



**Mental Health Beliefs and Practices
Among Low German Mennonites:
Application to Practice**

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Executive Summary

Low German (LG) Mennonites are a group whose lifestyle is based upon their religious principles and values. Our study findings regarding their mental health beliefs and practices note the significance of spirituality and religion in how they understand and care for those with mental health problems. Our accompanying *Best Practices Document* (Kulig & Fan, 2016) is meant to assist those unfamiliar with this group to provide care and assistance to those who are mentally unwell, or to family members who act as caregivers.

Approach

The purpose of this mixed-methods study was to identify the cultural and religious understandings and beliefs related to mental health wellness and illness in general among the LG Mennonites, with the intention of applying what was learned to assist in the development and deployment of more appropriate healthcare services for the LG Mennonite communities. Specifically, the research questions were as follows:

1. What are the knowledge and beliefs about mental health wellness and illness among LG Mennonites in the locations where they reside in Alberta, Manitoba and Ontario?
2. What are best practice guidelines for mental healthcare of LG Mennonites in the three participating geographic areas?

We developed an advisory group consisting of individuals from the clinical and social service sector; these individuals provided guidance and advice about all aspects of the project and assisted in ensuring that appropriate dissemination of the findings took place in their agencies. The latter helped fulfill our goal of integrated Knowledge Translation (iKT), which helped to ensure that all aspects of the project would be shared in a respectful but informative manner. We also approached and worked with LG Mennonite ministers to build trust with the population while being transparent about our purpose. This particular study was conducted in Alberta, Manitoba and Ontario and also included fieldwork and interviews in Durango Colony, Mexico conducted by the first author. The theoretical framework for the study was based in cultural safety which goes beyond cultural competence; it was chosen because it offered an opportunity to develop care that meets the community's specific cultural and religious needs.

Data Collection

The majority of the interviews were conducted by Mennonite individuals who could speak *Plautdietsch* (Low German, the language spoken by this group). Research assistants (RAs) were hired in each province; the second author travelled to Ontario to conduct the interviews there when the RA for that province was unable to continue in this role. The first author conducted the interviews in Mexico. The second author also conducted several interviews with health and social service providers (HSSCPs) in Alberta.

The research included qualitative interviews with healthcare providers (i.e., psychiatrists, psychologists, nurses, teacher aides) and other relevant individuals (i.e., ministers). We had also planned to conduct a review of relevant documents that focused on the mental healthcare of diverse groups, but found an insufficient set of materials and hence abandoned this aspect of our research plan. In total we interviewed 47 LG Mennonite individuals (28 females and 19 males) and 47 individuals who work with this population. The care providers represented mental health nurses, counsellors, social workers, pastoral care providers, physicians, and teaching assistants.

Data collection and analysis were conducted simultaneously allowing for revisions of the interview guide and discussion about the ideas that were being generated at the time of the interviews. This process also led to the RAs generating a list of Low German terms that the participants used to describe information related to mental health; these terms helped enhance understanding of their perspectives.

Results

The interviewees found the concepts of mental health and mental illness difficult to discuss but with encouragement were able to explain their own personal perspectives. A recurring theme throughout the interviews was the links between spirituality and good mental health; being guided by God helped individuals to be mentally well.

Particular kinds of mental illness were noted among the group particularly *narfun trubble* or “nerve troubles,” also referred to as “broken nerves;” some people are believed to have weak nerves. An important distinction among attitudes toward mental illness was whether or not the participants believed it was within the control of the individual or was beyond their control. Mental illness was believed to “run in the family” by those who felt that mental illness was outside the individual's control. When being mentally well was considered to be within the control of the individual, it was thought that the unwell individual could make changes and become well.

Those who were mentally ill or their relatives might have experienced shame and judgment by others in their communities and did not always feel supported by their ministers. We found that mental illness was often associated with other factors including substance abuse and family factors such as domestic violence.

The providers noted that it was challenging to provide care to the LG Mennonite population who were experiencing mental health issues because of the differences in language and understanding of their signs and symptoms, which meant that treatments such as counselling and medication were not always understood or accepted.

In conclusion, mental health illness is viewed within a spiritual context among the LG Mennonites. Although this finding cannot be generalized to other Mennonites because of variations among groups, care providers need to consider this context when working with individuals and families from LG communities.

Mental Health Beliefs and Practices Among Low German Mennonites: Application to Practice

Context

Mental illness continues to be one of the most stigmatized conditions in society (Scheyett, 2005). In Canada, one in ten individuals will experience major depression in their lifetimes, and each year more than a million Canadians experience a major depressive episode (Patten & Juby, 2008). Mental illnesses include a range of mood disorders (e.g., major depressive disorder, bipolar disorders) and anxiety disorders (e.g., panic disorder, post-traumatic disorders). Suicidal behavior also needs to be considered within the rubric of mental health wellness and illness because it is often the result of a number of inter-related factors. Substance abuse disorders are also associated with mental illness, and are often experienced as a concurrent disorder with emotional or psychiatric problems. In addition to understanding these key definitions, consideration needs to be given to Canadians' access to healthcare services that address mental health. A seminal document in this regard was *Out of the Shadows at Last: Transforming Mental Health, Mental Illness and Addiction Services in Canada*, a report of The Standing Senate Committee on Social Affairs, Science and Technology

(Kirby & Keon, 2006), which highlighted the need to address mental health issues from a national perspective, including ensuring that services are available. The recommendations from this report ultimately led to the development of the Canadian Mental Health Commission which has identified seven specific goals, including developing a mental health system that responds to the diverse needs of Canadians, and responding to the mental health needs in underserved areas of Canada including rural areas (Mental Health Commission of Canada, 2009).

