Unser Satt Leit: Our Sort of People
Health Understandings in the Old Order Mennonite and Amish Community

by

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I hereby declare that I am the sole author of this thesis. This is a true copy of the thesis, including any required final revisions, as accepted by my examiners.

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Abstract

Our cultural orientation informs our fundamental understandings of health. It has the potential to guide how we define health, how we understand the determinants of well-being, and how we respond to illness. For researchers, the recognition of this reality is central to not only how we interpret our findings, but also to the ways in which we develop the approach, questions, and methods central to our research.

The Old Order Mennonites and Amish are a culturally, ethnically, and religiously distinct population existing within the North American society. This thesis sought to improve upon previous health-related research on this population by asking several basic questions: Among Old Order Mennonites and Amish, how is health perceived and 'good health' understood? What are the perceptions of the determinants of health? How is illness perceived? What is the response to illness? And how does culture relate to health in the Old Order community?

A hermeneutical approach was adopted to address these questions and a qualitative textual analysis of an Old Order magazine, *Family Life*, completed. To allow the voices of community members to guide understandings, a broad approach to health was adopted throughout the examination of two years of the publication (2001, 2000).

Findings indicate that in the *Family Life* writings health is primarily defined by an individual's ability to fulfill his or her role. A focus on nutrition and reproduction dominated discussions of the determinants of physical health and an individual's relationship with God was viewed by many as the central source of mental health or illness. Emotionally, analysis suggests that individuals may have a range of responses to illness including a desire to accept the experience of illness as a part of God's plan, a struggle to find this acceptance, and the incorporation of community and Divine support throughout this pursuit. Behaviourally, health information appears to be transferred through a variety of mediums including health practitioners, community members, and advertisements. Individuals expressed concern with appearing too quick to seek professional medical care and may incorporate a range of considerations into the decision of whether to begin, continue, or end medical treatments.

The textual analysis indicated that a mixture of methods may be adopted for achieving health. Individuals appear to care for themselves through home remedies or non-medical measures (including alternative treatments) for as long as possible. In situations of acute physical illness, however, there appears to be comfort with seeking formal medical care. Amidst limited discussion of a physiological root of mental illness, analysis suggested that the main method of treating mental illness is refocusing concentration toward God rather than the self.

In consideration of the cultural understandings guiding these submissions related to health and illness, there were two primary themes. The first is that God determines life and is an active and present force in the lives of individuals. The second theme is that the community responds to this belief in God's defining role in particular ways. More specifically, the Old Order orientation to life which includes a deferment of individual will to that of the authority of God and Community (*Gelassenheit*) and appreciation for a set of rules guiding behaviour (*Ordnung*), directs discussions and understandings of health in culturally-unique ways.

Overall, this study highlighted the distinct ways in which cultural perspective guides understandings of health and illness within the Old Order community.

Acknowledgements

> "A person's devotion to an idea is not tested until the newness has worn off, until the challenge has lost its initial excitement, and the fun and glamour have faded. Then, when only the hard work remains – the daily tasks, the mundane labor – that is when a person's commitment to a project is truly tested" - Elmo Stoll

Early in my research I came across this quotation by Elmo Stoll, a former editor of *Family Life,* and the truth of the words emerged at different points throughout the entire project. This experience of research has been filled with moments of both excitement and frustration, but through it all there have been a number of individuals who have been instrumental in guiding my efforts and helping me to see this project through – even after the *glamour had faded*.

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Table of Contents

Idea

The Pursuit of Health

The desire to unlock the mysteries of the body in the pursuit of health, wholeness, and happiness has driven thought and challenged societies for generations. In Western society, despite the tremendous advances in knowledge and treatment, much about our health remains a mystery.

Voltaire was known to reflect that doctors know little of drugs, less of diseases, and nothing of humans. In an effort to address this gap in knowledge, much of health research is devoted to increasing knowledge related to the understanding and treatment of illness. In their report, the CDC contends that health is often narrowly and negatively measured with "objective procedures" and illuminating only its lowest levels or "severest manifestations" (Center for Disease Control and Prevention, 2000, 5). The study continues that such an approach is too simplistic and unable to capture the multidimensional nature of health.

In studies that seek to explain and document medically perceived and objective differences in the distribution of illness, often only when answers cannot be found in the biological realm, do researchers consider psychological, social, or broader cultural influences (Corin, 1994). This approach to health research, with a focus on illness, narrows and limits learning as we contain our study of health to discussion of rates, counts and percentages.

Although it is an avenue less often pursued, an equal mystery in the pursuit of improved understanding of human health is the influence of our cultural understandings and behaviours. Loustaunau and Sobo (1997) assert that "The ways in which we perceive and interpret health and illness, and seek and deliver care, are inextricably bound up with cultural norms, beliefs, and values, as well as with social structure and environmental conditions" (1). It is our cultural framework that provides us with the balance and the reason, method, and support for how we

live. If we accept that individuals act in accordance with their beliefs, then the study and practice of health must consider cultural perspective.

When we go beyond the study of genetic codes, pharmaceutical treatments, and individual changes, we can approach the power of one of the most fundamental aspects of our health: our culture. Specific treatments and epidemiological research are crucial to the pursuit of health, but through a study of culture we may be better able to understand the dynamic of health.

The aim of this study is to gain an understanding of the culture-health relationship among the Old Order Mennonites and Amish; a religious group that has chosen to follow a separate and unique way of life amidst Western culture.

Health and Culture

Understanding Health

Disease occurs as a result of exposure to the pathogenic agent with both the pathogenicity of the agent and the degree of *resistance/ susceptibility* of the host determining the consequences of such exposure (Cassel, 1976). Illness, however, is typically seen as a culturally defined state of mental or physical imbalance or disruption of a sense of well-being (Dubos, 1977, Pelto & Pelto, 1996). Conversely then, health is broadly defined as a state of "mental, physical, and social well-being" rather than the absence of disease (WHO, 2001).

There are generally four key factors seen to be affecting our health: the social and economic environment, the physical environment, educational factors, and the individual's characteristics and behaviours (Helman, 2000; Canadian Health Network, 1999). More specifically, the Canadian Health Network (1999) breaks these down to include income and social status, social support networks, employment and working conditions, education, physical

environments, genetics, personal health practices and coping skills, healthy child development, health services, gender, and culture.

Health is a central component of our well-being and, increasingly, health perception research has allowed for an expansion of our understanding of health to go beyond "biomedical paradigms" and approach "lay models of health" (James & Eyle, 1999, 87). Understandings of health are significantly and closely tied to societal and cultural values and social cleavages arising from differences related to gender, age, education, and socio-economic status (Calnan, 1987; Stacey, 1988; James & Eyle, 1999).

Understanding Culture

> A [person] can prefer to be together with others and even avoid [his or her] own people: [he or she] can feel estranged from them – but [he or she] can never be a stranger to them. The very intimacy of the experience, which is nothing but common memories that have become unconscious excludes the possibility of cutting a tie that was formed, not alone by the same blood, but by the same rhythm of living (Theodore Reik, quoted in Winland, 1993, 113*).*

Culture is our image of the world, our pattern for living, the public manifestation of a world view that includes the norms, beliefs, values, knowledge, and experience of a group and provides a description to those within it of how the world works (Friesen, 1983; Dimou, 1995; Shatenstein and Ghadirian, 1998).

Culture is the evolving force that dictates language, religion and beliefs, music and arts, social organization, how to care for the less fortunate and the aged, how to view and use material objects, and what should be the aim and form of schooling (Wissler, 1923; Helman, 2000). It gives meaning to experience (Corin, 1994). Further, in his work *Beyond Culture*, Edward T. Hall (1976), suggests that there are three characteristics of culture agreed upon by anthropologists: 1. Culture is learned, 2. The individual facets of culture are connected with all

the others, as in a web, and 3. Culture is shared and defines the boundaries of different groups. Obviously, one's culture is a powerful influence on perception, role, and lifestyle.

No culture exists in a pure form, all being influenced by others to some degree (Friesen, 1983). While this may be true, it has been suggested that we are creating a global or monoculture of lifestyle and thought that goes far beyond normal cultural evolution (Jacobs, 1961; Fawcett, 1986). Increasingly, society's character is being guided and fuelled by the "engine of change" (Bell, 1976, 75).

As Alland noted in 1977, the rate of societal change has increased to such a pace that there is little time for the adaptive process (both conscious and unconscious). The author continues that, "For the first time in history of [humankind], the biological and social experience of the father is almost useless to his son" (41). This statement is certainly extreme, but not without basis when we review the content of our lives in relation to that of those just one generation removed (in either direction). In fact, as true as this statement was in the late nineteen seventies, more than twenty-five years later the reality of this assertion only gains more power with the growing influence of technological and social change.

As distinct traditions are merged into one with the speed of 21st century efficiency it may be as James (1995) contends, that culture and identity are becoming optional and there is the sense that we can *remake* our circumstances and our *selves* virtually at will. Further, when traditions fall and are replaced by continual change and overwhelming subjectivity, so do the frameworks that once gave us guidance and reason.

While this state of rapid change is pervasive in society, it does not affect all cultures to the same extent. As will be demonstrated in the section on the *Old Order beliefs and practices*, the maintenance of the Old Order culture has largely been made possible due to a resistance to

change stemming from a religious foundation passed down from their Anabaptist ancestors that continues to guide the beliefs and practices of this group. Amidst a society of change, we have much to learn from these unique groups.

The Culture-Health Connection

> The ways in which society regulates employment and economic cycles, provides education, assists its members in times of economic or other difficulties, sets up strategies to counteract poverty, crime, and drug abuse and to stimulate economic and social growth have just as much, if not more, impact on health than do the quantity and quality of resources being invested in the detection and care of illness (Renaud, 1994, 318).

While culture is given a place as one of the many determinants of health it is suggested here that this component requires a more fundamental position. Culture not only has a direct relationship to health, but it has the ability to influence other determinants of health. Work choice and conditions, style, extent, and content of education, raising of children, characteristics and focus of health services, the quality and type of social networks, the condition of the physical environment, distribution of social status, personal lifestyle, the social construction of gender roles and even the mores guiding reproduction are decided by the cultural framework within which one exists. These relationships deserve attention because, as Evans (1994) suggests, if our understandings of the determinants of health are based on "shaky assumptions," then our efforts to increase preventive measures will likely fall short of the goal of better health (4).

By helping to define the constructs held by a group, Angel and Thoits (1987) contend that "Culture constrains the perceptual, explanatory, and behavioural options that individuals have at their disposal for understanding and responding to illness" (465). Acknowledging the powerful influence of culture, it seems obvious that this force should be incorporated into studies of health. But the role of culture in health research has received far less serious attention than have the individual biological aspects. As Corin (1994) maintains, even as numerous studies have

demonstrated that the connection between health and culture is real, many epidemiological studies in Western industrialized countries continue to focus on individual response mechanisms without consideration of the impact of the larger sphere of life.

Rather than culture being relegated to the status of afterthought, Cassel (1976) writes that by identifying the social and cultural processes important to health, researchers will be able to aid in the selection of key characteristics for further study as well as help in the interpretation of findings. Others agree and have considered the cultural factors at work in our health. In particular, some maintain that the way we live in modern Western society may not be as healthy as it could be. 'Diseases of civilisation' such as coronary heart disease, cancer, and disorders of the cerebral system have been linked by researchers to factors including a breakdown of social support networks, accent on the individual over the community, and a lack of stability as individuals find themselves unprepared for the continual flux characteristic of present-day life (Marmot & Syme, 1976, Dubos, 1977, Corin, 1994).

While it is certain that modern societies have numerous health advantages over many traditional societies in regard to health care, the lack of cultural attention in research is contributing to a less than optimal experience. In fact, psychologist, Ed Bennett (cited in McCarthy, 2000) suggests that 'pathological' modern values of individualism, competitiveness, and indifference to history are creating a society that works against greater wellness and happiness within communities. Adding to this in relation to social supports, House, Landis, and Umberson (1988) contend that "changes in… risk factors…and improvements in medical technology are still producing overall improvements on health and longevity, but the improvements might be even greater if the quantity and quality of social relationships were also improving" (544).

Other health studies, such as those on Native Canadians and the Japanese also present strong evidence for a culture-health link. In regard to the Aboriginal peoples of this country, it is difficult to ignore the possible relationship between their loss of traditional culture and an increasingly poor health experience. More specifically, this community has experienced increasing rates of diabetes (Baschetti, 1998), ischemic heart disease (Shah, Hux & Zinman, 2000), alcoholism (Frank, Moore & Ames, 2000) and high rates of youth suicide (Borowsky, Resnick, Ireland, & Blum, 1999) as European influences on the community grow and traditional ways of life are lost.

A study by Health Canada (1999) on the health of First Nations and Inuit people found that this population has a mortality rate of almost 1.5 times higher than the national rate. In terms of social conditions, Aboriginal children are more likely to live in single-parent families, and 44% of individuals live under the low income cut-off point (compared with 20% of those in the general population) when compared with those in the general Canadian population. As well, in this community housing is less secure, there is a greater likelihood of homelessness, and increased involvement in risk behaviours such as problem gambling, family violence, low physical activity, drug use, and smoking (Health Canada, 1999).

In their discussion of the sources of this community's below average experience of health, the authors of the Health Canada (1999) report draw attention to the poor socio-economic standing of the group. A more profound reason for the situation may be linked to the fact that only 3 of the 50 Aboriginal languages in Canada are secure from extinction and that over 80% of those Aboriginal persons surveyed believed that a return to traditional ways would be beneficial for community wellness. It would appear that the removal of community determination of

lifestyle and the systematic destruction of a cultural rhythm of life has contributed to widespread difficulties in this community.

In another study on the acculturation process, Marmot and Smith (1989) report that with recent increases in life expectancy, the Japanese enjoy the greatest longevity in the world; a finding that has been supported recently by the World Health Organization. More specifically, Marmot and Syme (1976) write that Japan has the lowest mortality rate from coronary heart disease (CHD) of any industrialized country, while the United States has one of the highest rates. Further, they report that when men of Japanese background with similar diets were compared, those living in Japan had lowest CHD mortality, those in Hawaii had intermediate amount of risk, and those in the mainland U.S. had the highest (controls were in place for differences in serum cholesterol, blood pressure, and smoking).

By way of explanation for this finding, Marmot and Syme (1976) note that traditional Japanese culture places emphasis on community and group cohesion, collective achievement, and social stability (increasingly, un-North American characteristics). Noting that the Japanese are concerned with the encroachment of Western ways of life on their more traditional culture and rhythms, Marmot and Smith (1989) found that Japan has been able to maintain significant aspects of lifestyle as they become economically more powerful. More specifically, the authors suggest that:

> Baseball and 'fast food' notwithstanding, the way people relate to each other and to organizations is very different in Japan. The loyalty and commitment to the group, the family, and the organization and the sense of duty to one's superiors in age or status are particularly noticeable (Marmot & Smith, 1989, 1550-1551).

The authors' note, as well, that the long life expectancy of Japanese women is somewhat perplexing in that it is difficult to reconcile this low death rate with their *unliberated* state and

high maternal mortality. While there are obviously other sources of CHD risk such as genetics and other health conditions, Marmot and Syme (1976) contend that the male/ female ratios of CHD are certainly tied in some degree to social and cultural factors.

In both the overviews of North American Aboriginal struggles and Japanese successes, the importance of culture is clear. In the first example, colonialisation has acted to dismantle traditional beliefs, methods and markings of life with obvious implications. Even language has been lost to this community as their culture has been altered largely out of their control. Efforts within the group have been initiated to rebuild the community, but there is a strong impression that this, in many ways, is a shattered culture. Conversely, Japanese society has been able to maintain much of their traditional cultural beliefs and practices and while the influences of the West are apparent, the control of change still rests largely within the hands of the Japanese.

This consideration of culture does not diminish the importance of acknowledging the power of individual behaviours. Certainly, individual aspects of culture such as diet, occupation, social supports, biology and genetics also contribute to the explanation of the health experience of people in modern Western society, the Aboriginal people of Canada, and the citizens of Japan. It is important, however, to also consider the dynamic that creates these influences if one wishes to understand the experience and develop a culturally-attuned health promotion strategy.

To this effort, there is knowledge to be gained by studying those cultures with identifiable boundaries that have a unique health experience in comparison with the general population and exploring what aspects of culture may be working to produce these results.

Where to Begin?

A study of the culture and health connection is daunted by the sheer immensity of the task. It is difficult to know where to begin. If it can be agreed that the cultural influence on health is both real and significant, where do we go from there? Joseph Alter (1999) proposes that we start by asking: *What is good health?* In his study of ontological assumptions in health care the author explains that although an understanding of how an individual or cultural group perceives the state of *health* is a basic component of illness treatment and health maintenance, this question often goes unasked as medical systems attempt to identify illness and restore health.

Loustanau and Sobo (1997) add that what some cultures see as a state of physical or mental illness, other groups may view as not being of concern. In this way, indicators and practices of health are unique among different cultural groups. Some cultures value thinness, while others view larger bodies as symbols of greater health. As some take to the gym for better health, others seek renewal of spirit and body in the sweat lodge (Loustaunau & Sobo, 1997).

One example of this culturally-guided perspective of health is the discussion surrounding the role of leisure in the well-being of industrialized societies over the past decades. For those cultural groups with the technological and social capabilities to sustain it, "the liberation of time" represents tremendous economic, political, social, and health opportunities and challenges (Reid, 1995, 92). As leisure has become segmented from work in the modern life of many societies there has been increased research attention regarding the implications of this aspect of life on the health of individuals and communities.

While the connection is not without its complexities related to activity selection, race, gender, age, and ability, among other influences, leisure has been found to be an important factor in a range of components of well-being including the ability to cope with stress (Coleman, 1993;

Iwasaki & Smale, 1998; Iwasaki & Mannell, 2000; Kleiber, Hutchinson, & Williams, 2002), dealing with illness and loss (Iso-Ahola and Park, 1996), spiritual development (Heintzman, 2000), advancement of a sense of self-determination (Iso-Ahola, 1997), and improved mental and physical health (Stephens', 1988; Paffenbarger, Hyde, & Dow, 1991; Morgan, 2001). In these relationships, leisure may act as both a determinant of health and an indicator of the well-being of an individual and the society.

Medical anthropologists are among those who have taken up the task of both engaging in the development of understandings of illness and treatment across cultures and, more fundamentally, seeking out how different cultures understand health and how this understanding impacts behaviour (Alter, 1999; Helman, 2000). As Pertti and Gretel Pelto (1996) point out,

> One of the central contributions of anthropology to applied studies of health issues is the delineation of the complex ways in which cultural belief systems interact with other factors in affecting rates of disease, definitions of illness, differential responses of illness, and other outcomes of interest (302).

Introduction to Medical Anthropology

A sub-field of anthropology, medical anthropology brings together the social and natural sciences in the pursuit of a richer understanding of health and illness. Although the term first came into use in the early 1960s, the ideas forming the basis of this area of thought are as old as anthropology itself. Current medical anthropology research continues the pursuits of those who studied the health-culture relationship many years ago by investigating the culturally-based belief systems that impact how disease causation is conceived and how treatment is accepted (Moore, van Arsdale, Glittenberg, and Aldrich, 1980).

A diverse range of questions and approaches to research can be brought together within the expansive boundaries of medical anthropology. Addressing both factors that contribute to illness and how individuals respond to disease, medical anthropology adopts historical,

geographical, biological, cross-cultural, and evolutionary perspectives. The primary concerns of medical anthropologists have been to examine how health knowledge is *produced and utilized.*

Within the larger themes of culture and evolution that are central to anthropology, the basic research questions of medical anthropologists center around three main areas:

1. *Descriptive questions*: What are the beliefs around illness – the causes and treatments; What are the characteristics of chosen health care systems; What is the nature of interactions between the healer and those with an illness?
2. *Analytic questions*: How are variations in beliefs, actions, and outcomes explained?
3. *Intervention-oriented questions*: How can health be improved within a population? What system, knowledge, and behaviour changes are necessary (Moore, van Arsdale, Glittenberg, and Aldrich, 1980; Pelto and Pelto, 1997).

With a growing body of literature providing a significant amount of baseline descriptive information, medical anthropologists have been able to increase the attention they give to the second and third categories of questions. This has enabled researchers to actively address health concerns within a community, thus moving the theoretical understandings into practice.

Although they share an interest in the cultural, social and biological determinants of illness, medical anthropologists and epidemiologists take unique approaches to the study of health. Medical anthropology frequently operates within a more naturalistic and holistic framework than does epidemiology and is more likely to use participant observation methods. Additionally, whereas epidemiology typically focuses on defined disease, medical anthropology considers the experience of health and illness by seeking understanding of not only the behaviour, but also the cultural conditions giving rise to it. As Inhorn (1995) explains, to the "who, when, where, and how" questions posed by epidemiologists, the medical anthropologist adds the "why" (288).

While medical anthropologists previously sought distant and isolated cultural groups for study, researchers are increasingly applying their research framework and methods to the consideration of the dynamics of cultural pluralism. More specifically, there is increased attention to the impact of indigenous health cultures coming into contact with mainline health systems. As Pelto and Pelto (1996) explain, there is concern about how the traditional "cultural systems" (or 'rules for living') mix with "cosmopolitan medications and practitioners" (302).

Through the Eyes of Another: The Old Order Mennonite and Amish Experience

If the impact of culture is profound, when the individuals of a culture also share an ethnic heritage (often with a religious component), the impact of cultural authority is intensified (Shatenstein & Ghadirian, 1998). This is the reality of the Old Order Mennonites and Amish who, as Fretz (1989) contends, can be classified as a religious body, an ethnic group, and a cultural minority. More specifically, Fretz (1982) notes that Mennonites:

> Have a set of unique traditions, beliefs, customs, and social practices that go beyond the conventional views of what constitutes a religious denomination. The particular religious beliefs of the Mennonites have always had strong ethical emphasis, therefore, strong social implications […] The customary opposition to and resistance to change, the reverence for traditions, plus the emphasis on social isolation and separation from the world have all contributed to establishing Mennonites as a cultural as well as religious group (36).

Living amidst and interacting with North American culture, Old Order Mennonites and Amish (or as they refer to themselves, the Plain People) are bound together not only by a common belief system, but by a common ethnicity, language, and way of life. Over the generations these people have established themselves as a religio-cultural group distinct from others.

Focusing on the culture-health connection, the evidence presented by researchers considering the health experience of the Old Order Mennonites and Amish (henceforth also referred to as the Old Order people) is intriguing. As will be demonstrated in the literature

review, the relatively few academic studies published have found that this population of individuals has a lower population death rate, a mortality ratio closer to one, and a different risk of certain illnesses when compared with the general American population or with less conservative (or culturally distinct) Mennonite and Amish groups (Cross and McKusick, 1970; Miller, 1980, Levinson et al., 1989; Fuchs et al., 1990; Hamman, Barancik & Lilienfeld, 1981, Hewner (1997).

Additionally, many of these findings are marked by relative uncertainty as to the cause of the differences in health experience. A majority of epidemiological studies reporting on the health of the Old Order community focus on and cite genetics as well as behavioural factors such as a rural lifestyle, a less preservative ridden diet, and high levels of physical activity as possible factors in the difference. The authors of many of these studies, however, share a general sense that genetics and individual lifestyle behaviours in isolation do not provide sufficient explanation for the differences.

In light of these findings, one of the obvious, but largely unexamined questions is whether there could be something about the Old Order cultural perspective that is working to create a unique health experience. Sharon Hewner (1997) is one researcher who has explored this question directly. She suggests that part of the explanation for the apparent difference in health status between Old Order groups and the general population may rest in aspects of their culture such as mutual assistance, co-operation, and altruistic behaviour.

As well, numerous researchers in the field of epidemiology of religion have noted that lifestyle based religions, such as Old Order faiths, may contribute to an improved health state (Jarvis & Northott, 1987; Troyer, 1988; Dwyer, Clarke, & Miller, 1990, Koenig, 1997; Matthews, 1998). These writers cite attributes of religion such as social and coping resources,

positive beliefs and attitudes, lifestyle guidelines, and a sense of coherence to explain the health differences. Aside from the interest of these researchers, however, there has been relatively little specific attention given by epidemiologists to the health-culture relationship in this population.

In the 1960s, Janice A. Egeland conducted a landmark study on the health perspective of those in the Old Order community. Additional consideration of the topic has been given by the well-known Amish researcher, John A. Hostetler in 1964 and by a number of other researchers over the years (Wiggins, 1983; Cavan, 1984; Adams & Leverland, 1986; Donick, 1986; Buccalo, 1992; Miller-Schlabach, 1992; Palmer, 1992; Kreider, 1995; Blair & Hurst, 1997; Donnermeyer, 1997; Yoder, 1997)

Unfortunately, outside of the research conducted by Egeland and Hostetler, many of these works considering health perceptions and behaviour are based on very small samples and have a narrow regional focus. Additionally, a number of the research efforts have used methodologies that incorporate a pre-determination of what areas of health are most important to the population rather than allowing these areas of focus to be defined by the Plain People themselves.

In studies on related issues, authors have investigated understandings of care, health instruction, use of folk medicine, mental health experience, health narratives, and guidelines for culturally-sensitive treatment in the Old Order community (McGrath, 1985; Wenger, 1988; McKegney, 1989; Reynolds, 1995; Nelson, 1999; Reiling, 2000; Oyabu, Ido, and Sugihara, 2001). In general, this body of research suggests that the Old Order community as a whole has a culturally unique understanding of the determinants of health and is often engaged in health care practices that are different than those of the general North American population. More specifically, health is a central concern, often treated pragmatically, and seen within a religious

perspective. Additionally, individuals in this community often seek to incorporate both folk and professional medicine into their health care decisions.

While these works offer a variety of opportunities for improved understanding about the culture-health relationship in the Old Order community, much of the existing research is dated, small-scale or tangential. These drawbacks limit credibility and trustworthiness and in the absence of more current data much of the information targeted at health professionals continues to be based on the works of Egeland and Hostetler.

Consideration of how Old Order individuals understand health is an important first step in the exploration of the culture-health relationship among this population. Although this was the goal of Egeland and Hostetler's works, the data they presented is nearly forty years old and the research conducted over the intervening years contains gaps that warrant further consideration of the issue. The Old Order community is operating at a much slower pace of change than is the rest of society, but it is conceivable that in light of other changes in this community such as growing tourism influences, encroaching development, and movement away from farming, health understandings may be evolving as well.

Additionally, because a majority of the literature in this area is based on interviews conducted by non-Old Order individuals there must be consideration of the effect of an outsider. A new look into this area based on written document produced by and for Old Order individuals would present an opportunity to witness the sharing of health knowledge within this community without the influence of an outside researcher. It would also provide a more current point of reference for health studies on the population and help contextualize epidemiological findings. In the interest of the study of cultural pluralism, there would be opportunity to determine what effects the dominant culture may be having on Old Order beliefs.

Purpose Statement

The Old Order Mennonites and Amish are a unique population. Culturally distinct and claiming a unique health experience, understanding, and approach in relation to the dominant North American population, there are possibilities for insight into the culture-health dynamic through a greater understanding of how these individuals currently understand health. Additionally, their geographical proximity to others, consistency in manner of living, and use of modern medical systems make the Old Order population an ideal one for a culturally-focused health study.

Medical anthropologists typically undertake studies of culturally-based understandings of health in the effort to improve the health experience of the examined cultural group. Learning, however, can go both ways and there are strong indications that the Old Order way of life may hold some important lessons for other cultural groups regarding health. Therefore, while the approach in the examination of the culture and health relationship taken here is similar to that of medical anthropology, the goal is broader. Not only is this an opportunity to identify potential areas of difficulty within the Old Order health experience, it is a chance to identify what health-related perceptions may be beneficial.

This study sought to elucidate the culturally-based understandings of health within the Old Order population. Using a hermeneutical approach to conceptual textual analysis focused on a contemporary Old Order publication, this constructivist-interpretive study provides a cultural portrait of a community in relation to their understandings of health.

Research Questions

Among Old Order Mennonites and Amish, how is health perceived and 'good health' understood? What are the perceptions of the determinants of health? How is illness perceived?

What is the response to illness? How does culture relate to health in the Old Order community?

Using a community based publication, this study examines stated beliefs and practices about health within the Old Order Mennonite and Amish community. Information is sought on current community definitions of health, perceptions of health determinants and challenges, and methods of maintenance and treatment. These health perceptions are interpreted in the context of the Old Order worldview and with the aim of understanding the broader themes functioning throughout the discussion.

Significance: Learning in diversity

Amidst the global tendency toward Westernization and modern values, those cultural groups who continue to operate on a different 'rhythm' are perhaps more striking and more important to the understanding of ourselves and our experience of health universally. As anthropologist Wade Davis (2000) contends, the visions of indigenous people (and traditional cultures) are "our ultimate source of hope. They're the ones who tell us there are other ways of being, that the world that we live in does not exist in some absolute sense, but is just one model of reality" (1).

There are two primary ways in which this study is significant. Shatenstein and Ghadirian (1998) propose that health professionals need to be aware of cultural influences operating in their client's lives. As well, Dimou (1995) contends that cultural differences are much more important to the treatment of individuals than has been acknowledged. At the practical level, this research aims to improve the relationship between Old Order individuals and those who provide health care to them. It is hoped that the suggestions provided at its close on how to incorporate cultural understanding and importance into health initiatives and policy in relation to the Old Order community and beyond prove beneficial to both practitioners and researchers.

At the theoretical level, by considering the role of cultural perceptions of health, we allow more room for the study of those aspects of health that often get relegated to 'areas of future research'. It is hoped that this research will join the works of others in challenging our understanding of health and encourage further study into the impact of culture on our perceptions, our behaviours, and subsequently, our health.

Assumptions

This study is based on a number of informed assumptions and foremost among these is that the Old Order Mennonites and Amish are a unique population in regard to health issues. Additionally, it assumes that there is sufficient consistency in the Old Order community to allow for a holistic study of health based on community publications.

Further, as this study includes consideration of both Old Order Mennonites and Amish there is an assumption made that these groups are similar enough in lifestyle and perspective to allow for such a grouping. While they do have historical and cultural differences (for example, timing of immigration and location of settlement, beards on men, colours of clothing, and type of meeting place for worship), it is believed that the similarities in terms of way of life and beliefs among the Amish and Mennonites are close enough to allow for the dual-inclusion.

Most importantly, because this study relies on a publication, it is of note that in general, Old Order Mennonites and Amish read the same newspapers and periodicals and have the same doctrinal base. As an Amish man reflected on his time spent at a Mennonite service, "So different, yet in many ways our thoughts and problems are the same" (quoted in Kraybill, 2001, 226). A thorough comparison of these groups as well as other Old Order sects is offered in Donald Kraybill's book, *On the Background to Heaven* (2001).

More broadly, this study is based on the belief that culture affects one's understandings and practices, that a cultural community can be identified, and that a researcher can accurately understand the mores, systems, and jargon of a cultural group.

Each of these assumptions is held with caution. It must be acknowledged that culture does not equal behaviour and that it is not the only influence on understandings and practices (Pelto and Pelto, 1996). As well, we must incorporate into the research process an understanding that it is at times difficult to identify the boundary marks of a cultural group, as individual and sub-cultural factors blur the image, and that cross-cultural study is highly susceptible to bias and misunderstandings.

While the concerns related to researcher awareness of the multitude of factors impacting how we think and act are addressed throughout the design, data collection and analysis stages of this study in a theoretical way, the latter two concerns require more immediate and practical attention. For this reason, the literature review that follows provides a description of the historical development of the Old Order culture and a consideration of the worldview and accompany practices of present-day Old Order groups in addition to discussion of the health-related literature on this group.

Developing understanding: The Literature

The Old Order Community

Anabaptist History

> ***Wer Christo jetzt will folgen nach***
> *Christ's servants follow him to death and give their bodily, life, and breath on cross and rack and pyre. As gold is tried and purified they stand the test of fire/ Renouncing all, they choose the cross, and claiming it, count all as loss, e'en husband, child, and wife. Forsaking gain, forgetting pain, they enter into life.*
> ~ Hymn, Text, Ausbund, 1564 (translation Augsburber, 1962)

Reformation. The first step in developing an understanding of any culture is to consider how it came into being and identify the markers of their history. The past of the Old Order Mennonites and Amish begins in Europe during the Reformation.

The Anabaptists rose out of the intellectual and political unrest that was gripping Europe in the early 1500s. The desire for change and discontent with the ruling Roman Catholic Church led to what is termed the Reformation. During this time there were numerous uprisings although Martin Luther and Ulrich Zwingli led the most noted efforts among the first-generation reformers (Hostetler, 1980).

The name Anabaptist comes from the nickname 're-baptizers' and stems from the practice of adult baptism initiated in many accounts by a frustrated follower of Zwingli, Conrad Grebel (Nolt, 1992). In Zurich, Switzerland in 1525, Grebel gathered some others together for a Bible study and at this meeting the group baptized each other (Dyck, 1993). Those gathered believed that baptism should occur as an adult because only then could one make the decision to commit him or herself to give and receive counsel. Further, they held that without the spiritual reality present, water is only water and cannot "purify, reassure, or save" (Dyck, 1967, 33). When town council heard of this 're-baptising', the meetings were declared illegal. But the

Anabaptist movement had already been born and began to spread across Europe to the Netherlands and Germany (Dyck, 1967).

Hostetler (1968) explains that if the medieval Catholic church stood on the 'right' end of the spectrum, resisting any change, from this point and moving leftward, were Luther and his followers who, while rejecting some of the teachings of the Catholic church, largely wished to maintain much of the traditions. Ulrich Zwingli was more liberal than Luther, but continued to support the union of church and state. On the far left, demanding drastic reform, were the Anabaptists.

While a great number of religious sects rose up during the Reformation, Anabaptists were marked by their peaceful stance, desire for the separation of church and state, belief in religious freedom and the struggle for the establishment of a voluntary church (Hostetler, 1980; Friesen and Friesen, 1996). Hostetler (1980) explains that Anabaptist beliefs held that individuals were saved by grace rather than works, could find conscious change through faith in Christ, develop a personal consciousness that was set apart from sinful and worldly manners (nonconformity), and commit to community and discipleship. More specifically, Friesen and Friesen (1996) outline the Anabaptist beliefs:

- The Bible is the guide of faith and should be open to interpretation by all. Priesthood of all believers.
- The Church should be composed of believers who come to worship freely and of their own choice. As well, the Church and government must remain separate.
- Infant baptism is opposed in that it removes the opportunity of choice and only serves as initiation into a state church.
- Although they should pay taxes and obey their rulers, Christians should remain outside of government office.
- It is wrong for a Christian to kill as an individual, by judicial process, or by military force.
- Christians should live separate from the World.
- Members of the Church who sin should be excluded from the rights of membership until they seek repentance.
- The Lord's Supper is to be conducted in memory of the death of Christ, but the bread and the wine do not contain the Real Presence.
- Christians should not take an oath and must keep their word without swearing.

Centred in Zurich, Switzerland and calling themselves Swiss Brethren, individuals part of the Anabaptist movement were also present in the Netherlands. These Dutch followers were called Mennists or Mennonites after a pastor-leader in Wimarsum and former Roman Catholic priest, Menno Simons (Dyck, 1967). Gingerich (1972) asserts that Simons' most important role was in the organization of the movement and the establishment of a common doctrine and practice. The name Mennonite would eventually be used to describe Anabaptists of both Swiss and Dutch background.

Because of their beliefs and the threat to the established church and combined state, in Switzerland many Mennonites were martyred in the early years of the Reformation with on-going persecution over two centuries. The first Anabaptist martyr, Felix Manz, was an associate of Grebel, and was drowned in Zurich in 1527. Many deaths would follow as it is estimated that more than 5,000 Anabaptists (including women and children) would be tortured and executed for their beliefs in the 16th century (Canadian Mennonite Encyclopedia). Documented in the Martyr's Mirror (1660), persecution of these people continued into the 17th century.

Migration. Beginning what would be long history of movement in search for a place where they could live freely, the Mennonites moved into the rural areas of Switzerland and Northern Germany in the mid 1600s and took hold of the farming life where they remained isolated. In the Netherlands, toleration was granted to the Mennonites after a century, and many became prosperous merchants, while others migrated to Russia, Prussia, Germany, and the United States. The settlers often migrated to lands offered by rulers with the promise of religious toleration – a promise that was frequently broken (Hostetler, 1980). As Melton (1996) notes, however, despite

the continued persecution based on religious beliefs and practices, Mennonites were able to establish themselves and grow strong.

European life remained difficult for the Mennonites as the toll of discrimination, economic concerns, and the pressure to have their children put into the military grew heavy. When William Penn, a Quaker, offered land and tolerance to the Mennonites of Switzerland and Germany in the late 1600s many accepted the offer. Penn's Woods, or Pennsylvania, was the next stop on the journey for many of these people. Until the early 1800s nearly all the Mennonites arriving from Europe would settle in Pennsylvania (Nolt, 1992).

When war broke out in the States against the British and ended in local control, the Mennonites found themselves in an uncertain situation. Many fearing pressures associated with the change in control of the land moved northward to what was then Northern Canada. It was here that land was inexpensive and the familiar British rule still reigned. In the last part of the 1700s these Mennonites took to covered wagons and headed north on what would be known as the Conestoga Trail. Many settled in Waterloo County, Ontario where Benjamin Eby served as a prominent leader (Fretz, 1982).

While settlement moved on in North America, the history of the Mennonites continued back in Europe as well. In Russia, Catherine the Great (II) encouraged Mennonites to move out of Prussia into her land because of their well-known farming expertise. They were promised freedom from military service and were able to speak their native German. As the years moved on word came from Canada that there was land available and an interest in farmers immigrating to the area. This news combined with a fear that changing regulations in Russia would threaten their exemptions from military service, over 20,000 Mennonites left the country for Manitoba and the Midwestern United States in the late 1800s. Another large group of Mennonites

(approximately 21,000) left Russia in the ten years after the Revolution in 1919 because of uncertainty surrounding the intentions of the new communist government (Canadian Mennonite Encyclopedia).

By 1930 the Russian government no longer permitted the emigration of the Mennonites so it was not until after World War II that another group would be able to leave with the help of the German Army. Around 60 per cent of those among this group were forcibly taken back to Russia although over ten thousand individuals were able to remain in Western Europe and around seven thousand others moved on to Canada, including a number who settled in Ontario (Canadian Mennonite Encyclopedia).

The Amish. To study the origins of the Amish, one must move back to the late 1600s when differences in conformity began to arise among the Mennonites in Switzerland. While the details are complex, the controversy was based in a number of issues related to congregational practice.

A young bishop, Jacob Amman, serving a congregation in Markirch began to institute some changes within his congregation regarding the number of communions held per year, the practice of footwashing (a symbol of servitude and equality), and uniformity of dress. As well, Amman insisted that congregations adopt the practice of *Meidung,* or shunning. In keeping with the emphasis on practical Christian living, this practice held that any of the followers who failed to live by the standards of the New Testament scripture would be confronted and admonished. If the admonishment was not effective, the individual would be ostracized or shunned from the rest of the group, meaning there could be absolutely no contact with the offending person. The aim was to bring the *wayward* follower back into the community after repentance (Hostetler, 1980).

Amman's desire to have all congregations follow similar rules to those he had instituted at his congregation, brought opposition from others, particularly from an older bishop in the area, Hans Reist. Amman began an investigation into churches across Switzerland and Alsace forcing ministers to state their policy in regards to shunning and to other issues. Tensions rose fuelled by a personality conflict between Reist and Amman and the continued efforts by Amman to bring others to his way of thinking. At several points Amman demanded the excommunication of Reist and several others and sent letters to the Swiss ministers demanding that they agree with his Biblical interpretation. These actions served to polarize the churches and while reconciliation efforts were attempted, they were not successful (Nolt, 1992).

The groups split and the followers of Amman, the Amish, were formed mainly out of the Alsatian congregations. As with the Mennonites, many Amish voyaged to Pennsylvania in the first half of the 1700s although emigrations also occurred to Ontario and Ohio throughout the 1700s and 1800s. It is only in North America that the Amish continue as we know them now as those remaining in Europe eventually merged again with the Mennonites in the area. Despite the conflict that surrounded the birth of the Amish church, there are few fundamental cultural differences that exist today between the Amish and Old Order Mennonites (Nolt, 1992; Hostetler, 1980).

Life in the New World. For over a century and a half after the first members journeyed to North America, the doctrine and practice of the Mennonites and Amish remained relatively stable. In the case of the Mennonites, by the late 1700s and mid 1800s other religious movements began to impact on the group. As the 19th century came to a close, much had been transformed in the Mennonite church with the aid of two particularly influential leaders, John F. Funk and John S.

