Urban Appalachian Health Behavior

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Preface

This paper is one in a series to be published by the Research Committee of the Urban Appalachian Council as part of our effort to document the urban and rural realities of Appalachian life.

In 1972, the Urban Appalachian Council was organized to act as a regional resource and educational center for Appalachian affairs and to promote pride in cultural heritage among Appalachians in an urban setting.

The Urban Appalachian Council functions as an advocate and catalyst. It is a fundamental commitment to the concept of cultural pluralism which directs our work in research, advocacy, community organization; cultural affirmation and program development.

My discussion will deal with health and related issues facing Appalachians in cities and will emphasize those whose economic circumstances force them to use our public health clinics and other public facilities.

Probably one of the first things that comes to mind when one thinks of Appalachian health problems and health needs is folk medical practices. Home remedies for colds, stomach aches, ear aches, removing warts are all cared for by using teas, herbs, poultices and the like. When Appalachians leave the mountains and move to the cities outside the

region, they bring with them knowledge of these home remedies and folk medicines. When the traditional herbs and teas and other remedies cannot be found in their new location, various substitutions are made such as vicks salve, aspirin and other "over the counter drugs."

Supernatural and faith healing is an additional part of Appalachians' health heritage. Marion Pearsall describes one such situation: "religious gatherings in which the patient has sometimes risen from bed to dance in the middle of the room in the excitement of exhortative prayers, testifying to miraculous cures, and the clanging of cymbals and tambourines used to drive out demons" (1960, p.12). In both Kentucky and Virginia, I have experienced the more subdued "praying over" the affected body part in order to cure the disease or wound. My Aunt, who is a faith healer and now lives in Northern Ohio, has prayed over me to cure my smoking and remove my warts, unsuccessfully, I might add. She does claim success with others. In interviews with Appalachian women in Detroit, it was found that faith healing was a vital part of their beliefs. All those interviewed "considered faith the most important factor in curing disease, and over three quarters of them retained a firm belief in faith healing". (Stekert, 1970, p.117)

Faith healing and folk medical practices are generally used in conjunction with prescription medicines and the use of a physician.

There are other factors which are equally important in understanding the health behaviors of urban Appalachians.

Due to the historic unavailability of professional health care in the mountains, little conception of preventative health measures, such as periodical check-ups and good nutrition are considered as a means of attaining good health (Pearsall, 1960, p. 18 and Stekert, 1970, p. 135).

Secondly, physicians and professional health care are viewed suspiciously. "These suspicions, enhanced by an unfamiliarity with forms and procedures, often are a result of the impersonal care which low-income people receive" (Kunkin, 1973, p. 15).

We have found at the 12th Street Health Center in Cincinnati that Appalachian patients fear and suspect doctors and large hospitals. But when patients come to trust their doctors and other staff and are able to talk with them, they are more ready to go to the hospital for that operation or come back to the clinic for return visits. This doesn't mean that their fears are necessarily alleviated but the situation becomes one that can be dealt with.

Third, physical conditions are ignored until they are seen as, or are in reality, crisis conditions. These are taken to the physician only after home remedies have failed (Pearsall, 1960, p. 9; Stekert, 1970, p. 135; Looff, 1971, p. 129; and Kunkin, 1973, p. 15). This is not so difficult to understand when one realizes that life in a poverty neighborhood is one of struggle and conflict and first priorities are to earn a living and

stay alive. And there has to be some time for enjoying what little one has. Illness is an intrusion into that life style.

Fourth, professional health services that are utilized are located in familiar places with personnel well known to the patients. Looff's research with emotionally disturbed children and their families in four eastern Kentucky counties, indicated the need to personalize psychiatric clinic services. The public health nursing staffs of the public health departments in the four counties acted as go-betweens for the patients and the psychiatric staff. The people knew, accepted and trusted the nurses as helpers.

"This exaggerated fear of unfamiliar institution is not, however, confined to children. Stories abound of the very real apprehension and anxiety of adults forced by circumstances to utilize the services of the unfamiliar organization such as a hospital..." (Ford, 1969, p. 113).

The fear of and resistance to hospitalization, in particular, has been observed in Leslie County, Kentucky with tuberculosis patients. In 1960, fewer than half of the cases of active tuberculosis were actually hospitalized (n-28). Of the 13 who were discharged from the county sanitorium between 1958-59, eight left without formal dismissal and against the advice of hospital staff (Pearsall, 1962, p. 206). This resistance holds true for other diseases as well. For example:

> needed operations put off for months or years until nature forces the issue, refusals to send crippled children away for corrective surgery; parents making daily seventy-mile trips with a severely anemic child rather than leave her in the hospital; a woman refusing hospitalization for a back injury although this meant extra trips back and forth over fifteen miles of extremely rough road; a man with a broken back violently and unsuccessfully demanding his release from the hospital after an automobile accidentl and so on (Pearsall, 1962, p. 205).

Looff experienced similar behavioral patterns in working in hospital-based childrens' psychiatric clinics in Baltimore and Cincinnati. "Migrant families were referred in great numbers to these agencies, but a majority of them did not return after meeting the large, strange staff in the unfamiliar setting..." (1971, p. 130).

So, we can see that many times Appalachians must choose between traditional health care and modern health support systems. This choice "lies in the availability of services in an area too poor to attract or support modern health facilities and personnel without outside assistance" (Pearsall, 1960, p. 8). Rural Appalachians have to travel long distances, suffer inconvenience of bad roads and poverty in order to reach modern health facilities. Modern health facilities seem to be then the last choice between traditional health care and modern health systems (Pearsall, 1960, p. 8). So that, when Appalachians relocate in cities where health care is primarily dispensed through private physicians, clinics, and hospitals, a dilemma occurs. A choice must be made between using the established

systems or the traditional ones. Should they have to resort to using the systems which are unfamiliar, frightening, and act as a threat to family stability, or should they continue to use the traditional remedies as best they can? The religious denominations and home remdies are not readily available in the cities. Should Appalachian cultural values and life styles be put aside to receive adequate health care?

I think not. Methods must be found in order that Appalachians receive adequate health care within their realm of acceptance. The primary factor must be consideration of rural Appalachian cultural values in the delivery of effective health care. This can be accomplished by health services utilizing personal approach in order to reach those whose cultural values stress importance of personal relationships (Looff, 1971, pp. 131-136; Weller, 1965, pp. 49-57). Careful attention should be given to personalizing the large medical complexes by properly introducing the Appalachian patient to both the medical personnel and the medical facilities.

As I noted earlier, Looff found that Eastern Kentucky residents sought professional care in a setting that is familiar to them-- the public health department. If health centers or physicians offices were established in Appalachian neighborhoods, this could potentially become a place where they could go for help. This would also alleviate time and travel difficulties in reaching proper medical attention.

Finally, bringing health support systems into concordance with the cultural ways of Appalachians can be accomplished by working woth personnel in community institutions so that they obtain a better understanding of the health behaviors, beliefs, and life styles of the Appalachian poor (Ford, 1969, p. 132; Powles, 1964, p. 281; Looff, 1971, p. 141). Knowledge of home remedies, herbs and teas, could be valuable and harmless ones recommended in conjunction with medicines acceptable to the physician.

In conclusion, in light of the cultural heritage that Appalachians bring with them to the cities, changes must take place on both the part of the migrant and the health care system so that Appalachians can adjust successfully to the urban way of life and yet maintain their identity in their new home.

JMW/ks

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