Religion represents a complex domain of human life which includes behaviors, attitudes, beliefs and values. It can be considered a protective factor against stressful events that an individual experiences due to the resources it provides (i.e., prayer, support), while also providing an opportunity to construct a sense of meaning relating to stressful experiences including mental illness (Ellison & Levin, 1998). "Spirituality" refers to the personal experience of the meaning and purpose of life that is not tied to any particular religious affiliation (Hinshaw, 2002). It is a deeply personal experience of the search for the meaning of life (Koenig, 2005).

The links between religious beliefs and mental health wellness and illness show that they can be at various times both mutually supportive and non-supportive. On the negative side, because religious communities help individuals develop their values and norms, the kinds of violations of such values and norms as may be experienced during times of mental illness may lead to feelings of guilt, shame or fear of divine abandonment (Ellison & Levin, 1998; Leavey, Loewenthal, & King, 2007) or even divine punishment (Ellison & Levin, 1998; Idler, 1995; Peres, Moreira-Almeida, Nasello, & Koenig, 2007; Wright, Watson & Bell, 1996).

In some religious groups, mental illness is believed to be a result of sin (Stanford, 2007), leading to additional feelings of guilt and shame. Framing the illness in this manner may lead the person to believe that they are responsible for their own symptoms due to their flawed character (Ellison & Levin, 1998; Leavey et al., 2007; Marshall, Bell, & Moules, 2010; Raphael, 2008). This belief can further erode their self-esteem and competence, causing more emotional stress further reducing their coping abilities. In addition, the possibility of gossip and judgmental attitudes from their fellow parishioners can have an additional negative impact on the ability of the mentally ill individual to cope (Ellison & Levin, 1998; Leavey et al., 2007; Raphael, 2008; Marshall, Bell, & Moules, 2010; Wright & Bell, 2009).

Other researchers have noted that some ministers focus on the church as a collective rather than the individual, which can lead to the marginalization of the individual who is mentally ill (Leavey et al., 2007). Further, not all ministers have the training to deal with mental illness, and some associate mental disorders with spiritual issues that they feel need to be resolved before the individual feels mentally well (Leavey et al., 2007). Many LG Mennonite churches and their members are reliant on part-time ministers who have juggled their time and schedules to fill the church's needs and their own life.

On the positive side, commitment to a religious community may denote the availability of social resources including social ties, and formal and informal support (Ellison & Levin, 1998; Evans, 1999; Mindell, 2004; Wright et al., 1996), as well as the provision of moral and ethical teachings and the adherence to a positive, low-stress lifestyle (Loewenthal, 2006; Wright et al., 1996; Ysseldyk, Matheson & Anisman, 2010). For some religious individuals, suffering and mental illness provide the opportunity for spiritual growth or learning (Stanford, 2007). Mental illness may also be seen as part of God's plan and help remind individuals that they need to reflect on who they are and the nature of their relationship with God.

Affiliation with religious groups may be a positive experience for those who are mentally ill in other ways as well. For example, prayer and worship may lead to the expression of certain emotions such as forgiveness, love and contentment that could positively affect outcomes. Prayer and confession may also enhance personal willpower and the ability to cope with mental illness. Finally, focusing on hope may help individuals with mental illness to deal with negative emotions such as guilt and fear (Mindell, 2004; Wright, et al., 1996; Wright & Bell, 2009).

Low German Mennonites

Mennonites are members of the Anabaptist religious group which also includes the Amish and Hutterites. Menno Simons, a former Roman Catholic priest who was born in modern-day Netherlands, was the founder of this particular branch of faith (Redekop, 1969). Starting in the mid 1800s, large groups of Mennonites relocated to the Americas from Europe, including Russia and Germany, seeking countries where they could practice their religion without interference from others (Jaworski, et al, 1988). Today, there are different religious groupings of Mennonites and variations within the different denominations based on economic and social factors. Anabaptists believe in adult baptism, pacifism and a literal interpretation of the Bible, which among the more conservative denominations includes maintaining a separation from the modern world (Redekop, 1969; DeLuca & Krahn, 1998; Sawatzky, 1971). "Low German" or *Plautdietsch*

is the predominantly oral "everyday" language that is most often used by these conservative Mennonite groups; the term "Low German" is used to distinguish it from "High German," which refers to the more formal language used by the larger German population (Hedges, 1996). The LG Mennonites view themselves primarily as a religious group because their everyday decisions and lifestyle are dictated by biblical interpretation.

The LG Mennonites are a conservative denomination among the Mennonites, with three primary groups: Kleine Gemeinde (most liberal); Sommerfelder; and Old Colony Church (most conservative). The Reinlanders are another, less prominent denomination that falls between the Kleine Gemeinde and the Sommerfelder in its level of conservatism. In all of these denominations, the ministers are responsible for interpreting the Bible and determining its application to everyday life; therefore, decisions regarding healthcare practices, including such details as whether a woman can cut her hair prior to head surgery, may involve the minister. It is expected that the minister's interpretations of religious documents typically has a significant impact on a congregation's views of mental health wellness and illness.