Coffman. Sunday schools, educational institutes, organized missions, English church services (as opposed to those delivered in High German), and revival meetings were among some of the new introductions. Those who resisted this trend to modernity became what we now know as the Old Order Mennonites (see Wenger, 1959).

At the same time the more conservative Amish groups also became known as the Old Order Amish and were thus differentiated from their more progressive cousins who eventually merged with mainstream (non-Old Order) Mennonite churches or established more liberal variants such as the Beachy Amish.

As reported in the *Mennonite World Handbook*, as of 1990 there were 127,800 Old Order Amish in North America, 56,200 of whom were adult members. A significantly smaller population, the Old Order Mennonites numbered 15,000 in all with 10,000 members (Goetz Lichdi & Kreider, 1990).

The Old Order People: Beliefs, Practice, and Socialization

> ***Forth in thy name***
> *Forth in thy name, O Lord, I go, my daily labor to pursue; thee, only thee, resolved to know in all I think, or speak, or do/ The task thy wisdom hath assigned, oh, let me cheerfully fulfil, in all my works thy presence find, and prove thy good and perfect will…* ~ Hymn, Text, Charles Wesley, 1749

Beliefs. As discussed, Anabaptism arose out of opposition to a number of positions enforced by the reigning Catholic Church during the early 1500s. Years of struggle and persecution for these beliefs as well as strong group development has resulted in the beliefs of the early Anabaptists continuing in the daily life of the Old Order people and creating a way of life that is inseparable from the church. More directly, Old Order individuals belong to more than a religious group, but are a distinct cultural group with unique practices, traditions, customs, and beliefs (Fretz, 1982).

In his study of these communities, Donald Kraybill (2001) examines a number of themes common to Old Order life. Among these, *Ordnung* and *Gelassenheit* guide behaviour and thought at a fundamental level. The *Ordnung* sets out the rules for life defined by the Church and the Community and establishes a moral authority. Bringing belief and custom together as it covers not only religious rituals, but a wide-range of practices including leisure, economics, family life, and dress, the *Ordnung* guides life. Those who fail to follow the rules are sanctioned.

The German word, *Gelassenheit* means to yield to a higher authority. For the Old Order people this is lived out by putting focus on community over the individual and, as Kraybill (2001) explains, it is the most fundamental point of difference between Old Order and modern values. Not only are they taught to see themselves as a member of the community first, they learn to give in to tradition and to their leaders. Just as plainness, humility, obedience, and meekness are seen as virtues, their opposites such as pride, complexity, and disobedience are considered vices. Community norms are seen as "divine precepts" and "to resist the Church is to resist God" (Kraybill, 2001, 181).

With the strong influence of the church in the development of moral order, the Old Order people "live their religion constantly, as everything they do and wear has religious significance" (Wittmer, 1973, 143). Also speaking to this reality, Hostetler (1968) writes that among this community "religion and custom are inseparable. Conviction and culture are combined to produce a stable human existence" (11). The author continues that the core values of the Old Order community are their religious beliefs. Essentially, the belief of these people that God is present and directive in all aspects of life affects everything from their conception of the universe

to the undertaking of daily, weekly, seasonal, and yearly rituals, social interaction, understanding of health, type of work undertaken, and manner of travel engaged. The list goes on.

Further, while faith affects this community in very personal ways, an implication of their way of life is that there exists a behavioural, psychological, and even physical separation from the remainder of society. The Old Order community aims to follow an interpretation of the *Bible* that calls believers to remain 'in the world, but not of the world.' Those within the community, *unser Satt Leit* (our sort of people) and those outside of it, *anner Satt Leit* (other sort of people) are clearly divided (Hostetler, 1968).

In addition to *Ordnung* and *Gelassenheit (also included in the listing)*, there are a number of other prominent characteristics of Old Order faith. Combining the works of Friesen and Friesen, 1996, Yoder, 2000, and Kraybill, 2001, ten are presented below. Unless otherwise noted, the accompanying quotations for selected points are from Kraybill's work (2001, 19).

1. *Religious guidance*. Communities are characterized by the belief that that one must live according to the teachings of Jesus Christ. It is important to note, however, that the Old Order community does not take to the practice of proselytising nor is it evangelical. Theirs is a grounded theology based in the practice of 'brotherly love' and focused on helping others in need, not in conversion.

2. *Disciplined Church Community*. Those who are baptized in the church are making a choice to stay committed to its rules and repentance is expected of those who break them. Those who sin or fail to keep by these guidelines are expected to repent to their community or potentially face punishment, including excommunication[1]. "Obedience to authority brings order and unity", "Yielding to community brings meaning, identity, and belonging"

3. *Community focus.* The Old Order community is central. The needs of the community supersede those of the individual. "The individual is not the primary reality"

4. *Non-resistance*. As was a central tenant of their Anabaptist ancestors, Old Order people are opposed violent means of problem solving. Basing their position on the teachings of Jesus, they are conscientious objectors during wartime and may even be reluctant to defend themselves in court. "resist not evil" (*Bible*)

5. *Separatism.* Non-conformity with general society is part of every aspect of life from dress, to language, to education. "Love not the world neither the things that are in the world" (*Bible*)

[1] Also referred to as shunning, excommunication is rare among the Old Order Mennonites although slightly more common among the Old Order Amish.

6. *Simple Life. Demut* (humility) is central and pride, enjoyment of power, war, and violence must be avoided. "Personal sacrifice is esteemed over pleasure"

7. *Family Life*. The family is a central unit in the Old Order life and the community. There is no intermarriage, separation is rare and divorce is not permitted. Families are large and sex roles are strictly defined.

8. *Hard work / Harmony with Soil and Nature*. Hard work, thriftiness, and manual labour are considered virtues and the rural life is considered preferable to the city where unnecessary spending and leisure occur. "Work is more satisfying than consumption"

9. *Mutual Assistance*. The community takes care of all who are a part, financially and socially.

10. *Tradition over modernity*. The teachings and practices of the past are seen as at least equal, if not preferable, to the ways of the present. "Tradition is valued over change"

Speaking to this last characteristic, Peters (1987) notes that modernity is seen as threatening force by the Old Order Mennonite community in that it alters the values and social fibre of a people, encouraging a trust in government and individuals rather than God and the community. This does not mean, however, that Old Order people are trapped in a different time resisting all change. The community is evolving, but at carefully guided rate. As Kraybill (2001) explains, these people are "cultural conservationists" and work to accept change only when it coincides with their established moral order and contributes to, rather than alters, traditional ways (17).

Practice. To those who have the opportunity to view this community, the life-style characteristics of the Old Order Mennonite and Amish, including dress, occupation, manner of transportation, and style of home seem from a different time. It is true that the tenets of belief guiding the Old Order worldview lead to a way of life that is largely pre-industrial (Friesen and Friesen, 1996; Kraybill, 2001).

The degree of behavioural variation within this community, however, adds some complexity to the description of behaviour practices of the Old Order people. Because of the

Anabaptist belief in the 'priesthood of all believers', the proscription that all persons should have the right to read and interpret the Bible for themselves, the larger Mennonite and Amish communities have witnessed generations of change and division fuelled by differences in how individuals understand the teachings of the Bible and how they bring belief into practice.

Interpretational differences regarding everything from where to meet for services, to the colour of buggies and style of suspenders, to the use of various technologies such as generators, indoor plumbing, or cell phones have led to debates and splintering of congregations. This practice is so common, in fact, that there is a word for it: *Taeuferkrankheit*, or Anabaptist Sickness. The splits have occurred since the earliest days of the Anabaptists and continue today. Often, the disputing sides will separate and form independent congregations.

Traditionally, Epp (1974) suggests, Old Order groups have been more susceptible to splits than their more progressive cousins due to need for uniformity of practice and belief on strict and specific ways of life. In other words, "the more specific and detailed these rules were, the greater the potential for division and dissension" (Epp, 1974, 268).

While the details of differences in practice can quickly become bewildering, the ten characteristics of Old Order belief outlined in the previous section generally hold true across the variations. When one considers the more progressive Amish and Mennonite congregations (non-horse and buggy), the relative behavioural differences become more severe. Within the Old Order Mennonite and Amish groups, however, while distinctions are important in the community and worth consideration, they are not severe enough to disable a conversation on Old Order practice in general.

Because their worldview is so different than that of many North Americans, some may have difficulty accepting or even understanding Old Order practices. As Kraybill (2001) writes:

> If we take them seriously, if we go beyond the captivating nostalgia, Old Orders and their ways are troublesome, even offensive. We are troubled by folks who limit education, restrict occupations, curb personal freedom, and stifle personal achievement and artistic expression. Their pleas for obedience – for yielding to community – appear offensive, sexist and suffocating by any stretch of contemporary standards. The provincial uniformity of Old Order culture irritates our penchant for diversity and pluralism (277)

This perspective is also acknowledged within the community as Old Order Mennonite writer, Issac Horst (2000), explains that to the outsider his community's way of life may appear odd and without reason while others may even appear offensive to those in larger society. Of course it can be said of every cultural group, including our own, that what we take for granted as 'normal' can be viewed as puzzling by those not raised with the same cultural perspective.

Within each of the Old Order guidelines and ways of living, however, there is meaning whether it is Biblical, traditional, or simply based in effort to maintain a distance from the outside World. Scott and Pellman (1999) provide further insight in their publication, *Living Without Electricity*. The authors outline a number of different aspects of Old Order life and offer some explanation for the chosen way of life. Addressing such topics as why (and how) this group of people conducts daily life without the use of electricity, telephones, mechanized farming equipment, automobiles, plumbing, and television, the authors suggest a common theme of self-denial, simplicity, separateness from the World, and focus on the church and family without distraction.

Furthering this point in the words of an Old Order person himself, in response to questions regarding prohibitions on the use of cars and telephones, one minister explains that to his people:

> They are instruments of worldliness. We do not condemn them. We condemn no one or anything. We try to live in peace, in humility and in meekness, after the way of the Lord….Do not misunderstand, these outward forms will not win us salvation. We do not put store by them. We know they are but defences to preserve us from worldliness and keep us each hour and each day in humble and hourly remembrance of our Christian faith" (quoted in Fretz, 1982, 34).

Still, Friesen and Friesen (1996) suggest that it may be difficult from a secular perspective to fully comprehend how completely individuals in the Old Order community are able to imbue the sacred into every aspect of life. Simply, all that one does is in service to God

Acknowledging the potential points of differences across communities, in general, education is limited, gender roles are strict, conformity is demanded, and obedience is taught early in life. The man is the head of the family and women are typically homemakers (or as Hostetler (1968) contends, "the farm is the Amishman's kingdom, and his wife is his general manager of household affairs," p. 149).

A combination of Pennsylvania Dutch, High German, and English are often known and spoken. Modern technologies including electricity and motorized transportation are generally not utilized. Cameras and photographs are not permitted in keeping with Biblical passages that speak against the creation of 'graven images' or simply because such items could lead to pride (Horst, 1996).

Telephones are increasingly becoming accepted in some communities. While some allow phones in the home, others permit the use of cell phones for business, and still others accept only a community phone located in an outside structure. In general, musical instruments are not permitted for personal or church use (Kraybill, 2001). Smoking of cigarettes is either strongly discouraged or forbidden as is consumption of alcohol (Hostetler, 1980; Blair & Hurst, 1997).

Homes are often without ornaments such as mirrors or pictures although plants are permitted. Seating in the home primarily consists of straight-backed chairs although the kitchen often has a couch and a rocker or armchair. Because their typically large homes are heated using wood stoves or small propane heaters, not all rooms are used and individuals often gather in the

kitchen on cold evenings and children typically share bedrooms. Simplicity and practicality are central aspects of lifestyle (Kraybill, 2001).

In this highly prescribed life there are also a significant number of rituals. From family meals, religious services, and leisure activities to births, deaths, and difficulties within the community, there are customs and patterns laid out. For example, there is a protocol to barn raisings in terms of assessment of damage, collection of materials, and execution of the work. Sundays are days set aside for church and visiting with friends and relatives. Weekday evenings are primarily reserved for games or reading at home with family and there are substantial limitations in terms of what may be read. When young people reach a certain age they are hired out to other families to learn farming practices or how to take care of a home, and there are defined manners by which people court for marriage (Fretz, 1982; Peters, 1987; Kraybill, 2001).

Socialization. The importance of community over the individual is a crucial aspect of Old Order religious culture and socialization. Fretz (1982) speaks to the strength of community when he writes that among these people there is the belief that "human life is basically group life" (18). The author goes on to point out that the family and church are seen as the primary groups of importance because "within these two institutions are determined the value systems of the group. Within them the basic virtues of goodwill, integrity, generosity and imaginative concern for others are developed" (18).

Socialization among Old Order peoples begins early as children learn what is appropriate in belief and practice. Wittmer (1973) explains that very early on (around the age of 2 years) Amish girls and boys are modelled after their mothers and fathers, respectively. Dress and values are passed on directly with little evidence of a generation gap as parents raise their children in the same manner as they were raised. The author continues that his research

demonstrates that Amish parents are more similar in their child-rearing practices than non-Amish parents.

This power of socialization is apparent when one considers the very specific statements of intention by two young Old Order children (quoted in Hiebert, 1998):

> I wish to become a farmer when I grow older and bigger. First I will help my father with this work around the farm until I am about seventeen years of age. I will help in the fields, raking and baling hay, plowing, or cultivating. I will help to drive the corn or hay loads around. Then I will be a hired man for one or two years, for more experience. I might go hunting while camping by the river with my friends. I like to catch pigeons in the barn loft, feed rabbits, do other chores around the farm. ~ Old Order boy, 13

> When I grow up I hope to be a mother. I would like to get married at the age of twenty and have about eight children. We would live on a farm with forty-five cows and some sheep and rabbits. As I grow older, I hope to sew pants, shirts and dresses, and bake cookies and squares, and best of all, make some delicious cakes. As I grow older and become a grandmother, I hope to be able to make thick blankets, coats, sweaters and thick woolly socks for winter, and some thinner clothes for summer. I will sell them at the Stockyards and use the money to buy groceries for the poor. ~ Old Order girl, 11

There is little doubt when reading these statements that children are taught at a young age what will be expected of them. As well, there is a great likelihood that both children quoted here will end up doing what they have planned for that is what their mothers and fathers did and their parents before them, and so on. While all societies incorporate active socialization of children and parallels certainly exist in the other societies, the rhythms and patterns of the Old Order community are distinct.

Perhaps because they look more to the past than to the future for guidance and seek collective wisdom over individual decision making, Old Order socialization practices are more consistent across the generations. As Hostetler (1968) explains, "the Amish community is homogeneous in the totality of its culture and psychology. Ways of thinking and behaving are much alike for all persons in corresponding positions of age and sex. 'States of mind' are much

alike from one generation to the next" (15). Roles are passed down from parent to child and life-styles are common.

A study of young Amish men compared with non-Amish men from the same community presented by Wittmer (1970) furthers the implications of this type of socialization into the social-psychological realm with the finding that the personalities of the Amish were more similar on nine of sixteen measures than that of the non-Amish. Those measures of greatest homogeneity among the Amish included: reserved vs. outgoing; affected by feelings vs. emotionally stable; humble vs. assertive; shy vs. venturesome; tough-minded vs. tender-minded; trusting vs. suspicious; forthright vs. shrewd; group-dependent vs. self-sufficient; and casual vs. controlled.

As noted in part previously, it is maintained that the church, the family, and the school are the primary institutions that have enabled the continuation of the spiritual and cultural heritage of the Mennonites throughout generations (Fretz, 1989). Addressing these forces as well as acknowledging the role of work and leisure provides more insight into the practices of these people.

What a friend we have in Jesus / All our sins and griefs to bear;
What a privilege to carry / Ev'vrything to God in prayer.
Oh, what peace we often forfeit / Oh, what needless pain we bear,
All because we do not carry / Ev'vrything to God in prayer
~ *What a Friend We Have in Jesus*, Hymn

The Church. In the Old Order community, church members often meet biweekly on Sundays for services and worship is conducted in a mixture of High German and Pennsylvania Dutch (an unwritten German dialect). Individuals are seated in the church according to age and gender, with men and women on separate sides of the church (Kraybill, 2001).

Ordinances of the church include Baptism services once a year (those being baptized are usually between the ages of 17-19 and have gone through instruction classes), Communion twice

a year (on Thanksgiving and Good Friday), and foot washing (this practice of humility occurs on the same Sunday as Communion). While Amish church services are typically held in the homes of members, Old Order Mennonite church buildings are structurally plain and lack decoration such as stained glass windows, statues, wall hangings, or pictures. As well, while singing is a central part of the service, there is no musical accompaniment (Hostetler, 1980; Kraybill 2001)

The churches are organized into Districts and all within a particular district are under the guidance of an ordained Bishop who is in charge or ordinations, baptisms, weddings, and funerals. The Bishop typically travels around the district to all the churches and preaches when visiting. Further, he holds the most weight in terms of decisions making in church and lifestyle matters. Individually, the churches are led by a minister who does the preaching on most Sundays and a number of deacons in each church act as assistants (including help in financial and charitable work) to the minister and bishop (Fretz, 1982; Hostetler, 1980; Kraybill, 2001).

Men hold all leadership positions and ordination to position of Bishop, Minister, or Deacon is for life and occurs by 'lot' selection. In this practice, men in community make nominations. A piece of paper is placed between the pages of a book. A number of books are then set out on a table (as many books as men) and the man who selects the book with the piece of paper is appointed to the position. Rather than through the process of congregational voting, the name selected in this way is in keeping with the Biblical process that was undertaken by the twelve Apostles to replace Judas Iscariot and it is thought that this process allows for God to choose the leader. None of these are paid positions and the men are expected to conduct the duties in addition to their other responsibilities such as that of farmer or teacher (Fretz, 1982; Kraybill, 2001).

Few people convert to the Old Order faith, and a majority of new members to the church are children of members. Also, Fretz (1989) notes that members of the church are expected to be active in this intimate community and attend church regularly unless ill or infirm.

Among the Old Order people there is the belief that the individual should be self-sufficient, that the family should provide for itself and, if more help is needed, the church should offer assistance (based on *Biblical* text: "Carry each other's burdens, and in this way you will fulfil the law of Christ" Galatians, 6:2). Due to these beliefs, in general the individuals of the church community do not participate in any insurance programs, including health insurance, old age pension, and medical allowances. Instead, individuals and the church community pay medical costs, care for the aged, and contribute time, energy, and money in the event of barn fires and other difficulties (see Epp, 1994).

The Family. While it is typically assumed that Old Order families are quite large, Fretz (1989) reports that in actuality, less 5% of the families included over nine members and 30% had over five members. It is proposed that the families may appear larger because in this community children stay with their parents for a longer period of time.

It is also quite common to have multigenerational households. Grandparents are often a very important part of the family in Old Order communities. Instead of being sent to nursing homes with advancing age, older adults may live in a part of the main family home or a separate structure built beside the house called a 'doddy house' so that they can remain active in the family taking care of children or helping around the farm (see Hewner, 1998).

Young adults in the community socialize in groups rather than date in pairs and causal dating is not accepted. The large majority of Old Order Mennonites and Amish marry others

within the faith. Once married, divorce and separation does not occur and is grounds for excommunication in some communities (Kraybill, 2001).

The status of individuals in relation to their gender is an important consideration in any cultural study. This issue takes on particular significance, however, in light of the proposition by some researchers that lower social status may play a role in the less optimal health experience of Old Order women as compared with men (Glick et al. 1998).

Old Order Amish women are more likely to be involved in financial and legal affairs than their Mennonite counterparts, but in both communities the father is the authoritative head of the household (Fretz, 1989; Kraybill, 2001). As Fretz (1989) notes, however, this reality does not mean that the father is necessarily oppressive. Often, the woman and children do have a voice in decision-making. The author continues that the roles ascribed to each member of the family are seen as the way Christian families are arranged and are typically accepted without critique. Along with these roles, there is teaching in the church that each member should respect and love the others: children should respect their parents; men and women should respect their partners; and parents should respect their children.

Fretz (1989) asserts that this patriarchal family structure appears to work in the Old Order population for a number of reasons. Among those highlighted by the author are that: family goals are embedded in the lifestyle; it is supported by a church to which all in the community belong to and which is strengthened by a parochial school system; the community is close-knit, mutually-supportive, and socially segregated; and because their way of life is based in the small family farm agricultural economic system. Adding emphasis to the importance of the church in the family construction, Kraybill (2001) explains, “The faith community coordinates weddings,

prescribes gender roles, and admonishes couples about birth control and the proper training of children – continual reminders that the family is under the thumb of the church" (187).

In her study of attitudes toward women's liberation in Canada, Billson (1994) found that the Mennonite women she met in the Waterloo Region of Ontario felt themselves to be liberated despite the doctrine of male 'headship.' The author quotes one of the women with whom she spoke as stating the following: "The choices that I have made would probably make me appear not to be liberated. Those are my choices and I'm very happy in them. I've come through the whole process of wanting to be an individual – it is much nicer to be part of a unit. I have tremendous freedom" (Billson, 1994, 12). Billson (1994) echoes Fretz's earlier comments when she writes that Old Order Mennonite women believe their domestic role is in keeping with their vision of what God wants and in this role they find happiness and blessings.

From the perspective of an outsider, the quality of the experiences associated with different roles may be elusive, resulting in a misinterpretation of the reality in this community. An illustration of this is found in an anecdote shared by a woman visiting an Old Order home. After a meal she offered to help with the dishes in light of all the work that the woman had put into making the meal. The Old Order woman replied that preparing the meal had not been work, it was what she did every day (Fretz, 1989).

Still, in her conclusion, Billson (1994) wonders whether women in traditional societies, including Mennonite women, are in a state of unliberated "false consciousness" or whether the dominant feminist ideology created by educated, urban, white, middle class women, is too distant from their cultural beliefs and way of life. Only the women who are part of this community hold the answer to this question.

School. In the family, children are raised with strictness and taught at a very young age the importance of submission so that they can grow into adults who believe and act with respect to the Church. With the maintenance of private parochial schools, the educational system is also a proven and critical part of the maintenance of the Old Order lifestyle. More precisely, one author refers to the Old Order school system as the "synthesising factor" promoting a way of life (Friesen, 1983).

Education has typically been viewed among this population as means to an end rather than something with its own integrity (Fretz, 1982). Further, education is kept at the eighth grade level because of the belief that beyond this point schooling encourages the young people to replace their focus on faith and practice with a more philosophical and logic-centred approach to matters in life. In other words, the socialization process and perspective on education is based in the belief that to keep an individual from defecting from the community, he or she must be kept physically, emotionally, and cognitively within the Old Order community during adolescence (Meyers, 1997).

The schools of the community stress moral and ethical teachings. There is a common adage among Old Order Mennonites that "as the school, so goes the church." Fretz (1989) notes that this belief translates into an effort to ensure that the practices and objectives of the school and the church support one another.

Similarly, Meyers (1997) notes that order, separateness from non-Old Order culture, and community are stressed through school and even in games at recess there is no emphasis on winning or individual success. Issues such as religion and sexuality are taught in the home, and teachers are expected to convey core values to students through example. Because of the tight control of the educational system, isolation of the community, absence of media influence, and

discouragement of 'book learning', individual achievement and creativity, values typically taught at school or learned from peers, rarely conflict with those taught at home (Peters, 1987).

Tis the harvest time, 'tis the harvest time / To the fields I must away
For the Master now is calling me / To go and work today
Gleaning on the hillside / gleaning on the plain
Working for the Master / 'Mong the gold grain
~ '*Tis the Harvest Time*, Hymn

Work. Although increasing numbers of Old Order individuals have had to look elsewhere for work in a time of decreasing availability of land, farming continues to be the primary occupation of these people. A long history of working the land has followed the community from its roots in Europe and is thought to afford an ideal environment for church and family ideals (Fretz, 1989).

Farming not only provides an occupation that enables a family to care for itself, but where others in the community are farmers as well, it provides an environment for self-sufficiency, full participation, and mutual assistance. Old Order men and women are partners in full-time farming as they each work long hours. It is not uncommon for a farmer to put in eighty-hour weeks and children and ageing grandparents have work to do as well. The women also grow and preserve large quantities of food for the family in the aim of self-sufficiency. A visitor to an Old Order home describes a typical pantry:

> There were crocks of cheese, elderberries, apple butter, bags full of schnitz (dried sliced apple), dried corn and beans, pails of maple syrup and sacks of sugar and flour. Her cellar looks like a store. A room twelve feet square has shelves all around it from floor to ceiling filled with quart and half-gallon jars of canned beef and chicken, and pork sausages hang from the beams above. There are great bins of potatoes and turnips. Other vegetables are stored in boxes and there are barrels full of apples (quoted in Fretz, 1989, 197).

Leisure. Among the Old Order people, leisure does not carry the same positive connotations it may for many in modern Western society. To explain the discomfort with the

concept one must forgo labels and activity lists and, instead, address the essence of leisure. Shaw (1985) asserts that while leisure can occur within nearly any activity, four factors are typically associated with the experience. These include: freedom to choose the activity, intrinsic motivation, relaxation, and enjoyment. The researcher continues that when three or more of these factors are present, there is a higher probability that the activity or situation is leisure-related.

In a community where all that is done has religious significance (Wittmer, 1973), it is the notion of intrinsic motivation that appears to conflict most strongly with what is known about Old Order culture. While there is evidence that freely-chosen, relaxing, and enjoyable activities are deemed appropriate and even beneficial in this community, the idea that an adult should do an activity for no other reason than the personal satisfaction gained through it is potentially highly problematic among Old Order people.

Instead, leisure may blend with work as many free time activities such as quilting, Sunday visits, singing and even caring for elderly family members or new babies, are centred on developing or focusing one's relationship with God, establishing and maintaining social connections, or creating something of use for one's family or the community. As psychologist Csikszentmihalyi asserts, the free time of Old Order individuals is typically "useful and productive either in a material, social, or spiritual sense" (Csikszentmihalyi, 1997, 74).

For members of the more modern, individualized society the approach of the Old Order people may appear neglectful to the well-being of the self. But their community- and Biblical-based reality is difficult to impossible to understand through the eyes of a person who has not experienced this form of socialization. Not only is the belief system different, but it is also reinforced by the reality of farm life which creates a different rhythm of life; one that does not

offer evenings and weekends off or extended vacations. Workdays typically begin with the sunrise and end long after the sun has set.

While hard work is considered a virtue among these people, opportunities for personal fulfilment, renewal, and connection with others are not unknown. In fact, *chores* may include leisure-like elements when they are both challenging and fulfilling and times for socialising are scattered throughout the day. Sundays are days of worship and rest and weddings, funerals, quiltings, barn raisings, singings, auctions, and religious holidays all offer time for social connection and leisure. Along these lines, Fretz (1989) presents the thoughts of one woman on the leisure lives of Old Order Mennonites:

> What is work for some is leisure for others and what is leisure for some is work for others […] Many of their work bees and ways of making a self-sustaining living are actually very enjoyable get-togethers with friends, family and relatives […] Recreational facilities and leisure time activities are more numerous and varied than outsiders realize: checkers, crokinole, jigsaw puzzles, quiltings, apple schnitzing (paring and slicing to dry), Sunday evening singings followed by folk games, farm sales, wood carving, knitting, skating, and swimming in season at local creeks, repair work around house and barn, barn raisings and reunions, weddings and funerals must all be considered as meaningful and pleasant leisure-time activities for old and young (220).

Sunday visiting is an important ritual within this community. While customs vary from population to population, families are typically uncertain of who may be dropping in on a given Sunday, but the women are prepared to feed how ever many guests arrive for dinner. The afternoon is spent visiting and in the evening young people of the community often gather in one of their homes where the group will sing hymns, play games, chat, and even square dance in some communities (Peters, 1987).

When leisure does occur it is often practical and without financial cost. For example, quilting serves to supply the home with enough warm blankets as well as ability to offer supplies to relief organizations such as Mennonite Central Committee, while also providing an opportunity for women to visit with one another. Similarly, while young children do not have

exposure to television or radio, they fill their days with outdoor pursuits such as hunting, swimming, playing with pets, skating, or reading (Hostetler, 1980).

Stability Amidst Change. How the Old Order Mennonites and Amish have been able to survive while many other religious sects have dissolved away with assimilation is a complex question. While, Ericksen, Ericksen, and Hostetler (1980) suggest quite directly that the Old Order culture is maintained through the establishment of children on farms, others have considered more fully the power of the Old Order belief system.

Fretz (1989) contends that the religious faith of the Old Order people helps in maintaining old ways. Further, the author explains that without the "regular religious reinforcement of their commitment to lives of discipleship, their resistance to change through the week could not be sustained" (Fretz, 1989, 286). Similarly, Epp (1994) suggests that the preservation of the Old Order lifestyle despite the pressures of change is attributable to "internal stability as well as strong religious integrity" (32)

Some clarity on the maintenance of this culture may also be found in the Old Order perspective on change (for a discussion on sect development see Wilson, 1959). Iannaccone and Miles (1990) suggest that those churches with lifestyle dictations are continually seeking a balance between their traditions and the prevailing social norms. To this point, Iannaccone (1994) suggests that the Amish provide one of the clearest examples of selective adaptation and Kraybill (1989) explains that this community has a "process of negotiation which enables them to retain their ethnic identity while simultaneously adapting to economic pressures" (8).

This "process of negotiation" is such that when changes do occur in this community, they are carefully planned. Fuchs et al. (1990) suggest that changes in Old Order communities are

generally unwelcome if they threaten religious beliefs, family stability, the pursuit of peace, or create conflict. Along these lines, Savells (1988) suggests that "most of the trends in our society that suggest commercialism, profit-making, materialism, mass consumption, leisure-seeking, and 'life in the fast lane' are objectionable to the Old Order Amish" (129).

This attachment to tradition is evidenced acutely when Old Order groups splinter off from each other on the basis of debates surrounding such issues as hairstyles, neckties, spectacles and rings, mechanized equipment, and telephones. Because of such a strong desire to remain separate and the belief that change is not always *progress,* such seemingly innocuous aspects of life are not simply accepted and allowed to pass into life without discussion and, at times, create conflict and division. Despite the minor lifestyle differences, however, the basic principles of Old Order Mennonites remain the same (Friesen and Friesen, 1996).

The Old Order community is not simply stuck in an earlier time (Hostetler & Huntington, 1992; Epp, 1994). As Epp (1994) explains, "the Old Orders are inevitably confronted and influenced daily by the styles and trends of their host society [and] one sees a subtle but persistent adaptation of traditional ways to the changing environment" (30). When viewed in comparison with many other cultural groups who have undergone continual change over the years, however, the Old Order culture has remained remarkably stable in regard to beliefs and practices.

While these people have largely found a way to maintain a chosen identity in a world that is swiftly moving around them, there are threats to their way of life. As farmland decreases, cities encroach, and their culture is increasingly commodified, the ability to maintain a rural lifestyle and a separate life becomes more difficult (Epp, 1994; Kraybill, 2001).

But the outlook for the maintenance of cultural integrity is positive. This group of people has demonstrated over the generations that they are capable of controlling both the rate and direction of change in their communities. They question what many of us have merely accepted as normal. As Kraybill (2001) explains, Old Orders demonstrate that it is possible to live life on a more "humane scale".

Unfortunately, because of how Old Order groups have been presented in the media, by purveyors of tourism, and by some academics a study of this cultural group is not complete without a caution. Conversation with Old Order individuals on their thoughts of how they are represented by others yields a common theme: They have no desire to be raised on a pedestal or perceived as a community without flaws. In fact, they are very much aware of the difficulties existing in their families, their schools, and their churches. Although they may deal with areas of conflict, expression of poor judgement, and other concerns in a way different than others, they are people with the same capacity for making mistakes as the rest of us.

Amidst these human characteristics, however, the Old Order people do have something unique. They have a singular religious worldview that enables them to evaluate their choices, successes and their failures. Although it may seem stifling to an outsider, the Old Order individual knows with certainty where wrong begins and where right ends. Donald Kraybill (2001) expands on this idea:

> By the end of their journey, Old Orders hope to reach the outskirts of heaven, with the pearly gates in sight. Their backroad journey may appear virtuous at times, but make no mistake: Old order virtues come with a price […] they require forgoing individual preference in dress, transportation, and education. They require accepting restrictions on convenience, friendship, marriage, mobility, and occupational choice. They require striking a delicate balance between communal restraint and personal freedom […] These outcomes require the embrace of a different world – a world where the welfare of the community supersedes personal freedom, a world that by most benchmarks is provincial and restrictive. The personal costs of Old Order ways are high, but the benefits – identity, meaning, and belonging – are surely precious commodities in the midst of social fragmentation (280).

The Health Experience of Old Order Mennonites and Amish: A Unique Population?

Researchers have reported a range of findings on rates of cancer, hypertension, and diabetes, among other disorders in the Old Order community contributing to a weight of the evidence suggesting that this group of people may have a unique health experience in comparison with the general North American population.

Epidemiological Findings. Hewner (1997) found that in 1960, the Old Order Amish age standardized death rates were 19% below those of the general US population. Further, the longer life expectancy among the men of this community has been noted as the mortality ratio between Amish men and women is closer to one than that of the general population (Cross and McKusick, 1970; Miller, 1980). Some attribute this ratio to increased rates of maternal mortality due to high number of pregnancies (Cross & McKusick, 1970), or because of less smoking (due to religious restrictions) among the men in the community (Miller, 1980). Others have suggested that the longevity rate is related to lower community levels of hypertension and lower than average rates of mortality due to cancer and cardiovascular disease among other major causes of death (Levinson et al., 1989; Fuchs et al., 1990; Hamman, Barancik & Lilienfeld, 1981).

It is true that genetic concerns have been high among this population. Isolation of communities and the concern with marrying within one's faith has lead to a relatively high frequency of consanguineous marriages in the Old Order community. While there have been effective efforts made to reduce this, the result of the practice is an increased number of genetic disorders in the community such as dwarfism (Ellis-van Creveld Syndrome and cartilage-hair hypoplasia), albinism, deafness, and maple syrup urine disease (MSUD) among others (McKusick, 1978; Khoury, 1986; Khoury et al., 1987; Fisher, et al., 1991; Sulisalo et al., 1995;

McKusick, 2000). Consequently, a majority of the medical research conducted on Old Order populations (specifically the Amish) has been in the area of genetics.

While genetic disorders can affect individuals at any stage of development, those that present themselves in the early stages of life have been noted here and are a real concern to the Old Order community. Despite this overwhelming focus, a few studies have considered the health of the Old Order population apart from these genetic challenges.

Hamman, Barancik, & Lilienfeld, (1981) found that although cancer mortality rates were slightly (but not significantly) higher for Amish males under age 40, the mortality rate between age 40 and 69 was significantly lower for Amish males and dropped to a 27% lower death rate after age 70 when compared with the general population. Although the cancer ratios among females were less consistent, the researchers also found that Old Order men and women aged 40-69 had a substantially lower risk of mortality from all digestive disorders.

In a consideration of cancer rates among religious sects, Troyer (1988) reports that the Amish had lower overall rates of cancer than the general population. In particular, within the total population, rates of colorectal cancer and neoplasms of the lung, mouth, pharynx, larynx, and esophagus were found to be lower than average. Amish men had significantly lower incidence of prostate cancer. A greater number of Amish women died from stomach cancer than non-Amish women, but this was not true for men in the Amish community.

Troyer also found that rates of mortality from breast cancer (the data collected did not include survivorship figures) were quite high for Amish women although death from cervical cancer and rates of ovarian cancer were found to be very low within this population. No differences in rate of urinary bladder cancer or death from leukemias were found among the

Amish population when compared with the general population except for a small excess of leukemia among Amish males under the age of 10.

Glick and associates (1998) found that despite their higher caloric index, Old Order men and women had lower than average body mass indexes, and the men had a lower risk of coronary heart disease. Researchers have also found that Old Order individuals have a lower rate of hypertension despite a high level of reported obesity among older adults (Fuchs, et al. 1990). These findings are supported by an earlier study by Jorgenson, Bolling, Yoder, and Murphy (1972) that reported a less pronounced rise of systolic and diastolic blood pressure with age among the Old Order population when compared with more liberal Amish and Mennonite sects.

A recent study considering Type 2 diabetes rates in the Old Order Amish in a Pennsylvania community found that the prevalence of the condition among Amish was *half* that of the general U.S. Caucasian population despite similar rates of impaired glucose tolerance rates in both populations (Hsueh, et al., 2000).

Mental Health. Apart from studies investigating a genetic link for bi-polar disorder, the research on the mental health experience among Old Order groups is more limited than that on physical health. Additionally, as Reiling (2000) contends, what does exist may be flawed methodologically and theoretically. Certainly, the highly conflicting findings presented by researchers in this field demonstrates that a clear understanding of the incidence and rate of mental health concerns within this community is difficult.

Findings range from those suggesting a *higher* frequency of phobias, schizophrenia, affective disorders, and psychosexual dysfunction among the Amish (Coblentz, 1991), to those identifying a *lowered* risk of psychological, economic and social stresses among the Amish in

comparison with urban Americans and *lower* rates of general mental illness and affective disorders (Von Heeringen and McCorkle, 1958; Egeland and Hostetter, 1983)

As mentioned previously, Fuchs et al., (1990) report that, unexpectedly, nearly ten percent more of Amish women were likely to report feeling depressed or low than non-Amish women and Amish men were slightly more likely than their non-Amish male peers to report these emotions. Lending some support to this finding, Hostetler and Huntington (as reported by Hamman, Barancik, & Lilienfeld, 1981) suggest that there exists an undercurrent of anxiety in this population that is possibly greater than that among non-Amish although this is less discernible by outsiders.

Some of this anxiety may be due to the pressures placed on the community by the outside world and the maintenance of an increasingly unique way of life. Particularly, there is concern associated with the decreasing availability of land and the encroaching force of modernisation in Old Order communities across North America (Hamman et al., 1981). In some areas individuals have been forced to leave the farm for trade work and the impacts of this transition away from farming and a way of life they believe they are meant to live (Friesen and Friesen, 1996) are still largely unknown.

Fuchs et al. (1990) do acknowledge the possibility that there may be different stigmas in the Amish and non-Amish communities regarding depression that affect reporting. A hint of support for this proposal is found in Coblentz's (1991) report as he contends that the Amish may have a positive attitude regarding seeking help for mental health concerns (in consultation with a minister or medical doctor primarily) and are possibly less negatively impacted by social stigma. More research is necessary to determine if this is in fact the case.

The male advantage. A number of the studies conducted on this population highlight what appears to be a male health advantage or, perhaps more accurately, the lack of a male disadvantage. As Miller (1980) found in his research, the six to eight year advantage in life expectancy that women have over men in the United States is not found among the Old Order Amish. Similarly, as discussed, other studies have also demonstrated this difference (Cross and McKusick, 1970; Hamman, et al., 1981; Fuchs et al., 1990; Glick et al., 1998).

Although Old Order women do experience some health differences in comparison with their non-Old Order peers, a majority of findings highlight the improved health status of Old Order men. Most researchers offer little to no consideration into the difference between men and women in this community, but Glick and colleagues (1998) do offer some insight. The researchers propose that the lack of positive impact of physical activity on cholesterol levels in Old Order women may have two possible biological causes. First, that the beneficial effects of physical activity and weight loss are more effective in lowering LDL cholesterol and raising high-density lipoprotein cholesterol levels in men and in post-menopausal women. Secondly, multiple pregnancies might have a negative effect on cholesterol as it has been found to increase by as much as 50% during and after pregnancy.

Interestingly, as alluded to previously, Glick et al. (1998) also consider a more socio-cultural reason behind the results. Admitting their uncertainty as to the source of the male advantage, they call on a well-known study by Marmot and colleagues (1978) that studied the health of British civil servants in an attempt to help explain the difference. Glick et al. (1998) note that the social hierarchy in Old Order Mennonite culture places men in positions of power. Further, as demonstrated by the British study, higher social status is related to reduced blood pressure and reduced coronary heart disease mortality, while serum cholesterol does not exhibit

such a relationship. The impact of gender roles was addressed previously in the literature review and the gender difference in health status is clearly an important research issue.

Why a health difference? A number of years ago Polgar (1962) criticized research conducted on the health status of communities for merely describing the situation and not inferring anything from their findings. While the situation has changed to a certain degree, a survey of the medical literature on the Old Order populations suggests that while some may begin down this road, there continues to be relatively little attention granted to specific, thoughtful conjecture. By way of explanation for the lower mortality rates (particularly among the men of this group) and differing rates of incidence of some key causes of death, epidemiologists do offer a number of considerations, some culture-related, as well as admit a certain degree of uncertainty.

