Introduction: A Regional Approach and Multidisciplinary Perspective

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This volume of essays documents the contemporary practice of several widespread and culturally significant systems of "traditional" or "folk" medicine in the eastern regions of North Carolina and Virginia. Traditional and folk are terms used interchangeably throughout this book to refer to "those beliefs and practices relating to disease which are the products of indigenous cultural development and are not explicitly derived from the conceptual framework of modern medicine" (Hughes 151). Such indigenous medical systems are known by a confusing plethora of terms including alternative, unorthodox, vernacular, fringe, nontraditional, unofficial, and ethnomedical. The labeling of these systems as "traditional" is consistent with the terminology embraced by the World Health Organization (WHO) during their International Conference on Primary Health Care in 1978 (Mahler 7). WHO officials emphasize that traditional medicines are found in all societies throughout all periods of history and predate the rise of modern scientific medicine or allopathy at the beginning of the nineteenth century (Bannerman et al. 9–11).

Any culture's traditional medicine includes perceptions of health and definitions of illness, beliefs about etiology and appropriate preventive and curative practices, as well as roles for indigenous practitioners who not only treat illness but also act to restore health for individuals and a sense of well-being to the community as a whole. Traditional beliefs and practices do not develop in isolation but are part of an integrated set of social institutions within a cultural system. Consequently, they serve many functions for adherents and are often highly resistant to change even when the cultural tradition itself is no longer viable.

In many parts of the world, the expansion of Western culture has brought scientific biomedicine into direct confrontation with traditional care. Yet both here and abroad, adherents of traditional medicine do not necessarily embrace all aspects of the scientific system when it becomes available to them. The study of how and why traditional beliefs and practices persist in the wake of such change is of vital importance for those who want to improve the health status of a population. A key goal of the authors in this volume is to describe and explain the logic of traditional medical systems to health planners and practitioners in order to suggest how they can be integrated more effectively with biomedicine in order to improve the overall delivery of care.

More useful than a collection of individualized studies done in disparate and culturally disconnected regions of the United States, this book applies a multidisciplinary approach to a coherent cultural center of traditional folk medical systems as practiced by Native, Anglo-, and African-Americans in the eastern regions of North Carolina and Virginia. This book is unique because it carefully documents the traditional medicines of a long-settled and culturally important region that has received little serious scholarly attention; it is also important because it articulates a model of multidisciplinary inquiry applicable to the study of traditional medicine in any cultural context.

The eastern region of Virginia and North Carolina was among the first areas of the United States to be permanently colonized by the British. Inhabited by a thriving population of Native Americans at the time of contact, it remains home today to the largest number of Indians found east of the Mississippi River. In addition, a vibrant African-American culture has endured and flourished since the earliest days of slavery in the colony. Surprisingly, however, the existence of these diverse cultural traditions in a region relatively unaltered by outside influences has not occasioned much systematic scholarly inquiry. Most folklore research in the two states has been done in the Appalachian zone while the well-known and prestigious Frank C. Brown collection of North Carolina folklore was drawn almost exclusively from the piedmont region.

The coexistence of these three traditions, however, presents researchers from different disciplines with the unprecedented opportunity to study the ways in which folk medical systems of culturally differentiated groups converge and influence one another, operate in tandem and conjunction with scientific biomedicine, and provide beliefs and practices integral to the individual's expressions of kin and community-based iden-

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tity. While each of these groups maintained its own unique medical tradition, culture contact led to the diffusion of certain beliefs and practices across system boundaries; the expansion and eventual dominance of Christianity has given each a common theological underpinning. Significantly, these beliefs and practices persist and remain strong, providing adherents with a continuity of tradition that influences and shapes their encounters with the ever-expanding biomedical system. A brief description of the history and present sociodemographic profile of the region illustrates some of the reasons why these traditions have endured.

The eastern region of Virginia and North Carolina lies within the broad coastal plain that extends from the Atlantic Ocean on the east to the fall line of the major rivers in the piedmont zone to the west. The tidewater zone itself extends inland from the coast as far as the effects of the tide are visible and encompasses many of the region's major coastal port cities including Norfolk and Newport News in Virginia; and Washington, New Bern, Jacksonville, and Wilmington in North Carolina. The geographic diversity of the region is striking. The tidewater zone is low and swampy with numerous bays, inlets, and natural lakes. To the west, the coastal plain contains much fertile farmland and a zone of pine-covered dunes in southeastern North Carolina (see Merrens 32–49, for a more detailed description of the land).