Large groups of Old Colony Mennonites immigrated to Canada from Eastern Europe between 1874 and 1880 (Jaworski, 1988; Loewen, 2001) and these people were known as "Kanadier Mennonites." When they settled on the Canadian prairies, they received a charter of rights that allowed them to educate their children in German. As the provinces became more established, and as non-Mennonite communities around them expanded, there was a growing tendency from non-Mennonites to believe it was inappropriate for Mennonite children to be educated separately from other children. Disagreements also occurred among the Mennonite populations themselves. The more conservative populations wanted to maintain their traditional lifestyle, while more liberal families supported changes, such as integrated education for their children. The debate was fueled by the growing sense of prejudice experienced by the Mennonites who, as pacifists, had refused to be involved in World War I (Janzen, 1990; Loewen, 2001).

Mennonite elders who felt their way of life was threatened in Canada turned to the government of Mexico, from which they sought and were given a *privilegium* (i.e., a statement confirming their religious freedom) to live peacefully in Mexico and maintain their own educational systems. In the 1920s, more than 7,000 conservative Mennonites emigrated from Canada to Northern Mexico (Benson, 1998; Sawatzky, 1971) and became colloquially known as "Mexican" Mennonites. Even in Mexico, however, conservative

Mennonites faced pressure to change and modernize. In some cases, splinter groups developed and moved to other countries, such as Belize and Paraguay (Sawatzky, 1971). Many of the families that had moved to Mexico found it difficult to adapt to the climate and agricultural differences and returned to Canada (Benson, 1998). Some of these families established communities in isolated areas such as Fort St. John and Burns Lake, British Columbia and La Crete, Alberta (Benson, 1998). By the 1970s and 1980s, other conservative Mennonites returned to Canada from Mexico and Belize, setting up residence predominantly in Ontario, Manitoba, and Alberta. It is now more common and acceptable to the Mennonite communities to refer to these groups as “Low German” (LG), rather than “Kanadier” or “Mexican” Mennonites.

Accurate statistics for the LG Mennonites in Canada are difficult to obtain because of the historical migrations of this population back and forth between southern locales and Canada. We do know that these migrations are occurring less often, and large numbers of LG Mennonites are now staying in Canada. In 2004, there were approximately 57,000 LG Mennonites in Canada (Janzen, 2004) but current information from Mennonite Central Committee Canada indicates that there are now about 80,000 – 100,000 LG Mennonites in Canada with 20,000 in Alberta, 15,000 in Manitoba and 40,000 – 50,000 in Ontario. In all of these provinces, the majority of LG Mennonites have been attracted to the southern regions, where they live near or in agricultural communities and work in feedlots or on other agricultural operations, such as potato and sugar-beet farms.

Most individuals who live in these communities have low literacy skills, a limited education (usually only to age 12), and little exposure to technology. This leads to many challenges for them in Canada, including limited access to healthcare. Some health regions have employed health promotion specialists who work exclusively with the LG Mennonites to provide translation and advocate on their behalf. In other locales, non-profit groups have been created to assist in this regard. For example, in southern Alberta, the Southern Alberta Kanadier Association (SAKA) was founded by the first author of this report and members of her research advisory teams. In other geographic areas, Mennonite Central Committee (MCC) and Mennonite Community Services (MCS) are actively involved in the resettlement of LGS Mennonites.

Cultural Safety as a Framework

As Canada has become a more ethnically diverse country, cultural diversity challenges healthcare systems and providers in various ways. Culture affects both healthcare providers’ and patients’ experiences, such as the choice of treatments and prevention strategies. Some ethnic groups and other minorities have experienced health disparities that are closely associated with differences in social identity, language, religious beliefs, cultural knowledge or other sociocultural factors (Kirmayer, 2012).

Cultural competence is described as having behaviors that help the individual care provider to effectively function in situations where there are cultural differences between the provider and care recipient (Leavitt, 2002). The attribute helps reduce disparities in access to healthcare, and to improve the quality of healthcare services. In general, cultural competence has been mentioned or emphasized as a guiding principle in some of the healthcare policies implemented in Canada, which include *A Cultural Competence Guide for Primary Health Care Professionals in Nova Scotia* created by the Nova Scotia Department of Health and Wellness, *Enhancing Cultural Competency: A Resource Kit for Health Care Professionals* developed by Alberta Health Services, and *Cultural Competency and Safety: A Guide for Health Care Administrators, Providers and Educators* developed by the National Aboriginal Health Organization (NAHO) to improve the health status of Aboriginal people in Canada.

However, many cultural disparities and cultural barriers in mental healthcare services continue to be overlooked. Cultural, social and spiritual practices and barriers have prevented members of ethnic minorities from receiving appropriate care. These barriers include mistrust and fear of being judged on the part of patients from minority groups, beliefs about factors associated with illness and health, a lack of effective communication, and a lack of diversity in the healthcare workforce (Sullivan & Mittman, 2010). A few policies and guidelines have been developed for mental healthcare providers in Canada. The *Canadian Code of Ethics for Psychologists 2005* does emphasize that psychologists should respect the dignity of their patients and the patient’s personal characteristics, social status and cultural background (Canadian Psychological Association, 2005). The Canadian Mental Health Association and the Centre for Addiction and Mental Health have developed some resources that aim to improve the ability of mental healthcare providers to work sensitively and efficiently with people within different cultural contexts. Such measures are intended to enhance the delivery of quality and accessible mental healthcare services for ethnic minorities or people with limited English proficiency.

However, although it seems that many mental health organizations are aware of or acknowledge the importance of providing cultural competence training programs, there remains “little guidance on how to proceed” (Ryder & Dere, 2010, p. 6).

The term “cultural competence” has in recent years grown beyond the description of mere competence to include the concept of “cultural safety,” which describes the empowerment of both healthcare providers and the users of healthcare services (Richardson & Williams, 2007). It asked the question: “How safe did the service recipient experience a service encounter in terms of being respected and assisted in having their cultural location, values, and preferences taken into account in the service encounter?” (Ball, 2007, p.1).