While some researchers suggest that this group is less physically active in leisure (Levinson, et al., 1989), the less technologically dependent lifestyle may increase overall levels of physical activity within the Old Order population. As mentioned, Glick et al. (1998) refers to higher levels of physical activity as having a positive effect on male cholesterol levels and the body mass index of both men and women. Additionally, Hsueh and colleagues (2000) hypothesize that the Amish may not be protected against glucose intolerance, but that fewer individuals in this population develop overt diabetes due to higher activity levels. The authors back this assertion with reference to others studies that have found an impact of physical activity on insulin sensitivity and glucose intolerance. Hsueh et al. (2000) also propose that genetics may have a role as well although more research is necessary to speak to this with any confidence.

Jorgenson et al. (1972), in their study of lower increases in hypertension also acknowledge the possibility of a genetic determinate in the explanation, but note a clear and

linear relationship between advancing systolic blood pressure with age and increasing liberalisation (including use of technology) of the group. In other words, the Old Order population, employing the fewest technological tools in daily life fares better in terms of blood pressure than less conservative Amish and Mennonites although they largely share a common genetic heritage. The authors even cautiously acknowledge the possibility that "modern life increases physical and emotional stresses" and that their findings on blood pressure are in accordance with others that found connections between domicile and type of work (Joregenson, et al., 1972, 343).

Fuchs et al. (1990) suggest that the reduced risk of hypertension may be linked with the fact that the Amish diet contains fewer chemical preservatives in food and that the group reports a lower likelihood of adding salt to food at the table. On this latter point, however, it should be noted that it appears that the researchers did not consider the addition of salt to foods during the cooking or canning process. The authors also contend that the higher rate of reported obesity among the Amish could be related to less stigma associated with greater weight (a stigma that may cause the under-reporting of weight among the general non-Amish population). Further, in a study by Levinson et al. (1989) the authors notes that the Amish were more likely to take vitamin supplements than were non-Amish persons.

Researchers also note the rural lifestyle as a possible source of explanation for the health experience of the Old Order people. Notably, Hamman et al. (1981) suggest that the pattern of higher mortality rates until age 35 they found for Amish men is consistent with findings for US farmers. Referring to a study by Guralnick (1962), the author explains that she also found that farmers were the only occupational group with higher relative mortality rate under age 35 and lower rate over age 45. Hamman et al. (1981) also contend that reduced exposure to hazardous

environmental agents because of their rural lifestyle may reduce the incidence of neoplasms, cardiovascular diseases, and external trauma in this community.

Fuchs et al. (1990) assert, however, that although the rural lifestyle may explain some differences, their findings suggest that the Amish differed from other rural peoples living in similar geographical and occupational circumstances. As well, despite their rural-based contentions Hamman et al. (1981) also admit that the specifics of the relationship are not clear. The authors state:

> The observation that mortality rates differed in the Amish for numerous diseases was not unexpected. Understanding the reasons for these differences is more difficult than describing them […] Additional research is needed to provide more detailed and quantitative data on the personal habits and the rural environment of the Amish before these mortality patterns can be fully understood (Hamman et al., 1981, 860).

Speaking to the impact of lifestyle, Troyer (1988) offers a number of explanations for the differing rates of cancer among the Amish. Prohibitions against tobacco and alcohol may be related to the lower risk of cancer of the lung, nose, mouth, pharynx, larynx, and esophagus among the Amish. Cultural prohibitions against promiscuity and intercourse at an early age may help to explain the lower rates of prostate and cervical cancers.

The researcher continues that high parity among Amish women may explain their lower rates of ovarian cancer, but the high rate of breast cancer among Amish women does appear perplexing given their tendency to have a first child at an early age (the most important variable identified in previous studies). Weight, genetics, reluctance to have regular examinations, and delay of medical treatment may partially explain the mortality rates from breast cancer. Diet, particularly meat consumption, is typically seen as one of the main determinants of neoplasms of the stomach, colon, and rectum making the findings related to the rate of these cancers among the Amish (who do eat meat regularly) somewhat difficult to understand. As well, the usual

determinants of leukemia, including exposure to radiation, alkylating chemicals, and certain drugs, fail to explain the rates of juvenile leukemia in the population.

In one of the few studies addressing Old Order cultural beliefs as they relate to health, Hewner (1997) contends that her research on mortality rates suggests that altruistic behaviour, belief in mutual aid, and community co-operation have a beneficial effect on the health of the Amish. The author also suggests that behavioural factors including high fertility rates combined with low infant mortality, planned migration to address population increases, and selective use of the Western medical system are cultural patterns that have enabled this population to experience reproductive success and longer life spans (Hewner, 1998). Further, the incorporation of aged individuals and those with disabilities or disease related morbidity are integrated into the community in a manner that acts to "minimize the impact of morbidity and [does] not hasten mortality" (Hewner, 1997, 80). Essentially, all persons have a role in the community and are cared for by the community.

Literature from the religion-health area of study also provides some insight. George et al. (2000) contend that religion can be defined as the collective reinforcement of a spiritual identity. With the behavioural and community proscriptions associated with religion, a number of researchers have noted that a religious culture (opposed to individual spirituality) may explain some of the differences found as well.

Troyer (1988) notes that cancer findings among religious sects offer challenges to conventional understandings of risk factors. In fact, the author contends that when assigning risk factors for types of cancer, "it may be just as valid and more realistic to consider composite risk factors (or life-style) as to try to implicate isolated, discrete risk factors" (Troyer, 1988, 1014).

Research conducted by Dwyer, Clarke and Miller (1990) suggests that in counties where there is a high concentration of conservative and moderate Protestants and Mormons there is a lower rate of cancer mortality than in those communities with greater numbers of liberal Protestants, Catholics, and Jewish individuals. The Old Orders were included within the analysis under conservative Protestants. Among other researchers who have acknowledged the improved health of the Old Order population in relation to religious beliefs are Shatenstein and Ghadirian (1998) and Troyer (1988).

Uncertainty Remains. The weight of the variables studied in these reports such as physical activity, lack of chemical preservatives in the diet, salt intake, mental health reports, community-focus, mutual support, and rural lifestyle cannot be calculated with much confidence with the limited health and community studies available on the Old Order populations.

While information is limited, the general trend of available research points to some important health differences between the Old Order people and the general population. To investigate this further, it is necessary to better understand the Old Order *perceptions* of health, not merely their behaviours. This information, while not able to provide definitive rationale for the differences provides context and guiding information in conjunction with the epidemiological studies.

Beyond Epidemiology: Health Perceptions and Behaviours. As limited as the epidemiological literature on the health experience of Old Order populations is, research into the health understandings of this community is even more difficult to find. Medical anthropologists, it has been noted, may be the group most likely to consider these questions of culturally-based views and acts. Although these researchers have increasingly found it important to give attention to the

experience of those geographically near as well as those in far-away lands, a literature search did not produce a single published study in the medical anthropology field on the health perceptions and behaviours of Old Orders. Instead, dissertations and articles in nursing and social science journals compose the bulk of the literature that takes a non-epidemiological approach to the study of culture and health in the Old Order community.

Of those researchers who have conducted research into the health of this community, John A. Hostetler and Janice Egeland are perhaps the most well-known. In 1964, John A. Hostetler considered the folk and scientific medical practices of the Amish. A well-known researcher of the group, Hostetler began his discussion by explaining that:

> Every known society has developed methods for coping with disease and thus has created a theory of medicine in keeping with its whole culture. Although sickness and medical behavior have concerned social scientists the past few decades, we know little about the sociology of folk medicine as a type in contrast to medical behavior in civilisation (1964, 269).

In an effort to address this deficit, the researcher interviewed nearly fifty physicians serving Amish communities across North America and examined 26 issues (one year) of an Amish newspaper, *The Budget*.

Hostetler (1964) created a list of ailments and treatments listed in *The Budget* and asked physicians to rate the prevalence of certain physical symptoms presented by Amish clients in comparison with non-Amish patients. In addition to the finding that health is a central concern within the Amish community, Hostetler (1964) found that Amish individuals were perceived by physicians to have complaints and symptoms different than those of their non-Amish peers and that there was a high level of knowledge regarding modern medical terminology and practice as well as usage of folk treatments among the Amish. As well, the researcher noted that in comparison with many of the other barriers to change in place in this community, medical

information is largely accepted. In fact, Hostetler (1964) asserts that "the acceptance of scientific explanations of disease and treatment suggests that medical knowledge may be one of the most vulnerable inroads to change into a folk culture" (270).

For nearly 40 years Janice Egeland has been working with the Amish of southeastern Pennsylvania. Although her current publications centre around the study of affective and genetic disorders in this community, at the time of publication of Hostetler's (1964) study, Egeland was working on a doctoral dissertation on the health beliefs and practices of the Amish based on the hypothesis generated by Hostetler's work.

Over the course of 6 years, Egeland (1967) used a combination of interviews, participant observation, and case studies to collect information for her ethnographic study of the health beliefs and behaviors of an Old Order community in Lancaster, Pennsylvania. Although Egeland decided not to pursue publication of her research, her extensive Doctoral dissertation details the findings. Focusing her research into three main areas, Egeland sought information on the systems of medical belief in the Old Order community, the system of medical behaviour, and how these systems related to and reflected cultural values.

Egeland (1967) summarizes her findings into seven main areas:

1. Family is important at every stage of an individual's illness. There is a strong belief in the importance of family support in the individual's recovery and continued wellness,
2. Individuals should strive to maintain independence through illness so that they are able to continue service to others through interdependence,
3. Individuals should continue to be active in their unique community role to the highest degree possible throughout illness.
4. There is a belief in the supernatural etiology of some health concerns. Some believe in the symbolic or magical aspects of illness and these beliefs can operate along with professional medical beliefs.
5. Belief in the acceptance of "God's will". "Mer wisse doch das es so sei hot sella (This has happened and we may be sorry for it) but we realize that it was supposed to be. It simply is as it was to be" (Egeland, 1967, 432).
6. Belief in the holistic treatment and the natural restorative capacity of the human body in harmony with nature.
7. Folk pragmatism – Willingness to try new methods for the control or cure of illness if effective and offered with enthusiasm, understanding and encouragement.

More recent literature also suggests that Old Order health beliefs and practices are unique relative to the dominant culture of North America. Among the other studies to explore these issues, a number of common themes emerged. The first of these is the tendency of Old Order individuals to measure health by whether the person looks 'healthy' and has the ability to do work (Wiggins, 1983; Donick, 1986; Blair & Hurst, 1997; Nelson, 1999). This perception combined with a belief in God's Will and the fact that many Old Order people do not use health insurance programs creates a pragmatic approach to health and contributes to a situation where many Amish individuals are *sub-optimal* users of the health care system (Hostetler, 1968; Donick, 1986; Kreider, 1995; Palmer, 1992; Blair & Hurst, 1997; Yoder, 1997). This practice may lead to a situation where, to their detriment, Old Orders have a greater likelihood of waiting too long for care and passing on preventive health practices such as yearly exams or immunizations (Blair & Hurst, 1997).

In line with Egeland's (1967) findings, the literature also suggests that family and community supports and sources of information are viewed as a key aspect of achieving and maintaining wellness (Wiggins, 1983; Donick, 1986). Additionally, individuals were often in the practice of caring for aging parents in their home (Palmer, 1992).

A holistic and natural approach to health by the Old Order people has been noted by a number of researchers. Use of vitamins and foods are frequently found to be an important part of maintaining health within this community (Donick, 1986; Miller-Schlabach, 1992; Palmer, 1992). As Donick (1986) found in her study, Old Order individuals were likely to cite the following practices for maintenance of health: "closely watching my diet", "eating high fiber foods, lots of vegetables, and few sweets". When sick, individuals outlined the following treatment: "take a tea depending on the problem".

Many researchers interested in Old Order health beliefs and practices have also explored the associated issue of folk treatments and alternative therapies. Although there is a high level of acceptance and belief in the benefits of allopathic medical practices and no biblical proscriptions limiting use of professional health services, there exists an apparent preference for alternative and natural methods of healing.

Explanations for this preference have been offered by a number of authors. As Hostetler (1968) suggests, the higher rate of use of folk medicine may be due to the community tradition of separation and practice of carefully planned change. As well the author raises the possibility that this community may be experiencing some psychotherapeutic results of folk medicine that they have not found in the "highly rational" non-Amish community. Similarly, Blair and Hurst (1997) add to Hostetler's first point when they explain that "The close knit ties among the Amish, their separateness, self reliance, internal networking, cost consciousness, reluctance to impose on each other, and general distrust of healthcare providers from the outside contributes to Amish acceptance of folk medicine and alternative healthcare practices" (42).

Although their preference has been noted, the decision to use alternative or folk means or professional services for the treatment of illness has been found to be based on a number of considerations. Among these are cost of service, transportation needs, guidance from family and friends, and severity of illness or condition (Donick, 1986; Hostetler, 1968; Miller-Schlabach, 1992). In her study, Donick (1986) discovered the following breakdown of treatment decisions:

1. Folk care (*brauche*) – For small children who cannot express what is wrong with them or for ailments with no known cause. For a more 'natural' or geographically close option.
2. Alternative care – For headaches, sore muscles, or back troubles.
3. Professional care – If ailment is serious or surgery required.

Often the community is found to have achieved a balance between the various methods of treatment. This finding is also supported by Hostetler's (1968) analysis.

Perhaps due to the peculiarity of the practices, much of the literature considering the health beliefs and practices of Old Order groups is heavily dominated by discussion on the use of folk medicine among this group. A number of writings outline what the Old Order Mennonites call *Charming* and the Old Order Amish call *Baruche* or Pow-wowwing (McGrath, 1985; McKegney, 1989). A practice with roots reaching back before the Anabaptist beginnings in the early 1500s, the nature of these folk healing practices ranges from use of hand movements, prayers, and physical manipulations, to herbal medicines.

Christian Eby, a well-known charmer in turn of the 20th century Waterloo region of Ontario was frequently approached by locals to cure such diseases as cancer, rheumatism, or 'stomach fever'. Eby would send powders and ointments to those who called on him as well as do his charming from a distance. In one of the more unusual practices, Eby instructed individuals to pet guinea pigs to heal sore joints caused by rheumatism (McKegney, 1989).

As did other charmers or practitioners of *Baruche*, Eby saw himself as a "vehicle of God" rather than as one with special powers. The practice, however, became a point of debate within the community in the early 1960s as a more fundamentalist movement arose and some became suspicious of the folk methods. While some Amish and Mennonites discontinued the practice, others continued but did it more quietly, while still others merely used the folk remedies in balance with allopathic treatments (Schlegel, 1999).

Folk medicine practices (*brauche*, charming, or pow-wowwing) are thought to be decreasing, but are considered by many to still be in practice among some of the more conservative Old Order groups. A fair amount of variation in use of alternative therapies within

the Amish community has been found in a number of studies (Palmer, 1992; Blair & Hurst, 1997). Prevalence of these practices cannot be based only on the number of 'charmers' in existence within a community for as Donick (1986) suggests, folk medicine is not only maintained by practitioners, but also through the health practices passed down through the generations.

Associated research. Among the works to approach the health understanding of Old Orders in related ways is a study by Francis Wenger (1988) who entered an Old Order Amish community in the United States to examine the cultural meanings of care. In this study, cultural care was defined as "the meanings and expressions known by Old Order Amish which support and enhance a sense of personal, family and community well-being, assisting them to improve human conditions, or face disabilities or death" (17).

To develop understanding, Wenger (1988) investigated how community structure, practices, and beliefs impact community and family care beliefs and, consequently, the promotion of well-being among Old Orders. Additionally, this study considered the factors that influence the use of allopathic and folk medicines and looked at differences in care beliefs and practices across families and generations. Her ethnographic study included interviews with 13 families from several different church districts.

Among her findings, Wenger learned the following:

1. Care is *central to the Amish worldview* and highly integrated into values, beliefs and practices;
2. The Amish are *active participants* in their care. Health is valued highly and the Biblical proscription to treat one's body as a temple was taken seriously;
3. Through maintenance of *high-context relationships*, the Amish remain knowledgeable about the care needs of others in their community and allow them to anticipate the needs of others.
4. A *pragmatic approach* to care is taken by the Amish. Care choices were influenced by the cultural beliefs and values with a general principle being: "if it helps, it is good, and if does not help, it will not hurt" (181).

There have been few studies conducted on the mental health of Old Order communities outside of the work of those researchers seeking a genetic link to bipolar disorders. Denise Mae Reiling (2000) in her dissertation on the relationship between Amish identity and depression among the Old Orders, however, provides a comprehensive look at mental health concerns in this community. Through participant observation and formal interviews with Amish individuals at different stages of connection with the community, Reiling discovered that in addition to individual triggers, there were five cultural dynamics important to the development of depression in this community. These factors include social control, suppression of negative emotional states, suppression of worldly thought, surveillance, and community gossip.

Among the few Japanese researchers who have found a specific interest in the Amish, Oyabu, Ido, and Sugihara (2001) recently completed a study that compared the health textbooks used in Amish schools to those used in American public schools. Through extensive quantitative analysis, the authors discovered differences in the nature of *what* is taught and *when* information is presented. It was found that unlike the American public school texts, the Amish instruction materials only addressed issues that were seen to be directly related to daily Amish life. In this way, specific *physical issues* are stressed by the Amish while broader environmental issues, disease concerns such as HIV, and tobacco and drug use are addressed in a limited way and in relatively later grades compared with American public schools. The authors of this study concluded their work by questioning the stability of the health information system in Amish schools. There was concern that a combination of localized-health focus and increasing contact with the non-Amish society would result in the Amish being confronted by health concerns with which they were not educated to address.

Challenges. Some researchers have expressed concern for the health of Old Order groups because of their beliefs and practices. In addition to the concern regarding a below average usage of preventive health measures, a number of factors are seen to potentially reduce Old Order usage of the western medical systems. Among these is the tendency to believe their fellow Old Orders over health professionals combined with the reality that educational restrictions result in a situation where they must seek professional medical help outside of their community (Caven, 1984; Wiggins, 1983; Miller-Schlabach, 1992). As well, because they do not use health insurance the rising cost of care may exceed the financial capabilities of the community (Wiggins, 1983).

In relation to their willingness to incorporate alternative health practices into their treatment programs, Old Order groups have at times been the targets of unethical vendors of questionable cures. In the series, *Plain Prey*, Kansas City Star reporters discussed this growing problem in the Old Order community. As one Pennsylvania preacher shared, "We have a major problem among our people. We are gullible. I can stop at a store on the way home from work and pick up something that, if you suck on it, it's supposed to fix everything from the colour of your hair to the length of your nose" (quoted in Canon, 1997, 1). In many communities, leaders have been speaking out about the dangers posed by those who prey who Old Order trust.

Summary. Although no study has matched the extent of involvement or range of findings that make Janice Egeland's dissertation so important, many of the findings from these more recent studies are consistent with Egeland's work.

The common themes emerging from the existing literature on health perceptions and practices of individuals in the Old Order community centre around similar themes as those that guide the remainder of their life: belief in the influence of God and the desire to follow the path

God has set for their lives, a holistic understanding of health and illness, focus on ability to carry out their role in the community, desire for practical and pragmatic treatments, and the influence of community in personal decision making.

In respect to the goals of this research project, a particularly interesting finding among the existing body of research is how many of studies reviewed note concern with the paucity of literature in the area of health behaviours and beliefs among the Old Order Mennonites and Amish. While it is true that there has been relatively little data collected in this area, this literature review has demonstrated that there has been some research in the area.

The problem may not be as much in the lack of information, but in four main limitations. First, much of the research is restricted to Doctoral/Master's theses or nursing journals that have specific readership and divergent goals. Over the course of a year, I conducted repeated literature searches using typical methods that yielded very little information. The two primary sources of literature eventually discovered were both fairly obscure. The first was a bibliography on health and the Old Order Amish posted on the Internet by the University of Buffalo library. Many of the documents outlined there, however, were difficult to access because of their limited distribution. The second source of information, and the richest, was an Old Order Amish library in Aylmer, Ontario. With a significant amount of shelf space devoted to Health and the Amish, this library run by an Old Order individual is a rare and valuable find.

Secondly, the technique of doing personal interviews while offering the potential benefits of depth of information, limits the opportunity to go beyond a specific region or to gather a range of opinion. Although Egeland was able to conduct over a hundred interviews during her 6-year study, many of the other studies are bound by time and economic constraints resulting in much smaller sample sizes. Additionally, because of the separation that exists between this community

and the remainder of society, researchers are often forced to limit their conversations to a select group of individuals including leaders or 'experts' in the community and those who are comfortable enough to agree to speak in English with an outsider.

Similarly, a third limitation may be that personal interviews conducted by outsiders may encounter issues of socially-desirable reporting or reduced openness. As in most cultural groups or societies, individuals are not often eager to share negative characteristics with those on the outside. Additionally, individuals in the Old Order culture are socialized to appreciate the boundaries between themselves and the outside world. Studies of mental health in this community have made this point particularly well. The extensive range of findings related to mental health in Old Order populations may be a direct result of the unwillingness of these individuals to discuss such issues with people outside their community. Individuals may be more likely, however, to discuss such issues anonymously in their own newspapers.

Finally, the pragmatic approach to life shared by many Old Order individuals may reduce the effectiveness of an interview aimed at getting at the more abstract aspects of health (Hostetler, 1964; Miller-Schlabach, 1992). In other words, when an interviewee is approached to participate in a discussion of health, pragmatism may limit the ability for the interview to get beyond health being defined as feeling good or looking good and beyond what teas are taken when ill to reach health related issues such as social supports, stress, rhythm of life, or the more indirect aspects of religion. Additionally, when researchers are outsiders to the community, this effect of the interviewee focusing on the facts, rather than the meanings, may be intensified.

With the exception of the first point, it is proposed that a textual analysis may provide unique opportunities in light of these identified limitations. It is anticipated that a broader understanding can be obtained through the study of community documents containing the

contributions of many than if one were to interview people individually. Additionally, the range of offerings has the potential to be more diverse because individuals from across North America submit writings to the selected publication.

By observing conversation within the community there may be less pressure for participants to censor what they are saying. While one must consider the reality that scribes to the studied newspapers are constructing their contributions with a specific audience in mind and may alter their submission based on this, the primary audience is other Old Order individuals, not researchers. They are engaged in conversations; sharing knowledge and understandings about life with those who they can assume share a common worldview to the one they themselves hold.

Document analysis may also allow for more fundamental insights into the health-culture relationship than would be possible for an outsider in direct communication with Old Order individuals. Although text analysis does not allow for the benefits achieved through an interactive dialectic with the interviewee, consideration of written documents provides the opportunity to glean understandings and practices of health through observance of every-day discussions of life. It allows one to observe how knowledge about health is shared with a community.

A consideration of the literature on the cultural dynamics of this group, the epidemiological information on health experience, and the studies detailing Old Order beliefs and practices of health suggest there is still a need for study. The separate life of the Old Order people is increasingly being challenged by tourism pressures and reduction of farmland among other factors and continuing to evolve at its own rate. Studies on cancer rates, diabetes, and mortality rates continue to present findings without a clear understanding of causation and

without incorporation of cultural understandings. And the information on health beliefs and practices, while notable, is limited by date of publication, degree of focus and methodology.

A Step Back

> It is strange that while the term 'public health' has been used for generations, the significance of the fact that it consists of two words has only recently been appreciated. It should always be realised that we are dealing here both with a product, health, and a recipient, the public, and the most complete knowledge and understanding of the one is pointless without the corresponding information about the consideration of the other (Hanlon, 1955, 96).

Janice Egeland (1967) began her study on the health beliefs and behaviours of the Old Order Amish with this quotation by Hanlon, noting that it was this idea that formed the basis for her research. It guides this project as well. When we acknowledge that culture guides our perceptions, actions, and behaviours the need to incorporate it into studies of health is clear.

Shatenstein and Ghadirian (1998) contend that research undertaken in the aim of understanding what determines behaviour patterns in cultural groups provides "clues to the interactive consequences of social, environmental, and biological influences on disease prevalence and outcome" (224). The Old Order Mennonites and Amish are a group unique in their worldview, cultural ways, health perceptions, and health practices. If we step back from the isolated determinants of health and consider the cultural framework guiding beliefs we may be better able to understand the dynamic of health in this community. This foundation of understanding may contribute to an improved ability to effectively focus our research efforts, interpret results of health studies, and provide culturally-appropriate health care.

An effort has been made to present a literature review that forms the basis for this research pursuit. If, as the evidence suggests, beliefs within a cultural context may be indicative of positive or negative health attributes (Shatenstein & Ghadirian, 1998, 228), we must strive to both understand the dynamics of the culture as well as hear the voices of the people themselves.

In pursuit of this first call, the history of these people has been presented to provide a deeper insight into their cultural creation and development. It is through an understanding of the history of the Mennonites and Amish, complete with the stories of persecution, displacement, splits, convictions, cohesion, and perseverance, that we can better understand the Old Order people of today. It is by studying the roots of these people who share a common ethnic heritage that we better understand their beliefs and their way of life.

The distinct lifestyle and view of the world held by the Old Order population was addressed in the section on beliefs and practices. While it is important to consider the many aspects of this unique culture as a way of better understanding the sample under consideration, it is easy to become caught up in the particulars and peculiarities. Essentially, a strong belief in God and the teachings of the *Bible*, the observance of a traditional way of life separate from the rest of society, and focus on community above the individual are some of the hallmarks of these people and their way of life.

An understanding of the dynamics of this culture helps one to understand the rigid sex roles, education limits, expectations for children, and self-denying way of life. Although to outsiders these strict controls on life may seem smothering, it appears that for those who have been raised within this reality, the Old Order culture appears to provide clear rules for life, known and accessible goals, and a role for all in the community. In this way, as one young Old Order woman maintains, while her community may have many of the same difficulties and conflicts that are present in all societies, they also have an "abiding personal faith in the central truths of Amish understanding" and this is what holds life together (Stoltzfus, 1994).

Perhaps even more importantly, this way of life is so revered by the community that change is greeted with active scepticism, great consideration, and when it does occur is often

very slow and, at times, conflictual. As Fretz (1989) notes, unlike many of those around them, the Old Order Mennonites:

> Do not seem to feel the need to conform to every wind of change. They have a strong commitment to their own lifestyle and prefer continuing to conform to it rather than to the many new ideas, fashions, and inventions that constantly present themselves. This for them spells a significant measure of stability and avoids the constant need to adjust to the new, the unknown, the uncomfortable, and often the impractical (296).

Understandings of health perceptions must be developed within the context of this worldview.

The Old Order community, in the company of other increasingly dwindling traditional societies, appears to be presenting an alternative to the continual flux of modern culture. In the Old Order *Gemeinschaften* society all are brothers and sisters and the individual is secondary to the group. The community shares a common understanding of truth and this truth is founded in their religious beliefs. As strong as this common understanding is, there still are threats and stresses challenging the Old Order way of life. Although they are a community held by tradition, the Old Order Mennonites and Amish are living their lives amidst Western culture - one of the most quickly-changing cultures in the world.

A review of the health data compiled on this population demonstrates that in some key areas there is a difference in the health experience between the Old Order community and the general population. Further, this difference is largely in the favour of the Old Orders in relation to death rate, life span, and risk of certain illnesses including cardiovascular disease, certain types of cancer, hypertension, and type 2 diabetes. There exists uncertainty as to the source of these differences with researchers citing genetic, behavioural, and cultural factors.

When we go beyond the rates of illness and consider the culturally-based health behaviours and practices of the Old Order population we find that while the data has notable limitations, there is a strong indication that this population is unique in both how it approaches

understandings of health and how it seeks to maintain wellness. Researchers have found that a belief in God's will, holism, and function are key aspects of health beliefs and community guidance, balance, and pragmatism influence health behaviours.

There is much to learn from these previous studies, but the topic deserves a new look. There may be new possibilities for learning if we broaden our approach to include not only an understanding of illness frequency, but consider how a community answer and engages with the fundamental question of "what is good health?" There may be new possibilities for learning if we allow the voices of the people themselves, rather than the researchers, to guide the discussion.

In their communities, newspapers such as *The Budget, Die Botschaft, Family Life, and Young Companion* allow for Old Order individuals across North America to connect with one another and discuss issues of life. By the people and for the people, these publications offer a unique, non-invasive window into this separate society. Examining the writings of a publication in an interpretive study with a broad understanding of health, this research has attempted to both build on what has been done previously and offer new insights into the health experience of the Old Order community.

There is significant learning to be done within the cultural realm where we learn how to live, where we find our community, and where we find our purpose. Supported by an understanding of the cultural dynamic of this community, this study has sought to listen to the printed testimonies, thoughts, and discussions Old Order individual's share with one another and further knowledge related to how Old Order individuals understand health.

Methodology

> Any effort to understand human behaviour must take into account that humans are cognitive beings who actively perceive and make sense of the world around them, have the capacity to abstract from their experience, ascribe meaning to their behaviour and the world around them, and are affected by those meanings. - Palys, 1997, 16

In keeping with the aims outlined in the section on *Purpose of Study*, this study was designed to achieve an understanding of the stated experience and meaning of culture and health in the Old Order community. Through the examination of community documents, this research has endeavoured to identify and develop themes related to culturally based perceptions, understandings, and practices of health and uncover the meanings behind the culture-health relationship.

In any discussion on methodology, there must be considerations of the type of relationship existing between the researcher and those individuals being studied (epistemology) in addition to the usual concerns regarding the theoretical perspective and the approach and techniques associated with data collection (Guba, 1990, Samdahl, 1999). Epistemology guides the researcher's choices, actions, and understandings (Denzin & Lincoln, 2000) and informs how a researcher wants to "live the life of a social inquirer" (Schwandt, 2000, 205).

In this study of the Old Order community, the centrality of understandings of individuals necessitates a constructivist-interpretive epistemology. The application of constructivism means that this research approach accepts that, as do other cultural groups, Old Order individuals actively construct culturally-based understandings of health. In other words, this study does not presume a single reality, but rather seeks to understand the lived experience from the viewpoint of those living it (see Schwandt, 1994).

The focus on community publications is based in the understanding that one avenue of expression regarding health perspectives is through written documents which not only represent the beliefs of the author, but may also affect the health understandings of those who read them. As well, the incorporation of interpretivism means that this research seeks to make visible, through careful analysis, the underlying health-related meanings and themes of the text.

In a constructivist-interpretive study the researcher and those being studied are often close. Because this study is based in the analysis of texts, however, it not possible to have collaboration between the researcher and those being studied. Despite this, there are still possibilities for some form of interaction between the researcher and the author of the texts. As Ian Hodder (2000) suggests, although the texts cannot "speak back," the researcher can be challenged by the data when he or she follows appropriate procedures. The "interpreter learns from the experience of material remains – the data and the interpreter bring each other into existence in dialectical fashion" (Hodder, 2000, 714).

The theoretical perspective that provides the context for this study is hermeneutics. The Greek root of the word hermeneutics (*hermeneuein*) is defined most simply as the "art of interpretation" (Schweizer, 1998, 47). As with the emergence of the Anabaptists, the origins of this art began during the Protestant Reformation with the assertion of the right of all believers to interpret the Bible for themselves. Through the work of German philosophers and theologians such as Husserl, Heidegger, Schleiermacher, and Gadamer as well as others, hermeneutics has developed over the centuries into a research approach and tool that goes beyond the analysis of sacred texts while still maintaining a focus on the interpretation of meaning (Milner, 1996).

Crotty (1998) explains that the hermeneutical approach is unique in a number of ways. First, it goes beyond semantics to consider the intentions of the author, the relevance of the text

for the reader, and the author-interpreter relationship. Additionally, hermeneutics is more than academic – it is a practical pursuit that considers how information from the text can be applied. Thirdly, hermeneutics is situated within the history and culture of text. As Rundell (1995) asserts, "Through hermeneutics, interpretation has become part of our cultural self-understanding that only as historically and culturally located beings can we articulate ourselves in relation to others and the world in general" (10).

A fourth aspect of hermeneutics that makes it distinct is the intention to interpret beyond the understanding of the author. In other words, it is the hidden meanings in the text that the researcher seeks to uncover. The hermeneutical circle is a fifth element that distinguishes the approach and is the dialectical process of "understanding the whole through grasping its parts, and comprehending the meaning of parts through divining the whole" (Crotty, 1998, 92).

In modern times, Crotty (1998) explains, there are two primary usages of the term hermeneutics. Literary critics and theorists have commonly used the term in its broadest sense, as a method of interpretation, while a more philosophical and profound approach is adopted by those considering spiritual, historical or religious concerns. In this study, which looks to the culturally-based perceptions of individuals, the former approach is adopted. The text selected for analysis in the study has been approached empathically as I have attempted to understand what is being said from the author's perspective. In addition, I have engaged the text through a transactional approach in an attempt to discover something new and achieve understanding that goes beyond what the individual authors are saying.

Theoretical Framework

Theory is an orientation. It is an explanation. It aids research by giving "order and insight" to that which is observed (Henderson, 1991, 38). Although theory development has traditionally been situated either at the beginning or the end of the research process, Berg (1995) suggests that every step of the research process can incorporate theoretical considerations throughout the life of a study. In other words, Berg suggests that rather than a linear path, the research experience is more similar to a spiral pathway incorporating evaluation and reconsideration, development and change continuously from the genesis of an idea to the dissemination of one's findings.

As identified, the purpose of this study is to understand how Old Order individuals understand health. In this inductive study no pre-determined theories were tested. This position is in keeping with an assertion put forth by Pelto and Pelto (1997) that it is possible to pursue a range of questions within medical anthropology without making a commitment to a defined theoretical position. Further, the methodology of the medical anthropologist is notably consistent regardless of the theoretical base set by the researcher.

Although no theories are tested, theory did act to give some guidance to this study. Among those offering direction were two presented by Francis Wenger (1988) in her study of the cultural basis of care in the Old Order Amish community. In her work, Wenger combined Madeline Leininger's (1985) cultural care theory with Hall's (1976) conceptualisation of high context culture. There is benefit in exploring these theories within the framework of this study of health as well.

Hall's (1976) theory of high context culture is well known and has been outlined in his work, *Beyond Culture*. Essentially, the theory states that meaning can only be understood in context and context varies across a continuum from high to low. Depending on the degree to

which cultural groups are involved with another, share knowledge, hold distinctions between insiders and outsiders, accept change, experience variability in cultural patterns, and find the level of social control and support will determine if they are a predominantly high or low context culture.

Hostetler (1980) explains in his study of Amish society that Old Order groups are positioned at the high end of the continuum. As was discussed in the cultural review of this group, Old Order Mennonites and Amish have a high level of intergenerational knowledge, less variability in lifestyle, high levels of social control and support, a desire for considered and slow change, a high degree of contextual understanding, and clear distinctions between those who are within the community and those who are not. These factors join together to create a point of comparison with the experience of those operating within a low context culture such as the general North American society.

Wenger (1988) draws parallels and concordances with both Hall's and Leininger's theories. Using a combination of anthropological and nursing perspectives, Leininger (1985) developed her internationally-respected theory in an effort to provide care that is congruent with the cultural beliefs and practices of those being served. Essentially, Leininger asserts that care always occurs within the context of culture. The Sunrise Model she developed demonstrates the interrelated dimensions of care as it incorporates the influence of Worldview, Social structure and cultural dimensions, and the many subcomponents of care.

Although Leininger's (1985) model is care-focused rather than centred on health perspectives and behaviours, it holds meaning for this study as it demonstrates the importance of a strong understanding of the dynamic nature of cultural understandings and actions in the experience of health. By bringing together Hall's and Leininger's theories, Wenger (1988) lays a

framework for her study that is also applicable to this study as it acknowledges that "cultural contexts vary and affect all aspects of persons' lives" (13).

Initially conceived outside of the discipline, it has been noted that the study presented here finds structure and guidance within the discipline of medical anthropology and this work is also guided by Joralemon's (1999) identification of theoretical priorities for medical anthropology researchers. Among these is the effort to focus on the range of health risks facing a cultural group rather than adopting a disease-by-disease approach. I would add to this that it is important as well to consider the health benefits facing the community using the same broadly-based approach. With this perspective, Joralemon (1999) contends, there is a greater possibility of research elucidating the impact of a wide range of health impacts – not just those of a biological nature. Further, the author suggests that researchers look beyond biomedical services to consider the variety of health promotion sources including social networks, nutrition, infrastructure, and safety regulations that are available or not available within the group.

Incorporating knowledge from these theories, in design and analysis this study explores a range of culturally guided health perceptions in this community and framed interpretation within the understanding of the Old Order community as a high context society.

Context of study

As Hall's (1976) theory states, meaning must be understood in context and the distinct division between insiders and outsiders in the Old Order community has affected the context of this study in a formative way. The potentially significant impact of an outside researcher on the data collection process has been one of the primary influences in the decision to observe from the outside an on-going practice within the Old Order community; the sharing of community

information and knowledge through periodicals. Although this approach carries its own concerns about context (type, purpose/motivation, style, and limitations of the contents of the periodical), it allows for beliefs to be observed in a natural setting and without interaction between Old Order individuals and researcher.

Beyond this decision, however, throughout the study a thorough understanding of Old Order culture and awareness of my deficits in knowledge was incorporated into the data collection and analysis process. In a community where there is a high level of social control and intergenerational knowledge, and where understanding is highly contextual, there are many opportunities for misunderstanding by an outsider. False certainty must be avoided and opportunities taken to check understandings with others familiar with this cultural group.

Data Source and Sample

> Rich qualitative data are neither forced nor formulaic. They are naturalistic, revelatory, and authentic (Robinson, 2001, 706).

Data source

In practice, medical anthropological research typically incorporates an ethnographic and comparative approach (Helman, 2000). Focusing on small-scale societies to understand how they view the world and organize daily life, a fundamental assertion in these studies is that one's perceptions are an essential part of the health dynamic. While the study presented here has similar goals, it does not use the fieldwork methods common in ethnography. Instead, adopting a hermeneutical approach using the written statements found in an Old Order publication, the study seeks to identify the expressed beliefs and perceptions of health embedded within written stories, poems, letters, and information pieces.

A concern in any study is ensuring that one obtains high-quality and meaningful information. Some communities are more difficult than others to access and the process of interviews does not always ensure that one is obtaining a range of understandings on a topic. As Groger, Mayberry and Straker (1999) illustrate in their study "What we didn't learn because of who would not talk to us", sources of concern in interviewing often include gatekeeper bias, institutional barriers, sampling frame, and refusals to participate.

Qualitative data collection techniques that consider the traces left behind by individuals and communities are typically called unobtrusive research methods. Certainly there are costs and benefits to any methods, but the use of unobtrusive methods is one way in which researchers can gain quick access to quality information from communities into which it may be difficult to gain entry.

There is a wealth of information held in the public and private archives. Available to researchers are **Commercial media accounts** (newspapers, photographs, books, magazines, TV programs, comics and maps) as well as **Actuarial records** (birth and death records and wills)**,** **Official documentary records** (statements and records from schools and hospitals), and **Autobiographies** and diaries of individuals (Lincoln & Guba, 1985; Berg, 1998).

Although some researchers prefer the spoken to the written word or vice versa, each form of communication is uniquely informative. In praise of written texts, Ian Hodder (2000) offers the belief that these forms of data present unique opportunities for qualitative researchers in that they may provide information that is not found in an oral form (such as historical records, correspondence, diaries, etc.), allow for historical insight, may be easily accessed, and are typically low cost. Through these data sources, an individual can analyse beliefs, behaviours, and frequency of activities without introducing themselves into a community. As Berg (1998)

suggests "What people do, how they behave and structure their daily lives, and even how humans are affected by certain ideological stances can all be observed in traces people either intentionally or inadvertently leave behind" (177).

This study incorporated the use of Commercial accounts in data collection. Among the existing English-language Old Order Mennonite and Amish publications (*Young Companion*, *Family Life*, *The Budget* and *Die Botschaft) Family Life* was selected for analysis because it is subscribed to by Old Order individuals across North America, the bulk of its contents come from the contributions of these subscribers, it is geared toward the entire family, and it contains a range of personal stories, thoughts, poetry, and factual information. As researcher Brad Igou (1999) noted in his analysis of *Family Life*, this magazine allows one to "meet" countless Old Orders as they discuss social, religious, and personal issues within its pages. Stephen Scott, author of numerous books on the Old Order community, adds:

> *"Family Life* articles demonstrate the unique approach the Amish have taken to keep themselves 'unspotted from the world' (James 1:27). Unlike much literature written about the Amish by outsiders, Family Life does not put the Amish on a pedestal or on a dissecting table, nor does it present them as a mission field. 'In their own words,' they come through as real, down-to-earth people, with both strengths and weaknesses." – Stephen Scott (Forward to Brad Igou's, The Amish: In their Own Words, 1999)

Published by Pathway Publishers in Aylmer, Ontario, *Family Life* (Appendix A) has been printed since 1968 and serves the plain community with an annual circulation of approximately 25,000 across North America as well as some subscribers in Central America and abroad in Germany, Japan, and Australia. An editorial staff of six men and two women currently runs the publication of this monthly magazine. This textually dense, but graphically simple publication includes black and white sketches of animals and landscapes as well as other aspects of life, but does not print pictures of human faces, in keeping with Old Order beliefs.