The eastern regions were first explored by the French and Spanish. It was the English, however, under the leadership of Sir Walter Raleigh, who attempted to establish the first colony in the area on Roanoke Island, part of the Outer Banks of North Carolina. This attempt failed, and the first permanent settlement in the east was the English colony at Jamestown, Virginia, established in 1607. Large-scale colonization in eastern North Carolina began in the 1650s as Virginians moved south in search of good farmland (Lefler and Powell 31–35). Settlers, primarily of English and European backgrounds, eventually followed from other colonies; but then as now, few of these inhabitants were foreign born (Lefler 423). The early settlers were primarily agriculturalists, and many depended on imported slave labor to operate the plantation economy based on the cultivation of cotton and tobacco. African-American slaves accounted for about one-third of the population of the region at the time of emancipation and today African Americans comprise approximately 22 percent of the population (Lefler 423).

When the first colonists arrived, they encountered an estimated 25,000 Native Americans living in highly stratified, agriculturally based

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chiefdoms in the eastern zone (Wetmore 49). As white settlement expanded, conflicts with the Indians increased, culminating in a long series of skirmishes in the region that began in 1675 with the Susquehanna War in Virginia (Rights 34) and ended with the Tuscarora Wars in eastern North Carolina, fought between 1711 and 1713 (Lefler and Powell 66–74). The cumulative effects of disease, slavery, the disruption of agriculture and hunting by the encroachment of whites, and deaths in warfare reduced the Indian population to just over 1,000 by the 1730s (Merrens 20). The surviving Tuscarora either fled to New York State or moved onto reservation land in eastern North Carolina, while the few remaining members of the other tribes banded together and retreated into the more rural and isolated parts of the region (Wetmore 40). Of necessity, most of these Indians intermarried with whites and blacks, adopted the language of English and the customs of the colonists, and, in the process, lost most of their distinctive Indian heritage. Today their descendants are located primarily in eastern North Carolina and identify themselves as either Tuscarora, Haliwa, Coharie, Waccamaw-Siouans, or Lumbee (Wetmore 170–71). None of these groups has been granted federal recognition, primarily because of the difficulty each has in proving a continuous cultural and linguistic tradition. Nonetheless, they are the largest group of Native Americans located east of the Mississippi River, and the Lumbee, who numbered 35,400 in the 1980 census, are the largest tribal group in the state of North Carolina (U.S. Department of Commerce).

The disruption caused by the Indian wars along with the relative isolation resulting from a lack of transportation networks led to slow growth for the eastern region during the 1700s. In North Carolina, for example, the government of the state was dominated by the landed aristocracy of the east and, after the Revolutionary War, economic decline caused thousands of inhabitants to leave the state to seek opportunity elsewhere (Lefler 434). After 1835 settlement began to expand rapidly in the western piedmont zones, and an increasing sectionalism developed as political power also began to shift westward. The new centralization of power led to reforms in the tax system and the spread of state services to rural areas. This period of progress, however, came to an abrupt halt with the outbreak of the Civil War—a conflict that destroyed much of the state's wealth and took the lives of 40,000 of its inhabitants (Lefler 436). Once the war ended, moreover, the state had to adjust to the emancipation of an estimated 350,000 slaves in its efforts not only to rebuild the economy but to provide services and political rights to all inhabitants.

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After the end of Reconstruction, the Democrats won control of the legislature and political influence shifted completely from the agricultural establishment of the eastern region to the industrial and business interests of the west. During the period prior to the Great Depression, thousands of miles of railroads were built in the state and the expansion of manufacturing and textiles grew rapidly. The economy of the east lagged behind that in the west, causing the majority of the region's small farmers to suffer economically. Moreover, the Democratic establishment repealed suffrage for blacks in 1900, causing the large population of African-Americans concentrated in the east to suffer disproportionately from the region's decline.

In the boom period after the end of World War II, the legislature moved to expand economic development and the delivery of services to disadvantaged areas of the state. There were intensified efforts to diversify industry and improve agricultural efficiency and productivity. These efforts resulted, however, in a drastic decline in the number of farms in the eastern region, forcing an increasing number of landless laborers to seek work in textile and small manufacturing plants in other parts of the state (Lefler 436). The 1970s and 1980s have seen an expansion in the east of poultry and hog processing plants attracted by the availability of a large pool of inexpensive labor. Today this industry is one of the major employers of nonfarm labor in the eastern regions of North Carolina and Virginia (Freedman).