In Canada, “cultural safety” has been used as a way of describing health inequalities encountered by diverse Aboriginal people. It is well demonstrated that racism and social discrimination against minorities have created pervasive inequalities that have long-lasting and intergenerational effects on people’s health and social well-being. Cooney (1994) defined culturally unsafe practices as “any actions that diminish, demean, or disempower the cultural identity or well-being of an individual.” Cultural safety as an improvement strategy encourages healthcare providers to reflect on their own cultural and social identities and to recognize the impact of their own cultural beliefs or practices on their professional practices (Baba, 2013). It allows the healthcare service users, especially people from marginalized groups, to define “culturally safe care” according to their own cultural beliefs and practices (Brascoupé & Watters, 2009). This, in turn, will help to improve the healthcare systems and professional practices to provide more supportive and efficient care to meet the special or specific needs of those from marginalized groups (Native Mental Health Association of Canada, 2010).

The LG Mennonites are not just “culturally diverse;” they are a group that emphasizes its religious beliefs in its everyday decisions. Hence, cultural safety with these individuals means recognizing the importance of understanding, acknowledging and incorporating religious beliefs and practices when providing care to this group. One way to achieve this approach is to apply the following framework when planning and implementing care (Ball, 2007): access personal knowledge (i.e., providers reflect on their own attitudes); process (i.e., assess the individual patient’s preference for information); positive purpose (i.e., help the individual build his or her spiritual comfort); and partnerships (i.e., engage the support of family members).

Approach

The purpose of this mixed-methods study was to identify the cultural and religious understandings and beliefs related to mental health wellness and illness in general among the LG Mennonites, with the intention to of applying what was learned to assist in the development and deployment of more appropriate healthcare services for the LG Mennonite communities. Specifically, the research questions were as follows:

1. What are the knowledge and beliefs about mental health wellness and illness among LGS Mennonites in the locations where they reside in Alberta, Manitoba and Ontario?
2. What are best practice guidelines for mental healthcare of LGS Mennonites in the three participating geographic areas?

The research included qualitative interviews with healthcare providers (i.e., psychiatrists, psychologists, nurses, teacher aides) and other relevant individuals (i.e., ministers). We had also planned to conduct a review of relevant documents (i.e., grey literature and policy reports) that focused on the mental healthcare of diverse groups, but found an insufficient set of materials and hence abandoned this aspect of our research plan.

It was imperative that trust be established and maintained with the LG Mennonites in order to be successful when conducting the research. This study is the fourth one our research team has conducted with this group; the others focused on other health topics – many of which related to mental health, including the ones into women’s health (Kulig, Babcock, Wall, & Hill, 2009; Kulig, Wall, Hill & Babcock, 2008) and death and dying (Kulig & Fan, 2013). While conducting these previous studies, we were often encouraged by the community and our clinical partners to engage with the LG Mennonites to generate information about their specific perspectives on mental health. It was noted by social service and healthcare personnel that this particular group was experiencing problems with postpartum depression and substance abuse. The clinicians wanted to provide the most appropriate care but were not always sure of how to proceed. Thus, a decision was made to conduct a formal study of mental health in the LG Mennonite communities, and thereby generate information for the development of a care guideline for this unique group.

We learned early on in our work that establishing an advisory group, consisting of the most appropriate individuals from clinical agencies and other relevant organizations, as well as representatives from Mennonite Central Committee (MCC),

was an important first step in conducting research with the LG Mennonite communities (Hall & Kulig, 2004). We therefore continued this practice in the current study and were able to include a LG Mennonite individual as an advisor at the Ontario site. As was the case in previous studies, our advisory group members have been instrumental in guiding the research into mental health by providing input on the research question, the interview guide, the data collection process and the analysis and interpretation of the results. They have also provided assistance and advice about the dissemination of the results.

The research discussed in this report was conducted in Southern Alberta, Manitoba and Ontario in 2012 to 2015, with fieldwork being conducted in Durango Colony, Mexico in 2012.

Before we began collecting data, both authors (i.e., the principal investigator [PI] and the project coordinator [PC]) held meetings with some of the LG ministers in Manitoba to explain the study. In past studies, we had used similar opportunities to interview the ministers and talk at length about the topic that was being investigated, but this time our meetings were briefer because the research assistants (RAs) – rather than the PI and PC – would be conducting formal interviews, including some with ministers. In Ontario, we met with some ministers when we were preparing the research proposal, but due to logistics it was not possible to meet them all individually before the interviews began. However, the PC did meet and interview some ministers when she went to Ontario to conduct interviews there. We were unable to hold similar meetings in Alberta, due to the fact that the ministers of the LG churches there – particularly the more conservative – are not supportive of our research and have openly indicated that they believe the interviews “mix up” their congregation members.

For the most part, the interviews were conducted by Mennonite individuals who could speak *Plautdietsch*. Interviewers were hired in each province; those hired in Alberta and Manitoba had worked with the authors on other research projects and were therefore familiar with the research process, including ethics and confidentiality. The individual who was hired in Ontario was provided with training, to ensure that there was consistency in the quality of interviews across sites. When it happened that this individual was no longer able to continue in the role as RA, the PC travelled to Ontario to conduct the interviews there.

The interviews were normally held in participants’ homes or work places. The LG Mennonite interviews were not tape-recorded, due to this group’s general concerns with technology. Short notes were taken and thereafter a summary of the information was typed by the research assistant and

subsequently transcribed by the transcriber or the research assistant for future analysis.