Focusing on the primary unit in the Old Order community; the family, this publication strives to provide individuals with an opportunity to share what they have learned about the day-to-day life of a Christian. In its inaugural issue, an individual writes:

> "Family Life is the name of the magazine you are holding in your hands. But it is much more. The family is the heart of the community and the church. Even a nation is made up of families. If there is a strong family life, then the church, the community and the Nation will be likewise. […] Family life must be translated into terms of every day living. What can we do to promote peace, love and good will among members of a family and members of a church or community? Do we realize that our everyday work should be a God-given opportunity to serve Him? Can we appreciate and make the most of the everyday blessing we receive? Do we stop to enjoy God's creation all around us, and the works of his fingers? This is the goal of *Family Life* – to be an instrument through which thoughts and ideas can be transmitted" (D.W., January 1968, 3).

Although run by members of the Old Order Amish community and geared primarily to this population, a range of individuals from a variety of plain communities including the Beachy Amish and David Martin Mennonites, subscribe and submit articles to Family Life. Additionally, while some articles and sections in these magazines are typically written by staff, there are numerous 'cultivated' pieces, in addition to the poetry, advice requests, and stories submitted by readers. Typically once a year, the staff will put out a call for paid articles and poems as well as unpaid contributions. An example of this call is the following published in the December 2000 issue:

> With the coming of winter's more leisurely schedule and those long hours between supper and bedtime, we would like to put in our annual plea to writers (and would be writers) to help replenish our dwindling stockpile of material. What type of material do we need the most? At the top of the list I would place first-person real-life experiences. Or you may wish to write in story form what someone else has experienced. How-to articles on a variety of subjects would also be appreciated. We encourage writing in simple and clear language, with human interest and strong moral teaching built-in rather than tacked-on at the end. In other words, our goal is to have Family Life reflect the way Christians really live, think, speak, act (and sometimes react!) But it is important for our readers to learn from what they read, and to be encouraged and inspired to a closer walk with God. The type of material we need the least are poems and children's stories, (Because those files are relatively full). Yet we still welcome further poems and stories if they are better quality. We do reward our writers with either a check or a credit card slip for major items. Moreover, any material that we cannot use will be returned to you. Please understand, however, that we do not acknowledge, pay for, or return any unused "Letters to the Editors" or to "The Problem Corner", etc. Nevertheless, these responses are a very important part of the

> magazine and we greatly appreciate your input. Actually, for beginning writers, this is a good place to start and you have a better chance of getting into print. We look forward to hearing from you. Without our faithful writers, the Pathway magazines could not long continue. (page 6)

Family Life offers a wide variety of sections for their readers including regular pieces including: Letters to the Editor; Staff notes; Anabaptist history; Learning about your health - An information column by a non Old-Order physician; Homemaker's page; Problem Corner; Children's section; and much more.

Although there are occasional indications as to the age, gender, and geographical situations of those contributing to the periodical, these are very rare and in a majority of situations individuals do not include their name in their contribution, signing instead with such titles as, "A Michigan Subscriber", "Name Withheld", "A Young Ohio Mother", or "Hoping for change in PA".

In its unique way, this publication offers important information on health understandings in the Old Order community. *Family Life* incorporates a wide variety of material devoted to community values, challenges, opportunities, and intergenerational concerns have a great deal to offer to an improved understanding of the desired path to health in this community.

Taking a unique approach to data gathering, Katherine Morton Robinson (2001) conducted a search for care-giving narratives on the World Wide Web. She found that not only did this data source allow for the possibility of hearing the voices of people from a wide variety of settings and geographical regions, but she discovered that the relative anonymity provided by the internet seemed to encourage profound sharing of fears, hopes, and other concerns that may not have emerged as readily through face to face contact.

Although this study does not incorporate the use of the Internet, Robinson's discussion is applicable to this research. Like the Listserves, Bulletin boards, and Guestbooks of the Internet,

the Old Order magazine examined in this study allows for individuals to share unsolicited information relatively quickly, to a large audience, and anonymously if they prefer. While for the researcher, the limited demographic information accompanying the submissions frustrates opportunities to identify individuals by gender, age, or other characteristics, it may allow for contributors to offer more uncensored and potentially more honest information. In a high-context culture this opportunity for anonymity is rare.

Sample

Patton (1990) suggests that "the validity, meaningfulness, and insights generated from qualitative inquiry have more to do with the information-richness of the cases selected and the observational/analytical capabilities of the researcher than with the sample size" (185). Essentially, the sample needs to be large enough to develop the picture. With sampling occurring at the level of the articles within the magazine issues, the sample size for this study focused on the broader Old Order community in North America and was determined largely by availability of information and resources and guided by a focus on depth of understanding.

In an effort to focus on current understandings, analysis began with the most current complete year of issues; those from 2001. Upon completion of analysis on one full year (twelve issues) of the publication, issues from the year 2000 were also analyzed (eleven total) to increase the overall sample size. The second year of data did not significantly alter the coding structure that had emerged with the 2001 issues, but it did help to deepen the codes.

As identified in the opening sections of this proposal, this study aimed to increase understanding of Old Order perceptions of health related to maintenance of health, treatment of illness, and the determinants of health. Further, the determinants of health can include

culturally-related factors such as income and social status, social support networks, employment and working conditions, education, physical environments, genetics, personal health practices and coping skills, healthy child development, health services, and gender (Canadian Health Network, 1999). While length of the letters or articles did not determine inclusion or exclusion from analysis, the text had to address some aspect of health perceptions. More information is provided on the data source in the following chapter on descriptive findings.

As an additional note on sample, care was taken throughout the development of the data collection and organisation framework to not assume homogeneity of practice and beliefs within a cultural group. This consideration is addressed to a large extent by the selection of only a specific group within the larger Mennonite and Amish community. It is not proposed that the more liberal Mennonite sects or other selected conservative Mennonite groups (such as Old Colony Mennonite in Mexico) would have similar experiences to those investigated here. As well, the point has been made in the literature review that there is significant similarity within the Old Order population, although it is acknowledged that these people are *individuals* within a cultural group.

Data Analysis and Interpretation Strategies

Babbie (1992) suggests that if something exists, it can be measured. This statement is tempered by the acknowledged reality that the distance between research questions to data collection does not always follow a linear path.

In terms of the present study, Sandra Kirby and Kate McKenna (1989) outline a number of important considerations. These include thought given to what kind of content the researcher is seeking and why, where she is likely to find it, whether she has permission from participants to

use the information or whether the documents are publicly available. Additional considerations include whether what is gathered is related to what the researcher wants to know, whether or not she needs to illustrate the information, and how she will ensure that she understands correctly. The first concern – what is being sought and why has already been explained, but throughout the following sections the remaining points will be addressed.

Because of the base established with the literature review, this inductive study with its aim of identifying in-group (emic perspective) cultural understandings related to health beliefs, must follow the words of Old Order people to discover where they take one in the study of health. By allowing a broadly-based approached at the onset, the areas of community-defined importance were more likely to emerge.

Analysis of Data

Helman (2000) suggests that a number of levels of data can be addressed in culture and health studies. These include what people say they believe, think or do, what they actually do and really think, and the context of these previous points.

In the context of a cultural understanding of the Old Order Mennonites and Amish, this study investigated *stated* perceptions about, or actions related, to health. Therefore, analysis focused on the meanings and purpose of stated beliefs using descriptive information. While behavioural data were not analyzed, the study does provide an opportunity for an examination of the *lived* actions and thoughts in future studies.

A multitude of factors must be acknowledged and addressed as one approaches analysis of written text. Was it edited, signed, commissioned, targeted? What factors allowed for an individual to write this and what might have kept others from contributing? What was the

context of the writing? How does the meaning of the text change over time? Hodder (2000) contends that there are three primary concerns in the interpretation of material culture. These include context definition, development of patterned similarities and differences within consideration of this defined context, and employment of relevant theory along the way.

More specifically, in his discussion of textual analysis within a hermeneutical framework, Walhout (in Lundin, Walhout, and Thiselton, 1999) outlines five actions present in the formation of a text and the associated factors relative to the process of interpretation. Although his focus is on fictional accounts, the relevance is transferable to other forms of writing as well. Speaking to the responsibility of the individual conducting the analysis, the researcher must:

1. have an understanding of the language and linguistic devices being used in the creation of the text.
2. have an awareness of what is being said – the literal meaning
3. give consideration to what is being held up by the author as being of greater or lesser significance in the text
4. have an awareness of personal biases in how one approaches the text and conceives of the dimensions of experience presented by the author. Recognising these limitations, the researcher must be careful not to generalize too broadly
5. consider what model or paradigm of the world the author is presenting as well as demonstrate awareness of personal biases related to how the text is interpreted (Lundin, Walhout, and Thiselton, 1999)

As will be illustrated in the findings, because the documents analyzed were written in English (rather than Pennsylvania Dutch) and due to my familiarity with this culture there was a strong understanding of the language and linguistic advices used in the text. The analysis took into consideration the cultural background/perspective of the writers and, where they are known, the motivations behind, constraints to, and other shaping factors behind the submitted works have been acknowledged and incorporated into the analysis.

Letters to the editor may carry different motivations than feature articles. Individuals may note in the text whether they feel comfortable writing on a certain topic or explain what led them to contribute their thoughts in written form. It is not possible, though, to be aware of all the

factors at work in the creation and submission of a writing. In fact, many of the concerns present in the relationship between researchers and narrators using the spoken word also apply to those relying on documents or material culture. Whether the stories are shared in person or through writing, Epp's (2000) assertion holds true: "the collector of stories holds the power of synthesis and interpretation, but the narrator inevitably maintains power over her own story to the extent that she can withhold, emphasize, and indeed, fabricate aspects of her life at her own choosing" (13). Recognising this, attention has been paid to these considerations while focusing primarily on what the author is saying, affirming as significant, and how this relates to the larger idea being presented.

This method worked well and appeared to serve the goal of allowing the voices of the Old Order people identify what health-related issues are of contemporary concern in their community. While there was initial concern that without a concrete definition of health to guide selection the opportunities for inclusion would be too vast, personal journal records kept throughout the coding process suggest that from early on there was less difficulty experienced in determining what was appropriate for inclusion and what was not than had been anticipated. Only items in which the writer made a link to health were selected for analysis. This open method allowed the key points of discussion to work themselves out of the text more naturally and reduced the influence of researcher judgement and bias.

Guided by the tenets of grounded theory, I sought to avoid pre-conceived notions about what would emerge from the data and allowed for interplay in the process of data collection and data analysis. During the progression of analysis and immersion in the data, I transcribed relevant articles including information on the publication date, location in periodical, length and

type of article, and demographics of author (where known). Once identified, I used NUD*IST to explore these submissions in depth.

A process of open, axial, and selective coding helped develop the data into an understandable and interpretable form (see Strauss and Corbin, 1990) and allowed my understanding to develop through the data. Using the constant comparative method (Glaser & Strauss, 1967), I went line by line through the *Family Life* submissions, and created over seventy separate codes for the range of ideas (e.g. prepared foods, sickness in babies, self-interest) expressed by the writers. As the data accumulated, information within these in-vivo codes was then categorized and linked together to build broader conceptual themes or sociological constructs (developed by researcher) such as Illness perceptions, Information transfer, and Definition of health.

These constructs allowed for an internal comparison of relationships as identified themes were arranged and viewed with consideration of their connections and points of dissonance. The categories used in the analysis were achieved primarily through an inductive approach, although it is acknowledged that some deductive opportunities did exist based on my previous research into the culture and health relationship. Throughout the coding process, memoing was performed to track thoughts, ideas, and decisions.

As part of the analysis, the findings established through this research were interpreted in light of cultural factors such as education, social networks, religion, gender, and occupation. In this way I endeavoured to provide insight into the nature of the culture-health relationship within this community. The findings from this study were also compared with those achieved through previous studies.

The Researcher's Role

In his discussion on scientific objectivity, Cole (1985) questions the possibility of completely objective research when he notes that all facts are adjusted by the eyes that view them and the minds that take them in. Even prior to the subjectivity of data collection, the author suggests, personal understandings impact research through the preconception of a problem and researcher focus. Cole (1985) draws on the words of Einstein to make this point. He quotes: "If the researcher went about [his/her] work without any preconceived opinion, how should [he/she] be able at all to select out those facts from the immense abundance of the most complex experience, and not just those which are simple enough to permit lawful connections to be evident?" (Einstein in Cole, 1985, 98).

The researcher, for myriad reasons, decides what is worthy of study and all information is filtered through individuals: the researcher and researched. Subjective reality in research is not so hard to accept when we consider that it is not just a fact of science, but a fact of life as well. Without venturing into a discussion on the existence of reality, it is held that the subjective experience is what touches and guides us. Further, individuals are continually making judgement in daily life on what is important to take into consideration. This understood, science is called to consciously consider these issues and while the inevitability of some bias is certain, measures must be taken to ensure that the research is as valid and reliable as possible.

Credibility and Trustworthiness

The credibility and trustworthiness of data analysis and interpretation is a central concern in qualitative studies as researchers strive to produce quality analysis, unbiased results, and develop accurate understandings that could be developed by another researcher studying the same data.

Whittemore, Chase, and Mandle (2001) note that this approach to research carries unique challenges due to the effort to bring rigor, subjectivity, and creativity into the process of science.

An important question for textual data is whether the data are "faithful to the context and the individuals it is supposed to represent" (Lincoln and Denzin, 1994, 578). To this Robinson (2001), Whittemore et al. (2001), and Savage (2000) suggests the following questions: Do these data make sense with data gathered from other sources? Is this analyzed record in response to another shared previously and does the letter/posting undergo review? Are the results believable? Where were the data found and does this source encourage single or multiple perspectives? Does the representation of the emic perspective allow for the differences among voices? Are the findings relevant? Have researcher biases been examined? Are thick descriptions provided? Have the investigations been conducted with sensitivity and creativity? These considerations must be tied in with data collection and analysis throughout the process of theme development and interpretation.

In this study, subjectivity was treated with respect and appropriate measures taken to ensure that findings were as accurate as possible in regards to the information taken in and the analysis conducted to elicit the findings. Among these measures are the following:

1. **Prolonged engagement**. I spent over a year in analysis and write-up (Lincoln & Guba, 1985).
2. **Peer debriefing**. I met regularly with my advisors and engaged in discussions with colleagues (Lincoln & Guba, 1985).
3. **Negative case analysis**. As I became immersed in the data and began to identify patterns, I would test each new case against the developing observances or explanations. This process allowed me to consider alternative explanations throughout the process of analysis. If the case did not fit I would either alter my understanding or identify a new explanation (Kidder, 1981; Lincoln & Guba, 1985).
4. **Reflexive journaling**. Throughout the analysis of the data, I kept a journal in which I recorded what decisions were made and the rationale behind different choices. I also used this journal to record thoughts and ideas related to my experience with developing categories of information and identifying emerging themes, as well as identify questions, feelings and any other thoughts related to the project (Lincoln & Guba, 1985).
5. **Respect for the data source and the individuals studied**. Throughout data collection and analysis, I worked to recognize the opportunities and limitations of the data source, to present the words and

ideas expressed by individuals in the publication as accurately and appropriately as possible, and to recognize my individual effect in this research process (Patton, 1990).

6. **Thick description**. In order to provide the reader the opportunity to consider the transferability of the findings, throughout the literature review and the discussion of findings I have attempted to provide detailed information about the community being studied, my method of study, and what is being said in the pages of *Family Life* (Lincoln & Guba, 1985).

Although it should be acknowledged and addressed, subjectivity should not be feared as its recognition allows the researcher to examine her own cultural biases. In consideration of subjectivity, then, it is important to address my background and initial perspective.

Personal statement

I was raised in a Mennonite family in Lancaster, Pennsylvania and my ancestors have lived in that area since the early 1700s. While I am not, and never have been, Old Order Mennonite, I do have Old Order connections two to three generations back on both sides of my family and interacted significantly with these individuals while they were living. I am currently involved in the Mennonite community religiously and socially.

Regardless of whether the interaction is through conversation or immersion in text, it is necessary to consider the perspective of the researcher. Palys (1997) contends that valid qualitative research requires intimacy. The author continues that to understand the research participants "you must spend time with them, get to know them, feel close to them, be able to empathize with their concerns, perhaps even be one of them, if you hope to truly understand" (Palys, 1997, 19). Essentially, by being part of a culture or at least associated in some way with the people of a society, one may have a deeper understanding of the cultural processes and have greater opportunity to gain the trust of those one studies. This perspective can be contrasted with that of Corin (1994) who asserts that it is often easier to understand the influence of culture in societies to which we do not belong; that our own culture is largely invisible to us.

Both of these points are important and, rather than being exclusive, they each can be incorporated into this study. The Old Order Mennonites have made a choice to remain separate from outside society and, for this reason, my having a common ancestry with these people may dismantle some of the immediate conceptual boundaries in place. As well, because most of my connections have been with the more modern Mennonite church, the Old Order way of life is still different enough to my own experience that much of the influence of culture is not transparent.

My familiarity and respect for this community make me conscious of the opportunity I have to learn from people who desire peace and separation from the outside society.

Ethical concerns

Consideration of the safety, privacy, and well-being of the individuals who allow the study of their experience is paramount in research. Neutens and Rubinson (1997) contend that there are ten primary ethical issues in research. While framed in the context of experimental research, a number of these concerns are applicable to text research as well. Those identified by the authors include informed consent, confidentiality, truth-telling and deception, responsibility for harmful consequences, duty to continue a successful experiment/ *study*, and publication of findings.

As Neutens and Rubinson (1997) assert, "any researcher may mean well, but failure to consider ethical dilemmas is inexcusable" (17). With these words in mind, the highlighted issues are considered in the design, implementation, and completion of the research project. Because this study is based on analysis of text, a primary ethical concern is consent. Because of the nature of the publications being analyzed, it was deemed to be difficult or impossible to gain consent for the information used. This reality raised important considerations.

Robinson (2001) notes that the Office for Protection from Research Risks (OPPR), a division of the National Institute of Health (NIH) provides guidelines for decision making regarding ethical concerns. Two of their key concepts are existing (prior to research activities and created for reasons other than research) and publicly (open to the knowledge of all). Similar to the cautious conclusion Robinson (2001) drew, it is maintained here that because subscription of these newspapers is open to anyone, individuals expect that people they do not know will have access to what they have written and may comment on it.

Of course, the researcher must take all measures to protect those who have submitted information. As Robinson contends, if a name is included with the submission, it must be omitted from the report. As well, if a contribution has the chance of being damaging to an individual or community, every effort must be made to contact the individual who wrote the information and try to obtain permission.

Beyond the analysis there are also ethical concerns regarding what is done with the findings of the study. While the author must remain true to what findings emerge, effort was made to present the information with respectful consideration of the individuals whose lives have been opened up to the researcher.

Descriptive Findings: Meanings of health and illness

This study asks a number of descriptive questions about health and I began a search for increased understanding about the culture-health relationship among Old Order people in the context of community dialogues. The writings in *Family Life* are offered by Old Order individuals across North America and take the form of stories, poems, letters, and informational pieces. Before beginning a discussion of what emerged from the data a closer look at the distribution and nature of the data itself is necessary.

As stated previously, the inclusion criteria required that some direct mention of health be made for an article to be part of the analysis. Of the twenty-three issues of *Family Life* examined in this study, there were 217 articles, poems, letters, stories and editorials found to include some reference to physical or mental health. On average, a single issue of *Family Life* may contain 50 pieces of writing or submissions (including individual letters to Dr. Hess or to the Editor). Based on these figures, approximately 19% of all submissions are typically related to health.

Of the 217 pieces taken into analysis, more than a third (37.3%) were from the section *Learning About Your Health* where a non-Old Order individual, Dr. Hess, fields questions about health concerns. Seventeen percent were from the Letters to the Editor section, 11.5% were fictional stories, and 11.1% were informational stories. Poems accounted for 8.8% of the total pieces included in the analysis, 6.4% were non-fictional stories or accounts (including *Time of Trial* pieces) and Problem corner articles were 4.6% of the total. Staff notes and Special Section pieces rounded out the total with representations of 2.8% and 0.5%, respectively.

As anticipated, it was difficult to include demographics into analysis. In a majority of situations individuals did not sign their submissions and while one may be able to ascertain gender, general age, or geographical location from some pieces, very rarely were all available for

analysis. In 58.1% of the 217 pieces included in the analysis, it was not possible to identify the gender of the writer with certainty. Even when the undefined cases were further analyzed to consider whether the story was written from the perspective of a male or a female, the gender of the author was still unclear in half of the articles (49.8%).

Of those that did make specific note of the gender, however, it is of interest that 33.6% were submitted by women and 8.3% by men. These figures were consistent with overall submission percentages. When all articles in several randomly selected issues of *Family Life* were considered (including non-health related submissions), gender was unidentifiable in 52% of the submissions, 27.6% were clearly from women and 10.4% were from men.

While the content of the submissions suggests that a majority were from adults, 2.3% were clearly from teenagers and 4.7% noted that the individual was an older adult (over age 60). As for the location of the writers, forty-three percent of individuals did not include information on their geographical location. Of the remaining 57% of individuals who did indicate location, 9.2% were from Canada (the vast majority from Ontario) and 46.9% were from the States. Individuals from fifteen different states submitted articles with a majority of these coming from Pennsylvania (17.0%), Ohio (5.1%), and New York (4.1%). Other states that occurred with less frequency were Kentucky, Wisconsin, Missouri, Iowa, Indiana, Michigan, Montana, Maryland, Illinois, Virginia, Kansas and Tennessee. Also, a small percentage of pieces were submitted from individuals living in Central/South America (2.3%). It is possible that some individuals writing into the *Family Life* publication are not from Plain communities, but the geographic representation suggests that the majority are from areas with significant Old Order populations.

In addition to the limitations presented by the lack of demographic information, the data source itself presented a number of challenges. Among these was the necessity of recognising

that individuals submit their writings to *Family Life* from a variety of circumstances and with a range of intentions. Looking at the 217 pieces selected for analysis, those writing to Dr. Hess frequently had direct questions about their health. While not providing a great deal of reflection on the nature of health and illness, how individuals framed their concerns often gave indications about what healing methods had been tried and what they believed was appropriate treatment.

Letters to the Editor were primarily responsive to what had already been stated. In addition to offering reinforcement for an idea expressed by another, they also provided an opportunity to get a sense of some of the stronger differences in opinion in the community. Those taking the time to respond to an article often feel quite strongly about an issue and in the findings these letters feature prominently as individuals spoke out on topics they deem important.

As noted previously, in their call for submissions, the editors emphasized that they would like stories that have "strong moral teaching built-in". The fictional stories selected for analysis appear to have answered that call well. Many, including the serial *A Time to Speak* which ran throughout most of the two years, were based within the community, told an engaging story, and offered a clear message to the reader. Created less for diversion and more for the enforcement of community belief, the stories addressed issues such as proper nutrition, allowing others to help one in a time of need, using the health care system, caring for elders, dealing with loss or illness, having children, or experiencing stress. The focus was on presenting a relevant and important message to the reader. In this way, even though they were fictional, the stories offer an important contribution to an understanding of the health perspective.

The information pieces analyzed often sought to educate the reader about an issue that was deemed important by the author. Again, the topics chosen were tied closely to the daily lives of those who read the magazine. A quarter of these articles were related to mental health

struggles and 20% dealt with food issues and nutrition. Authors also provided suggestions or teaching on such topics as the importance of helping another person in a time of need, care of babies, dealing with personal trials, disability, and health treatments. The topics chosen did not appear to present particularly contentious ideas, but rather often reinforced or enhanced what was already a part of the community. As well, while there was some recognition of outside research in these pieces, the articles drew heavily on personal experience and Biblical teachings.

As one would expect, the poems submitted were often of a very personal nature with the majority (63%) focusing on illness or death of a child or other loved one. The remaining poems centred on emotional or physical struggles. As well, non-fictional stories typically appeared to offer an individual the opportunity to discuss very personal experiences. Accounts of personal physical illness, sickness of a child or other family member, mental health struggles, and death, dominated the pieces analyzed within this category.

As with the Letters to the Editor, the Problem Corner pieces allowed a range of individuals to respond directly to a question and express a variety of opinions on such topics as treatment of a child's bedwetting. The Staff Notes section allowed the editors of *Family Life* to reflect on the entire magazine issue as well as address concerns they saw arising within its pages or within the community. Finally, the Special Section provided a forum for topics, such as abuse, that may not ordinarily be discussed.

Awareness of the role of linguistic devices, or embellishments, in the writings received attention throughout analysis and focus was given to the literal meanings of texts as well as areas defined as significant by the author. In this way, with an eye to these differences in form and style, analysis of the documents maintained focused on the *message* of the pieces. Additionally, throughout the analysis the model or paradigm presented by the authors was considered and

explored with recognition of the potential influence of research bias. Each type of submission had something to say about health and by taking the pieces together it was possible to explore the range of beliefs about health in this community.

In its opening pages, this study asked the following: How is health perceived and 'good health' understood? What are the perceptions of the determinants of health within the Old Order community? How is illness perceived? What is the response to illness? How does culture relate to health in the Old Order community?

In an attempt to address these questions, this chapter puts forth the words of Old Order individuals as found in the pages of *Family Life*. A focus is placed on what is being said by the authors as well as what is being held up as more or less significant. Divided into two main parts, the first section on Health includes findings related to how individuals within this community approach and define health and what factors are deemed important to determining/maintaining physical and mental health. In the section on Illness, there is discussion on the understandings of illness itself as well as emotional and behavioural responses to this experience.

This chapter on Descriptive findings speaks directly to many of the questions initially proposed by this study. Conceptual discussion is also necessary, however, to answer the more fundamental, and equally important, concern of how culture relates to health in this community. An investigation into this question is offered in the following chapter on Interpretation and Discussion. This latter section provides a consideration of the connections and themes emergent in the Descriptive findings as well as provides some comparison with previous research.

Health

In the Review of Literature it was noted that one of the defining aspects of the Old Order culture is that the core values of the community are religious values (Hostetler, 1968). Not unexpectedly, then, a discussion of Health begins with the understanding that in Old Order community, life itself is understood to be creation of God.

> "Once there was a Surgeon who undertook to create a man. He formed him perfectly and we could talk all day about the wonder of it. He made eyes by which man could see. He made ears to pick up sound waves. He designed the nose, the mouth, the lungs, the heart, the liver and pancreas and host of other marvels. The brain and nervous system are beyond comprehension." – J.L.L., *The Breath of Life*, (April 2000, 5-6)

Throughout the writings in *Family Life*, the belief that God ultimately decides when life begins and when it ends, that God's Will determines the reality and the experience of existence, was repeated. This fundamental understanding was expressed throughout the 217 health-related pieces considered and is called upon in letters to the Editor, poetry, fictional stories and non-fictional accounts. It is spoken of in regard to the presence of illness and disability, positive relationships, the ability to have children, provision of health care, and the length of one's lifespan and timing of death.

> "At any moment, the silver cord between life and death may be severed. With every step we take, we place ourselves into danger. It is only by the Lord's mercies that we are not consumed." – A Friend Who Cares, *To My Friend, After Your Loss* (December 2000, 4).

> "In life or death, in sickness or health, there is no safer place to be than in God's will." – G.M.W., *Under the Juniper Tree (How to Deal with Depression*) (November 2001, 9-12)

> "Nothing is going to happen to me that God does not know beforehand" – Sign Me Saskatchewan, *Letters to the Editor*, (October 2000, 2-5)

Looking more specifically at the discussion of physical and mental health, in the pages of *Family Life* individuals engage in a discussion where the state of health and the factors important

to maintaining health are tied closely to mutually understood 'ways of living' rather than exterior, objective measures. This is not a surprising finding considering the fact that the publication strives to offer an opportunity for individuals to share stories, poems, thoughts, and concerns of daily life and is not specifically focused on health.

The nature of a high-context culture may also be at the root of the difficulty faced when trying to identify the definition of health or the perceived determinant of health in this community. Rather than finding reflections on the nature of health or investigations into the determinants of health, the discussions in *Family Life* indicate that health is discussed in a pragmatic and in-process way with a great deal of assumed knowledge.

State of Health

There is little direct discussion in the writings about how health is defined, but analysis indicates that there are two markers of health referred to in the writings. Foremost of these, a healthy person as discussed in this publication, is viewed to be able to carry out his or her role in the family and community (Role Maintenance). Although mentioned to a far lesser extent, there also appears to be an understanding that health is also defined by Appearance.

Role Maintenance

In this cultural group where the needs of the community are paramount and an individual's role is central to their identity and important within a larger network, it is not surprising that persons gauge health by their ability to function as a community member, a worker, a parent, or a partner. As well, it is demonstrated that both physical or mental health concerns can lead to an inability to function within one's role.

> "The worst thing was that almost constant 'tired to death' feeling and the discouraged "smaller than dirt" feeling as my house became dirtier and untidier. I am wondering, can any woman - no matter how talented a housekeeper - keep things neat and clean if her health is poor and she is bone weary most of the time? I really doubt it." - A Resident of Missouri, *Letters to the Editor* (February 2000, 2-5)

> "A caring husband is priceless at a time like this. How often my husband's reassurance was a balm to my soul, especially when I felt guilt-stricken for being unable to be the wife and mother I longed to be."– Author's Name Withheld, - *What is Postpartum Depression?* (July 2000, 22-23)

> "'Has mom always been unwell?' […] 'Oh, no. Used to be such a hard worker. Took some giving up for her.'" – by an anonymous author, writing on Ella's behalf, *A Time to Speak* (June 2000, 14)

> "After all was silent, Marie let her mind go back to their morning devotions and that verse that wanted to stick like a burr. 'Wives, submit yourself….' But how was she to submit when Davy did not have the ability to lead?" - Name and State Withheld by Request, *A Flicker of Hope* (August 2001, 15-18)

> "Dear Lord, I am ill again. My whole nature fights against it. I am resentful, for I detest lying here so weak and helpless. I despise not having the energy to get up and work, or the strength to properly care for our children. It is hard on me not being able to help my husband as he goes about his many duties. I don't like having to depend on others to do my work." - A Shut-in Mother, *A Prayer of Acceptance* (November 2001, 8)

> "Since the diving accident when he was eighteen that had left him paralyzed from the waist down, Walter had put on a lot of weight. But he was able to get himself in and out of his wheelchair. His arms were enormously strong, as testified by his bulging biceps. He kept himself busy assembling harness and doing other tinker jobs for different businesses in the area." - by an anonymous author, writing on Ella's behalf, *A Time to Speak* (January 2000, 10-18)

> "About four and a half years ago, my husband (then in his early 70s) was stricken with a painful and incurable illness, thought usually not life threatening. This has been a very humbling experience for us, with him being in the ministry and no longer able to take an active part. But it has been a rewarding time of sharing and companionship which we often did not have time for (or did not take time) when he was well and strong. His health has improved a little in some ways, and he has not missed our church services; so we still have much to be thankful for." – Ohio Residents, *Letters to the Editor* (December 2001, 2)

Interestingly, the majority of individuals writing on the connection between health and the ability to continue in their role are women. In fact, even the few submissions regarding health and role maintenance among men appear to be composed by women. Speculation on why this is the case is limited by the data, but there are a number of potential reasons. It is possible that in addition to the reality that women are more likely to write into *Family Life*, men may not feel as

comfortable about expressing their concerns regarding their ability to fulfill their role as women do or they may do so through other methods.

As well, the distinct gender roles in this community may also feed this difference. Old Order women are often mothers, wives, and homemakers and clearly the related writings regarding women are centred on responsibilities to the family, the needs of others, and the home. Old Order men are farmers or labourers as well as fathers and husbands. Although the focus on community is central for all members of the community, the struggle for men may be less relationship-based and more personal as they seek to do meaningful and useful work. In other words, women may be defined more by their relationships and responsibilities to others in the family while men are defined to a larger extent by what they do. There may be benefit in future studies addressing this question more directly.

Appearance

Spoken of less frequently, but also notable is the demonstration of a pragmatic approach to health through a focus on physical manifestations of health. The exact markers of what it means to 'look healthy' are difficult to identify based on this data, but there is clearly a sense among individuals in the community that health can be perceived as well as felt.

> "Dad unlaced his shoes, then stepped over to stand beside the rocker. 'He doesn't look very healthy,' he spoke with concern. 'He doesn't have the chubby legs and arms that Laura had when she was a baby.'" – J.K., *A Glad Sacrifice*, (September 2001, 13-15)

> "I slumped down on the porch steps and wept out loud, my whole being rebelling. 'No, no, this cannot be true. Strong, healthy Grandpa Mast.' He was slim and nimble for his seventy-five years and no one thought of him as an old man." – "Ruth", *Sharing the Caring* (June, 2001, 19-23)

The Determinants of Health

Closely related to the defining of a healthy state is the understanding of what factors are important to determining health. In *Family Life*, individuals were not asked directly what they believed were important factors in the maintenance of health, but perceptions emerge as individuals submit articles related to their experiences of feeling more or less healthy, what they believe is the best approach to caring for the body, and how they frame questions about health.

Within the Plain community, the continuing belief that God is in control of all that happens in life is evident as individuals place their ultimate health and life in God's hands.

> "We have, after all, only a short time to stay here, so if it is Thy will for me to suffer this illness, let it be for Thy glory. I am Thine. I submit myself to Thee. I surrender all. 'Take my life and let it be, consecrated, Lord, to Thee.' Thy will be done. Amen." – A Shut-in Mother, *A Prayer of Acceptance,* (November 2001, 8)

> "As Christians, we may expect to suffer – stresses, persecution, affliction. That has been promised to us. Jesus said, 'In the world ye shall have tribulation.' So it is normal to suffer. If Satan cannot get someone to spit in our face or burn us at the stake, he may seek God's permission to try us with physical illness, with financial catastrophe, or with grief through bereavement." – M.R., *Job: An Example of Affliction* (December 2001, 12-14)

Physical Health

Nutrition. Nutrition is one of the most commonly discussed factors of physical health. As exhibited in articles on fats, processed food, quality of meat, personal stories of reduced health in one's family, observances of children with diets high in junk food, informational pieces on the dangers of GMOs (Genetically Modified Organisms) and livestock hormones, the value of natural versus synthetic fats, and debates over grass fed versus grain fed cattle, individuals appear to put a high health value on choosing a natural approach to farming and one's diet.

Although there is recognition that food that is homemade or prepared with 'natural ingredients' is not necessarily healthier, there is a strong assertion that home-based, homemade

foods are typically of better quality than processed foods. This finding is not surprising considering the high percentage of farmers in the community.

> "What is a more satisfying sight to the eyes of a farmer than a herd of cattle voraciously munching their way through a field of green? And although the big, modern dairies and beef operations can no longer 'afford' to turn their animals out to pasture, the latest findings in the health field are bearing witness that what seems so right and please to behold is just another of God's well-designed ways of providing food for the human race. […] And really, now that one does think of it, one has to wonder why we didn't think of it before that the meat and milk from a grass-fed animal should never have been blamed for the rise in heart attacks and strokes the last generation has experienced. For after all, a diet high in meat and milk is as old and older than Abraham, Isaac, and Jacob. It seems it is whenever man starts taking shortcuts and trying to make improvements over God's original design that things run afoul." – J.S., *Staff Notes* (July 2000, 4-5).

As some outside research is incorporated into discussion on nutrition, there is also an awareness that individuals need to be cautious regarding the many health fads that arise in the larger society. In a discussion on polyunsaturated fats versus monounsaturated fats, one writer suggests:

> "Nevertheless, a word of caution may be in order not to fall too readily for every new 'discovery' that comes along. In fact, when it comes to recommendations about fat, the record of science in the past forty years is not very impressive. Hopefully, the confusion about fats is beginning to clear simply because we have come full circle. We are ready to go back to a balanced and more-natural diet that is truly of benefit to our health." – L.R., *Of Fats and Confusion* (August 2001, 33-34).

Tied closely to discussion of the importance of a natural diet, in opinion pieces and staff notes, individuals encourage each other to seek balance in the type and amount of food they consume. In letters to Dr. Hess individuals acknowledge the importance of a balanced diet with sufficient vitamin and mineral intake.

> "My midwife says prenatal vitamins are very important, especially folic acid. We try to eat a well-balanced, healthy diet – homemade whole grain products, homegrown fruits and vegetables. Isn't the reason people need supplements is because their diets are not providing sufficient nutrients and vitamins? How many ounces of orange juice daily will provide the necessary 400

micrograms of folic acid?" – Planning Ahead in NY, *Learning About Your Health* (June 2001, 35-36).

"In my lifetime I have seen the trend toward so-called "junk foods" gather momentum and become a threat to health, especially to the younger generation. Today many parents are alarmed by the unwholesome diet their teenagers are choosing – frequent snacks, fast foods, sticky pastries, soft drinks, candy, French fries, potato chips – a diet high in fats and sugar but lacking in real food value. The result is many overweight youngsters who are flabby and weak and destined for early disease. […] Today health-conscious parents are urging their children to eat a wholesome and balanced diet – fruits and vegetables, whole grain cereals and breads, dairy products, eggs and wholesome meats. There is a constant struggle to encourage healthful foods and to somehow limit the junky stuff." – J.S., *Staff Notes* (December 2000, 5-6).

"The article 'A Change in Diet' in the May issue brought back memories of the day we were at a gathering. All kinds of foods were set out. I was filling our preschoolers' plates when I heard a mother ask her two-year-old, 'What do you want to eat?' 'What does the little child want to eat?' I thought to myself. 'How can he know what is good for him among all the goodies?' […] That very same afternoon her mother was worried about her two-year-old getting into puddles. 'Oh, he'll dry off in this warm weather,' someone assured her. 'Yes, I know, but I don't want him sick again. Seems he is always getting wet and gets a cold,' she lamented. My thoughts went back to the meal we had just eaten and her question, 'What do you want to eat?' I thought maybe, just maybe, he is not getting a nutritious diet, and that is why he gets sick so easily. Just one mom's opinion." – An Iowa Mother, *Letters to the Editor* (August 2001, 2-4)

One family's re-told discussion on a previous *Family Life* article, *On Fats and Confusion*, illustrates the need for moderation and thankfulness in diet.

"Dad went on, 'The food we eat is a broad subject. The author failed to mention two hazards to a healthful diet. One is to not be thankful - not asking God's blessing on our food. The other is a lack of temperance. […] We could all do better. How often do we overeat? We take second and third helpings of a favorite dish because it tastes so good, when at other times we figure our stomach is full enough after we've eaten bean soup.' […] Now Dad had another question, 'If healthful foods can be eaten unwisely, can the so-called 'unhealthy' food ever have a benefit?' Aaron at once mentioned an earlier discussion they had had at the breakfast table a few weeks before. The Kellogg's company had donated several trailer loads of Froot Loops to a local organization to be sent to the starving people in foreign lands. This particular time the shipment of food had gone to Romania. […] 'I suppose the Froot Loops benefited the Romanians a lot more than they would have helped us,' commented Aaron. 'They didn't overeat, and they shared.' 'Temperance is one reason,' Dad agreed. 'Another is that they asked the blessing on the food and constantly thanked God for it. How often do we eat something between meals and forget all about being thankful, or asking God's blessing on the food so that it may nourish our bodies? If we have time to eat, we have time to pray.'" – By a Wisconsin Parent, *More Than Fats* (December 2001, 10-11).

"When we are invited away for a meal, and I see the table laden with a great variety of rich, elaborate dishes, I know that I will be tempted to eat too much. Before I indulge, I make myself pause and recall that feeling of discomfort and guilt of an overloaded stomach. I tell myself

> firmly, 'Deny the lusts of the flesh – overeating is a sin!' – Blessed with A Good Appetite*, An Overloaded Stomach* (November 2001, 32)

Along with this encouragement for balanced diets and moderation is the awareness that such a path is a difficult one and some acknowledge the failings of themselves and others.