Historically, the eastern regions of North Carolina and Virginia have been poor, and that situation remains unchanged today. While they were among the first areas settled, and while some large landholders in the colonial period accumulated vast fortunes and exercised considerable political influence, the region since then has been and continues to be dominated by small farmers and poor, landless laborers. Today most of the eastern region of both states is officially designated as rural, although there is considerable diversity in that designation.

Three predominant population patterns prevail. The coastal rural counties of the region are inhabited largely by whites of English descent who have, until recently, been isolated from the mainland. Residents of these counties are involved in marine extractive activities, shipbuilding, seasonal agriculture, and, increasingly, tourist-related occupations. In addition, these counties are presently experiencing a boom in development spurred by the construction of recreational and retirement housing.

The inland rural counties, formerly characterized by a plantation

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agriculture system focused on cotton and tobacco, are largely inhabited today by small farmers and landless laborers. As agriculture has declined in profitability, many white landowners have emigrated, leaving behind a largely black and impoverished population in these counties. Some of these laborers were able to find employment in textile and manufacturing plants, but as these industries have become less competitive on a global scale, plant closings have led to a second wave of large-scale unemployment in the region. Finally, there is a small number of inland, urban-nucleus counties in this region. These counties have a central city, usually with a population of 50,000 or less, surrounded by rural zones of agricultural activity. Many impoverished inhabitants of the rural counties are moving into the urban areas to seek employment opportunities which, more often than not, are unavailable to them.

About 25 percent of the population of this eastern region lives below the poverty line, compared to 14.4 percent nationally (Freedman 41). Median annual family income in the inland rural counties is $13,502 as compared to $19,917 nationally (Freedman 41). Perhaps a more striking illustration of the level of poverty in the region is shown by a comparison of county figures within North Carolina. In 1980 the average per capita annual income in the state was $7,832, which was 82 percent of the national average. Of the thirty-two counties in the eastern region of North Carolina, thirty fell below the state average, and ten of the inland rural and predominantly black counties had average per capita annual incomes of less than $6,000 (Wilms and Powell 8). For Indians in the region the figures are even worse, with an estimated 44 percent of the Lumbee population, for example, reporting a per capita annual income below the poverty level (Red Corn).

This extreme poverty, combined with the relative isolation, low educational levels of the population, and the lack of infrastructure to attract new industry, has led to a massive emigration of younger and more able-bodied people. Consequently, the percentage of the population which is elderly, disabled, or living in large families is rising (Friedman 42). Many of these residents are poor and unable to work, and the proportion of those dependent on some form of public assistance has grown. Further complicating the situation is that the entire eastern region of North Carolina, as well as that of southeastern Virginia, is an officially designated "health manpower shortage area." Although the average physician to patient ratio in the state of North Carolina improved from 1 per 911 people in 1978 to 1 per 637 people in 1987, the ratio in the eastern

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counties declined dramatically. There were more than 1,000 practicing physicians in the eastern 32 counties of North Carolina in 1980; however, the distribution of these physicians in the population varied dramatically from a ratio of 1 for every 539 people in the urban-nucleus counties, to an average of 1 for every 3,550 in many inland black counties, to a low of 1 for 9,486 and 16,117 and none at all for 25,000 in the three most isolated counties (Wilms and Powell 17; *What If . . . ?* A4; *Statistics on Physician Availability*).

In addition to the lack of care, the health profile of the region is a poor one. In 1988 the region had one of the highest infant mortality rates (12.6 per 1,000 live births) in the nation; and, even more disturbing, nonwhites averaged 18.7 deaths per 1,000 live births, a rate far worse than that found in all of the industrialized nations of the West and in many Third World countries (Bloch A1; *North Carolina Vital Statistics* 2–1). In addition, the incidence of hypertension, obesity, diabetes mellitus, arteriosclerosis, cancer, chronic obstructive pulmonary disease, tuberculosis, renal calculi, and cardiovascular disease far exceeds the national average (Fabsitz and Feinleib). This is consistent with the greater incidence and prevalence of chronic illness in rural areas in general (Norton and McManus).

Clearly, then, the long history of geographic isolation in largely rural areas, coupled with the lack of access to educational opportunities and government services occasioned by extreme poverty, has forced the inhabitants of the eastern region to be self-reliant in meeting their needs. Because cultural traditions have survived relatively intact in this area and because many inhabitants have had to rely on their own knowledge and skills in treating illness, it is not surprising that traditional medicine continues to flourish in this population. Although efforts have been made to extend biomedical services in the area, many inhabitants of the eastern counties do not have access to them. Moreover, those who do often continue to rely on traditional techniques, sometimes using them in conjunction with biomedical ones.