The research team used telephone meetings and email to discuss interviews and address any concerns throughout the data collection period. The team also discussed the meaning of particular *Plautdietsch* words in relation to mental health, and compared interpretations of what was being discussed by the LG participants in the different provinces. The RAs also provided us with a list of *Plautdietsch* words that were used in the interviews to supplement the data.

When the data collection was complete, the authors undertook a data analysis to generate themes that reflected the perspectives of those who had been interviewed. The data analysis was enhanced by discussions with the RAs about the meaning of *Plautdietsch* words and the beliefs that the LG Mennonites shared. We ensured that we fulfilled established standards for trustworthiness of the findings by meeting the criteria set out by Lincoln and Guba (1986) for: credibility (i.e., the data “fits” the viewpoints of the participants); transferability (i.e., the data can be generalized to other LG Mennonites); dependability (i.e., the results match the data that were generated); and confirmability (i.e., the interpretation matches the participants’ viewpoints). The “credibility” criterion was met through our hiring of LG Mennonite individuals as RAs, and through the discussions we held to discuss the data that was generated and to ensure we interpreted its meaning correctly. “Transferability” was established through the feedback we received from our research advisory members about our findings and the practice guideline that was developed. The details about the data collection and analysis process helped to ensure that the “dependability” criterion was met. Finally, by obtaining agreement among team members about the themes, we were able to establish “confirmability.”

The research included an integrated Knowledge Translation (iKT) to help ensure that all aspects of the project would be shared in a respectful but informative manner. The web site Mennonitehealth.com was updated to indicate that the research was being conducted; this final report and the practice guideline will be available free of charge on the site, and details about publications and presentations relating to this study and the others will also be noted there. With the assistance of the advisory committee members and other contacts, during the study we established connections with contributing agencies, and we reconnected with them to plan presentations of the findings and to hold small group discussions about the practice guideline that was developed (Kulig & Fan, 2016). Scientific presentations about this study were also made at conferences.

Perspectives of the Low German Mennonites

In total 43 interviews were conducted in the LG Mennonite communities, involving 47 LG Mennonite individuals (n=47). These included 24 females and 19 males, with a range of ages from 24 to 79 years.¹ The interviews were conducted in four places: Manitoba, Alberta, and Ontario, Canada, and the Durango area in Mexico. Four female LG Mennonite individuals were interviewed in Alberta, and the range of age was 31 to 46 years. In Manitoba, 18 LG Mennonites were interviewed, including ten males and eight females; their ages ranged from 35 to 79 years. In Ontario, ten LG Mennonite participants were interviewed, including four males and two females, with ages ranging from 37 to 49. In the Durango, Mexico area, 15 LG Mennonites were interviewed, including five males and ten females; their ages ranged from 24 to 72.

The majority of the LG Mennonite participants in this study had been born in Mexico and were members of the Old Colony Mennonite churches. After they had moved or resettled in Canada, many of them had started attending different, less conservative, Mennonite churches. According to the demographic information collected from the participants, most of the LG Mennonite men had more years of education than did the LG Mennonite women in this study. The private LG Mennonite schools in Mexico have their own educational system that provide a different curriculum from that of the public schools in Canada. Therefore, the grade levels used in the private Mennonite schools may not be equivalent to the ones used in Canada (Kulig & Fan, 2013).

Mental Health and Illness Beliefs

For this study, we interviewed either LG Mennonites who had mental illness or were caregivers for individuals who were mentally unwell. Several of the participants were caring for husbands who had been diagnosed with depression or schizophrenia, or were women who were struggling with postpartum depression. Although for a number of the participants the mental health challenges may have started in Mexico, we focused on their circumstances in Canada since their resettlement here. To gain a better understanding of how their lifestyles in other countries has affected the LG Mennonites' mental well-being, we also interviewed LG Mennonites in the Durango colony in Mexico to talk about their concerns and challenges associated with mental health issues.

The interviews all started with a general question about the meaning of health, and then moved to a question

about the meaning of mental health. For the most part, the participants found these difficult concepts to discuss and explain. Those who were more comfortable in talking about these ideas mentioned that those with good mental health can think clearly, and that they are able to “take care of their minds.” There was acknowledgement that focusing on stressful situations is detrimental to people’s mental health. A recurring theme throughout the interviews was the link between spirituality and good mental health; thus there was mention of the need to read the Bible and pray not only to support good mental health but also to restore mental health.

Individuals who did not have good mental health were thought to have something wrong with their *vestaunt* or brain and were described in a variety of ways: they were sometimes referred to as *dvautsch* (i.e., “crazy” or “different”) and were described as having antisocial or unusual behaviors. They were often described as having *narfun trubble* or “nerve troubles,” or sometimes as having “weak” or “bad” nerves. Despite these types of descriptions, those we interviewed noted that they believed that these individuals did not have a choice in how they felt or behaved.

One interpretation of having mental illness was that it serves a purpose; one participant said:

Illness is allowed by God...illness brings a new insight. A person who never had illnesses remains in a particular mindset; having gone through a time of stress [brings] new insights and new ways of thinking, new ways of coping, and new ways of understanding or compassion for those who were suffering. Mental illness is definitely suffering. Suffering both for the family and community.

Some of the participants said that pondering the causes of mental illness was not helpful in their everyday coping. One of our female participants, who cares for her mentally unwell husband, said, “I think about [why he is unwell] sometimes and wonder. But when it comes down to it I really just live it.” Still others saw mental illness as God-given and as representing “our cross to bear” while on earth. There was some indication that the participants felt that our lives are pre-determined in terms of what we will experience, and that what we have to endure has therefore been already decided.