> "Julie was having a hard time concentrating on the sermon. Amid the clamor of the babies sitting on their mother's laps, the minister's words had a way of fading out. It was now ten o'clock and the little ones had just started snacking and drinking their Jello bottles. Several had been given low sugar foods such as crackers or pretzels. […] "I must remember," Julie told herself, "that I am still young and inexperienced. But I hope I never cause a 'sugarbaby' to ruin the sermon for others." – By A Mother, *Letters to the Editor* (April 2000, 4)

> "A few months later when Lucinda took their little son to the doctor, Dr. Miller studied all the children's charts, looking puzzled. 'I haven't seen some of your children for at least three years,' he said. 'Before that, you were in here frequently. You must be doing something right.' Lucinda squirmed. She hated to admit how far they had fallen short of healthful eating habits in the past. But it was truly remarkable how the change in their diet had made such a difference in the health of their entire family. Although they are still far from perfect in their eating habits, Edward and Lucinda have come a long way and they hope that maybe someone else can learn from their mistakes. Most important, they have come to realize that it is wrong to abuse their bodies with unwholesome food that results in ill health and extra pounds." – "Lucinda", *A Change in Diet* (May 2001, 24-25)

Reproduction. Although unique from the day-to-day experience of nutrition in the pursuit of health, the approach to reproduction in this community also emerges as a factor in the determinant of health among women. Much of the discussion surrounding reproduction, however, is centred on the spacing and care of infants. Infertility is mentioned, but primarily as an emotional struggle to accept the inability to have children, a state decided by God, rather than as a physical, treatable, health-related concern. As well, the experience of childbirth itself is discussed only indirectly.

The question of whether or not to breastfeed babies appears with the greatest frequency perhaps due to the fact that a feature article on the topic elicited a large number of responses. It is not clear, however, why the discussion around reproduction is limited to nursing and spacing of children considering the relatively high rate of pregnancy experienced in this community. It is

possible that some elements of reproduction are not deemed appropriate for discussion in this publication. While this is a question for other studies, it is clear that among the Old Order people, childbirth is a central part of life and children are seen as a gift from God.

> "We thought the days ahead would bring, Once more to us the wondrous joy Of tiny, dimpled baby hands, Belonging to a little boy, Or little girl, We did not know - We did not care; it mattered not. Whichever God would choose to send, Would add a blessing to our lot." – L.B., *Dreams Laid Away* (January 2001, 6)

> "But as I gaze into your eyes, I know that God has given us a child with special needs. Some say you are retarded. Other call you special. But we - We just love you." – Name Withheld, The Baby of Our Dreams (July 2000, 3)

The information that is provided in *Family Life* indicates that the practice of breastfeeding and the spacing of children are tied together for some as there is the suggestion that by following this more natural approach, individuals allow God to decide how many children are brought into a family and when pregnancy occurs.

> "An acquaintance of mine who is in her early thirties and the mother of seven children told me that in her area many of her friends her age have had their last child. Why? Because they had not learned the art of nursing properly, and therefore had a new baby nearly every year. By the time they were in their early thirties, they were worn out, both physically and emotionally, and their doctor advised them not to have any more children because the mother's health did not permit it. How sad if we have strayed so far from God's order and will! If we check family records in genealogies, we see that in our grandparents' generation and earlier, the children were spaced further apart in the average family. That was before the nursing bottle came into use among our people, and babies were still being fed the way God intended." – By a Grandmother Now, *Dear Nursing Mothers*, This letter was written to a group of young mothers in a circle letter (January 2001, 15-16)

Although the individual in this previous writing notes the potential physical and emotional health costs of frequent pregnancies, the emphasis in this discussion is not on adopting the practice of nursing for health reasons. Instead, the author places weight on following God's plan throughout the process of creating a family. This idea is furthered by another individual who questions the idea of limiting the number of children for health reasons.

> "Dan paused for a moment before he answered 'We humans are not capable of raising our children by our own strength. We must look to the Lord for guidance, regardless of the number of children. Where there is love, peace and happiness, the size of the family is not an issue.' 'Some people justify limiting the size of their family because of health reasons,' James continued. 'Do you think this is acceptable in God's eyes?' 'That may be difficult to answer,' replied Dan. 'Remember, God doesn't see only our outward reasons for our decisions. He sees the motives in our hearts. He will know if our decisions are based on selfish reasons or not.' […] James' thoughts went to another verse in Psalms. 'As arrows are in the hand of a mighty man, so are the children of his youth. Happy is the man that hath his quiver full of them.'" (Psalm 127; 4-5). – By a Young Farmer, *The Rejected Heritage* (January 2001, 11-12)

And more directly, one individual speaks on breastfeeding and spacing of children, demonstrating the need to accept God's role in both.

> My husband and I found the articles 'The Rejected Heritage' and 'Dear Nursing Mothers' to be thought provoking and worthwhile. While at first glance these two pieces seem to be in direct opposition, they actually do complement each other very nicely. We are also in favor of breastfeeding, but we feel the primary reason for it must be because it is the natural, God-given way to nourish and cherish these little ones. Any benefits that result are secondary. Furthermore, we should exercise caution in insisting that proper breastfeeding will always effect the spacing of children. There may be instances in which we, with our weak human minds and hearts, and – may I say selfish desires? – will not feel we are 'ready', when God in His perfect timing and according to His great wisdom, allows a new little life to be given. Then, what is there to say but, 'It is the hand of God'?" – Parents in Wisconsin, *Letters to the Editor* (March 2001, 2-4)

These writings suggest that by following God's plan throughout reproduction, an individual may achieve health benefits. Therefore, the relationship between reproduction and health is important, but, as the author above points out, secondary.

Along with this suggestion that breastfeeding is the natural and Godly approach to reproduction, however, there is the recognition by others that exceptions do occur. The opinion piece submitted by an older woman on nursing shown in part above ("By a Grandmother") elicited numerous responses in the letters to the Editor section in the following months. A majority of those who wrote exhibited frustration with being unable to nurse and feeling judged by others because of this.

> "I would like to point out that there are mothers out there who would really like to nurse their babies, but through no fault of their own, they are not able to. It is a simple fact of life – all mothers are not created equal. In a case where the mother's milk is not plentiful enough or rich enough, or where there are other health reasons, I feel it is perfectly acceptable to offer the bottle. I would much rather see a plump, happy baby than an undernourished one." – Not All Created Equal, *Letters to the Editor* (March 2001, 2-4).

> "The author of 'Dear Nursing Mothers' meant it well, I'm sure. She encouraged mothers to nurse their babies properly, and this is commendable. But for those of us who have really tried and still have been denied the benefits, let us not lose heart. Just because a family has a new baby every year doesn't prove things were not done properly, as this isn't always the case. Some mothers do have a choice. But there is one choice we do have, and that is to accept the way God made us and to love all these sweet little gifts He gives to us." – The Choice Remains, *Letters to the Editor* (March 2001, 2-4).

In response to these frustrations, the author of the original piece concedes:

> "You are right. There are exceptions to every rule. Please accept by apology for not including this possibility in my nursing article" – *Letters to the Editor* (March 2001, 2-4).

Other determinants. Several other determinants were mentioned as well, although not as frequently as nutrition and reproduction. Stress is introduced as a part of a life out of balance and a potential determinant of health. One writer of an information piece on dietary fat discusses the potential physical effects of stress in association with concerns about environment and diet:

> "Why were cancer deaths increasing? Was it the fact that our environment was more polluted? That our lives were more stressful? That we were not eating enough fruits and vegetables? Yes. Yes. Yes and yes." - L.R., *Of Fats and Confusion* (August 2001, 33-34).

And another addresses concerns regarding stress more directly through a fictional story,

> "Edwin shook his head. 'It's pretty bad. I'm convinced in my own mind that if it weren't for these problems in our community, Uncle Andy would still be with us. Maybe I shouldn't say that, but I think he troubled himself so much about this disunity that it ruined his health. He simply refused to give up. He was determined there had to be a better way, that the church couldn't be permitted to split. You know, if a person has something like that on his mind all the time – in the long run it can put him in his grave.' Roy didn't say anything for a while, but with a sinking feeling he realized that the weight on his chest was returning, pressing in on his lungs so that it was hard to get his breath. Was that the same kind of weight that Uncle Andy had lived with, and which finally had ruined his health?" – *All But the Ceremony* (May 2001, 17-23).

Also receiving some mention in regards to determinants of physical health is recognition of the role of genetics. While not defined as such, in the context of letters to Dr. Hess, individuals demonstrate awareness of the health concerns of their parents and other relatives including rheumatoid arthritis, diabetes, varicose veins, and even bed wetting that may be of issue to themselves as well.

> "Both of my parents became diabetic as they grew older. Quite a few of my aunts and uncles and some cousins on both sides of the family are diabetic. Naturally, I fear I may become diabetic too as I grow older. […]" – Wondering in Pennsylvania, *Learning About Your Health* (March 2000, 35-36).

> "I have several aunts with rheumatoid arthritis and others in the family who often have sore and aching joints, though not as severe. What are the chances of me getting it and how soon? I am 27 and it is not unusual for me to have pain in my fingers, wrists, and knees. Is it something to worry about?" – Wondering in Indiana, *Learning About Your Health* (February 2000, 36-37)

Analysis indicates that there is also an understanding of the importance of immune system function and that the health of an individual can be determined by exposure to a pathogen. Whether or not the fears are based on quality research, concern expressed about building up a child's immune system, medication side effects, the safety of fluoride, the presence of aluminum in the environment, parasites, and carbon monoxide are all mentioned in the publication.

> "What can I do to help build up my child's immune system? Recently she started school and seems to catch most of the viruses going around." – A Pennsylvania Mother, *Learning About Your Health* (June 2001, 35-36)

> "We have heard that some cancer patients have a high level of aluminum. Does this have anything to do with using aluminum foil wrap or exposure to deodorants containing the active ingredient of aluminum zirconium trichlorohydrex gly?" – Curious in Iowa, *Learning About Your Health* (November 2000, 35-36)

Also mentioned, but to a far lesser degree was careless behaviour leading to accidents.

Mental health

Mental illness is a frequently discussed health concern in this publication. While occurring most often in the Letters to the Editor section, within the two years of analyzed documents there were a range of poems, personal stories, fictional accounts, informational articles, and editorials on the topic of depression, fear, and anxiety. Of the total articles analyzed, 12.4% were related to mental health.

Within the medical community there exists a range of diagnoses related to mental health, but the discussion in *Family Life* typically approaches this issue in a more general way. With reference to "affliction", "emotional pain", "struggles", and the "blues" it is at times difficult to determine the type or degree of the illness being discussed. Although the vast majority of articles appear to deal with depression-related mental health concerns, including postpartum depression (rather than other forms such as schizophrenia, bi-polar disorder, etc.), the blurring of discussion at times frustrates analysis and discussion of the perceived determinants of mental illness as the same terminology is used to describe very different experiences.

The lack of clarity in mental health discussions has been recognized by at least one *Family Life* writer:

> "Thanks for printing the article, 'My Darkest Hour'. We need more such stories about the different types of disorders of the mind. Maybe it will lessen the stigma among the sufferers. As a doctor once mentioned, he feels the Plain People shy away from these illnesses. Why? Because we are uneducated, thus forming our own opinion. Since we don't feel comfortable talking about mental illness, we don't understand it, and incorrect advice is passed out by well-meaning people which hurts the wounded all the more. The word 'depression' gets overused. many people make the comment, 'Oh, I've been depressed, too. Mine went away.' They are speaking merely about a healthy person's 'bad days' and cannot comprehend the pain of those who are truly depressed." – A Pennsylvania Subscriber, *Letters to the Editor* (November 2000, 2-4).

While not present in all, there is a strong sense in many of the submissions that mental illness is determined by the state of an individual's relationship with God. In informational

pieces dominated by *Biblical* references, individuals are encouraged to review the suffering of Job, the agony of the Israelites who drifted from God's will, and the fear felt by the prophet Elijah in the attempt to demonstrate the misery that arises when individuals focus on their own desires rather than on the will of God, when they do not follow God's plan, and when they allow fear to overtake their lives. In each of these cases, it is held that difficulty arose when people had ceased to fully submit and put their trust completely in God and accept God's Will.

More directly, while many stop short of suggesting that mental illness is something outside of God's plan, it is often proposed that individuals experiencing emotional illness are looking too much within and not enough to God. At times this distance from God is also connected with the belief that Satan has increased control in one's life.

> "Is it wrong to fall down on our face before God and weep about it? Surely not, providing it is a prayer of submission and a petition for the wisdom and the strength to do as God would have us do. That is totally different from weeping in despair and self-pity. Despair is just another world for a lack of faith, and self-pity is the opposite of submission. This is a pattern of thought that circles around and down in a dark, slimy rut of self-centered filth and depression. On the other hand, the prayer of submission is the key to God's power and to deliverance." – C.S., *Get Thee Up!, Insights and Ideals* (January 2000, 7-9).

> "Today we are no stronger than Elijah. We are made of the same flesh and blood. We have the same weaknesses, if not greater ones. We too sometimes forget that God has everything in His control, and we suffer emotional problems such as worry, fear, and depression. […] If fear is at the root of emotional problems, where does fear come from? What is at the root of fear? In thinking about the different kinds of fear, we conclude that fear nearly always springs from the root of self-interest. The less we think about ourselves and the more we think of God's ultimate plan and the welfare of others, the less fear we have. Self-interest is selfishness. Interest in God and in our fellowman is love." – G.M.W. *Under the Juniper Tree, How to Deal with Depression* (November 2001, 9-12)

> "No matter what our circumstances, let's do our best not to give the wicked one the triumph of seeing us grow bitter and resentful because of the things in our life that we'd like to control." – For Mothers and Others, *Overcoming the Blues* (March 2001, 18-19)

While this belief is pervasive in the publication, some offer an alternative perspective that acknowledges the impact of distance from God, but does not accept this as the only cause of depression.

> On Postpartum Depression: "There are some people who without experience blame the sufferer as having 'lack of faith', yet many times the depressed mother has a stronger faith amidst the misery than the accuser." - With Heartfelt Support, PA, *Letters to the Editor* (October 2000, 2-5)
>
> "Some people think that all emotional problems are caused by spiritual problems, just as some people of Bible times thought all sickness and misfortune were caused by sin (see John 9:2). I cannot agree with that conclusion […]"– G.M.W. *Under the Juniper Tree, How to Deal with Depression* (November 2001, 9-12)

While discussion is relatively vague in the examination of the causes of depression, there is some mention of hormonal and chemical imbalances causing depression in writings related to treatment options (examined later in *Treating Mental Illness*). While this may allow one to assume that there is at least partial acceptance in the community that chemical imbalances are at the root of some forms of depression, such a path should be taken cautiously. The physiological discussion is rarely distant from the reflection on the spiritual struggles.

Finally, while there is less discussion of explanations for reduced emotional health outside of what has already been mentioned, there is acknowledgement that strenuous relationships and a life out of balance (too much stress) can also contribute to mental illness or, more specifically, postpartum depression.

> "Are there more P.P.D. or nerve cases than there used to be? – The older women will have to answer this one. For myself, I was interested to read the following statement in an old book: 'Many a wife is not herself for a year or more after she has given to the world a baby.' […] It seems depression has so many aspects. Some people overwork themselves into "burnout". Others eat wrong and take in too much junk food and caffeine. Other may have hormonal problems and need to have a good examination from an endocrinologist. Someone else may let the news of the world such as recent traumatic events fill them with fear. Then, also, there are relationship problems such as a highly critical spouse whose complaints wear down the mate. Or it may be dealing with a chronically ill family member or a rebellious child." – A Hopeful Reader, *Letters to the Editor* (December 2001, 3-4).
>
> "Some people insist that stress has nothing do with bringing about P.P.D., but my feeling is that it often does. Stress is hard on all of us. We all know that animals get sick if they are under too much stress. People are no different." - Author's Name Withheld, *What is Postpartum Depression?* (July 2000, 22-23)

Findings related to the definition and determinants of health in the Old Order community are highly consistent with research presented previously. The tendency to measure health by appearance and ability to do work was reported in previous studies (Wiggins, 1983; Donick, 1986; Blair & Hurst, 1997; Nelson, 1999) and a focus on diet in maintaining health was also found in earlier research (Donick, 1986; Miller-Schlabach, 1992; Palmer, 1992).

The study of health texts by Japanese researchers Oyabu, Ido, and Sugihara (2001) suggested that the Amish tend to focus their education around specific, practical, and physical issues of health, forgoing broader environmental issues or concerns such as HIV or drug use. This finding is clearly consistent with the strong and nearly exclusive focus on nutrition and reproduction as factors central to maintaining health.

Illness

As all of life and death is according to God's plan, there is also emphasis placed on the belief that illness is a natural part of life, the human body is temporary, and the soul is central. In her study of the Old Order community, Egeland (1967) noted a belief in the supernatural etiology of some health concerns. The terminology is different in this research, but it is clear that many of the authors believe that while a person should care for his or her body, God ultimately determines illness.

Life on Earth is viewed with respect and appreciation, but whether the soul leaves the body due to the Second Coming of Christ or through death, heaven is the future and the focus.

> "This invisible part, this person living inside is what really counts in each of us, isn't it? The body, as wonderful and marvelously formed as it may be, is worth little without that living soul, the part that makes me 'me' and you 'you'." – J.L.L., *The Breath of Life* (April 2000, 5-6)

> "Surely, none of us is promised a tomorrow. Rather, just the opposite is true – 'Whereas ye know not what shall be on the morrow. For what is your life? It is even a vapor, that appeareth for a

> little time, and then vanisheth away' (James 4:14). We are all living on 'borrowed time'. Christ may well appear one of these days in the clouds with a shout and the voice of the archangel, and the trumpet of God, to claim His own. We do well to live in expectancy of that great event, and to look forward to it. For verily, it is coming." – J.S., *Staff Notes* (January 2001, 6)

Reflecting on the self-denying approach to life of some of the early Anabaptists, one writer contends that we have much to learn from those who placed their focus on God's will over their own desires and earthly well-being:

> "We live in a time when we have come to think a lot of our own importance – we place a lot of value on our own opinions. In the early days of Christianity and during the Reformation, when martyrdom was very common, it seems that Christians had very little self-interest. The general outlook seemed to be that life was like a vapor, and only what was done for the cause of Christ and the welfare of others was of any real importance. The length of one's life, or the trials and pleasures that come into it were of little account. All that really mattered was to be in the center of God's will." – G.M.W., *Under the Juniper Tree, How to Deal with Depression* (November 2001, 9-12).

This belief is central, but the understanding that God is in control and life temporary does not mean that illness always elicits an automatic or expected response of acceptance. Further, as will be explored in the following sections and in keeping with what has been demonstrated already, physical and mental illness are discussed differently within the publication.

While exceptions do exist, physical health is often addressed more directly than is mental health. In the discussion of physical ailments attention is typically limited to concern as to when and if to treat the illness and by what methods, less often venturing into an exploration of the roots of the illness. Further, while there are a range of responses to physical illness dependent on the type, timing, and severity of the illness and the situation of the person affected, these types of concerns appear to be relatively clearly understood, accepted as natural, and are accompanied with a set of beliefs that are more or less accepted universally. In other words, while the behavioural and emotional response to a physical illness or concern may fluctuate depending on the situation, the reality of the illness is largely accepted. This is not the situation for mental

illness where a great amount of attention is placed not only on the response to the concern, but also on the very nature of the illness itself. Taken as a whole, there are a variety of emotional and behavioural responses that appear to be experienced when health is compromised.

Emotional Response to Illness

How illness is understood is a fundamental concern that impacts not only when treatment is sought, but also what form it will take. Analysis suggests that there are three main areas of concern that emerge related to the Emotional response to illness. These are: Striving for Acceptance, A Struggle to Follow, and Support for the Journey.

Striving for Acceptance

The writings indicate a belief that the human mind is insufficient and that individuals must strive to accept what God brings them. Individuals are encouraged to give over their fear, uncertainty, and struggle to God. Even though the reasons are not always understood, the belief endures that God is doing what is best for each life.

> "[…] Thy wisdom clear to choose aright, / For only Thou has perfect sight. / And all the rest (which is so much) / We shall not even try to touch / Or figure out. Our minds are small; / We won't get very far at all. / The ways are perfect; we can rest / And trust the One who knows what's best. / We shall not fret; we shall not blame; / We'll simply magnify Thy Name. / We know that all Thou has designed / Was truly with our good in mind, / And it's the way that we can bring / Most perfect honor to our King!" – M.H., *When We Don't Understand* (February 2001, 6)

> "Today we are four thousand years away from Job's tears and trials, yet there is so much we can learn from his example. None of us knows what suffering we may yet experience. Who can tell? […] God has a noble purpose when He allows suffering to come into our lives. […] When distress comes to us human beings, we are tempted to ask why. Yet we have been taught that asking why is a breach of trust in God, so we avoid it. We curb our questions and smash them down in all their curious forms. […] The fact is, having the inside story and being aware of the possible reasons behind our suffering is to have knowledge, but not necessarily to have faith. And until we have faith, we will always feel rather woebegone. Simply put, unbelief

gnaws away at the fibers of our fortitude. – M.R., *Job: An Example of Affliction* (December 2001, 12-14)

"'Salome,' Isaac began slowly, 'how are you feeling? Can you accept it if I should die?' He looked at her beseechingly. 'I had quite a struggle last night,' admitted Salome. 'But yes, I have surrendered my will. Whatever God sees best is what we want, isn't it?' Isaac nodded in agreement." – Name Withheld, *What Will the Children Say* (August/September 2000, 31-32)

"'Then why did He make Lena deaf?' Ada wanted to know. […] 'We don't always understand everything God does,' Mom began slowly. 'Just like the verse in the Bible that tells us His ways are past finding out. That means He is so great and wonderful we can't always understand why He allows things to happen as they do. We must simply accept what God has planned for baby Lena,' Mom went on. 'God never does anything wrong. He knows just what is best for us. That's why it doesn't help us to complain about the way God has made Lena. Rather, we should trust in God to care for us. Since God decided that it would be best for Lena to be deaf, we must accept that.'" – Anonymous, *A Story to Tell - The Baby Who Could Not Hear* (December 2001, 23)

Struggle to Follow

The conversations held within *Family Life* demonstrate an acknowledgement of the struggles that individuals and communities face in following God's will. Evidence of a struggle with God's Will in regard to health emerged frequently and was largely focused around difficulties dealing with death, particularly in the instance of the loss of a young child or infant, but also addressed such trials as mental health difficulties, disability, and illness.

"We were sure any breath would be his last and his life would end after four short days. We tried to pray, 'Thy will be done,' but could we say it from our hearts?" - Wesley's Mother Pennsylvania, *Time of Trial - Is Our Baby All Right?* (August 2001, 19-20)

"Wait on the Lord, So easy to say / But deep is the suffering I meet on the way / So trying, so difficult; tears fall so fast / The skies of my life with weeping o'ercast. / The path is so rugged, I stumble along / Yearning to hear the sweet strains of song. Wait on the Lord? / Yes, I long to do so, / But the road is uncertain burdened with woe. / The night is so dark, the way is untrod, / I'm searching with heartache the hand of my God. / I'm sick with the waiting, the hour grows late, / 'Oh Father, where are you, with mercy so great?' Wait on the Lord! I'm striving for this - / The rough road will soon change to pathways of bliss." – By a Reader, *Waiting is Not Easy* (January 2001, 4)

"'It's this question of heroic measures.' 'You mean, like when he had pneumonia and was in intensive care? But why should there be any questions about that? We couldn't let him die, could we?' Ella protested." - By an anonymous author, writing on Ella's behalf, *A Time to Speak* (January 2001, 17-20)

"'You know, I'm afraid of dying,' he told a friend, honestly, less than a week before his death when he took his outside one last time in a wheelchair. - By a daughter, *Thoughts on My Father's Death*, (June 2001, 25-26)

"They all knew it was just a matter of time until death would come. It seemed almost cruel to see her suffer so, and yet they were helpless to do more than had already been done. Besides, the members of the family were suffering, too, as they struggled to fully submit to the will of the Lord. […] The late Bishop Henry N. Miller of our community was a gifted minister. He could preach moving sermons on many different subjects, including the prospect of dying. On his death-bed at the age of seventy, he said, 'Preaching about death and facing it are two quite different things.'" – J.E.M, Middlebury, IN, Waiting for God's Tomorrow – Insights and Ideals (October 2000, 7-9)

In situations of illness individuals question God's plan and they talk of the pain felt when one is torn by their very human desire for a different route than the one they face. When dealing with mental illness, however, the sense of struggle appears to go even further. In talk of dealing with this form of illness, individuals not only strain to find answers from God as to why they or a family member suffer emotionally, they may also experience the additional burden of a lack of acceptance and understanding from those in their community.

There appears to be a belief that one must treat the physical manifestations of mental illness (fatigue, weight loss, etc.), but the very nature of the depression or anxiety appears to offer important emotional and intellectual struggles in this community. Struggles that some would rather not face:

"[…] people also encounter emotional and spiritual pain and injury. I believe we often react to those problems and hurts much as the pilot and I did to physical ones – the former as a victim and I myself as an observer. We simply do not like to face reality, but would rather pretend that everything is all right. […] We like to think of ourselves as strong, capable, self-sufficient, and independent. We shrink from the idea of being vulnerable, hurt, weak, and in need of help. We avoid touching any wounds and perhaps even deny that festering sores exist. We would much rather think, "I'm all right. You're all right. We're all all right." […] We live in a world poisoned with sin. Invariably emotional injuries occur to all of us. We have all been affected and we all need a cure. […] Perhaps we too construct an image of how "normal Christians" should be, and do not include such human weaknesses as emotional problems or even spiritual infirmities. We ourselves make a valiant attempt to live up to that expectation. Admitting that we have problems seems like saying we are not normal. For the same reason we are reluctant to discover 'weaknesses' in the lives of our fellow pilgrims, especially those we consider to be

spiritual. Rather than tarnishing our personal image by exposing sores, we swallow hard, smile, and like the downed pilot in our neighbor's field, we insist, 'I'm all right! There's nothing wrong with me.'" – H.E.M., *I'm All Right, Insights and Ideals* (January 2001, 7-10)

This apparent general discomfort with emotional struggles seems to translate into personal turmoil for some individuals attempting to understand these illnesses within their loved ones and themselves.

"She still found it hard to believe that her husband's strange illness had been diagnosed as chronic depression and that he had to be on medication." – Name and State Withheld by Request, *A Flicker of Hope* (August 2001, 15-18)

Because of the problems some of my dear friends struggle with, I have recently given a lot of thought to the subject of depression. Then today I read the article, "A Flicker of Hope", the August issue of *Family Life*. I don't know quite what to say to Christian friends who tell me they are battling depression, and that their doctor has put them on medication for it. I don't know what to say for three reasons. First, because I have faced discouraging times in life but never have I been this low, so I don't have personal experience. Second, I don't want to say something that would make their burden heavier or sit in judgment on them. I also don't know what to say because I seriously question whether taking a pill, in most cases, is really the answer. - A hopeful reader*, Letters to the Editor* (December 2001, 2-4)

"When I look back now, I realize that the storm had been brewing for a long time. I had been under a great deal of stress, but since I am a calm person by nature, I thought I could handle it. When the first mild panic attacks gripped me, I was puzzled. As they passed, I shoved them to the back of my mind." – By "Ruth", *My Darkest Hour, Time of Trial* (August/September 2000, 13-17)

Support for the Journey

When individuals in this community find themselves facing health related difficulties, including struggles with accepting God's Will, many turn to God through prayer and reading of Scriptures as well as seek out individuals in their community for support. In many situations these sources of support appear to be interconnected as God is seen to work through family and friends and the community calls on God as they seek to help others. More specifically, individuals turn to the support of God and their community for dealing with such challenges as physical illness or crisis, mental health concerns, times of loss, relationship difficulties, disability, and making health decisions.

In discussion of God's help many often refer to the belief that God is always near and that God has a plan:

> "In some way or other, hard things will hit us. That is what we can expect in this world. We dare not let this frighten us. Though Jesus said, 'In the world ye shall have tribulation,' He also straightaway commanded, 'Be of good cheer.' He wants us to respond with fortitude. We have His reassurance, 'I will not leave you comfortless.' We have the steadying of His help, "My grace is sufficient for thee.' We have the prospect of His reward, 'He that overcometh shall inherit all things'." – M.R., *Job: An Example of Affliction* (December 2001, 12-14)

> "Our God is with you, holds your hand - / He'll guide you through your grief; / And in the midst of deepest sorrow / In Him you'll find relief. / And oft' in prayer we hold you near; / In sympathy we shed a tear." – Michigan, *Holding You Near* (August/September 2000, 25)

> "To other parents facing special challenges, let us always remember that God knows all the answers, all the reasons why, although He doesn't always choose to reveal them. We need to trust, we need to follow, and as we do so, He will lead us step by step, 'for He is faithful that promised' (Hebrews 10:23)." – Pennsylvania, *A Parent's Ponderings* (December 2001, 14)

> "Faint not, weary pilgrim, you are not alone, / Though your eyes are still wet and you seem far from home. / Look up, weary traveler, there's light up ahead! / Keep trying! God's near you!/ You've nothing to dread." – By a Reader, *Waiting is Not Easy* (January 2001, 4)

> "Always remember, our God is a loving God who is as near as a whispered prayer." - Sign me Saskatchewan, *Letters to the Editor* (October 2000, 2-5).

Help from community is often expressed through the knowledge that others are praying for them and through offers of financial or work-related assistance during difficult times:

> "We greatly appreciated the many ways in which family and friends reached out to help. We had to think of the many people in the hospitals who have no one to share their pain." - Wesley's Mother Pennsylvania, *Time of Trial - Is Our Baby All Right?* (August 2001, 19-20)

> "You and your family have been mentioned in nearly every prayer since I have heard or have prayed myself since we heard of the death in your family. There is so little one can do at a time like this, but we can pray. 'More things are wrought by prayer than this world dreams of,' therefore we let our prayers 'rise for you like a fountain day and night.'" – A Friend Who Care, *To My Friend, After Your Loss* (December 2000, 4)

Not only do individuals receive support, they are called to help others even though that can be difficult at times. This is upheld as an important part of being a member of the community as well as a way in which one can improve his or her own experience.

> "Look around. Is your neighbor or someone you know pleading for your help, your involvement, your advice, your love, your sympathy? Is someone hurting? Show them you care. Be there when they need you. Rejoice with those who rejoice, weep with those who weep. Help to bear another's burden. Pray for each other." – J.S., *Staff Notes* (August/September 2000, 3-4)

> "For a person who is injured to refuse to accept the fact is one thing. But for others to be reluctant to face up to it is also quite common. For most of us, getting our strings tangled up with emotional and spiritual problems in the lives of other people is something we like to avoid if possible. […] how often do we erect a wall between ourselves and fellow pilgrims who are hurting inwardly? For instance, why do we shrink from confronting an erring brother? Is it because we love him so much we don't want to hurt him? Or is it because we love ourselves so much we can't bear the risk of being rebuffed? Rather than taking that chance, we play it safe and hold our peace. How often do we 'cross the street' and look the other way, rather than going to the side of fallen, depressed, and emotionally-hurting people? We feel uncomfortable and tell ourselves we might make things worse. All in all, the 'safest' route is to put some distance between ourselves and the hurting one. Tragically, this can occur quite readily within our own family and between marriage partners. We are self-protective by nature and shield ourselves from as much pain as we can. (Of course, this doesn't mean we should appoint ourselves as the community watchdog, stalking around with a telescope, microscope, ax and a grindstone, scouting for someone to 'help'). I suspect another reason many of us, especially we men, steer away from thorny problems is that we don't like the feeling of inadequacy and not being able to 'do something about it.'" – H.E.M., *I'm All Right, Insights and Ideals* (January 2001, 7-10)

Although individuals are called upon to help others suffering from physical and mental illness, the stories of those who have fought mental illness or who are still in the pain of it suggest that there is at times a sense that they fear that they will not receive the support of their community that they would if there disease were of a physical nature.

> "How well I remember the time I got my first taste of this truth. I was going through a period of postpartum depression and I felt like a failure. I kept asking Mom, who was helping us at the time, what she thought I had done wrong. 'I only tried to do my best,' I sobbed. I felt so humiliated when the first cards and letters started arriving in the mail. 'Oh Mom, I'm so embarrassed and ashamed of myself,' I told her." – A Willing Pupil Who is Still Learning, *A Matter of Acceptance* (January 2001, 40)

> "We talked for a long time. I cried far into that night. It felt so good to finally have shared this monstrous burden with someone. And they didn't even act scared of me. I was so relieved. Even so I hardly slept that night." – Ruth, *My Darkest Hour, Time of Trial* (August/September 2000, 13-17)

Regardless of whether the illness is physical or mental, analysis indicates that sometimes the support received eases the struggle, but in some situations it is recognized that there can be a long process of repeated turning to God and the Community for help.

> "I find it is not something I can lay on the alter once and then be finished with it. It takes surrendering to be able to say 'Thy will be done' and really mean it. And yet I believe that his time was up and that it was God's will to take him. I cannot really wish him back when I think of what he has gained." – "Emma", *My Ways Are Not Your Ways* – (October, 2000, 15-18)

> "The hardest part may be admitting it and seeking help. I thank God daily for letting me return to a normal life, free from that awful darkness. I pray that if I ever need to go through this a second time, that I may have the strength and faith to seek help again." – By "Ruth", *My Darkest Hour, Time of Trial* (August/September 2000, 13-17)

The belief that one must accept God's Will in times of illness was also a central finding in Egeland's (1967) research. Her discussion including the quotation, "Mer wisse doch das es so sei hot sella (This has happened and we may be sorry for it) (432), is in keeping with the desire for acceptance of health expressed throughout the *Family Life* writings. Emphasis on community supports in times of illness and in the practice of maintaining wellness was also found in previous research (Egeland's, 1967; Wiggins, 1983; Donick, 1986; Wenger, 1988).

Behavioural Response to Illness

As God has decided all that is and all that will be, the occurrence of illness and the power to heal is also placed in God's hands and impacts treatment decisions.

> "Like Shadrach, Meshach, and Abednego in Daniel 3:17, we want to say that the God we serve is able to deliver us; and we know He is able to heal all our illnesses, too. But 'if not', we want to keep on trusting in His word and not faint by the way. For after all, we do know that for the true children of God who remain faithful to the end, the best is yet to be." – Ohio Residents, *Letters to the Editor* (December 2001, 2-4)

While it is difficult to provide specific information on illness treatment due to the nature of the data source used in this study, there are general trends that emerge related to how health treatment information is transferred, when action is taken regarding illness, and what methods of treatment are employed and preferred.

Information Transfer

How health information is exchanged is a central question in any community. The analysis indicates that among the Plain People there are three main sources of information that are called upon in the process of making health-related decisions: Health Practitioners; Family and community members; and Advertisements/Readings/Outsiders. The sources of information do not operate independently, but rather appear to overlap with individuals checking in with a variety of sources.

Health Practitioners. Much of the information in this study on how health information is transferred comes from letters sent to Dr. Hess for his popular *Learning About Your Health* column. On average, around 5 letters are published every month. Because of the very nature of this source of data there emerges a strong indication that individuals have a high regard for the knowledge of health professionals. In particular, Dr. Hess appears to be used as a trusted second opinion to one's own doctor, as an individual to entrust non-urgent concerns, and someone who can provide detailed answers to questions they may not be able, or wish not, to discuss with a family or clinic physician.

> "Could you 'fill us in' on the most recent research concerning tonsils? Our 5-year-old son has very swollen tonsils much of the time which become red and have white splotches. He needs antibiotics several times a year. Our family doctor, in whom we have a lot of confidence, usually finds an ear infection at the same time. However, our son rarely complains of an earache. Could there be a connection between the infected ears and the swollen tonsils? Our doctor says they don't remove tonsils as quickly as they used to. How do parents know when it is time to insist on

having them removed?" – Pennsylvania Parents, *Learning About Your Health* (February 2000, 36-37)

"I am an 80-year-old woman and would appreciate if you would explain about a herniated disk. Our family doctor sent me to a "spine specialist" who doesn't want to risk back surgery as long as I can walk. This is very much agreeable with me, although it takes much effort to keep going with so much pain. The medicines prescribed do not seem to help much." – A Kansas Subscriber, *Learning About Your Health* (July 2001, 31-32)

"I am a mother in her 40s and would like to ask several questions about my heart. Isn't the heart supposed to slow down while I am at rest? I frequently have nights when my heart keeps throbbing away as though I were taking a brisk walk. Is there something I could do to slow it down? Also, for some years now I have experienced a nagging discomfort in the left side of my chest. Usually it is not serious enough to be termed pain. The discomfort is situated under my arm rather than behind the breastbone. I guess I just what your assurance that this probably is not heart related at all." – An Ontario Mother, *Learning About Your Health* (May 2000, 31-32)

"At the age of twenty our son was diagnosed as having 'severe depression with psychotic features'. Six months after being hospitalized, he was discharged by the psychiatrist who recommended that in three months he discontinue the anti-depressant (Paxil 40 mg) and take a lower dosage of the anti-psychotic medication (Zyprexa 5 mg). But the family doctor who was to supervise this did not follow the psychiatrist's recommendation and says he needs long-term medication. Whose advice should be followed? Our son appears to be doing well, and we desire to see him continue so. But what are the long-term side effects of these medications? I would also like to know your opinion if recovery to the point where medications are not needed is possible. Of course, each case is different" – A Concerned Mother, *Learning About Your Health* (October 2001, 35-36).

"Seven years ago and I had severe chest pains during the night. The day before I had been working where the exhaust of a small gas engine drifted across my face. I went to a D.C. who gave me an adjustment and said my problem is from the carbon monoxide I inhaled." – A Missouri Reader, *Learning About Your Health* (November 2001, 35-36)

Family and Community Members. As evidenced in many of these letters to Dr. Hess and within other extracts it is clear that there are other utilized sources of information. Primary among these is the sharing of knowledge from friends, family, and others in the Plain community. Many of the letters submitted to Dr. Hess suggest that there is a significant amount of health information (and, at times, disinformation) circulating within the community. Among the letters covering topics from tooth decay to emphysema, and rheumatoid arthritis to allergies individuals write to Dr. Hess to obtain some clarification or consideration of the information they have heard from within their community.

> "When I was about 40 years old I began having heartburn. I got something from the drugstore to take after every meal, and it worked. Then after a couple of years my cousin told me to merely drink a glass of milk after every meal. That did the trick. I am now 83, and the milk still takes care of the trouble. Does that sound sensible to you?" – A New York Subscriber, *Learning About Your Health* (April 2001, 35-36)
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> "I love black pepper. In fact, I almost crave it. My dad says it could damage my heart; and my brother-in-law says anything a person craves isn't good for you because you will get too much of it. Are they right? I sprinkle black pepper liberally (about ¾ tsp. a day) on almost any hot dish because it adds a delectable flavor. Please let me know your opinion." – Wanting to Know in PA, *Learning About Your Health* (January 2000, 35-36)
>
> "But now some women tell me how dangerous these hormone pills are, and they cause breast cancer. I would hate to go back to the misery I was experiencing. Please give me your opinion; I will believe what you write." – A Reader in New York State, *Learning About Your Health* (July 2000, 31-32)
>
> "Several weeks later I was told (but not by a doctor) that I have two arteries close to my heart that are clogged. I am a 43-year-old sawmill worker used to a lot of exercise. I am now again getting sore spots around my left chest. Is it true that noise of a diesel motor can cause artery problems? I was told to take a large amount of vitamin E to get rid of carbon monoxide. How do you feel about all this?" – A Missouri Reader, *Learning About Your Health* (November 2001, 35-36)

Family Life itself also provides an opportunity for community members to share health information more formally. In these writings, there is very little emphasis placed on providing sourced information, but rather focus is placed on making the information accessible and relevant to the reader. In this way, personal experience and *Biblical* teachings are often used to further a point. As has been evidenced throughout the discussion of the findings, editorials and feature articles in *Family Life* address such issues as nutrition, mental health, care of children, and other health-related topics.

Advertisements/Reading/Outsiders. While the source of information is not always apparent, in addition to gathering information from community members and health professionals, it is also clear through the letters to Dr. Hess that individuals are exposed to outside sources of information through advertisements and salespeople.

> "At present there is a tick, Lyme disease terror in the Amish and Mennonite congregations in our area. It is due to a so-called doctor who gives scary talks in which he claims Lyme Disease is not curable and can be transmitted to your companion and children. He says he can treat it so that it becomes dormant but will appear years down the road. His treatment is shots in the head with medicine costing $600 to $1000 a bottle. You take this medicine for six months or more because he says it takes about four months to actually work. There are also regular office visits which also are expensive. I feel a good, honest article on this disease is badly needed." – A Family Life Reader, *Learning About Your Health* (January 2000, 35-36).