In a recent study Mitchell and Mathews interviewed 900 older adults sampled randomly in proportion to the distribution of racial and ethnic groups and of the sexes in the general population of twelve counties in eastern North Carolina. Part of the survey was designed to elicit information about the prevalence of traditional medical beliefs in the population and about the extent to which traditional practitioners and remedies were utilized and for what purposes. Preliminary results show that, on average

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across the twelve counties, 35 percent of the population surveyed is actively using some form of traditional or alternative medicine, most often in conjunction with some form of biomedicine. The traditional practitioners consulted include more exotic ones such as root doctors (specialists who can cause and cure illness with the use of magic spells known as "roots"), herbalists and palmists, together with more generally familiar and "orthodox" ones such as religious faith healers, ministers, chiropractors, pharmacists, health food vendors, and less formally, influential community members, particularly funeral home directors. Nonmedical remedies used include various foods and beverages, herbal potions, prayer, protective amulets, and magical spells or "roots." Medical resources used in nonmedically prescribed ways include a host of over-the-counter medications and more old-fashioned tonics or patent medicines employed locally both to cure and prevent illness (Mitchell and Mathews 1, 2). As anticipated, the rates of traditional use varied across the different types of counties. They were lowest, comprising 10–15 percent of the population surveyed, in the two urban-nucleus counties; average, comprising 35 percent of the population surveyed, in the coastal white counties; and highest, comprising 50–60 percent of the population surveyed, in the inland, predominantly black counties.

Mitchell and Mathews are among the first to document statistically the continued use of traditional medical practices in a randomly surveyed population (see also Roebuck and Quan). The investigators initially expected, in line with current assumptions about the general decline of traditional beliefs during increasing modernization and urbanization, that such use patterns would be found in only 10 percent of the population. Obviously, however, traditional medical beliefs and practices are still important to the region's inhabitants, and this surprising persistence raises the question of why they continue to exist, even when biomedical alternatives are available.

In chapter one in this volume, David Hufford responds to this question by discussing some of the reasons for the continued influence of traditional medicine in various parts of the world today. He suggests that such beliefs and practices represent "a universal set of efforts to cope with illness in ways that go beyond—but do not necessarily conflict with—what modern medicine has to offer" (15). He argues, consequently, that folk medical beliefs and practices are of major importance to scientific medicine because they are a crucial part of the foundation from which patients derive their attitudes and decisions with respect to biomedical care. A

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brief examination of the ways in which traditional medicines generally differ in philosophy and practice from biomedicine can help suggest avenues for the development of methods and procedures that accomplish the goal Hufford specifies of finding a "reasonable way of taking folk medicine into account in the clinic" (14).

As Bannerman et al. point out, all medical practice was what we now call traditional until the beginning of the nineteenth century, when the "great philosophical upheaval of the renaissance began to introduce Cartesian scientific materialism into all human activities and noticeably into the theory and practice of medicine" (11). The development of scientific medicine involved a shift from the mind-body holism of traditional systems to a dualistic conception that is posited to be the outgrowth of the following: first, a scientific method which tends to break complex phenomena into their component parts and deal with each in isolation (Bannerman et al. 11); second, the pharmacologic goal of isolating the active principles of disease coupled with the physician's desire to find efficient treatments for the physical causes of disease (Bannerman et al. 11); and, finally, the necessity of communication in a scientific medical language (Hall and Bourne 141). Over time, physicians became less involved in handling the complex life situations that patients often perceived as relevant to the diagnosis and treatment of physical illness. Consequently, while scientific medicine met with remarkable success in treating disorders caused by infectious agents, by poor sanitation and nutrition, and by personal injury, it has been markedly less successful in handling the effects of chronic, degenerative conditions and in resolving psychiatric and psychosomatic complaints where behavioral, emotional, and spiritual factors play a major role in etiology and outcome (Bannerman et al. 11; Hall and Bourne 141; Wintrob).

In contrast, traditional systems are based on a mind-body holism that is usually embedded in a society's view of personhood and the relationship of the individual to natural and supernatural realms. In such systems, the divisions between medicine and other cultural institutions such as religion, politics, social organization, and economics are not well demarcated. Foster and Anderson, therefore, argue that the efficacy of such systems must be evaluated in terms of their "ability to successfully play roles that lie far beyond the cure of illness and the maintenance of health" (125).