Participants frequently noted that mental illness led to suffering. One woman we interviewed said:

Having a mental illness makes everyone around me suffer. If I am in a depression I get angry easily, overwhelmed, and this causes tension in all of my relationships – I snap at my kids and my family. I do not know why people suffer; it is something I wonder about a lot. I think that God wants to

¹ There are four demographic sheets missing in the mail for four interviews conducted in Ontario; we are aware that the participants are female but no other information is known about them.

test us to see if we can use our strength and rely on him. Mental illness is Satan's work and this is when I need to rely on my spirituality. I question what God wants for me. He has a plan and I question why I go through it but I know it is on God's time. I need to be patient.

Some other participants did not view mental illness as based in Satan; one said that if this was the case, then physicians would not be successful in helping ease mental health problems.

Spiritual wellness was an important part of the discussions in the interviews. The participants emphasized the need to have a relationship with God which was maintained through reading scriptures, praying and attending church services. They felt that there had to be a focus on trusting one's life in God's hands. Being "spiritually well" meant that you had purpose in your life; this was described in the following way: "If you are spiritually good then you feel like you are somebody and aren't useless; you have meaning in life. I think [mental and spiritual wellness] are equally important. They are all dependent on each other."

An important point related to mental illness was whether or not the participants believed that mental illness was within the control of the individual or that it was beyond their control. Those who believed that mental illness was outside of individual control said that mental illness could be attributed to genetics or, in other words, that it "ran in the family." Although they did not completely understand how this happened, they provided examples of families where there were frequent instances of anxiety, panic attacks and other symptoms of mental illness among the family members. However, more often the participants expressed that being mentally well was within the control of the individual, and that the unwell individual could make changes and be well.

Participants offered examples of judgments made about those with mental illness. For example, the community may decide that an individual who is mentally ill cannot be baptized because they would not understand the significance of this event. In addition, those who are mentally unwell are not expected to contribute to the community and do not hold any kind of specific role. Gossip and rumors about individuals whose behaviors suggest mental illness were commonly noted by those whom we interviewed. The participants felt that the communities should be kind and show understanding in these circumstances. In further support of this concern, a female participant said: "I think people are more likely to go for medical help over the church though, because they do not want people from the community to know they are dealing with depression or having problems. There's too much shame with mental illness. I was not taught

to seek help or ask for prayer when I was younger, but it was the thing that helps me the most when I deal with my depression. I think Mennonites keep things back too much. It builds up and gets out of control. This is when you get spiritually ill and mentally unhealthy." This same woman noted that for the LG Mennonites who attend conservative churches, Bible study is not allowed. She felt it was difficult to become spiritually well when there was limited opportunity to engage in Bible study, reading and reflecting on God's word directly.

Extreme examples of the care of the mentally ill by family members suggested that they were at a loss about what to do with their ill relative. In one case in Mexico, the parents of a young woman had broken off her relationship with a young man. She displayed out-of-control behavior (e.g., destroying bedding, ripping off her clothing) and eventually the family perceived that their only choice was to place her in a locked box outside the house. Even when neighbors attempted to bring the young woman into their home to help out, her behavior did not improve. We can speculate that the young woman was schizophrenic; with limited resources and understanding in the Mennonite community in Mexico, it is easy to see the challenges the family would face in these circumstances. In another case, a man confronted and argued with ministers during church services about the interpretation of the Bible. Such behavior would not be expected nor welcomed, and would challenge the ministers as to how to handle the situation.

Questions about the basis for mental illness clearly showed the links and beliefs between health and spirituality that were held by the LG Mennonites. According to the perspectives of some of the LG Mennonites we interviewed, mental illness was believed to be rooted in sin. Humans were perceived as weak, and vulnerable to sinfulness; to avoid this, it would be best for them to follow God's plan as set out in the Bible. Reflecting on one's spirituality and engaging in prayer would assist in this process, as would choosing a lifestyle that adhered to a spiritual life. In other words, these interviewees believed that individuals who chose a lifestyle that did not exemplify their Christian beliefs would be prone to mental illness. Those who chose to abuse substances such as alcohol or drugs, for example, would stray further and further from God. The long-term impact of substance abuse was noted among the participants; one individual who we interviewed had heard that individuals who abused drugs burned their brains ("*abused drugs dee hauden daut Vestaunt vebrent*") and were not able to think clearly. Stress was seen as a major factor in causing mental illness. There was no clear answer however about how stress could be avoided or managed. Others perceived that stress was a precursor to substance abuse.

We asked participants to list types of mental illness. On the basis of their own experiences or those of relatives, they offered the following: depression (considered to be the most common disorder among the LG Mennonites); anxiety; bipolar disorder (referred to as “manic depression” by some of the participants); and schizophrenia which was the most commonly noted psychotic condition by the participants. Also mentioned were eating disorders (such as bulimia), Attention Deficit Hyperactivity Disorder (ADHD), autism and Alzheimer’s disease, even though these final examples are not considered forms of mental illness by mainstream medicine.

Interviewees said that mental illness could occur among the young and old, although some of the participants believed that those who were older had more life experience and therefore a greater ability to cope with the challenges of life. Women were considered stronger and more able to cope, but this opinion was in sharp contrast to descriptions of gender differences in response to mental illness such as these: “Men turn to drinking; women have nerves;” and “Men get angry and violent; women stay in bed and cry.”