> "Would you please comment on the practice called Radiesthesia or Radionics. A practitioner uses an electronic box with dials and registers to detect cancer and other ailments before any doctor can diagnose it. The box then channels healing energy to the patients. By using the patients' DNA (a hair or drop of blood put on the box), the practitioner can channel "healing energy" unlimited long distances through the air to heal patients anywhere in the world. Do you believe this is an effective and safe practice?" – Concerned in Ontario, *Learning About Your Health* (July 2000, 31-32)

> "I am concerned about a trend I see in our conservative churches. This is the idea that our colons need cleansing. I would appreciate if you would read the two advertisements I am enclosing and comment on them. Is there any truth to this?" – A Family Life Subscriber, *Learning About Your Health* (May 2001, 35-36)

> "I have seen advertisements for various things to prevent rheumatoid arthritis; but I don't know if it helps or is merely a money-making scheme." – Wondering in Indiana, *Learning About Your Health* (February 2000, 36-37)

> "From time to time I see health articles which make fabulous claims, such as the one I am enclosing entitled "Diabetes can be prevented and reversed". What is your opinion on this article?" – Wondering in Pennsylvania, *Learning About Your Health* (March 2000, 35-36)

In previous research, researchers have found that Old Order persons express a tendency to accept statements of those in their community over those of health professionals (Caven, 1984; Wiggins, 1983; Miller-Schlabach, 1992). This data source does not provide sufficient information to support this finding, but discussions in *Family Life* do not contradict the assertion.

The writings suggest that individuals in this community rely on a range of information sources and community understandings appear to be a key factor in the development of health knowledge among Old Order people. As well, the concern expressed in Canon's (1997) series of articles on *Plain Prey* is supported to some degree as a number of the writings in *Family Life* indicate an anxiety related to the attraction to magical cures by some members of the community.

Taking Action For Health Concerns

The belief in the ultimate healing power of God is constant, but does not appear to prohibit individuals in this community from actively seeking allopathic and alternative treatments. There appears, however, to be a belief that without sufficient cause, which typically means inability to function in one's roles, frequent trips to the doctor or demands of attention are not seen as appropriate in this community. In fact, rather than seeking individual attention, individuals writing into *Family Life* demonstrate a tendency to work to accept their health-related struggles, maintain their role as much as possible in the face of illness, care for themselves, and call on outside support only when absolutely necessary.

> "While they ate she asked hesitantly, 'Has your mother needed to see a lot of doctors over the years?' He shook his head. 'Two or three. Oh, she could have done a lot more doctoring, I suppose, but she isn't much for that kind of thing. Prefers to accept the state of her health the way it is.' […] 'There's a verse in the Bible that always makes me think of her when I read it.' […] A lump rose to Ella's throat as she read Philippians 4:11 which Ivan pointed out to her: "Not that I speak in respect of want: for I have learned, in whatsoever state I am, therewith to be content" – by an anonymous author, writing on Ella's behalf, *A Time to Speak* (June 2000, 14)

> "Grandmother looked thoughtful. 'Sara,' she began, 'I don't want to make you feel badly, but I have noticed that you seem to enjoy the attention you get from being sick or hurt. It is good for others to help someone who has been hurt or is sick; God wants us to do that. But a sick person must be careful not to be demanding.' Grandmother paused and looked kindly at Sara. 'Do you understand what I mean?' 'I guess so,' Sara answered quietly. 'Because you enjoy the attention, you tend to make the hurt or sickness sound worse than it really is,' Grandmother continued." – By "Sara", *Children First* (July 2001, 20-21)

There is suggestion of a belief in seeking medical attention only for significant limitations demonstrated in the following stories. As indicated, even when a condition appears quite urgent there is some time taken before a hospital visit is seen as appropriate.

> One evening when Harley was sitting at the table, he rolled of his chair and fell on the floor. He soon got up again and went over to the couch. Later he could not remember falling off the chair or going over to the couch. After several such experiences, Harley and his wife decided they had better give some serious attention to his condition. - By J.L.L., *The Breath of Life* (April 2000, 5-6)

> "'Is our baby all right, or isn't he?' I asked myself once more as he turned slightly blue around the lips and his breathing became irregular. But then, after I held him a bit, he seemed normal. […] Earlier, I had been startled to see our baby's face turn blue and his breathing become jerky. Our oldest children went for Leon, but by the time they ran up to the house, he seemed fine again. 'Surely he'll be okay soon,' I thought. […] By the time Leon returned to the house after chores, I was quite uneasy. Wesley seemed to be getting worse, so we called the ambulance. […] Oxygen seemed to be helping him. Even so, I kept thinking how silly I'd feel if we'd get there, all would be fine, and they'd send us home again." – By Wesley's Mother Pennsylvania, *Time of Trial - Is Our Baby All Right?* (August 2001, 19-20)

In addition to the question of when treatment should be sought is the concern related to when it should be ended and the results accepted. The question of whether to make use of heroic measures, particularly in the situation of illness in older adults, or treatments with limited results appears several times in the reviewed publication.

> "I gaze searchingly into the face of my little daughter and wonder what the future holds for her. She lies there, a picture of innocence, asleep, a beautiful child…I imagine her as a bubbling school girl, an enthusiastic young person, a radiant bride, a "joyful mother of children". My daydreams are cut suddenly short. I hurry over to roll her onto her side as her arms and legs stiffen and twitch and her eyes open wide into an unseeing stare. I rub her back until the seizure passes and she drops limply asleep again. Can she ever be all those things every parent dreams of for a child? Only God knows. We are presently a year and a half into our search for answers – a search for something to eliminate or at least control our toddler's seizures. We see her losing ground in her development, and that hurts our hearts, as it would any parent's. Then there are questions, oh, so many questions. The doctors, the medications, the testing especially….how far should we go? How long do we keep asking, seeking for answers, looking for help, grasping for a lifeline to a normal existence for our little darling? When is it time to stop seeking and accept the situation?" – Pennsylvania, *A Parent's Ponderings* (December 2001, 14)

> "'Dad has some questions,' Anna said quietly. 'You see, he was once confronted by a man who wondered how the Plain People can feel free to avail themselves of all the latest technology and computerized equipment when someone's life is at stake. Yet in our everyday walk of life we shun those things. Why do we use them to try and avoid death? This man made Dad feel that we are perhaps being inconsistent.' Ella shook her head slowly. 'But why don't more of our people question these things, if they are wrong? Doesn't everybody rush to the hospital when someone is seriously ill?' 'Maybe not,' Anna said. 'Some people die at home, you know. It may be that for some it is a deliberate choice. They prefer to die at home than to go to the hospital and subject their bodies to all sorts of torture in order to stay alive for a short time longer.'" - By an anonymous author, writing on Ella's behalf, *A Time to Speak* (January 2001, 17-20)

In addition to speaking to the question of how long to prolong life in times of illness, this second quotation also introduces the question of the use of modern technology for health reasons among a people who choose to remain separate from much of society.

This concern with medical technology did not appear at any other point in the analyzed documents but it does raise important questions and supports the possibility that there are a range of factors at work in guiding one's decision of when to seek or end medical treatment. The answer is likely multi-faceted. In addition to an understanding of health as the ability to maintain one's role and a belief in God's plan there are hints within the publication that this tendency for delayed treatment may also be related to the personal financial cost of health care.

> "Before we say, / "They made unnecessary hospital bills," / Let's pray!" – By a Reader in Pennsylvania, *Let's Pray* (July 2001, 10)

> "It is the opinion of some in our community that Vitamin E is essential for the maintenance and stabilization of heart failures. Over the years I have been on and off Vitamin E and still am not definite whether there is actually a significant change either way. Recently when I asked my heart specialist about it, he said, "I don't know." Would you have any reliable information? I'm one who likes to rely on proven studies rather than costly opinions." – Wondering in Ontario, *Learning About Your Health* (August/September 2000, 34-36)

Additionally, as will be discussed in the following section, with an apparent preference for a natural approach to treating illness individuals may be inclined to try a number of alternative methods before finally seeking medical treatment if necessary.

A desire to remain independent throughout illness and continue in their community role for as long as possible was also found by Egeland (1967). A concern that this tendency combined with a situation of self-pay and a definition of health that is role and appearance based may lead to a situation where individuals are sub-optimal users of the health care system has been introduced in previous research (Hostetler, 1968; Donick, 1986; Kreider, 1995; Palmer, 1992; Blair & Hurst, 1997; Yoder, 1997). While it is not possible to comment on the frequency

of medical visits by the Old Order people writing into *Family Life*, these factors of concern all emerged from the data.

Treating Physical Illness. Once action is deemed necessary, the writings suggest that individuals care for themselves as well as utilize the services of health practitioners. As they seek to treat themselves or their family members when physical health is compromised, general aches, strains, and minor pains may be addressed through a variety of methods.

Letters to Dr. Hess suggest that the allopathic medical approach is just one option among several employed by the Old Order People. Prior to approaching physicians for information, there are indications that individuals have tried over-the-counter pain medications, changes in diets, use of vitamin/mineral supplements, or other in home techniques such as wearing gloves to treat carpel tunnel, using vicks ointment on a teething infants gums, or the use of heating pad for treating intestinal pain.

Also, before seeking professional medical attention individuals may visit massage therapists or chiropractors for the treatment of ailments ranging from muscle tightness to bed-wetting and pressure in one's head to chest pain. As found in the discussion on determinants of health, incorporation of leisure or physical activity for it's own sake is notable in its absence among the options selected for treating illness.

The information provided by a majority of individuals suggests that if home-based efforts are not effective, the next step in tackling an illness may be to seek professional medical attention.

> "I am in my middle 50s and going through my change with the miserable effects it brings for women. I tried different herbs, but they did not help much. So I went to a medical doctor who prescribed estrogen balanced with progesterone and am feeling much better." – A Reader in New York State, Learning About Your Health (July 2000, 31-32)

Based on the letters submitted to Dr. Hess and the accounts by many of experiences in hospitals and clinics, use of the allopathic medical community is very common and respected. Individuals report seeking the treatment of family doctors, emergency room physicians and nurses, back specialists, cardiologists, pediatricians, oncologists, and many others. In fact, over a quarter of all the information pieces and in each of the 23 documents analyzed there was at least one mention of involvement with a doctor, nurse, or hospital.

Acceptance of the health care system appears to be based in the belief that hospitals are from God and that God works to heal the physical body through doctors, nurses, and other health professionals.

> How often do we thank God for hospitals? We hope we will not need them, but to an injured person speeding along the highway in an ambulance, the hospital is a welcome sight. What would we do if there were no doctors or nurses on the Emergency Department? After a recent hospital stay, I was awed at the number of people who so willingly work among the afflicted. We know that doctors can only do so much. Without God's healing power, health cannot be restored. But it hurts me to hear people complain about how poorly they were cared for. I got a firsthand view of an overworked and understaffed medical team. The emergency workers, especially, are often very busy as the steady flow of ill people are brought in for relief. So please, folks, if you are ever there, give the exhausted doctors and nurses a cheery smile of thanks, instead of grumbling about how long you've waited. They are doing the best they can and it may well be the only sign of appreciation they have received all day. Most of all, let us remember to thank God for still granting health care services. We do not want to be like the ten lepers who were healed, but only one came back to thank the Lord. – Ontario, A Welcome Sight (March 2000, 11)

As the parents of an acutely ill child recount their experience at a local hospital, they demonstrate their willingness to entrust the health professional with the care of their child even as they place primary emphasis on God's healing powers:

> "At the time of this writing Wesley is just past his second birthday and he has been walking on his own since 21 months. He seems to understand when spoken to and also talks some. He still has unusual notions and fears but the older he gets, the more he is able to comprehend. Thanks to God's healing touch and His continuing care, we are able to enjoy Wesley in our home today." - Wesley's Mother Pennsylvania, *Time of Trial - Is Our Baby All Right?* (August 2001, 19-20)

This acceptance is in keeping with and part of the constant process of negotiation in which the Plain people engage as they work to decide what aspects of the larger society to accept and from which they would like to remain distinct.

In this way, while there appears to be a strong sense of comfort with using the health care system if an individual has a legitimate concern, there does not appear to be a situation of unquestioning acceptance. Along with seeking medical attention, some may move back and forth between allopathic and alternative methods as they search for complementary treatments that are perceived to be less harsh or dangerous to the body.

> "A member of our church has been diagnosed now for three years with lupus. He is taking Plaquenil and prednisone with recommendations to receive chemotherapy. Can these medications be harmful themselves? Are there alternative treatments? What can you tell us about lupus." – Needing Information in Kentucky, *Learning About Your Health* (November 2000, 35-36).

> "Will you please inform your readers about reflex sympathetic dystrophy. Many doctors are not familiar with this and can cause a lot of damage and time lost by wrong diagnosis and treatment. What is the cause and what is the best treatment? Will massage help the healing process? What about tea baths and practices? Or anything by mouth such as teas, vitamins, or minerals? We have a daughter who has been diagnosed with this ailment." – Hurting in Central America, *Learning About Your Health* (January 2001, 35-36)

> "I am 64 years old and have tried various sleeping pills with little success. Now my doctor gave me Excedrin PM, and they work good. Do you know if it's safe to use them continually, or are there harmful side effects?" – An Indiana Grandmother, *Learning About Your Health* (July 2001, 31-32)

As illustrated in the section on information transfer, in addition to the letters focused on mainstream treatment measures, there are also letters sent to Dr. Hess regarding cures outside the realm of good science or logic. While some individuals demonstrate an awareness of the financial and health-related dangers of the extravagant claims made by some advertisements and individuals, others demonstrate an openness to such treatments. More research is necessary to address why certain people are drawn to these questionable methods, but it does appear that individuals attracted to these simple cures may be dealing with illnesses where there may not be

a low-cost, efficient, *or* effective medical treatment such as cancer, rheumatoid arthritis, sleep apnea, lyme's disease, and diabetes.

> "My 75-year-old mother has begun wearing a magnet which is supposed to take away her arthritic aches and pains. We have tried to tell her it is useless, but can't reason with her. Can you as a doctor tell her why it is a waste of money? She paid $65.00 for a small magnet. I would rather see Mom spend money on something that brings her pleasure (she's had a hard life and no extra money in her younger years) and hate to see her give it to someone who raises false hopes. Why are older people so gullible?" A Pennsylvania Daughter, *Learning About Your Health* (August 2001, 35-36)

> "I am a six foot, 200-pound man in my mid-50s with a sleep problem. I snore a lot; and often my wife says I stop breathing for a short while, then burst to life again, although I am not aware of this. I neither sleep soundly or rest well and seem to dream constantly. Unless I take Tylenol P.M. or something similar at bedtime, I wake up almost as tired as when I went to bed. Should I be tested for sleep apnea, or is that just one of those passing fads? Recently I found an advertisement for D-Snore, a spray which costs $50 per month, guaranteed to stop snoring and restore restful sleep. If I do have sleep apnea, would I be taking a risk to try this D-Snore? Is there something else available at less cost and risk?" – Weary in Virginia, *Learning About Your Health* (December 2001, 31-32)

One indication of the frequency of discussion in this community related to the use of questionable healing methods, is a letter prepared by Dr. Hess. In his article, *Raising Red Flags or Discerning What You Read* (March 2001), Dr. Hess acknowledges his concern with the large number of letters he receives that deal with *miracle* treatments. While maintaining an open mind on the value of complementary methods, Dr. Hess cautions individuals about falling prey to cures that sound too good to be true:

> "It is true that our bodies have in themselves amazing healing powers and that without them no treatment, medical or otherwise, can be successful. It should always be the practitioner's goal to have the treatment harmonize with natural process. But the very basis of Christianity is that we are created beings and because of the Sin of Adam and Eve and our own sins we are in need of our fallen state. All healing, both natural and spiritual, comes from God and to Him the credit and praise is due. We are not gods with internal supernatural powers that just need to be unleashed so that we not get sick and die. If you read literature relating to all kinds of cures, be wary of this lie that slips in over and over – and reject it." – Dr. Hess, Raising Red Flags or Discerning What You Read, *Learning About Your Health* (March 2001, 35-36)

Similar to what is indicated by the data in this analysis, Hostetler (1968) reported that physicians perceived their Old Order clients to be highly knowledgeable about modern medical terminology as well as usage of folk treatments. Use of folk or alternative treatments in this community has been attributed to a tradition of separation, self-reliance, and carefully planned change, as well as a general distrust of outsiders, preference for community guidance, the possibility that individuals may find psychotherapeutic benefits of folk treatments, the reality of economic and travel considerations, and the severity of the illness (Egeland, 1967; Hostetler, 1968; Donick, 1986; Miller-Schlabach, 1992; Blair and Hurst, 1997).

Hostetler (1968) also found that the Old Order people had found a balance between the various methods of treatment. While it is difficult to make such a statement based on the writings in *Family Life*, it is clear that individuals appear to move with ease between different methods of treatment. Certainly, the findings support what Wenger (1988) suggests in her study, that a pragmatic ("if it helps, it is good") approach appears to guide health decisions.

Although much research on Old Order health practices and beliefs is often associated with the use of older folk medical practices such as *Baruche* in this population, there was not sufficient information published in the analyzed issues of *Family Life* to offer discussion on this issue here. It is difficult to speculate whether the lack of attention in *Family Life* is related to the frequency of discussion about these practices, the frequency of occurrence, or the nature of the selected publication.

Treating Mental Illness. As demonstrated, use of allopathic medicine and the formal health care system for more severe health concerns appears to be quite high in situations of physical illness and incorporated into the belief system, but openness to this outside health system is not universal. This point is made most clear, perhaps, in the situation of mental illness.

While the occasional letter on mental illness may appear in the section on *Learning About Your Health*, a majority of the discussion is found in the context of feature length first-person accounts of struggles with depression, letters to the editor, and in information pieces that discuss general beliefs about mental health.

As noted, although much of the discussion of mental illness includes reflections on spiritual concern, there is recognition of other potential causes of this illness. Similarly, a variety of approaches emerge as being important in treating a loss of mental health: Medical, Spiritual, Community, and Professional therapy. In keeping with the other aspects of illness that have explored, these treatment options are not typically discussed in isolation and there is an indication that in many cases treatment is multifaceted.

The same factors that frustrate a discussion of the determinants of mental illness, however, make it difficult to discuss how it is treated in this community. Specifically, the lack of differentiation between the various forms of mental illness made by individuals contributing to the publication is important to the discussion of treatment. As mentioned previously, depression is the most common mental health concern mentioned, but in the two years of data analyzed there is very little discussion in *Family Life* of the range of depression that can be experienced. The young girl who writes that she begins each day with prayer to deal with her struggles, may be dealing with a very different experience than the woman who shares that her fear and anxiety became all-consuming to the point where she was unable to eat, sleep, or work.

While some do make reference to the possible range of mental illness, the broad-stroke approach to mental health appears to be common enough to help explain the apparent frustration of some suffering from mental illness and the far ranging discussion of how it should be treated. In other words, a perspective on treatment which places individuals with serious mental health

concerns in the same category as those experiencing "the blues" is akin to suggesting that those with Rheumatoid Arthritis seek the same treatment as those with a case of the flu. Frustration, on both sides, can be expected.

It may be inaccurate to suggest that medical treatment can serve as an indicator of the severity of mental illness, but in this community where professional health services appear to be used as a last resort, discussion of the use of medication to treat mental illness does carry some weight. The frequency of individuals discussing their experience of taking prescription medication (and to a lesser extent St. John's Wort) demonstrates that this form of treatment is not unusual. But it is important to note that discussion of use of medication does, at times, include an element of justification.

> "Mental illness is a long lonely road to travel. If people truly want to do their Christian duty, they will reach out and help those around them. Be patient and listen to the sick person's fears. Love them in spite of the awful things they may say. They are very much aware of who cares or who pushes them aside. And to those who say no to medication many of us would be in the mental hospital for life. Yes, I am one who has been there, and I am concerned for those still hurting." – A Pennsylvania Subscriber, *Letters to the Editor* (November 2000, 2-4)

This need to justify the use of medication appears to be linked to the strong perception discussed throughout the findings that mental illness is a spiritual concern rather than a medical one. Further, even when natural and prescription medications are noted as being available to individuals suffering from depression, it is typically held that these should serve as an aid, *not a cure*. The focus remains on the spiritual healing that must be part of treating mental illness.

> "Is there a cure? To the tortured mind, this is an all-important question. Certainly, there is help. There are antidepressants to restore the chemical imbalance in the brain. (Some prefer a herb called St. John's Wort, which for some people is also highly effective.) Using a natural progesterone cream has been helpful for some. A vitamin-mineral supplement is recommended (especially vitamins B-6, and B-12), plus a well-balanced diet without too many sweets. […] Is the Term P.P.D being used as a cover-up for emotional and spiritual problems? It may be so in some cases. But I feel we should be very slow to judge anyone, especially if we have not walked in their shoes. Besides, if someone's depression does stem from an emotional or spiritual turmoil,

> they are suffering even more than someone whose illness has an organic or physical origin. They need our help and understanding for sure." - Author's Name Withheld, *What is Postpartum Depression?* (July 2000, 22-23)
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> "In a case where depression and negative emotions have taken control of the mind, often it is nearly impossible because the patient is no longer able to make rational choices. In such instances, it is important to get medication to relax the mind so that the will of the patient is again free to work toward a constructive solution. The right medication often makes the difference between a cure or no cure. Just as medications for the physical body allow the body to heal itself, so it is important to take the medication long enough – until healing is complete, or nearly so. Then many of these medications need to be stopped gradually, over a long period of time, to allow the mind to adjust and to heal. It is essential to feel our need of God. There is a temptation to think of ourselves as self-sufficient – we are quite capable of obtaining food for our daily needs. But the fact remains, we still need God, and we must never forget it. Even aside from our physical needs, we should realize our dependence on God for our emotional and spiritual needs." – G.M.W., *Under the Juniper Tree, How to Deal with Depression* (November 2001, 9-12).
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> "If a person has mental problems because of spiritual reasons, how do prescription drugs for a doctor help? Do the drugs dull the person's conscience so that one's past is not so clear? Is there a danger in continuous low-level usage of drugs that deliverance and victory over a spiritual problem is harder to find?" – A Pennsylvania Subscriber, *Learning About Your Health* (August/September 2000, 34-36)
>
> "With due respect to physical answers, it seems that in many of these situations our highest hope lies in spiritual help." – A Hopeful Reader, *Letters to the Editor* (December 2001, 2-4).

While God decides all of health and illness, mental health is unique in that although outside measures may eventually be necessary to restore physical health, the road to mental healing is typically seen as a very personal pursuit – from start to finish. Those recommending a spiritual path to healing for mental health are less likely to refer to God working through medication and doctor visits, but rather suggest individual changes. These include increased prayer, a renewed or strengthened focus on God, and a change in perspective and attitude that is more centred on the positive aspects of life and accepts that all is in God's hands.

> "Let's give these things completely to God in prayer and concentrate on Christ and bearing fruit to Him. When you feel the clouds of depression gathering around you, when the sun is blocked out and that heavy weight rests on your heart until it is an actual physical ache on your chest, then flee at once to the arms of Christ. His arms are outstretched, ever waiting to take you in, to protect you from the onslaught of the storm. Abide with Him, He will not let you fall. Focus on Him, and on His restful peace. Do not be surprised if the storm rages on, maybe for days. The wicked one does not give up easily, but remember, he has no power over the Savior. Rest in

Christ's love, secure in the knowledge that He will keep you and heal you, and the sun will shine again in your heart." – *Overcoming the Blues, For Mothers and Others* (March 2001, 18-19)

"If we were to name Job's worse suffering in one word, we would call it discouragement. Any study of the book of Job is as relevant to our lives as discouragement is real to us. Most discouragement, we believe, is from the devil. The fruit of discouragement is sadness. It can undermine one's faith, and lead to complaining and brooding. The only way good can result from discouragement is if through it we can learn to appeal to God for strength to face each day. To complain or brood centers too much on ourselves and not on God. We must set our focus beyond ourselves to deal with discouragement profitably. One man who was so depressed he suffered a mental breakdown learned that he had to being looking at life as a joyful opportunity before he could find his way free from the clutches of Giant Despair. Indeed, this is commanded in the Scriptures, 'My brethren, count it all joy when ye fall into divers temptations.'"– M.R., *Job: An Example of Affliction* (December 2001, 12-14)

"Yet most of us can remember some time or other in our own lives when we too let things get us down. Discouragement is something we have all experienced. To have the "blues" occasionally is a normal part of life. The danger begins when we become a slave to this defeatist outlook on life, when it becomes a part of our very character. Then it will color our thinking and warp our whole being. In this frame of mind, we think negatively about everything. No matter what happens, we react against it. As our mood deepens, everything and everybody seems to be against us. We are defeated, so why keep on trying? The end result is chronic discouragement and depression. And all the while, the root and beginning of it all, if we admit it, is a lack of faith in God. […] Like Elisha's servant trembling in front of the Syrian army, he saw only the evil forces (2 Kings 6:15). He did not see what men of faith see, that the mountain was full of horses and fiery chariots – God's army - just waiting to be called upon. With this picture in our minds, let us not be faint of heart or depressed, but let us commit all into the hands of our Captain and "get ourselves up." God alone can increase our faith and if we submit to Him, he will do just that. Then come what may, we will be in good hands." - C.S., *Get Thee Up!, Insights and Ideals* (January 2000, 7-9).

"Can Satan effectively bring anger, fear and jealously into a heart that is filled with faith and love? I don't believe it is possible without first removing the faith and love. On the other hand, we need only remove that faith and love of God and focus inwardly on ourselves and we soon begin to see the symptoms of a sick mind. Our thoughts dwell on how people have wronged us, we become discouraged about our situation, we grow prejudiced and narrow-minded. Gradually we lose control of our thinking. Our minds turn constantly to what is wrong, and it becomes difficult to meditate on the things of God." – G.M.W., *Under the Juniper Tree, How to Deal with Depression* (November 2001, 9-12).

"I am a teenage girl who struggles, but there is one thing I have learned – start the day with prayer. That way, no matter what, with God's help you can face it. Even when you are carrying the biggest burden on your shoulders, you will have peace in your heart because you have sought Him." - A Teenager in New York, *Letters to the Editor* (December 2000, 2-4)

"A bit part of healing comes from bearing the cost, forgiving, and continuing to love. But as long as a person refuses to face up to Mount Injury, these steps cannot be taken. As long as spiritual problems are not recognized and dealt with, the damage will remain and worsen. Emotional healing requires spiritual victory." – H.E.M., *I'm All Right, Insights and Ideals* (January 2001, 7-10)

Discussion of spiritual help for mental illness often blends into discussion on the necessity for community support as some call for pastoral support or suggest that others help their depressed friends by serving as "prayer partners" or as supports.

> "The ministers should speak of these issues in their sermons. We should seek godly help instead of just running to medicine." – A Hopeful Reader, Letters to the Editor (December 2001, 2-4).

> "Could not our older sisters, in a Titus 2 role, become prayer partners to depressed younger sisters? Some of these causes are within our power to change, while other take patience and Godly grace to suffer through them. The ministers should speak of these issues in their sermons […] Our Saviour promised that in this world we would experience tribulation, but He coupled that with the assurance that we need not fear, for "I have overcome the world." We should not think it strange when fiery trials come our way. Believers of earlier generations were able to gain victory in their day, and surely, the church today should likewise have some solid answers to help believers win victory over depression." - A Hopeful Reader, *Letters to the Editor* (December 2001, 2-4).

> "Even if someone is a powerful worker for God, the time can come that he needs help. In such a situation, we should turn to God for help, but also realize that God often works through people – through other Christians who have God's Spirit within them. I would like to encourage those who face emotional struggles not only to pray to God, but also confide in someone human. This could be a Christian counselor, a minister, a spouse, or a close friend whom they trust. […] People who are depressed need understanding. They need someone to talk to, and to tell their problems to. They need someone who will listen, as God did." – G.M.W., *Under the Juniper Tree, How to Deal with Depression* (November 2001, 9-12).

Not only is it stressed that the depressed individual seek, or be offered, help from his or her community, but that those suffering from poor mental health may find healing through helping another.

> "One therapy that has been found to be very helpful in working with emotionally troubled people is to interest the patient in helping someone else who is in need. This involvement in helping another nurtures a love for others that gradually displaces the self-interest, fear, worry, anger, etc. in the heart." – G.M.W., *Under the Juniper Tree, How to Deal with Depression* (November 2001, 9-12).

> "Don't be an island. Communicate with others. Share your struggles with a few close loved ones and be willing to share in theirs." – Author's name withheld, *What is Postpartum Depression* (July 2000, 22-23).

> "Since I am in the middle of a battle against the blues, I am filled with a longing to write a few words of encouragement, through the spirit of Christ, to all of you who are also struggling and seeking. First, remember and believe that Jesus loves you and cares about you, and that He wants to help you. "The Lord is nigh unto them that are of a broken heart" (Psalm 34: 18) Second,

know that you are not alone. Look around you, study the expressions on the faces of your loved ones and others you may meet. They, like us, may be hiding their true feelings, when deep down they might be just as lonesome, just as insecure, just as much in need of encouragement and friendship as I was. You guessed it – I was greatly helped myself, by trying to be a friend. Third, know and believe that the things in life that trouble you, the trials, the disappointments, the heartaches – can actually help you to grow in your spiritual life, to become a better person, and to bear more fruit for the heavenly Master. […] Stay with Christ, in the spirit, while doing loving things with your hands for those around you. Do whatever possible to bring encouragement to the lives of others. Watch for sunshine breaking through on their faces. It cannot help but bring a sunbeam to you as well." – *Overcoming the Blues, For Mothers and Others* (March 2001, 18-19)

While there exists some support for the use of medication as one seeks spiritual healing, there appears to be far less acceptance of the use of therapy.

"No doubt there are those with genuine medically-diagnosed problems who are indeed in need of medical help, and medication serves a good purpose for them. Yet I fear all too often this not the case, but that our spiritual enemy, the one who prowls like a roaring lion seeking whom he may devour is causing God's children to look to worldy-minded 'mental health' practitioners for a quick answer to their problems." – A Hopeful Reader, *Letters to the Editor* (December 2001, 2-4).

"The world cannot understand Christ's healing power. Even those counselors who profess to have a Christian orientation suggest healing for the abused by getting away from the former abuser, not in restoring relationships. In their minds, the abuser will always be an abuser. Many of our people long ago came to the realization that public schools do not supply the needs of our children. May God also lay it in our hearts that modern psychiatrists, psychologists, and counselors cannot supply our needs to the preservation of our faith." – Deeply concerned Grandparent, *Special Section: Journey to Freedom* (February 2000, 28-35)

But not all speak negatively of the use of therapy. Acknowledging her lack of knowledge about what it would entail and her fear associated with seeking help from a psychologist, one individual shares her appreciation of the assistance she received from a therapist in battling her anxiety and depression.

"The day for my appointment at the therapist finally arrived. Yet I dreaded this too, because I had no idea what to expect. My befuddled brain took advantage of this and tortured me further. 'Suppose she hypnotizes me and I won't know what I am saying?' I worried. 'What if she never saw a plain person and thinks I'm a cult member? She might think I need to be in the hospital after all.' […] I left my first therapy session with new hope. Here was someone who understood the illness. Someone who didn't flinch when I poured out my awful thoughts and feelings. She was willing to help me sort through them and discard them. […] Such an unexpected kindness amazed my parents, too. However, they had their misgivings. 'Is this woman taking you away from our faith, our way of life? Does she encourage you to seek an easier way?' Dad was concerned. I could honestly say no. Although she admitted that she'd never before counseled a

> person from our church, she never discouraged my faith or our lifestyle in any way. For this I was thankful." – By "Ruth", *My Darkest Hour, Time of Trial* (August/September 2000, 13-17).

And another individual notes the important expertise of a Psychiatrist.

> "It is important to go to a psychiatrist who is a medical doctor with specialized mental health training. Just as a cardiologist sees heart patients, a psychiatrist sees the mentally ill. It is not fair to expect the family doctor to know about every illness or realistic to expect him to accurately diagnose and treat mental illness of which there are many types. So it is important to be evaluated and diagnosed properly by a specialist and to get help before it turns into a more serious problem." – A Pennsylvania Subscriber, *Letters to the Editor* (November 2000, 2-4).

The story of Ruth that has been excerpted in part illustrates the depths one woman found herself in because of the shame associated with mental illnesses and her fear of sharing these personal struggles with others. Ruth was fortunate to have had a medical doctor refer her to a therapist for help, but not all may have the same experience. In fact, amidst the variety of options discussed for those seeking help for mental illness, it appears that some are not receiving help. It may be that some individuals do not feel comfortable going to their friends, family, or physician for help and perhaps their prayers have not brought healing. Whatever the case, in addition to providing a forum for individuals to connect through the writing of personal stories and reflection on what they have read, there appears to be significant numbers of individuals turning to *Family Life* in other ways.

A Staff editorial on the large number of "Sad Letters" received, unsigned and desperate, suggests that some are writing to *Family Life* in search of help they have not found elsewhere.

> "Let me tell you about a big brown envelope that is lying on my desk. The envelope is no different from many others – it is the contents that are unusual. I don't know how many years ago the idea came to me to label this envelope, "Sad File", and to begin filling it with a certain kind of material. By now the envelope is bulging. By now, too, I am ready to change the label to "Bleeding Hearts" because that is more descriptive. What is in the brown envelope? Letters that we receive with pleas for help that we don't know how to deal with. Letters from readers who find themselves in desperate circumstances. Letters from people who are hurting and don't know which way to turn for advice. Unfortunately, most of these people do not have the courage to reveal their identity. Their letters come to us unsigned. No address. Only a vague postmark.

> We have no clue who is writing. (There are exceptions. Occasionally a letter is signed, but they warn us not to write back to them). The letters are sad. This is the element they have in common. To the writers, the letters are sad because they feel defeated, hopeless. To us the letters are sad because we feel so helpless. All we can do is to file them away in the big brown envelope." – J.S., *Staff Notes* (August/September 2000, 3-4).

As discussion of mental health concerns increase in the publication it is possible that the experiences of others may be of benefit to others. The strong response to such stories indicates that there is fertile ground for this.

> "But Ruth is more than a survivor; she is a caregiver now. Because she suffered through this extent of emotional pain herself, she can reach out to others with understanding and touch their lives with a degree of empathy that would not have been hers to give had she not felt the sting of depression." – Slowly Climbing Out in Iowa, *Letters to the Editor* (November 2000, 2-4)

> "Though I never again hope to journey through that dark valley, I truly thank God for the experience so that I can now encourage others. God faithfully guided me through, and I hope to share the lessons and insights gleaned from the experience." – With Heartfelt Support, PA, *Letters to the Editor* (October 2000, 2-5)

The information found in the pages of *Family Life* related to mental health helps provide some new insight into this experience in the Old Order community. In areas of both understanding and treatment of mental illness there is suggestion that this is an area particularly worthy of further consideration. Based on this analysis one cannot comment on the prevalence rate of mental illness, but findings do indicate that this is an important health concern in the community and one that is being considered in a unique way relative to the general trend in North American society.

Interpretation and Discussion: Understanding and Response

In qualitative research, the investigator is often faced with a dizzying array of shapes and colours in the search to discover the larger image. In the previous chapter on Descriptive Findings, the discussion of Health and Illness provides a look into what is being said through the medium of *Family Life* about issues related to defining and maintaining health, and understanding and treating illness. Through this analysis, part of the picture has been established, but the image is not yet complete.

Using information provided in the Descriptive Findings it is possible to examine the data and determine major points of connection expressed throughout the discussions of health and illness. That is the goal of this chapter: to identify the common themes that provide insight into the relationship between culture and health in the Old Order community and complete the image.

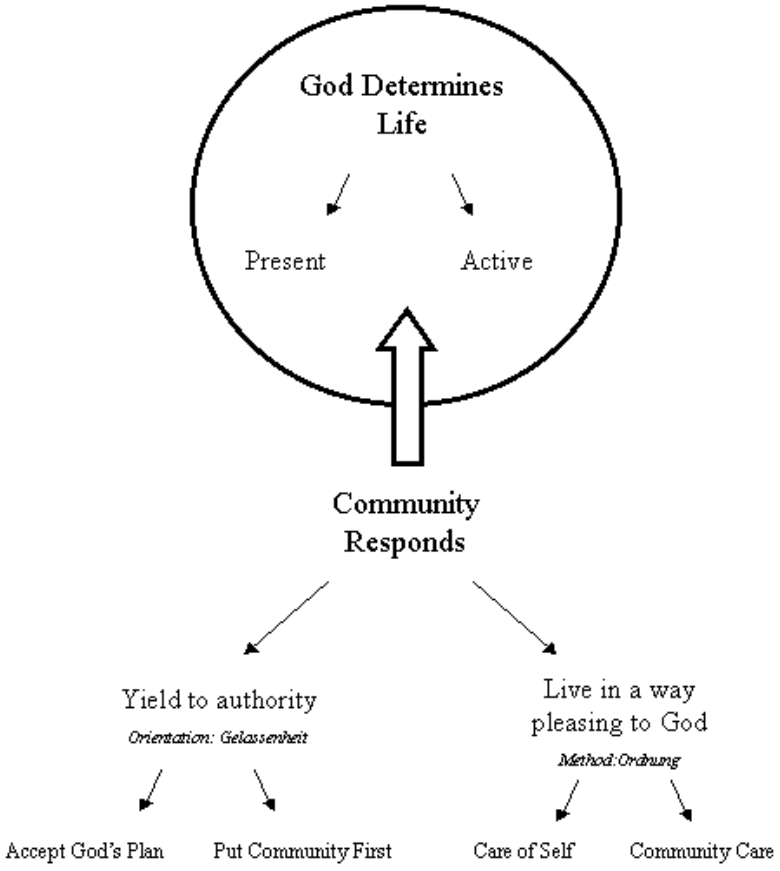
In the consideration of the broader understanding that guides the discussion of health and illness, it is important to note that the Old Order process of socialization results in a situation of significant consistencies across age, gender, and generation in how individuals behave and think (Hostetler, 1968; Wittmer, 1970). In part, this is because individuals are socialized within a high-context culture and into a reality where meaning is typically conveyed through setting, behaviour, and shared understanding of the history, social rules, values, norms and daily occurrences of the community rather than through explicit and exact statements. The consistency in knowledge base found in these types of cultures allows individuals within the community to communicate without the need to go into great depth.

The evidence of a shared knowledge base is clear in *Family Life.* Although it is not suggested that the writings analyzed fit the experience of all Old Order people, the direct manner in which issues are discussed in *Family Life* often speaks to a confidence in a mutual reality

shared between author and audience. As well, while the variety of submissions including poems, stories, letters, and informational pieces took unique paths of expression and chose different points of focus, they were largely guided by common fundamental beliefs.

Two central themes have emerged from the analysis of *Family Life*. The first is the understanding that God determines life. Simply, there is an expressed belief that God is present and active in daily life carrying out a divine plan that is beyond human understanding. All that is experienced is according to a Divine plan. The second theme is that the Old Order people appear to organize their health perspective and stated practices in accordance with this understanding.

Diagram 1
God determines : Community responds



As illustrated in the diagram above, the first theme is divided into two primary elements that feed the understanding of God's role in determining life. These include the understanding that God is present and that God is active. The second theme is defined by an *orientation* that seeks to accept the authority of God and Community and a *method* that is focused on living life according to God's plan.

Excerpts from the *Family Life* text accompany the discussion of the themes presented in the following section. The numbers accompanying the quotations refer to the page number in the Descriptive Findings where the statement was first introduced.

Central Theme 1: God Determines Life

It has been noted by researchers that the Old Order people are a cultural group where religious understandings are central to the belief system and inseparable from community practices (Hostetler, 1968; Wittmer, 1973; Fretz, 1982; Kraybill, 2001). It is not surprising, then, that throughout the analysis of *Family Life* a primary theme to emerge from the writings is a belief in the ultimate and defining role of God in life. In discussions of maintaining health as well as dealing with mental and physical illness, God is viewed as the Creator who is present and active throughout all of life.

God is Present

The Anabaptist community was created in part out of an understanding that every person is able to have a direct relationship with God (Priesthood of all believers). Even today the direct and active relationship with God that individuals write of is powerful. Accepted as an active presence throughout life, to an Old Order person God appears to be viewed not as a distant force, but as a personal Companion to be consulted and trusted. In *Family Life* writings, God is

discussed as a power who is present in everything from the smallest activities of the day to the very tether they hold onto life. It is held that as the Creator, God intimately knows the lives of each person; the past, the present, and the future and God's presence is constant throughout.

Individuals express the closeness felt to God throughout their daily lives and experiences. They thank God for the gifts in life and strive to give fears, sadness, and discouragement over to God, seeking strength and healing during times of illness and loss. In poems, letters, and articles, writers speak of God as a tangible force and encourage themselves and others with the belief that "Our God is with you, holds your hand - He'll guide you through your grief" (121), "God's near you! You've nothing to dread" (121), "Our God is a loving God who is as near as a whispered prayer" (121) and that one should "Flee at once to the arms of Christ. His arms are outstretched, ever waiting to take you in" (138).