In such systems, for example, the alleviation of physical symptoms may be of secondary importance to the goal of restoring the individual to social and/or spiritual harmony with the group. This goal is reflected in

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the frequent preoccupation of individual patients with finding out, as Wintrob writes, "*why* rather than *how* a particular person fell ill, progressed toward recovery, or died" (318). Such a preoccupation is, in turn, rooted in explanations for illness that are seemingly irrational and illogical, emphasizing as they do a combination of magical, supernatural, and social causes for illness. Yet as Foster and Anderson point out, the curing ceremonies and treatments congruent with these expectations often function to provide people with explanations for unexplainable phenomena, to exert a measure of control in restraining deviant behaviors that violate social norms, to reintegrate a deviant or mentally ill person into the community, to provide a therapeutic public confession that engenders emotional catharsis and a sharing of guilt for the patient, and to give psychosocial support to those in need (126–28). Moreover, empirically derived herbal pharmacopoeias may be effective in relieving distress for a number of routine illnesses, although comparative studies which attempt to document the efficacy along with the dangers of such remedies are few (Croom's essay, chapter eight, is an important addition to this literature).

The fact that a serious reawakening of interest in the emotional, spiritual, and irrational aspects of health is occurring today in precisely those societies that have a long experience with scientific medicine indicates that many of the psychosocial needs addressed in traditional systems remain unmet in the biomedical sphere (Bannerman et al. 12; McGuire). This is not to claim, as Hufford points out, that traditional medical systems are somehow better or more effective than biomedicine or that biomedical practitioners should try to be all things to all patients. Rather, the authors in this volume view the serious study of the contributions of traditional medicine to modern practice as a way of providing lessons for a more humane and culturally sensitive healing.

In chapter two Richard Blaustein presents a précis of the articles to follow and delineates the contributions of the various disciplines represented to a collaborative model of inquiry. As a folklorist with an academic appointment in family medicine and psychiatry, Blaustein is doubly aware of the difficulties inherent in attempting to grasp the pluralistic approach most Americans have to health care. He argues for the importance of a multidisciplinary perspective if we are "to realize once again the fundamental interdependence of mind and body, individual and society, humanity and the natural world" (40). Each discipline approaches the study of human behavior from a unique theoretical perspective, employs different types of research methods, generates different kinds of data, and, as a result, provides different solutions to common problems.

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For example, folklorists who document traditional beliefs and practices tend to focus analysis on the interactions between respondents. Consequently, they do not usually quantify responses to standardized questionnaires as is common in some social science and clinical research. Yet their data are no less valuable as a result and may, in the end, be more useful than survey research in suggesting ways to bridge the cultural and communication gap between physicians and patients. Similarly, anthropologists tend to rely on qualitative methods to determine how traditional beliefs and practices derive from an integrated cultural and social system and function to meet the needs of that system's members. Their data are useful in demonstrating how such beliefs structure the expectations and behaviors exhibited by patients in the clinical setting and in suggesting ways that such beliefs can be integrated into biomedical practice. Clinicians and scientists, on the other hand, use a range of experimental methods including epidemiologic research, natural experiments, clinical trials, and case-control studies to measure the efficacy of their own practices by delineating, in part, the impact of traditional beliefs and practices on the overall effectiveness of biomedical techniques. In other instances, clinical practitioners use carefully documented case studies to explore the effect on treatment outcomes of a patient's medical and family history, attitudes toward illness, interactions with medical staff, and compliance with care. Such case studies, as Peter Lichstein shows in chapter six, provide insights that enable clinicians to formulate strategies for promoting more effective therapeutic alliances with patients from different sociocultural backgrounds. Ultimately, the integrated picture that emerges from a multidisciplinary approach will provide a template for planners who have as their goal the development of community-based interventions for health promotion and disease prevention.

This multidisciplinary volume is intended to serve a varied audience including folklorists, anthropologists, health scientists, physicians, and other health care specialists in several ways. It provides illuminating commentaries on the major forms of naturopathic and magico-religious medicine currently practiced in the United States and on the physical, social, and cultural contexts in the focus region. It documents and explains the persistence of these traditions in our modern technological society. It examines the bases of folk medical concepts of illness and treatment and the efficacy of particular cures. It provides extensive bibliographical documentation of the scope and variety of research on traditional medicine. And, perhaps most significantly, it suggests a model for collaborative research that can be replicated wherever scholars in dif-

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ferent disciplines are united by a common interest in this important dimension of human culture and are committed to the serious, open-minded exploration of attitudes and behaviors that have often been dismissed as mere ignorance or quackery.

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