Incidences of psychosis were noted as occurring among the LG Mennonites but little understanding of psychotic conditions was evident among the participants. They realized that medication and counselling would be helpful, and they talked about how such treatments were more easily available in Canada compared to Mexico. They also noted that an individual with psychosis can act in unusual ways which are not understood by the community and hence in some situations, they are hidden from public view to prevent gossip and judgment from occurring.

Postpartum depression was cited by participants as common among women in their communities, as distinct from “depression” which can occur in both women and men. Among the sample, postpartum depression is mistakenly equated with “baby blues,” which are mood swings that can occur after birth and end quickly once the woman’s hormones are stabilized. In contrast, postpartum depression is a serious form of depression that can be debilitating for the mother. In extreme cases, the woman may commit suicide or infanticide or not be able to care for her child, her family or herself. Women in LG communities who suffer from postpartum depression may be seen as “lazy” when they do not attend to everyday chores such as housecleaning – an important part of being a “good” LG Mennonite wife and mother. In reality, the mother may require medication to feel better and will likely require assistance in her everyday chores. One male participant related how difficult it was to find people in the community to trust; he himself also struggled with his wife’s postpartum depression in part because she was unable to express how badly she felt. She did attempt suicide more than

once and had to be hospitalized for treatment, which included medication. Those within the communities who have more understanding and empathy in these circumstances describe women in this situation as having “low nerves,” and believe that they need supplements such as Vitamin B12 or folic acid. One of our female participants told us: “My sister and I had weak nerves after we delivered babies. She asked for help first, and she helped me. We talked a lot and prayed together. It is suffering for me but God did not make [the suffering]. It is Satan.” She also told us that she did not share her worries with her husband, and explained: “It is women’s problem. I need to pray more, and God can help me.”

We also talked with the participants about the care of the mentally ill; particularly those who were cared for at home. There was no shortage of comments about the challenges that this brought to the family. One woman whose husband was mentally ill and whose daughters had postpartum depression said:

(I) spent a lot of time listening to my daughters and talking to them...on one occasion when I talked to my daughter I said something like: you’re sitting here crying and I’m at home and my husband is crying, I come here and you’re crying. I feel like being somewhere in the middle between your house and my house. And then I felt bad; that had not been the right thing to say. But recently my daughter had said that it gave her something to think about, some perspective to what she was experiencing and she thought it had helped her.

It is not just women in the LG Mennonite communities who are criticized for not attending to their chores; an LG Mennonite man who was mentally unwell and could not deal with his farm chores was also seen in a negative way. Although it is common for other community members to help those with their chores when they are physically ill, when someone is mentally ill there is limited understanding. Community members have been heard to say: “*Wuarom halpt dee sich nich selfst?*” (“Why does he not help himself?”).

Suicides do occur among the LG Mennonites. There is shame about being mentally ill and some individuals believe that Satan takes over at the point the person chooses to end their life. There is not only shame involved in suicide but it is considered a sin, and the communities believe that the person will be judged by God in some Mennonite churches.

Repeatedly in the interviews there was expression of disappointment in the lack of assistance from the ministers. The participants felt that a number of the church leaders were unable to understand the behavior of the mentally ill and hence were incapable of dealing with them in any positive manner.

Perspectives of Healthcare and Social Service Providers

In addition to the 47 interviews with the LG Mennonites, we also interviewed 47 individuals who provided care or helped the LG Mennonites and their families to deal with their mental health issues. The care providers were from different disciplines, including mental health nurses, counsellors, social workers, pastoral care providers, physicians, and teaching assistants. Out of the 47 care providers, 28 worked in Manitoba, six in Alberta, 12 in Ontario, and one had worked in Mexico. More than half of the participants had a Mennonite background and could speak *Plautdietsch*, High German or both languages at different levels.

Health and social service care providers in the three provinces indicated that from their experience the number of LG Mennonite patients requiring assistance with mental health issues has increased in the last few decades. HSSCPs said that many of their clients or patients were suffering from various mental health problems, such as depression, anxiety disorders, and substance abuse. Mental health issues, in general, were seen as having been caused by a variety of sociocultural and environmental factors, and genetics was not discussed as a contributing factor.

Depression and Domestic Violence

Depression was one of the major health issues identified by both the LG Mennonite participants and the HSSCPs in this study. Domestic abuse was cited as one of the contributing factors to depression. One of the pastors interviewed in this study indicated that most of the church members who came to him for help had experienced serious abuse. Among these were LG Mennonite women who had been beaten severely by their fathers when they were children, and then were beaten again by their husbands after being married. Some women tried to suppress certain emotions and keep quiet about their needs or unhappiness in order to keep the peace or avoid being criticized. These experiences caused emotional strain on these women, giving them a fragile sense of self-worth.

The HSSCPs also indicated that people who had depression problems might also simultaneously suffer from other mental health issues, such as substance abuse. Alcohol and self-prescribed anti-depression pills have been used to address mental health problems among the LG Mennonite population. One of the HSSCPs explained that:

I've noticed that with a lot of my Mennonite women that they assume that the pills are going to treat their depression,

even though – I mean, there may be some underlying issues that they're not really talking about ...Yeah, or even self-medicating, right? Like, they're able to get their pills from Mexico and then they come here. And if that's not working then they'll still be taking their pills on the side but, you know, they want something else from the doctor.