God is Active (with a plan)

God is an *active* presence who not only possesses omniscience, but also is intimately involved in the lives of individuals. God is in control and has a plan. God grants life, God tests, God is the ultimate healer, and God decides when one's time on the earth is over. Often discussed as a benevolent power, the understanding expressed in *Family Life* is that if it is in God's plan, one may be given life, enjoy good health, experience illness, or may find healing.

Throughout *Family Life,* writers speak of the role and control of God in their lives. In a discussion of the process of reproduction, parents in Wisconsin write, "God in His perfect timing and according to His great wisdom, allows a new little life to be given" (109). In a letter to the editor one individual who admits a struggle with fear writes that amidst the uncertainty s/he knows that, "Nothing is going to happen to me that God does not know beforehand" (100). And

another speaking on the trials of depression asserts "We too sometimes forget that God has everything in His control"(113).

Individuals stress the role of God in the process of healing. In a discussion of physical illness parents write, "Thanks to God's healing touch and His continuing care, we are able to enjoy Wesley in our home today" (132) and "Without God's healing power, health cannot be restored" (132). Similarly, discussions of mental illness indicate a faith that if it is to be, God will bring healing. Writers assert, "We should seek godly help instead of just running to medicine" (140); "Our highest hope lies in spiritual help" (138); and that "He will keep you and heal you, and the sun will shine again in your heart" (139).

Even the support and care offered by others both within and outside of the Old Order community is discussed as the work of God. Speaking to the need for appreciation of health care one individual asserts, "Most of all, let us remember to thank God for still granting health care services. We do not want to be like the ten lepers who were healed, but only one came back to thank the Lord" (132). And in a discussion of mental health another contends, "Even if someone is a powerful worker for God, the time can come that he needs help. In such a situation, we should turn to God for help, but also realize that God often works through people – through other Christians who have God's Spirit within them" (140)

This belief in God's ability to heal and support, however, does not suggest that God's plan always includes the achievement of health. Writers in *Family Life* demonstrate a trust in God through the belief that not only are the opportunities found in life a part of God's plan, but the trials as well. While illness is not typically discussed as being a result of sin, it is stressed that all that happens to one, including illness and suffering, happens for a reason. As one writer contends, although God is able to heal, this is not always the plan, "Like Shadrach, Meshach, and

Abednego in Daniel 3:17, we want to say that the God we serve is able to deliver us; and we know He is able to heal all our illnesses, too. But 'if not', we want to keep on trusting in His word and not faint by the way." (123)

Reflecting on human suffering, one individual contends that "Jesus said, 'In the world ye shall have tribulation'" (121) and that it is important to remember that "God has a noble purpose when He allows suffering to come into our lives" (117). In a poem on the trials faced in life, one individual reflects, "We know that all Thou has designed Was truly with our good in mind" (117). And parents facing challenges express their faith in a divine plan when they write to others "let us always remember that God knows all the answers, all the reasons why, although He doesn't always choose to reveal them"(121). Whatever the outcome, God's role is constant.

This discussion of God's plan is accompanied by the understanding that the body is transitory, the soul eternal, and that heaven is the ultimate focus. Writing about illness in a brother, one individual contends, "This invisible part, this person living inside is what really counts in each of us, isn't it?" (115); And others reflect on the brevity of life and their hopes after death, "The best is yet to be" (123); "We are all living on 'borrowed time'" (116); "We have, after all, only a short time to stay here" (104).

This belief in the existence of a plan for each life as defined by God has the potential to affect health understandings and decisions in a number of ways. First, by giving God ownership of an individual's ultimate fate, a person may find a sense of security related to his or her health and the health of family members. Further, through the understanding that all is according to God's plan, individuals in this community are provided with a framework that has the potential to deliver answers during times of loss, uncertainty, fear, and confusion.

In the discussion related to treatment of illness presented in the descriptive findings, the writings indicate that God may work through a variety people to bring healing to the body including community members, allopathic and alternative medicine providers (e.g. Naturopaths, massage therapists, chiropractors, etc.). It is not surprising that in this community where education is treated as a tool rather a pursuit, emphasis appears to be placed on God's role in healing rather than the credentials of the practitioner.

Combined with a confidence in community knowledge, as indicated in the Descriptive section on information transfer, this belief system has the potential to lead individuals to pursue a range of treatments based on reputation of the provider rather the validity of the method. In other words, if God is viewed as the ultimate healer the methods are less important than the Will. In this way, incomplete and false information can be circulated and some may fall prey to the 'sounds too good to be true' cures offered by individuals or organizations. This is likely a complex situation and further research is necessary to understand the multitude of factors at work.

Discussion of the healing abilities of God also helps to explain the apprehension surrounding the usage of Psychiatrists, Psychologists and therapists, even amidst general acceptance of medical and alternative practitioners in treatment of physical health. While medication may allow for individuals to devote more attention to concerns related to their relationships with God, individual or community-based work on re-orienting an individual's focus on God is often discussed as the primary route to better health. As well, in keeping with the understanding of God as an active presence, whether it is believed that the root of depression is primarily spiritual or physiological, the role of health professionals, as it appears to be understood in this community, is to aid healing for illnesses through their use of medication and surgical procedures, but God is the ultimate healer.

Central Theme 2: Community Responds

As strongly as the *Family Life* writings indicate that Old Order individuals hold a belief in the ultimate role of God as determinant of health and life, there appears also to be a distinct, and largely universal, response to this understanding. In fact, what emerged throughout analysis is that this belief in God's active presence appears to be incorporated into understandings and expressed behaviours in the Old Order community through a set of societal constructs that have been discussed previously as central to the uniqueness of this cultural group: *Gelassenheit* and the *Ordnung*.

Gelassenheit is an orientation. Defined more formally as deference or surrendering to a higher authority (God, Community), the *Gelassenheit* approach is symbolized by the Lamb of God and leads one toward humility, obedience, contentment, and a yielding of personal will to that of God and community (Kraybill, 2001). Significantly different than the approach to life embraced by much of modern society, this approach to self, community, and God is a fundamental part of Old Order life and appears to be an important part of the culture-health connection. Specifically, two themes emerged as related to this orientation: Acceptance of God's plan and the need to place the community before the individual.

The *Ordnung* is a method. It gives definition to the *Gelassenheit* orientation by providing rules of conduct across all areas of life and translating religious beliefs into societal norms. The rules of the *Ordnung* can be formal, written statements such as a declaration against the practice of divorce or can be shared as a more fundamental understanding of "just how things are" (Kraybill, 2001). While not all are equally prohibited, the rules of the *Ordnung* demonstrate a powerful method by a community of incorporating a consideration of spiritual and *Biblical* implications into nearly every decision in life. The *Family Life* writings related to health indicate

that there are two themes within this call for a way of living that is pleasing to God. The first is related to Self care and the second to Community care.

Arising out of the understanding of God's role in life, these cultural frameworks work to define reality, they *actively* place the focus of a person's life outside of the self, and they inform decisions. In this community where religion and practice are inseparable, a defining of a hierarchy of will and adherence to community rules provides Old Order individuals with practical guidelines for life that extend into the experience of health. The specific health-related elements of these understandings are discussed in the following sections.

Yield to the Authority of God and Community *(Gelassenheit)*

Accept God's plan

The writings in *Family Life* suggest that individuals work to integrate a belief and respect for the authority of God into individual decisions and the routine of community life. In keeping with God's perfect sight and active role as Creator in each life, God is accepted as the Authority and individuals speak of the importance of not questioning God's methods or attempting to learn what is only God's to know. A *Biblical* verse quoted by one individual within the pages of *Family Life* may help to explain the roots of this belief:

> "Not that I speak in respect of want: for I have learned, in whatsoever state I am, therewith to be content" (Philippians 4:11).

Amidst their health trials, Family Life writers express respect for God's authority as a pursuit of the acceptance of God's plan for each life. In letters to the Editor, individuals reflect that even in the face of challenge "We need to trust, we need to follow, and as we do so, He will lead us step by step" (121). The author of a feature article on depression notes that "When

distress comes to us human beings, we are tempted to ask why. Yet we have been taught that asking why is a breach of trust in God, so we avoid it" (117). In a poem about questioning, one individual reflects, "Thy wisdom clear to choose aright, For only Thou has perfect sight. And all the rest (which is so much), We shall not even try to touch Or figure out. Our minds are small; We won't get very far at all. The ways are perfect; we can rest And trust the One who knows what's best." (117). And in a story of a woman facing the possible death of her partner an individual writes, "Whatever God sees best is what we want, isn't it?" (118).

In this effort to accept God's authority and plan, individuals speak of the connection with God as one not only to be appreciated, but one that must be actively nurtured. In the effort to follow God's plan, writers in the pages of *Family Life* speak frequently of the importance of maintaining close ties with God through prayer. In particular, in the discussion on the determinants of mental health in the descriptive findings it became clear that the personal relationship with God and acceptance of God's authority is understood as a force in one's life that guards against an internal focus that is viewed as one of the primary causes of mental illness.

In letters to the editor and features articles on dealing with depression and emotional struggles, *Family Life* authors assert that individuals will find healing by placing the Will of God above personal desires. In his article overcoming depression and despair, one writer contends that "The prayer of submission is the key to God's power and to deliverance" (113) while others assert "We must set our focus beyond ourselves to deal with discouragement profitably" (139) and "God alone can increase our faith and if we submit to Him, he will do just that" (139);

As these direct calls to place God's Will first indicate, the acceptance of God's authority is not always automatic. Highlighted in the section on the Emotional Response to Illness in the previous chapter, throughout the process of analysis it became clear that a central aspect of this

belief in the acceptance of God's plan and authority, is that in the day to day experience of living according to God's Will this pursuit does not always lead to a direct translation from belief into acceptance. This difficulty does not lessen the importance of the attempt, but is an important reality to recognize.

While research and the media tend to idealize or simplify the Old Order experience, individuals within the community appear to be very much aware of their human imperfections and use *Family Life* as an opportunity to express the fears, pain, uncertainty, and frustration present in their pursuit to accept what God has planned for their lives; the joys and the sorrows. These struggles are sometimes placed repeatedly before God and community.

Parents write of the fear of losing their child to an illness, "We tried to pray, 'Thy will be done,' but could we say it from our hearts?" (118), a child struggles with the failing health of a parent, "We couldn't let him die, could we?"(118), and individuals confront their own fear of dying, "You know, I'm afraid of dying" (119), "Preaching about death and facing it are two quite different things" (119). A poem also speaks to the struggle of accepting the plan laid by God, "Wait on the Lord? Yes, I long to do so, but the road is uncertain burdened with woe […] I'm searching with heartache the hand of my God." (118), and one individual, reflecting on the loss of a partner, asserts that despite faith, the pain does not quickly go away, "It takes surrendering to be able to say 'Thy will be done' and really mean it" (123).

In this effort to accept God's plan there are number of potential health-related implications. While the writings indicate that life is valued and individuals strive to have good health, this belief in God's control and plan could also be one of the factors at work in an individual's decision to pursue or continue treatments. As discussed in the previous section, the belief that all is according to God's plan has the potential to free a person from the fear of illness

and death, but it also may contribute to a tendency to delay treatment and a reluctance to make use of heroic measures. In other words, an individual may be more willing to accept a situation if it is understood to be a part of God's plan.

In addition to the potential physical consequences of this call to accept God's plan, there are also important emotional concerns. In fact, the belief that an individual must submit his or her will to that of God may have the greatest impact in situations where a person is unable to make that surrender. During times of illness, there is the potential for an individual to be additionally burdened by the need to emotionally accept a situation before he or she is prepared to do so. Further, those unable to find acceptance of what is seen as God's plan may experience a deeply emotional struggle that could serve to create a situation of personal conflict as well as distance them from God and their community as others may assume that all is well or *should* be well when, in fact, it is not.

As indicated in the discussion on mental health in the previous chapter, this perspective has the potential to be particularly difficult in situations of severe depression or other forms of mental illness. Because of a general lack of knowledge regarding these forms of illness and the belief that they are primarily relational and spiritual rather than physiological, continued struggles with mental illness may be attributed to a focus on the self and the inability to accept God's will. Fearing judgement, individuals may be less likely to admit their struggles and seek help in this environment.

The experience of struggle in accepting God's Will exhibited by many of the magazine authors, while not necessarily surprising, is a striking finding in light of the absence of recognition of this tension in previous studies.

Place the Community before yourself

As explored, the belief that the needs of the community come before those of the individual is central conviction in the Old Order community and a key part of the *Gelassenheit* approach. By reducing the amount of focus granted to the self, even something as personal as illness can become an experience that is viewed with eyes cast on the larger whole rather than on the individual. As illustrated in the discussion on defining health in the previous chapter, while there is some attention given to a practical view of the state of health in that one may 'look' or 'feel' healthy, the perspective on whether or not one is healthy appears to largely be tied to an individual's ability to fulfill his or her role and do work in service to the community and to God.

In Letters to the Editor, informational pieces, fictional and non-fictional stories, and written prayers individuals speak of their struggle with fulfilling their role in the community. Women struggling with illness write of their frustrations and the guilt associated with being unable to complete their tasks, "The worst thing was that almost constant 'tired to death' feeling and the discouraged "smaller than dirt" feeling as my house became dirtier and untidier" (102), "How often my husband's reassurance was a balm to my soul, especially when I felt guilt-stricken for being unable to be the wife and mother I longed to be" (102), "I am resentful, for I detest lying here so weak and helpless. I despise not having the energy to get up and work, or the strength to properly care for our children" (102). And a couple equates the ability to do work with being healthy, "'Has mom always been unwell?' […] 'Oh, no. Used to be such a hard worker" (102). And a wife struggles with the shifting of role in her family in the face of her husband's illness, "But how was she to submit when Davy did not have the ability to lead?" (102).

As noted in the discussion on behavioural responses to illness in the Descriptive findings chapter, individuals express a concern with not wanting to be seen as drawing too much attention

to themselves or wasting personal or community resources on treatments perceived to be unnecessary. A poem on judging others demonstrates this tendency: "Before we say, "They made unnecessary hospital bills," Let's pray!" (130) as does an article on parent's dealing with an ill child, "Wesley seemed to be getting worse, so we called the ambulance […] Oxygen seemed to be helping him. Even so, I kept thinking how silly I'd feel if we'd get there, all would be fine, and they'd send us home again" (129). And a child reflects with admiration on the attitude of his mother towards health, "Oh, she could have done a lot more doctoring, I suppose, but she isn't much for that kind of thing. Prefers to accept the state of her health the way it is" (128).

The consideration of community welfare appears to combine with elements of acceptance of one's situation as individuals question how much treatment is too much and when it is time to accept their situation. A family discussion on an ill parent notes a struggle with using medical technology, "He was once confronted by a man who wondered how the Plain People can feel free to avail themselves of all the latest technology and computerized equipment when someone's life is at stake. Yet in our everyday walk of life we shun those things. Why do we use them to try and avoid death?" (129). And a parent wonders when to end treatments for a sick child, "When is it time to stop seeking and accept the situation?" (129).

This perspective, which places the community first, helps explain some of the findings identified in the previous chapter. The apparent reluctance to seek professional treatment until a person's abilities have been significantly compromised is in keeping with the role-based definition of health that places emphasis on the needs of community. Further, the point at which professional medical treatment is necessary may be positioned differently than it is in other cultures as the consideration of the welfare of the collective may reduce an individual's

willingness to pursue preventive or costly treatments that may be seen to unnecessarily drain community resources.

As well, in combination with a significant amount of trust in community belief and knowledge, including understandings related to health, this tendency to care for oneself and avoid the use of hospitals, doctors, and medication unless absolutely necessary may also help to explain the expressed preference by many for home remedies. Finally, within this framework of community focus, a trust of others who share their particular way of life and belief system is developed and may help to further establish the boundaries between those who are part of their community and those who are not.

Live in a way pleasing to God *(Ordnung)*

Along with the acceptance of God's Plan for life, *Family Life* authors indicate in their submissions that an individual must strive to live in a way that is deemed pleasing to God. In particular, writings related to the determinants of health and community support during times of mental and physical illness speak to a larger pursuit that demonstrates an understanding of how an individual should conduct daily life. In this culture where the community defines understanding (Kraybill, 2001), it is not surprising to find that these beliefs about how to live rely heavily on *Biblical* and community guidance.

As noted, while the *Gelassenheit* approach primarily represents a responsive orientation of belief to the understanding that God determines Life, the *Ordnung* incorporates this orientation into a consideration of the more specific practice of living. The analyzed writings suggest that in health related discussions, Old Order persons are specifically concerned with activities related to self care (i.e., nutrition, reproduction, stress) and support of the community.

Care of self

While there is some consideration of health research and the advice of trained practitioners, in informational pieces and personal stories, authors write about how to live a life of which God would approve. As outlined in the previous chapter, a majority of the discussion on the determinants of health is tied to very practical matters of life, how to eat and how to parent, and values an approach to living that is in keeping with *Biblical* understandings and community perceptions of what God desires over what Science may suggest. In staff notes, the Editor contends that it is important to keep to God's plan in all things, including diet: "A diet high in meat and milk is as old and older than Abraham, Isaac, and Jacob. It seems it is whenever man starts taking shortcuts and trying to make improvements over God's original design that things run afoul" (105).

In letters and articles on reproduction and caring for children the understanding that God calls individuals to live a certain way continues to be expressed. One individual writes that "We must look to the Lord for guidance, regardless of the number of children. Where there is love, peace and happiness, the size of the family is not an issue" (109) and parents contend that "We are also in favor of breastfeeding, but we feel the primary reason for it must be because it is the natural, God-given way to nourish and cherish these little ones" (109).

Writers speak of overeating as sin and abuse and assert the need for balance in diet in stories and articles: "Deny the lusts of the flesh – overeating is a sin!" (107) and "It is wrong to abuse their bodies with unwholesome food that results in ill health and extra pounds (107). And others note that there is more to health than the type or amount of food consumed. A parent cautions his children on the importance of thankfulness when he writes, "How often do we eat

something between meals and forget all about being thankful, or asking God's blessing on the food so that it may nourish our bodies? If we have time to eat, we have time to pray" (106).

As discussed, because of the socialization process of the Old Order people which incorporates a greater consideration of the past than the future, practices are often more consistent in this community from generation to generation (see Hostetler, 1968). The discussion about what practices God desires for each life is not, however, without conflict. Patterns may shift more slowly than they do in other cultures, but amidst cautions to not fall for "every new 'discovery' that comes along" (105) the writings suggest that changes to daily life, good or bad, are occurring. Amidst the commonality expressed, writers also present a variety of ideas that challenge assumptions about what is natural and healthy and in keeping with God's plan.

Researchers have noted that within the Old Order culture and other groups marked by strong lifestyle dictations, communities must seek a balance between prevailing social norms and group traditions (Iannaccone & Miles, 1990; Epp, 1994). Although religious reinforcement and internal stability help to maintain traditional ways (Fretz, 1989, Epp, 1994) the disagreements expressed in the pages of *Family Life* are important points of consideration and suggest a range of influences and interpretations in the lives of Old Order people. For example, the young mothers writing in defence of bottle feeding in response to an article put forth by a grandmother on the Godliness of breastfeeding may suggest such a trend. The data in this study are not sufficient for an analysis of this type, but it is important to note that while attention is clearly given to living in a way that is accordance with God's plan, this understanding is not static and is certainly influenced by a variety of informational sources.

This perspective that incorporates religious understandings into the determination of self-care appears to be at the root of why certain aspects of maintaining health common in other

cultures were not discussed in the pages of *Family Life*. Although recognized to some degree, medical research was given less emphasis than *Biblical* teachings and while there was some mention of stress, the discussion of determinants of health rarely moved beyond very basic practices of life. The analyzed publication may not be the dominant forum for discussing health matters, but it was somewhat surprising to find such limited reflection on self-care.

One notable example of omission includes an absence of discussion related to the health benefits of social or physical activities. This is most surprising because in addition to the demonstrated health benefits of these pursuits, physical activity and social involvement appear to be an accepted and integral part of life in the Old Order community. Physical activity plays a central role in Old Order life where very little technology is incorporated into activities and work is largely farm-based. As well, the value of family and social relationships is demonstrated throughout the pages of *Family Life* as individuals discuss with appreciation time spent in family meals and at social events such as quilting, caring for children, and Sunday visits.

While physical activity and family are two of the central elements of Old Order life, the prevailing belief that life should be lived in a way pleasing to God or in service to God may reduce the attention given to activities, or aspects of activities, that are without direct purpose or tied to *Biblical* understandings. In fact, unlike other aspects of health such as nutrition, activities such as leisure may be seen negatively or in direct contrast to Old Order beliefs. This consideration of leisure (or lack of consideration) is consistent with information presented in the Literature Review section on Practices and Beliefs and has also been found among other cultural groups interfacing with modern North American society (See Tirone & Shaw, 1997).

Leisure is a subjective experience. As Shaw (1985) contends, physical setting, social context, and activity choice define the 'container' of the leisure experience. The author

continues that although some containers are more likely to lead to leisure than others, the experience of leisure can also be found in range of activities; including those that are obligatory (Shaw, 1985). In support of this finding, Henderson's (1990) study of farm women, Allen and Chin-Sang's (1990) consideration of the work histories of older African American women, and Dupuis' (2000) look into the leisure of caregivers all demonstrate that elements of leisure can occur in the context of activities traditionally considered work.

As indicated by these studies and evidenced in the *Family Life* writings, it is possible that Old Order people are finding benefits associated with leisure within the routine of work and community interaction. Although Old Order individuals do not classify time spent in social or physical activities as leisure and emphasis is placed on there being an extrinsic or religious purpose in activities, there is a clear presence of involvements in their lives that allow for relaxation, connection, and mental and physical development.

Additionally, this focus on purposeful activity may also have benefits. Morgan's (2001) research suggests that an individual may have a higher chance of *maintaining* an active lifestyle if he or she strives to incorporate exercise into the daily routine of life rather than simply pursuing physical activity for its own sake. Highlighting the health experience of Old Order people and their highly active and purposeful lifestyle, Morgan (2001) asserts,

> Inhabitants of the planet earth have been hunter-gatherers for most of history […] This has changed rather dramatically in the last half century; we now have large numbers of physically inactive individuals, and this inactivity is associated with heart disease and reported epidemics of both obesity and diabetes. How can we become modern day hunters-gatherers and farmers? […] I believe the answer is simple – we need to adopt forms of purposeful physical activity (376).

Community care

In Galatians 6:2, individuals are called to carry the burdens of one another for "that is how to keep the law of Christ". In addition to establishing an approach to self-care that is in keeping

with God as the ultimate determinant of life, the writings in *Family Life* suggest that an understanding of the importance of community care is central to discussions of health.

As demonstrated in the Descriptive Findings, along with the prayers that are offered up for one another, individuals demonstrate support for each other during times of illness through hands-on support as well as in sharing health information and treatment knowledge. This support is at times seen to be as much a benefit to the individual offering it as it is to the one to whom it is directed.

Family Life writers reflect a strong, fundamental belief in the practice of community care as an important part of God's plan. In a letter to the editor about mental illness, one author questions, "Could not our older sisters, in a Titus 2 role, become prayer partners to depressed younger sisters?" (140). Individuals are encouraged to help others and themselves as they "Rejoice with those who rejoice, weep with those who weep. Help to bear another's burden" (122), "Do whatever possible to bring encouragement to the lives of others. Watch for sunshine breaking through on their faces. It cannot help but bring a sunbeam to you as well" (141) and recognize that "Involvement in helping another nurtures a love for others that gradually displaces the self-interest, fear, worry, anger, etc. in the heart" (140).

As indicated in the selected excerpts above, a formal call to help those in difficult times is found particularly in relation to discussions of mental illness. Whereas mention of help during physical illness is valued and noted, it is more typically made in passing, possibly indicating that individuals may be more comfortable in offering and receiving support for physical concerns. For example, in the course of stories writers mention experiences of receiving help when faced with an overwhelming hospital bill or trying to care for a sick baby.

In discussions of mental illness, however, there is a repeated *call* for individuals to reach out and help those in distress, demonstrating that this is not always an automatic or easy pursuit. Individuals speak of their fear of appearing weak or unable to care for themselves, while others tell of those who shy away from difficult issues such as mental illness within loved ones and community members.

In a community where there is this common expression of the need for community care and an internal support network, the apparent difficulty with finding and providing support for those struggling with mental illness is striking and potentially difficult. Combined with a lack of differentiation between the types of mental illness, the belief in a spiritual cause and cure for mental illness, desire to care for oneself, and a lack of understanding and/or appreciation for the methods of mental health practitioners, a lack of confidence in community supports may create a situation where individuals suffering from emotional illness may be less likely to seek the support of those close to them. In the attempt to work out their difficulties alone and cure themselves through their relationship with God, there is the potential for an individual to become severely ill before outside assistance is sought.

Discussion regarding the treatment of mental illness in the previous chapter highlighted the stories of personal struggles with mental illness as well as the discussion of the Sad File by the editors of the magazine and demonstrated that some individuals are not finding the support they need. In addition to these writings, some recent research and discussion appears to suggest that mental illness is a growing concern in some Old Order communities.

In a study involving observation and interviews with 50 individuals in the Old Order Amish community, Reiling (2002) learned that although they reported high rates of depression, the Amish were reluctant to seek help and, consequently, had a low level of utilization of mental

health services. The author found that boundary maintenance is a barrier to help-seeking behaviour in this population. She adds that two social control mechanisms at work in the development of this boundary maintenance are a belief in the spiritual roots of depression and the lack of acceptance of mental health practitioners as legitimate sources of support.

Additionally, an Amish woman, Rebecca Huyard Smoker, who serves as a liaison between her community in Lancaster county (Pennsylvania) and a local clinic, recently spoke about the mental health situation among the Amish to a group of mental health practitioners (See Hawkes, 2002). Noting difficulties associated with a commonly-held belief in the spiritual roots of mental illness among Old Order people, a concern with appearing emotionally weak, a distrust of psychiatrists, and a preference for alternative treatments, Smoker contends that while some progress has been made, more needs to be done to meet the mental health needs of this community. It is difficult to gauge the severity of this concern based on the writings in *Family Life*, but findings indicate that this may be a growing concern in the community and one worthy of further consideration.

Clearly, the links between trial, struggle, and support are not always seamless and not always perfect, but in combination with a belief in the active presence of God, an orientation toward community care appears to create an important infrastructure within this cultural group to help individuals deal with the physical and emotional cost of illness and in the struggle to accept God's Plan in their lives.

Final Summary

The question

In response to research demonstrating that the Old Order community presents a unique cultural and health experience, a basic question was proposed: How do Old Order individuals understand health? From this root, the study presented here developed through the belief that a fuller understanding of health in a community can be achieved by looking at how individuals discuss health away from researchers, away from health professionals, and in the context of daily life.

This study considered "lay models of health" (James & Eyle, 1999, 87). Recognising that culture is learned, operates as a web in the lives of individuals, and defines the shared boundaries within a cultural group (Hall, 1976), this study explored how Old Order individuals define health, what is believed to be the most important factors affecting health, how illness is understood and treated, and how culture is linked with understandings of health. Although not often given the time or attention they deserve, these central issues help define the choices individuals make and the health risks and benefits they potentially face.

The approach

For this study I chose to employ a research design that would be in keeping with my understanding of the nature of reality and would provide an opportunity to achieve the research goals while also reducing the impact potentially wrought on Old Order individuals themselves. To this effort a constructivist-interpretive approach was adopted and a hermeneutical methodology selected.

These approaches to research acknowledge that reality is created and subjective and that the texts of a community offer tremendous opportunities to explore the realities of cultural

groups. We each bring innumerable considerations to our understanding of any experience, including health, and hermeneutics provides a researcher with a method aimed at understanding the intentions of the author and the importance of the text for the reader while acknowledging the author-interpreter relationship (Crotty, 1998).

For those within the Old Order community *Family Life* appears to provide a valued avenue of connection, information, and entertainment. As a researcher, I found that the writings also provided an opportunity to observe how beliefs about health naturally emerge within a community-based publication. I have been able to hear the voices of Old Order individuals engaged in conversations that are unguided by the influence of an outsider.

The opportunities are not without their qualifications; though. The analytical limitations of this data source are related to the inability to consider demographic differences, the reality that the voices of those who do not submit writings will not be heard, the inability to explore ideas mentioned only in passing, the lack of opportunity to involve individuals in the process of understanding and explaining emergent patterns and themes, and the impossibility of conducting a member check. While I am a witness to an in-group conversation, it is one that began without me and will continue long after I stop listening. Immersion in two years of *Family Life* has provided me with an opportunity to hear hundreds of voices, but my knowledge about the speakers is limited.

More fundamentally, it is an important acknowledgement that all research is intimately tied to the experiences of both the one who asks the questions as well as those who contribute to the answers. I have been continually aware of the many possibilities present for misinterpreting statements or misdirecting focus throughout the course of this study. While I have used a process of reflexivity to keep watch on potential areas of bias in this research pursuit, my

personal background, my education both within and outside of the classroom, and my relationships with individuals in this community are woven into the inception, the development, and the results of this research.

This variety of influence as well as the nature of the approach to the data contributes to a process of qualitative research that has proven to be "filled with chaos and order, predictability and surprise, confusion and great clarity, many commonalities and as many inconsistencies" (Dupuis, 1998, 55). The fact that research is never without both challenges and opportunities has been a constant reality amidst the subjectivity.

The findings

With its limitations and opportunities, the selected research design for this study has proven to be an effective tool in the process of learning about some of the stated understandings of health in this cultural group. The findings were divided into two chapters, the first descriptive and the second interpretive. In the provision of different aspects of the overall picture, each chapter is an important part of the pursuit to identify some of the health-related norms, beliefs, and values in this community and the effort to complete the larger image of the nature of the culture-health relationship among the Old Order people.

Descriptive

The Descriptive findings presented analysis that considers what is being said about health in the pages of *Family Life* and sought to organize these considerations into broad categories of Health and Illness. In this chapter an attempt was made to simply present the words of the Old Order people as they speak for themselves. On the topic of health, text was introduced that illustrated a tendency to define health by an individual's ability to fulfill his or her role in the community.

Nutrition and reproduction were central among the determinants of physical health and an individual's relationship with God was discussed as a source of mental health or illness.

Emotional and behavioural responses to illness were discussed with the former including elements of a desire to accept the experience of illness as a part of God's plan, a struggle to find this acceptance, and the incorporation of community support throughout this pursuit. Behaviourally, it was demonstrated that health information is transferred in the Old Order community through knowledge provided by health practitioners, family and community members, and from advertisements, outside readings, and contacts. These methods of information transfer appear to be integrated to various degrees in decision making.

In the decision to take action for health concerns, the writings indicated that individuals are slow to seek treatment and elicit professional care primarily in situations of significant limitations or concern. Individuals expressed concern with appearing too quick to seek treatment and seemed to incorporate a range of financial, spiritual, and traditional considerations into the decision of whether to use heroic measures or prolonged treatments situations of illness.

In the treatment of physical illness, the writings suggested that individuals seek to incorporate a range of methods for achieving and maintaining health. Making use of both allopathic and complementary treatments, the discussions indicated that in keeping with their reluctance to seek medical attention too quickly, individuals appear to care for themselves through home remedies or non-medical measures for as long as possible. In situations of acute illness, however, there was suggestion that individuals are comfortable with seeking formal medical care. Concern identified in the literature review regarding use of questionable cures was supported in the *Family Life* text. Although discussion was limited, there was a clearly

expressed unease related to the use of methods of healing outside the realm of quality allopathic or naturopathic science by some community members.

Writings that spoke to the treatment of mental illness supported previous indications that this struggle is largely understood as a spiritual concern. Amidst some recognition of a physiological root of depression and other forms of mental illness, a majority of the writings suggested that community involvement and support are an important part of treatment and the process of refocusing an individual's concentration toward God rather than the self. A couple of individuals noted the benefit of trained mental health practitioners, but comfort level with the work of these outsiders was clearly mixed.

Interpretive

Faced with this array of understandings, the next step in the analysis was to identify where the pieces connected and what larger themes were present within the discussions of health. In a consideration of the cultural understandings that guided these submissions related to health and illness, it became clear that one of the primary themes running throughout the writings was a belief in the role of God in determining the existence and experience of life. In the chapter on Interpretive findings, this understanding emerged as the first central theme.

The belief that God is present and active in life is a central foundation to Old Order thought. It is researchers who discuss the relative nature of beliefs, but for the Old Order people this acceptance of God's central role in life is not a matter of discussion or a relative understanding. Individuals express a belief that God is an accessible power who has a plan for each life and is there to guide, comfort, and, if God wills, heal.

Although this is an understanding also shared by other cultural and religious groups, the discussions on health and illness in the Descriptive findings illustrate the unique ways in which

the Old Order community takes action in accordance with the belief in God's defining role in life. On this point, Angel and Thoits' (1987) assertion, introduced previously, is given form: Culture defines and limits the options perceived as possible in the development of understandings of health and illness and in the effort to explain and react to these forces. This Community Response was the second central theme.

Gelassenheit and the *Ordnung* are foundational constructs in the Old Order community and may be a key aspect of the "central truths of Amish understanding" that the Amish woman quoted in the literature review held up as the stabilizing core for Plain people and a point of distinction between her community and others (Stoltzfus, 1994). These concepts demonstrate in the first instance an orientation to life through the yielding of individual will to that of the authority of God and community. Through the formal and informal set of rules constituting the *Ordnung*, individuals are able to identify how to match their behaviours with their beliefs and find a method of living.

Not surprisingly, the Community Response to God's role in life appears to align discussions related to health in keeping with this cultural orientation and method of living. In accordance with the pursuit to place the authority of God and community before the self (*Gelassenheit*), the writings gather into two primary areas: Acceptance of God's plan for each life and the importance of placing community needs and well-being before that of the individual. While these approaches are relatively straightforward, the writings indicate that the goal and the pursuit are not always seamless.

An important finding to emerge from this analysis of *Family Life* is that although individuals in the Old Order community seek to receive without condition the experience of life given to them from God, there are times when this acceptance is difficult to achieve. The call to

accept God's authority in each life is strong, but the faith in God's plan and trust that all happens for a reason does not always provide ready answers or soothe the divergent emotions associated with physical disability, illness, and death. As illustrated in the findings, although eventual acceptance is the goal, individuals express uncertainty, fear, and doubt as they struggle to make parallel their personal desires with the God-given realities of life.

The belief in placing the community before the self is expressed in how individuals define health by their ability to fulfill their role within the larger group and is demonstrated in a concern with drawing too much attention toward themselves through treatments that are costly or perceived to be unnecessary. This orientation that decreases the focus on the self is significantly different than that which defines much of modern society. Through this *Gelassenheit* approach the experience of health is no longer merely an individual pursuit, but one that is defined by a variety of needs that exist outside the self.

The understanding of how God wants a person to live his or her life is shaped and altered by community discernment, but the inspiration is higher. The Anabaptists were created largely from a desire to allow each person the opportunity interpret the Bible for his or herself. This spirit continues as communities study the *Bible* and actively seek to live in a way that they believe is in accordance with God's Will. The analyzed data are insufficient to assert that the approaches highlighted here are part of the *Ordnung* in all Old Order communities, but the strength of the belief and consistency in understandings presented here indicate that they are important and may represent fundamental understandings or unspoken rules.

Descriptive findings related to determinants of health and emotional support during times of illness are among those where discussion of the ways in which one should pursue life are particularly focused. An approach to life that is seen to be in keeping with the Will of God

includes elements related to such practices as nutrition and reproduction as well as the provision of community support during times of emotional and physical illness. In these discussions it is clear that there are some basic understandings that lead individuals to choose from a variety of paths to health. While the interpretations and the details may shift from community to community, this goal of following God's path remains the same.

The experience of mental illness, however, is an example where the community care structure is not entirely supported. It may be a combination of a lack of understanding regarding the nature of this form of illness as well as the belief in the spiritual root of emotional struggles, but the writings demonstrate that individuals do not always feel the support of their community during these trials.

While some characteristics of Old Order practice, faith, and health experience introduced throughout the Literature Review were not addressed in the discussions of health in *Family Life*, findings presented in this study are largely consistent with prior research. Additionally, despite the fact that a lack of demographic information frustrates analysis somewhat, this method has also lead to findings that present some possibilities for new understanding.

Demonstrating points of concern as well as achievement, the Findings are relevant, believable, offer multiple perspectives, and are tied closely to the words of the people who submitted their thoughts to *Family Life*. The descriptive information and the themes that emerged from the analysis provide, through both detailed and broad considerations, an overall picture of the health perspective of the Old Order people and a starting point in understandings.

Final thoughts

It is not suggested that the findings and themes presented in this study are the only forces at work in this culture or that they explain all health-related understandings, behaviours, and experiences

in the Old Order community. Discussions about health occur throughout *Family Life* without individuals making direct reference to God's role and there is certainly a range of potential influences on health knowledge in this community; while they choose not to *be of the world*, the Old Order people are still *in it*. Nor can it be asserted that all Old Order individuals or communities face the same health challenges and define the same areas of emphasis.

What has been demonstrated through this analysis, however, is that while these forces do not act in isolation, may shift across communities, and the words are not always spoken, the strong belief that God determines life and that communities respond directly to this understanding through their health related attitudes and beliefs is key to understanding the culture-health connection in this community. These themes are found outside of the community studied here, but entwined with the distinct history, evolution, and environment of these people, they create amongst the Old Order people a distinct "cultural web" (Hall, 1976) and an approach to health that is inimitably their own.

Taken together, the voices in *Family Life* tell a story of how one group of people understands health, illness, and life itself. At its most basic, the story is one of a people's relationship with their God. The belief in God creates a reality of existence. Individuals respond to this reality in a number of ways. As the understanding of God's plan develops, so will the response. What makes this story of health unique is not so much the specific choices made when seeking health or facing illness, but the perspective on life put forth by the Old Order people and their journey in translating these beliefs into practice.

Our own culture is largely invisible to us. When we encounter communities that are significantly different from our own in regards to dress, language, and way of life we are tempted to question why they have made the choices they have. We forget that our lives are as well a

product of a very specific cultural dynamic – a dynamic to which we give very little thought. Kraybill (2001) writes:

> "If you ask Amish children why they dress the way they do, they are likely to simply say, 'Because that's just the way we dress'. Some adults could supply a more elaborate answer, but most would have to pause before doing so in the same manner that modern men pause when asked why they wear ties […] After reflection, Old Orders might comment on the importance of simplicity, separation from the world, or humility, but these are legitimating accounts that are only invoked after the question is posed. […] The ordinary things we repeat day after day are not that well thought out. In a word, tradition's residence is at the intersection of habit and deliberate action. For most Old Order this is a broad intersection, and even for many moderns it is much broader than they would like to think" (246-247).

As are the clothes we wear, our relationship with health is largely defined by our culture. Unless questioned, we are unlikely to place our beliefs into formal statements, but they are evidenced in the ways in which we speak about life, health, and illness.

The understandings and themes presented here emerged in the course of Old Order stories, poems, conversations, questions, and statements. The writings that join together to create the Findings of this study were not brought forth by a researcher's question about health, they were created by individuals who have made a personal decision to share their ideas, concerns, and beliefs about the events of life. In this context, as an observer, I was able to consider health understandings in many cases at the point before legitimization.

The findings presented here must always be understood in light of the limitations of the data source, the methodology, and the researcher. My ultimate hope for this study is that it helps to illustrate how cultural perspective and an individual's framework for living guides both health understandings and the process of decision-making. This is a lesson that can be applied not only to Old Order populations, but also with any cultural group. While our bodies may share the same physical characteristics, our culture profoundly shapes our sense of reality and, consequently, our experience of health.

Influenced by history, geography, consciousness, and chance, the Old Order community has developed into a culture that appears to thrive. Separate but aware, they demonstrate an ability to recognize their limitations, control their pursuits, and care for one another along the way. Although not perfect, the way of life they pursue has many important lessons to teach. And there is much more to learn.

Considerations

This research is held up as significant in two primary ways. As discussed, at a theoretical level it is hoped that this approach to the study of health will encourage appreciation of the learning that can be achieved by taking a broad view and considering the cultural factors shaping health perceptions and behaviours. It has been noted that health understandings and actions are entwined in our system of "cultural norms, beliefs, and values as well as with social structure and environmental conditions" (Loustenau and Sobo, 1997, 1). Allowing this reality to help shape not only research preparation and methods, but also the approach taken in defining research questions may allow researchers to take their studies in new directions and seek out understanding that is relevant and context-based.

