put on him and told him about it one week prior to admission. The patient immediately developed anorexia; insomnia; initial and terminal; decreased libido; palpitations; “hot flashes”; and occasional auditory hallucinations of short phrases such as “watch out” and “don’t be a fool.” When the woman told him she would marry another man, he slashed his wrists in her presence and was hospitalized. In the hospital the patient did well without medication during a nine-day period. His symptoms virtually disappeared by the second day. During this period his mother visited a rootdoctor and got him a protective “rootbag.” The patient felt totally cured and was discharged. Two weeks later his girlfriend’s relatives stole his rootbag and burned it. At this point, all of the patient’s symptoms returned and he took a small overdose of Dalmate precipitating a second hospitalization. Again his mother got him a rootbag and he reconstituted quickly with supportive therapy. Following this hospitalization, the patient decided to leave his girlfriend because she had shown him “the kind of person she really was” by collaborating to have him rooted. Subsequent to discharge, the patient went to live with relatives in another city and continued to be asymptomatic at six weeks followup.

Conclusion

Rootwork beliefs are more common in the U.S. than is generally appreciated by physicians. A patient’s belief that he is the victim of rootwork may be the result of many different biological, psychological and social problems. Treatment must be based on a carefully maintained alliance with the patient and his family and on a careful biopsychosocial formulation. No one form of treatment will be appropriate for all patients, but most patients can benefit from therapy. An approach similar to that

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outlined here may be applicable in dealing with witchcraft beliefs that occur in other cultural groups.

REFERENCES

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