Fear and Anxiety

Some LG Mennonite patients or clients were overwhelmed by fear and anxiety, which seriously reduced their working ability, which in turn affected the quality of their lives. The one cause for their anxiety disorders was closely related to their living environments, specifically having lived in Mexico where there are security issues related to the drug trade. One of the HSSCPs stated that:

I would say fear is very high, anxiety is high...And just talking to a few ladies that I've worked with, too, [it] is just [that] they're very anxious for everything. It's almost like that has [...] come into their everyday life [...]: the fear that they have from leaving, running away, and then here they get phone calls or stories from [...]. They hear stories in the community about how another person was murdered related to the drug cartel or whatever that's going on down there, and then they're so afraid for their families over there. They still have family there. And then they come to the doctor and they say, I'm having this sort of pain and that, but [they are] not connecting the two. They don't connect the fear and anxiety that they have, [be]cause they would never say that they have anxiety or fear. It's just – you can tell, right? – when they tell their stories, it's all in their story when they tell you, and what sort of details they're telling you, I find [that] it depends on the details that they tell you, you can tell what sort of fear or anxiety they're having.

The HSSCPs explained that sometimes their patients' anxiety disorders were very complex because sometimes they were accompanied by other health issues, such as depression and substance abuse.

The Use of Mental Healthcare Services

Similar to people from other ethnic or diverse groups, some LG Mennonites also have difficulties in accessing or using mental healthcare. Difficulties arise for a variety of reasons. Some LG Mennonites have told the HSSCPs that they have financial problems and they cannot afford certain treatments. Others are not comfortable in seeking care because of their religious beliefs, which say that God is the one to provide assistance and help with their symptoms. Other LG Mennonites do not have a public health card, or they do not know how to use

the card, so the card remains inactive. Other factors, such as insufficient English language skills, lack of awareness of the availability of services, or the lack of services in local communities also affect the LG Mennonites' use of mental healthcare. One of the most important factors that prevents the LG Mennonites from seeking treatment, however, is their limited knowledge about mental health and illness.

Religious Beliefs and Mental Health Knowledge

According to the HSSCPs, when seeing physicians or counsellors the LG Mennonites would identify various physical signs and symptoms, such as migraines or sleeplessness. However, generally speaking, there was a lack of general knowledge and understanding about how these signs and symptoms reflected their mental health status. Some of the LG Mennonites may believe that prayer should be used to cure people's "weak nerves," instead of medical treatments. One HSSCP said:

A lot of depression, a lot of anxiety. And I think the large barrier too is the not knowing about it being a biological issue, right? So a lot of them by the time they're coming to me they've had a few hospitalizations but yet they're struggling with the fact that religion is kind of telling them, well, if they prayed more or if they went to church more it would all go away, and I'm here on the other side saying "No, it's a biological-chemical issue that's going on in your body, and the medication..." – then it's getting past the medication you're going to have to take long-term. It's not like an antibiotic.

Also some LG Mennonites were not familiar with mental healthcare, including counselling services. According to some of the HSSCPs, the denial of the existence of the problems was common.

I think the key thought that a lot of them have is that if they go in for counselling there's something wrong with them. I'm okay with there being something wrong with me as long as I can fix myself but now I have to go to someone else so you must – there must be something really wrong with you if you're going to a counsellor.

Cultural Safety and the LG Mennonites

There are several ways in which cultural safety can be applied when working with the LG Mennonites who are mentally unwell. Specifically, personal knowledge, process, positive purpose and partnerships can be applied in these situations. The caregiver can reflect on their personal knowledge and understanding about mental illness while also identifying their knowledge and awareness about the LG Mennonites. Second, an understanding of the process regarding mental illness needs to be developed among the LG Mennonite clients and their family members. This process may require the use of an interpreter to ensure that all terms are understood while allowing the family members to ask questions for their own clarification. A positive purpose is established when the family is provided the opportunity to discuss their situation with their minister and are given the time to make decisions about the care of their mentally unwell relative in a manner that reflects their spiritual beliefs. Finally, partnerships can be developed between the care provider and the LG Mennonite family and communities when activities such as prayer are supported.

Conclusions

In conclusion, this mixed methods study generated information about mental health illness being viewed within a religious and spiritual context among the LG Mennonites. Care providers need to consider this when working with individuals and families from this group; however, they also must avoid generalizing from one group to all LG Mennonites because of the variations among the groups. There was much discussion among the LG Mennonite participants about whether or not mental illness was within the control of the individual. For those who believe that it is, there is a lack of understanding that the individual cannot automatically make changes and be well. In addition, providers find that in these circumstances, individuals do not understand the importance of regular medication and counselling to assist them become well. The interviewees also expressed that they experienced shame and a lack of support within their communities. A cultural safety framework can be applied allowing the provider, in conjunction with the unwell individual and their family members, to reflect on what process would be most useful in enhancing their care.

Key Recommendations for Decision Makers

- Respect LG Mennonite individuals' religious practices that impact on their interpretation and understanding of mental health beliefs and practices.
- Work with the LG Mennonites to help ensure that their beliefs are respected and incorporated into their mental health counselling and support.
- Provide simple explanations about mental health illness and relevant services.
- Provide interpretation services for LG Mennonites who are not fluent in English.
- Be cognizant that LG Mennonite patients simultaneously ingest over-the-counter medications and home remedies with prescription medications.
- Provide inservice education to all healthcare and social service providers to help ensure provision of culturally safe and religiously respectful mental health services.
- Work with patients and their families to help ensure that members do not feel excluded or ashamed of their beliefs or practices.
- Work with LG Mennonite communities to help build capacity and recruit members into the health and social service workforce.
- Work with LG Mennonite school teachers and students to promote mental health among children, teenagers and youth.
- Encourage the LG Mennonite communities to use protective strategies, such as social activities and family cohesion, to improve their mental well-being.

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