More practically, it was hoped that by constructing an image of the Old Order perspective of health, an information base could be provided to Old Order people, and the practitioners and researchers who interact with or study this population. While this remains a goal, because of the nature of the data and the analysis, which considered stated beliefs and practices, it is not possible to provide specific recommendations. Instead, in this study emphasis is placed on identifying *areas of consideration* or *insights* related to the potential costs *and* benefits of the Old Order approach to health as expressed in *Family Life*.

Considerations for Researchers

Considerations for researchers have been examined throughout the literature review, methodological sections and in the discussion of how this study relates to others. In particular, researchers may find benefit in developing a stronger understanding of some of the cultural characteristics of the group they are studying prior to designing their study and collecting data. This development of cultural understanding may arise out of direct communication with members of the community as well as through a self-education process that can be based on community documents and literature.

Cultural understanding can also help define the methodology chosen and the process of interpreting the findings. Because of the high literacy level of the Old Order people, the apparent comfort with sharing information through *Family Life*, and the difficulty in transcending cultural barriers, analysis of written documents proved an effective method in this study. Another population, however, may not be developing accessible written documents or may use them with different goals, necessitating adoption of another method. Clearly, findings based on incomplete understandings and recommendations that are not in keeping with the cultural reality of the studied population may obscure relationships and be of limited use to practitioners.

Future Research

More directly to the population considered in this study, there continues to be more learning to be done related to the Old Order belief system regarding health. While there are benefits to be reaped from what is presented here, throughout the literature review and analysis many questions were introduced. Among the considerations for researchers is the need for further investigation into the relationship between statement and action; perception and practice. One *Family Life* writer alludes to this connection as he contends, *Preaching about death and facing it are two*

quite different things (J.E.M., Family Life, October 2000, 7-9). Matters of health challenge us and may threaten or deepen our beliefs. This study considered statements of belief and reported behaviours, but what would one learn through directly observing the health behaviours in this community?

A follow-up study to this project may find benefit in going directly to Old Order individuals and those health professionals who interact with them to further explore findings established here. Such a study could take the questions studied in this work to the next level by exploring whether beliefs and practices stated in publications coincide with or differ from those expressed in daily life. Personal interactions could also allow the researcher to pursue potential geographical, age, and gender differences in health understandings and identify specific health-related recommendations.

The method used here could also be extended by analyzing previous issues of *Family Life* and pursuing trend analysis. How was health discussed in the first years of publication? Was there more or less discussion of mental health among the Old Order people in previous years? Are the themes emergent here similar to those from forty years ago? Such an investigation would also allow one to consider issues that may potentially impact health understandings such as the impact of decreasing farmland and increased contact with outsiders.

Similarly, there may be benefit in considering what other publications in the community have to say about health. How are young people discussing health in the pages of *Young Companion*? What is being taught to children in school? How is health discussed in individual work produced by Old Order persons? Such analysis would allow for consideration of the differences related to target audience, author goals, and medium.

And finally, a particularly interesting study could be focused on the differences and similarities between the Old Order perspective of health discussed here and that expressed by other Mennonite groups. Such a study may offer opportunities for an examination of the distinct differences within the larger Mennonite community and how lifestyle interacts with beliefs.

Considerations for Old Order Individuals

It is hoped that the findings presented here will also be of relevance to the Plain community as an opportunity to compare personal understandings and behaviours to more general observed trends. Individuals within the Old Order community may not feel that all of what is presented here resonates with their personal experience, but there may be benefit in the *process* of discussion and the highlighting of some perceived areas of strength and concern.

Considerations for Health Care Practitioners

Recognising that any discussion of considerations is moderated by the fact that further study is necessary to determine how the stated beliefs in *Family Life* translate into action, some suggested areas of interest for health practitioners and organizations are also offered. This discussion is necessarily broad based on the information available.

Awareness of cultural beliefs

The most central consideration offered here is one that should be found in any study recognizing the importance of the culture-health relationship: The study and practice of health must be based on an understanding of the cultural factors at work within a community. Budget restrictions and regulations limit the flexibility of health professionals, but an active and guiding respect should be given to community norms and beliefs in the pursuit of offering quality care and treatment.

In regard to the community studied here, treatment for mental or physical illness should be offered with an understanding of the profound and guiding influence of religious beliefs in Old Order life. It is not important whether or not an individual personally agrees with the beliefs expressed within the two central themes, but respect should be given to the importance they hold in the lives of the individual who subscribes to them.

Beyond this central understanding the discussion offered in this section is presented as potential areas of consideration. How these are evaluated or incorporated is dependent on the specific situation and needs of each Old Order community. In this way, greatest benefit may be found in reviewing these findings and conclusions with local leaders and interested individuals in the Old Order community and determining together what may be necessary in the process of developing a positive relationship and health experience.

Communication

To provide quality care, there is the need for trusted and respectful communication paths between researchers, health practitioners and clients/patients. Individuals within the Old Order community have demonstrated a clear willingness to incorporate the assistance of medical professionals into their lives, but a health care worker who demonstrates accurate knowledge and honest appreciation for the beliefs and practices of their clients may develop a more successful relationship with these people than one who does not.

In particular, while a practitioner should not forgo the opportunity to develop a positive relationship and discuss a range of health related issues directly with the individual Old Order client, there may be benefit in indicating a respect for community systems by establishing formal connections with community leaders. These links could help to ensure that both sides are accurately being informed about current and potential areas of concern. As has been noted, the

Plain community is a high-context culture coming into contact with a dominant and largely low-context society; the opportunities of miscommunication are high.

Maintaining health

The findings indicate that health in this community is very much based in the context of life and is focused on living a life that is understood to be pleasing to God. This is at least part of the reason why issues such as nutrition, reproduction, and prayer are deemed important areas of discussion and improvement whereas individual-focused, non-purposeful pursuits, such as adult sports, is not viewed as appropriate.

Although activities with the primary goal of relaxation, personal development, or improved physical health can be important tools in health maintenance and illness recovery, I do not propose that the high presence of extrinsically-motivated activities in the Old Order community is a problem within this cultural group or leads to a deficiency in well-being. A different study would be necessary to comment directly on the presence and role of non-purposeful activities in the lives of these individuals and in relation to their health experience.

In this study focused on health understandings, I hesitate to go beyond what is already part of the community and suggest additional leisure-type activities that may be of benefit to mental or physical health. There are too many cultural considerations to be made by Old Order individuals themselves. Further, the importance of appreciating the need for purpose in activities should not be underestimated or devalued.

In accordance with this understanding, there may be benefit in seeking new opportunities within existing community networks and activities rather than introducing unknown activities. In other words, rather than introducing yoga as a method of relaxation or increasing flexibility, it may be a better path to emphasize positive aspects and recognize costs of current (purposeful)

practices such as children walking to school or adults working together to prepare a homemade feast following vigorous activity such as harvest work.

There is much knowledge already within the community and benefit may be found in drawing attention to some additional mental and physical health benefits and costs. These efforts may increasingly be important as individuals are drawn away from the rhythm and physicality of farm life and work due to decreasing availability of land in some communities.

Seeking treatment

As has been noted by other researchers and indicated in these findings, a belief in the healing power of God, a focus on maintenance of role as an indicator of health, and a situation of self-pay for health care may result in underutilization of the mental and physical health care system by the Plain community. The perceived reluctance to seek out medical attention in this community may be exacerbated by the speed at which the rest of society is turning to hospitals for the treatment of both minor and major concerns. In other words, in the question of frequency of medical visits, the concern may lie with the rest of society as well as with the Old Order community.

That said, individual health care organizations might find benefit in being aware of the potential needs of their Old Order clients who do not visit as regularly. It cannot be assumed that a lack of regular visits from Plain individuals means that all is well. Particularly, in the case of illnesses where early detection and rapid treatment are crucial to survival or may reduce long-term costs (for example, breast cancer, diabetes) it may be important to talk directly with clients as well as with community leaders.

Research suggests that individuals are receptive to practical, relevant, and quality health information, particularly if it is shared within the community. Through work with local leaders

or interested individuals, key areas of concern can be identified and culturally appropriate information disseminated regarding the ways in which individuals can monitor their own health as well as develop awareness of when it is necessary to solicit help. In this way individuals will not be fatigued by matters that are less of a concern to them and will have the security of knowing that those they trust have been involved in the process.

A similar concern is the support offered to Old Order individuals experiencing loss through illness or death. Although known for their stoicism, strong community supports, and belief in God's plan throughout times of health, illness, and death, it has been demonstrated that this belief does not always automatically translate into acceptance. In fact, many individuals do experience a sense of struggle and may be in need of additional supports. While they may prefer to seek aid within their community or through their relationship with God, this may also be an opportunity to educate individuals and community members about the services offered through mental health professionals and grief counselors. It would not be appropriate to put pressure on individuals to accept these methods of treatment, but by offering quality information about these services some possible misconceptions may be dismantled.

Complementary approaches

Old Order individuals may be more likely to accept an approach to healing that is not overly dependent on medication. The analysis revealed a preference to take care of one's self for as long as possible and an appreciation of alternative methods of treatment.

Individuals from this community may be willing to take a longer-term approach if it is seen to be more practical and less damaging to the body. Again, individuals appear to be receptive to quality information that makes sense and is respectful of their perspective. Safely incorporating quality complementary methods of treatment may both increase the individual's

comfort with treatment as well as allow for a practitioner to educate about the dangers of questionable cures.

Speaking more directly to the potential for acceptance of disinformation and health scams, *Family Life* demonstrates that there are members of the community who are aware of these threats and want to enact change. On this point, the benefit of trusted communication paths between the medical community and leaders within the Plain community is reiterated. In addition to being aware of what other treatments an individual under care is pursuing, on-going discussion between health professionals and community leaders may help to address difficulties associated with the circulation of disinformation.

Mental Health

The data provided here is not sufficient to make judgment on whether or not the treatment path supported within the Old order community for mental illness is the most effective for them. As well, the increasingly medicalized treatment of depression and other forms of mental illness in North American society is not upheld here as the benchmark of acceptable treatment. In fact, other cultures may benefit from an examination of how this community addresses mental health concerns. Specifically, acknowledging and addressing the roots of depression rather than just the symptoms and the suggestion that one path to better health may be found through helping another person are particularly striking in our individualized society that seeks quick answers and personal solutions.

Should mental illness emerge as a concern, however, health professionals may find benefit in approaching the situation with a respect for the Old Order belief in the role of spiritual healing and work with community leaders to determine the best way to provide assistance. This may be through the provision of written information, offering talks on mental health and the role

and practices of mental health professionals, or even developing programs that address the specific needs of Old Order persons. As with the larger society, a significant concern related to mental health in this community is the lack of information about its causes and treatments.

A dialogue regarding mental illness may be difficult to begin in this community, but is possible. As introduced previously, members of a Lancaster county Amish community have worked with local professionals to establish treatment homes to serve the mental health needs of Plain individuals in that area (See Hawkes, 2002). Central to this arrangement appears to be the involvement of trusted, understanding persons who are working *with* Amish persons to develop programs and centres that offer culturally-appropriate treatment options.

Considerations summary

While the topics discussed here are some of the key areas of concern that appear to extend throughout the writings, they are not the only considerations that could be extracted from this research. Each reader brings specific points of interest to this study and is encouraged to incorporate both the descriptive and interpretive findings in ways most appropriate to him or her.

As well, this culture will continue to shift in the face of challenges and, based on these analyses, there is reason to be believe that *Family Life* will continue to be an important source of information about the stated beliefs and practices of Old Order individuals. Respectful use of the publication may allow individuals in contact with this population an opportunity to observe the development of community understandings.

Amidst these considerations a call for trust in the Old Order community is also offered. With an acute awareness of their own limitations, these people have demonstrated on a range of issues their ability to effectively handle struggle within their own community and by themselves. This cultural group has existed for over a century and is notable for its relatively successful

health experience. In fact, practitioners are encouraged to consider the areas in which Old Order people excel and determine whether aspects of their approach could be adapted and extended to individuals outside the community. Finally, it is important to maintain awareness of the fact that among these "cultural conservationists" (Kraybill, 2001) change is carefully planned and must not be seen to threaten religious beliefs, family stability, or create conflict.

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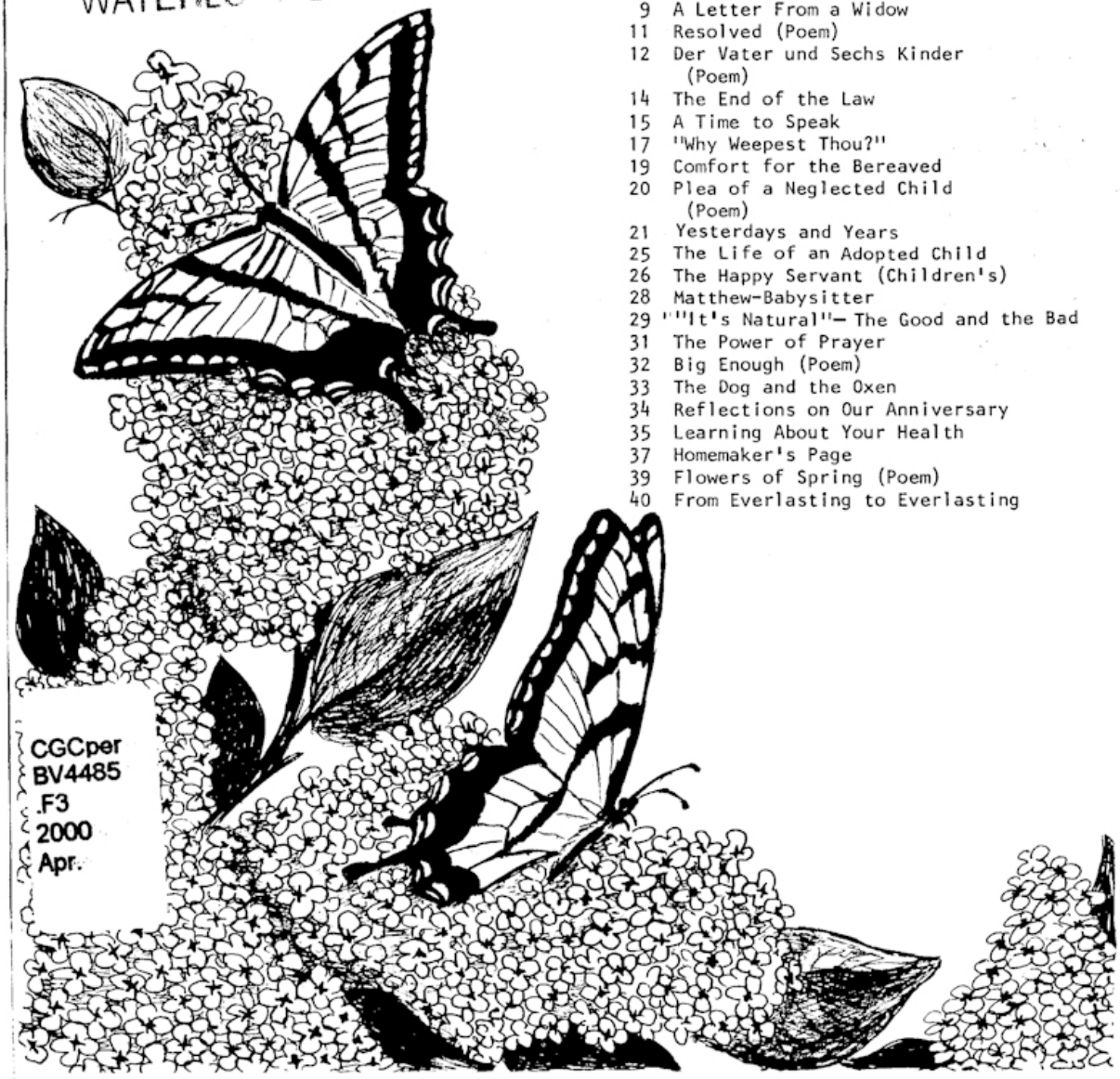
Appendix A: *Family Life* Excerpts

FAMILY LIFE

April 2000

Contents



Letters

TO THE EDITORS

A GOOD BALANCE

"A Time To Speak" promises to be an excellent serial. It is good that you print stories about single people sometimes, for we also come from families and have struggles relating to family members even though we are not married and have no children of our own. I would not keep getting *Family Life* if its whole emphasis was only child rearing. I know that for families in the thick of raising their children, these articles are very timely and much needed; but the whole spectrum of our lives includes more than that. I am glad for articles on managing money, single life, old age, and dealing with our neighbors and fellow members. I believe we are getting a good balance in *Family Life* and thank those who are responsible for each issue.

-A Single Subscriber in Alberta

A LISTENING EAR

The short article, "The Best Side", in the February issue was a day brightener for me, a mother of three teens going with the youth groups. At times their Monday blues are overwhelming; now I hope to think: "Yes, they need help with their worst side!" And, of course, the best side they can handle.

Many prayers are needed from us mothers on how to guide and speak to our children. Sometimes they just need a listening ear. It can be our most valuable work in a day. Try to take time to be alone with your children; it is surprising how they can pour out their hearts' contents better. Even if it happens only a few times a week, these are worthwhile moments. And keep the Good Lord in your heart.

-A Mother Still Learning in PA

COUNTING OUR BLESSINGS

"Acceptance is very important." How true are these words — not only for the childless couple, but for everyone. Although married over five years, we are a childless couple. So when the February issue came, the title "May I Hold Your Baby?" caught my attention immediately. The story was very well written. Thanks to the author for using her writing talent and letting us know we are not alone. For we are also the only childless couple in our community except the young married ones. I find that counting our many blessings helps me to accept it easier, even though that doesn't fill our arms on Sunday when other mothers are holding their little ones.

-Another Childless Couple, WI

EMPTY ACHE WAS FILLED

Thanks so much for the article, "May I Hold Your Baby?" I know just how Nancy feels on Sundays — the ache of empty arms. To mothers with babies, I would like to say not many of us will refuse when asked if we'd like to hold your baby. I have had the privilege to hold a baby in church a few times, and it did wonders for my spirit. The empty ache was filled for a few hours. A mother who can hold a baby every day of the week can not imagine what holding her baby can do for a woman who is not blessed with motherhood.

-Empty Arms in Ontario

A CHANGE IN MENU

Thanks so much to the author of "May I Hold Your Baby?" in the February issue. I found the "change in menu" very appetizing. The feature series, "Leading the Lambs", is good, wholesome reading; but the fact remains, there are other people who need to be fed besides parents. Sometimes the menu gets a little heady and hard to digest. So thanks for the change.

-A Reader in Tennessee

A DAILY HOURLY JOB

I want to thank the author for having courage to write "May I Hold Your Baby?". I too thought it was time for a change in the menu; but I did not see how I could complain

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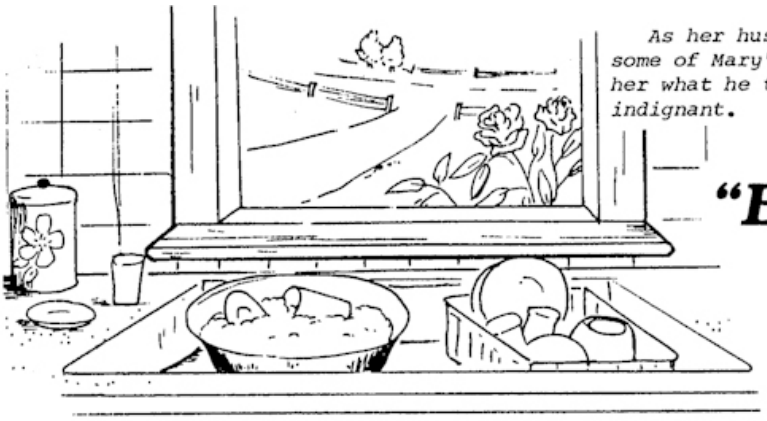


As her husband, Reuben was disturbed about some of Mary's attitudes. He tried to tell her what he thought was wrong, but she was indignant.

"But It's Not Pride!"

-By one who has also struggled with feeling inferior

MARY TURNED OVER AS the beep, beep, beep of the alarm clock interrupted her fitful sleep. Her husband, Reuben, got up and shut off the annoying sound.

"How are you feeling this morning?" Reuben asked when he saw that she was awake. "Is your headache better?"

Mary sat up and put her legs over the edge of the bed. The room spun around.

"No, I think it's worse," she answered. "I feel dizzy."

Reuben looked concerned. "I hope it's just this flu that's going around and not something worse. Why don't you stay in bed a while longer?"

"But who will pack Sara's lunch and comb her hair? And Jacob and Ruth might wake up soon, too..."

"I will wake Sara, and she can pack her own lunch. She usually helps anyway, doesn't she? I'm sure she and I can fix a breakfast of oatmeal and toast. And she can help Jacob get dressed if he wakes up. When Sara is ready to have her hair combed, she can come in here to you. Maybe you can sit on the edge of the bed and do it."

Mary knew there was no use arguing. With a weary sigh, she lay down. Soon she drifted off into a light sleep again. Reuben left the room.

An hour later Mary awoke. She listened for sounds coming from the kitchen. "Here, Jacob, can you put that in my lunch box?" Sara was asking. "There, that's right. Now close the lid. That's a good boy."

"What a lazy mother, staying in bed while my husband and children get breakfast!" Mary thought to herself. "Maybe if I force myself, I can still get a decent breakfast for them."

Mary stood up. The room spun around again. Holding onto the edge of the bed, and then the dresser, she made it to the closet. Finally she was dressed, but the effort had made her very tired. She sat down on the edge of the bed.

Sara knocked on the door. "Dad said I'm to come in here when I'm ready to have my hair combed. Oh, Mom, your cheeks are all red!" she exclaimed.

"I have a fever," Mary answered. "But if you bring your comb and water, I think I can manage to comb your hair."

Sara hurried to get the needed supplies. Mary began combing Sara's hair. The effort exhausted her, and she lay down again when she was finished.

When breakfast was over and Sara was off to school, Reuben came into the bedroom.

"How are you feeling?" he asked.

"Not so good," Mary responded. "I took my temperature, and it's 102.8 degrees."

"I think I will go and ask Anna if one of their girls can come over," Reuben said.

"Oh, no, please don't!" Mary looked horrified. "I can't let them see my house in a mess like this!"

"But you do need help, Mary," Reuben said. "Today's wash day, isn't it? And how are you going to take care of the little ones?"

"I'll manage somehow." Mary was determined. "I'll go out on the sofa, and the children can play on the floor beside me. The wash can wait. I won't have anyone coming into this house when it looks like it does now. Why, I only have three children, and the house looks worse than Emma's. And she has five children under school age."

"I've been in Emma's house when it *looked* like five little children lived there," Reuben said mildly.

Reuben saw that Mary was determined, so he soon left the bedroom. She heard him talking to Jacob; then she heard the outside door open and close.

"Maybe I should have listened to him," she thought half guiltily. "I know he really is concerned. But, no—no one will see my house looking like this!"

Mary got up and walked dizzily to the sofa. Jacob came running. "Mom sick?" he asked, looking at her with sober eyes.

"Yes, Mom is sick," Mary answered. "Can you play quietly here on the floor?"

Der Vater und Sechs Kinder

A TOUCHING GERMAN POEM, "Der Vater und Sechs Kinder", along with its translation, appears in this issue. This poem was submitted to us by a teenage reader from the state of New York in response to our discussion last month on caring for the elderly. Due to a mistake in sorting the mail, it did not reach us until after the deadline for the March issue.

I do not recall ever having read this outstanding poem before. Curious as to its origin, I wrote to the person who had submitted it. Did she know who the author was? Where had she obtained the poem? She replied, "I have absolutely no imformation concerning its origin or its author. I'm not even sure where I copied it from. It may have been in Die Botschaft several years ago."

We predict this is a poem that will become more widely known in years to come. Portions of it are suitable for quoting in sermons, to bring out our responsibility to our aged ones.

We would be glad to hear from our readers who know more about this poem. Where has it been printed before? What is its origin and history? Let us hear from you. - *J.S.*

Einst hat ein Vater treu ernährt
Sechs Kinder die ihn Gott beschert
Und schaffte unverdrossen,
Und allezeit mit groszer Fleisz
Sie zu versorgen, ist das Schweisz
Ihm von die Stirn geflossen.

Die Kinder wuchsen steig heran;
Der Vater war ein alter Mann,
Die Mutter lag im Grabe.
Da teilt er seinen Kindern aus
Was er besasz, sein Feld und Haus,
Und alle seine Habe.

"Sechs Kinder habe ich ernährt,
Bei denen will ich sein auf Erd,
Bei sie mein Nahrung finden."
So dachte er im seinem Sinn
Und geht zu seinem Ältsten hin,
Der wohnte bei den Linden.

Der nun der gute Vater war
Bei diesem kaum ein halbes Jahr,
Da ward's dem Sohn schon bange.
Er denkte hin und denkte her —
Die Wochen, Tage, zählte er,
Der Vater bleibt zu lange!

Und eines Tages bat er ihn
Zu seinem Bruder doch zu zieh'n,
Der hat ein groszes Stube.
Es wird ein Kind geboren heut;
Der Raum ist eng, es tut ihm leid;
Auch brüllet viel der Junge.

A FATHER AND SIX CHILDREN

Once a father faithfully nourished
Six children whom God had given him,
And labored long and tirelessly;
And ever as with great diligence
He sought for them to provide,
The sweat from his brow did flow.

The children rapidly grew up,
And the father became an old man,
The mother lay in the grave.
So he divided among his children,
What he owned, his field and house
And all he did possess.

"Six children I have clothed and fed,
With them I wish to dwell on earth,
And find my nourishment."
Thus he thought,
And went unto his eldest son
Who lived among the linden trees.

Now when the honorable father
Had dwelt by him scarce half a year,
Already the son became troubled.
His thoughts went here, his thoughts went there,
The weeks and days he counted.
"My father stays too long."

One day he entreated him,
To move on to his brother
Who had a large and spacious room
For today a child is to be born,
It will be too crowded (he is sorry),
Besides, the babe will cry a lot.

How the *DORDRECHT CONFESSION* Came Down To Us

by Joseph Stoll

IF YOU HAVE A GOOD memory from school days, you may recall the date Christopher Columbus discovered America – October 12, 1492. When we turn to church history, there are other dates that are important yet may be less familiar to us. One such date is April 21, 1632. That was the day our Confession of Faith was signed and adopted at a meeting in the town of Dordrecht in Holland.

If we read in the *Martyrs Mirror* and elsewhere, we find other confessions which our Anabaptist forefathers left back to us. But none of them has been as widely accepted and as much used down through the years as the one that was drawn up at Dordrecht in 1632. Today nearly all the members of our Amish and Old Order Mennonite churches can recall having been instructed in these "Eighteen Articles" before baptism. Yet the interesting story behind this confession is little known.

For instance, few people today are aware that the Dordrecht Confession resulted from a peace meeting where the two opposing sides of a church split laid down their differences, forgave each other, and were reunited. Few people realize that only one copy of the first Dutch printing of the Dordrecht Confession is known to have survived to the present. Likewise, it is not commonly known that the Dordrecht Confession played a leading role in the Amish Division, nor that at one time in Switzerland the confession was revised so that it had *nineteen* articles of faith instead of eighteen.

Also, you may not know that in some Amish communities today the young people memorize the eighteen articles before baptism, but the words they learn are quite different since some use one German translation and some another. Only historians are aware that there have been a half-dozen translations into English, and even they may not yet have heard that a seventh one is in preparation.

A Peace Agreement

Contrary to what one might think, the meeting at Dordrecht that spring day in 1632 was not to discuss doctrinal differences or to seek unity in the principles of the faith. The 51 ordained men from sixteen Dutch Mennonite congregations were well agreed when it came to doctrine. They were all of the same Anabaptist faith, all members of the Flemish branch of the Dutch Mennonites.

So why was a peace meeting necessary? What was dividing the Flemish brethren? The story begins in 1586, nearly a half century earlier. Certain unfortunate events in north Holland had led to a major division in the Flemish brotherhood. For several generations the two groups had not fellowshipped with each other.

(Actually, the groundwork for disunity had been laid even earlier, in the 1560s just after the death of Menno Simons and while Dirk Philips was still living. At that time the first important division among Dutch Mennonites had occurred, separating them into two camps, the Frisians and the Flemish. What a tragedy! Part of the tragedy was that it set the pattern for further church splits on both sides.[1])

And thus it came about that in 1586 in the village of Franeker an elder by the name of Thomas Bintgens bought a house from a man who was a drunkard and a ne'er-do-well. Thomas paid the man 700 florins but accepted a receipt for 800 florins to silence the other bidders. Thomas seemingly did this without giving it much thought, but his fellow ministers when they heard of it were aghast. They pointed out that not only had Thomas been dishonest, he should have consulted the man's many creditors before giving him any money.

To his credit, Thomas apologized at once when he was called before the church council and said he would rather pay for the house twice than to offend anyone. But the matter was not so easily settled. His opponents wanted him silenced in his ministry. It appears there had been some underlying tension and the house-buying disagreement brought it all to the surface. Thomas had been a little too strict in his application of the ban upon others, and now he himself had sinned![2] Tempers flared, grudges smouldered, sides formed, and before long the church had been split into two parties.

In the end, the trouble reached far beyond Franeker. Each side banned the other, and thus for years to come there was one church group known as the Housebuyers and another as the Anti-Housebuyers, or otherwise as the Old Flemish and the Flemish.[3] As one generation passed, and then another, it must have become more and more apparent that the two groups were basically alike. There was no justifiable reason for them to be separate. The original reasons for quarreling had been all but forgotten. The time came when an effort was made to reunite.

The reuniting began first at Dordrecht on a local level. The two congregations merged into one fellowship and then sought to spread the healing to other areas as well. A leader in the peacemaking movement was Adriaan Cornelisz, an elder of the church at Dordrecht. He was the man who wrote up the original draft of the "Eighteen Articles" and had copies prepared to bring to the meeting for discussion and approval. He may have also been the one who, on the day of the meeting or afterwards, wrote the lengthy introduction to the confession. In it he reviewed the unfortunate events at Franeker which had led to schism in the days of his grandparents. In the spirit of a sincere peacemaker, he wrote:

continued →

Children's Section

The Happy Servant

"ESTHER, PLEASE RUN TO the basement and fetch a jar of peas." This pleasant bidding came from Mother as she vigorously scrubbed carrots at the kitchen sink.

Twelve-year-old Esther looked up from the book she was reading. Her blue eyes clouded and she sighed deeply as she laid the book on the shelf. With an effort she started listlessly for the basement door.

Mother did not seem to notice the grumpy look on Esther's face as she placed the jar of peas on the cupboard. "Now you may quickly set the table. The men will be in soon." Deftly, Mother sliced the juicy carrots as she continued. "There's a fresh apple pie cooling off in the washhouse and the muffins are in the pantry. You may open a jar of peaches and bring some pickles along, too."

Esther looked disdainfully at the sink cluttered with dirty dishes, then at the table where an assortment of papers, patches, thread, scissors, and patterns had accumulated during the forenoon. "I wish you would have told me to bring the pickles and peaches along the other time," Esther muttered. Giving vent to her feelings, she snatched the items on the table and bunched them together in one great armload. As she headed for the living room, a pair of scissors clattered to the floor and a spool of thread headed across the room, unwinding as it went.

Mother turned around in a hurry. Her lips were set in a straight line. "Esther," she said sternly, "you're too old to act like that. I want you to put everything in its proper place, then set the table nicely. You have been reading too much again lately. That makes you feel unwilling and miserable and lazy. Working helps you maintain a healthy attitude."

Esther did not answer as she bent to pick up the stray scissors and thread. Tears of self-pity pushed at her eyelids. How could she help it that she was the youngest in a family of nine, with an eight-year gap between herself and her older sister? Nobody seemed to understand her and her longing for a sister her own age to work and play with. It had always been that way, but lately the situation had started affecting her in a new way. Little things irritated her and the jobs that were assigned to her became drudgery. Esther took refuge in a whole-hearted devotion to story books.

"If I'd have a sister my age, I would enjoy working and I wouldn't spend so much time reading," Esther's thoughts continued. She was careful not to voice her stormy reflections, however, because she knew her mother's reaction.

"Esther, I cannot help that you have no sisters your age," Mother had often told her. "You would be much happier if you would just accept the circumstances and try to make the best of them."

Esther would try for a while to be pleasant and willing, but right now she did not feel like being sweet. "It just isn't fair," she said darkly to herself.

"ESTHER, PLEASE FETCH a few armloads of wood for me," twenty-year-old Erma requested as she pushed back the damp hair from her forehead. It was baking day and Erma was making a batch of cookies. A delicious aroma hung in the hot, steamy kitchen.

Dad and Mom had left home early that morning to visit relatives in another community, so the two girls were alone in the house.

Esther groaned. She was curled up in her rocker in the living room. "Esther, do this. Esther, do that. Esther, come here and Esther go there. That's all I hear in a day's time," complained Esther in a whining tone. "I'm at a very exciting place in the story. I'll come when I'm finished."

"I need the wood right now. I have to watch the cookies or I could go." Erma's pleading voice fell on deaf ears. Esther was already deeply engrossed in her story book. On and on she read. One chapter merged into another.

Suddenly Esther became aware of an unusual silence in the kitchen. With a start, she remembered the wood. Guiltily, she sprang to her feet and headed for the kitchen. Erma had flung herself on the couch, her cheeks flaming and one arm crossing her hot forehead. "What's wrong?" gasped Esther in a frightened tone.

"Nothing much," Erma answered wearily as she struggled to sit up again. "I guess I'm starting with the flu. My head aches terribly, but I had hoped to finish the baking,

St. John's Wort

I am a person with anxiety and at times fears. A friend recommended I take St. John's Wort. I have been taking it twice daily for a week now and really can't see any difference. On the label it says to consult a doctor before taking it with other medicine; does this mean vitamins, too? Could you give me some information on St. John's Wort and how much should be taken daily?

-A Canadian Subscriber

Answer:

St. John's Wort is an herb, the flower of which yields an extract which has been used for centuries for the treatment of depression. The active ingredient is believed to be hypericin. It appears to have some definite benefit for depression (rather than anxiety) and is reasonably safe. As with many herbal preparations, there is wide variation in the quality and quantity of Hypericum and hypericin preparations available through health stores. Hypericum is the most widely prescribed antidepressant in Germany.

It is not known exactly how this medication works. Side effects are infrequent and mild, the most common being dry mouth, dizziness, constipation, confusion, and rash when exposed to the sun. It is not known how safe it is to take with other medications, but I would not expect a problem with vitamins in ordinary doses. The recommended dose is 300 mgm of Hypericum three times a day. Most antidepressants take several weeks to work, and that may be the case with St. John's Wort also.

There is still much that is unknown about the use of St. John's Wort for depression. It appears to have benefit and to be reasonably safe. Many people who diagnose their own problem seem to take it with benefit. From the medical standpoint, there is still too much information not available for me to prescribe it. Anyone who is seriously depressed to the point of interference with their life or are suicidal, should consult a professional to guide him in the treatment of his problem.

A Distressing Problem

I am a 35-year-old mother. My right ear starts ringing; then right on top my vision is shaky. My eyes don't shake, but all the things I see seem to. Many times I get severe pressure on the right side of my head, and it feels like my brain is being jerked around. The problem is worse when I have knots on the side of my neck. I've had my eyes examined, and they seem fine. Have been to the chiropractor many times but does not seem to help. About the only relief I get is from a deep muscle massage treatment, but it doesn't last and comes back again. I have this every day. On bad days it happens thousands of times, and I need one hour treatments every day. On good days it happens about six to twelve times an hour; then I get treatments three times a week. I have had this for a year and it's getting worse. Do you have any idea what my problem is and what can be done?

-Desperate for Help in MO

Answer:

Your problem sounds very unusual and very distressing. Is it accurate to say you are having it "thousands of times a day"? There are only 1,440 minutes in a day; so your episodes would have to be very brief to happen that often. The only thing I can think of which is that brief is the severe pain of tic doloroux which is a type of neuralgia. It usually occurs in older people and your symptoms aren't real typical, but it is still a possibility.

The other thing which occurs in episodes and may cause confusion is some sort of seizure. If you have not already done so, see a neurologist. Your problem should be identifiable and treatable; but I need more information and, perhaps, some more studies such as an EEG and MRI to help sort this all out.

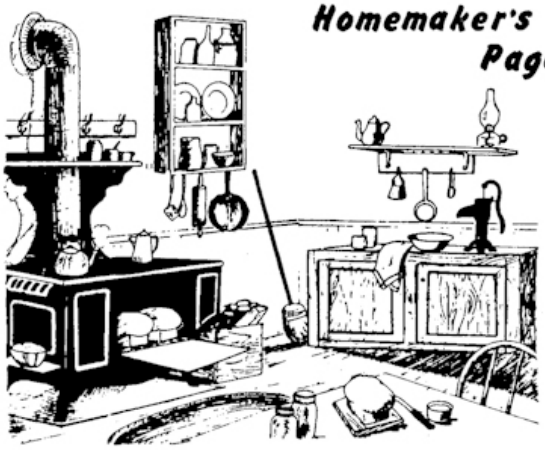
Autonomic Nervous System

What is "autonomic nervous system", and what procedure or test does a person take to be certain he really has the illness? Is there help available for it?

-A Lancaster County Subscriber

Answer:

This is a puzzling question. The autonomic nervous system is not a condition or an illness. It is a division of the body's nervous system and is sometimes referred to as the vegetative or involuntary nervous system because it controls those bodily functions which continue to occur when we are sleeping



Homemaker's Page

Joys of Folding Wash

I like folding wash
That has blown in a breeze
With the scent of purest air
Or of budding springtime trees.

The clothes feel soft and clean
As I put them all on piles;
There's many different sizes,
Some are big and little styles.

Each one is a reminder
With what we've been blessed,
While many in this world
Would long for shirt or dress.

I'm folding for each person
Whom God has given me...
In other homes their dear ones
Have passed to eternity.

And though there is some mending
Always needing to be done,
I'm grateful for the health
That is given to each one.

When we view the many diapers
Our infant needs to wear,
We're gladdened God has sent
A babe to us so fair.

As I fold some small pajamas
I think of nighttime's rest;
How nice to all be gathered
As each climbs to his nest!

It seems that folding clothes
Is a chore without an end;
No sooner are they stashed away
Than we begin all over again.

Yet every time we're given
This task again to do
We're granted thoughts of love
And joyfulness anew! -E.M.

MOM'S SOUP

Put a little lard in a skillet, then shake quite a bit of flour into the skillet. Next add 1 pint hamburger, canned or fresh, then flour over meat again. If desired, add a few fresh onions. Chop and stir till nice and brown. Then put meat in 2 or 3 qt. saucepan and add 1 pt. cooked navy beans. Add tomato juice till meat is well covered. Cook until thick, then add enough milk to make soup of desired thickness. Serve with crackers.

-A Reader

PIONEER STEW

2 lb. ground beef	2 cups kidney beans
1 cup chopped onion	1 qt. tomato juice
1 qt. corn	½ tsp. chili powder
2 tsp. salt	1 qt. cooked macaroni
1 qt. beans or peas	1-2 cups shredded cheese (optional)

Soak kidney beans overnight, then cook until done. Fry beef and onions. Mix all ingredients except cheese in a roast pan. Bake at 250° for 2-3 hours. Add cheese the last half hour. -Esther Oberholtzer

DANDELION SALAD

1 qt. dandelion greens	2 tsp. sugar
4 slices bacon	2 tsp. vinegar
3/4 cup sour cream (or regular cream)	2 tsp. flour
	2 hard-boiled eggs

salt and pepper to taste

Wash and drain dandelions. Fry bacon until crisp. Remove from pan and crumble into bits. Drain off bacon fat except for 2 tablespoons. Add the combined sugar, flour, and vinegar. Stir over low heat until thick. Add sour cream, salt and pepper. Pour over greens while dressing is still warm. Add chopped eggs. Serve immediately.

Very good dandelion salad.

-Mrs. Lavern Zimmerman

RHUBARB DESSERT

4 cups boiling water
4 cups rhubarb, washed and sliced

Bring to a boil and boil one minute. Add 2 cups sugar and boil one minute longer. Remove from heat.

Add 2 tbsp. plain gelatin soaked in 2/3 cup cold water. Also add small pack red or orange jello (1/3 cup).

Stir until dissolved. Add 3½ cups cold water. If desired, also add 1 can crushed or chunk pineapples, after it's cool and set.

Allow to set overnight.

-Mrs. Lavern Zimmerman

PLANTING POTATOES

If you dread the back breaking job of planting all those potatoes, cut a PVC pipe to the right length and drop your potato pieces through the pipe. You can carry the pieces of potatoes in a shopping bag or a small pail hung over your arm.

-A young mother