

The Low German Mennonites have had to make many choices...

Help them to make choices by understanding their beliefs and practices

**Cultural Guidelines to Support
Mental Health among the
Low German Mennonites**

Acknowledgements

A heartfelt *thank you* is extended to the Low German Mennonites who were involved in the research project; they willingly shared their beliefs and ideas with us. We also wish to thank the health and social service providers and the pastoral ministers who shared their time and knowledge with us. The research assistants not only devoted care and attention while conducting the interviews, but also assisted in meaningful discussions of the information.

Our research project, *Mental Health Wellness and Illness Knowledge and Beliefs among Low German Mennonites: Development of Best Practice Guidelines*, would not have been completed without the dedication, interest and knowledge of the individuals who were involved as members of the advisory group.

Alberta

Alberta Health Services:

Shirley Hill, Cathy Price, Vivien Suttorp,
Marni Bercov

Manitoba

Southern Health-Santé Sud:

Kim Dyck, Kathy McPhail, Cornelius Woelk,
Ken Kroeker

Eden Health Care Services:

James Friesen, Stanley Krahn, Nicole Szmerski

Formerly with Mennonite Central Committee, Winnipeg Office:

John Janzen

Ontario

Canadian Mental Health Association:

Heather deBruyn

Community Member: Henry Unger

Funding for the research and this document upon which it is based was provided by the Canadian Institutes of Health Research.



Suggested Citation:

Kulig, J. & Fan, HY. (2016). *Cultural Guidelines to Support Mental Health among the Low German Mennonites*. AB, Lethbridge: University of Lethbridge.

Photo credit (page 4, 7, 8, 9, 10, 16, 26):

Judith Kulig, RN, PhD

Photo credit (page 13, 14, 15, 17, 19, 20, 21):

LingLing Fan.

Table of Contents

Acknowledgements.....	2
How to Use This Document	4
Definitions	5
Recommendations for Working with the Low German Mennonites	7
Background Context.....	8
Development Process	10
Summary of Recommendations.....	11
Who Are the Low German Mennonites?	12
Mental Health Beliefs	16
Application to Practice	19
Advanced Decision-Making.....	22
References	23
Case Example Preamble	26
Case Example #1.....	27
Case Example #2	28
Bibliography	30
Web Links.....	31



How To Use This Document

This document is intended to assist health and social service providers (HSSCPs) in their role in caring for Low German (LG) Mennonites who have mental health issues, or working with the family members who are responsible for the care of LG Mennonites with mental health issues. The recommendations are included to assist providers in developing appropriate policies and strategies when working with this group. The suggestions are not to be considered a “cookbook” approach for all LG Mennonites. It is still the responsibility of the provider to invest the necessary time to appropriately assess individuals within their family and community contexts in order to ascertain their unique beliefs, practices and needs. It is hoped that this document will enhance health and social service providers’ knowledge and understanding about this unique religious group while also helping the LG Mennonite population make a smooth transition to life in Canada.

Organizations accessing this document may decide to:

- Implement the recommendations as discussed here,
- Develop more appropriate recommendations for their own organizations; or
- Use the information to deliver workshops or information sessions about the LG Mennonites and their beliefs and practices in relation to mental health.

Health and social service providers reading this document may decide to:

- Talk about these recommendations within their clinical settings; and/or
- Learn more about LG Mennonites.

LG Mennonites may decide to:

- Share this booklet with their health care providers to help them understand their perspectives; and/or
- Talk to their family members and their ministers about the type of care they would prefer to receive in order to ensure that they receive care within a culturally safe context.

Definitions

Mental Health has been described as having the capacity to handle stress, relate well to others, explore choices and make decisions.¹ It is associated with happiness, self-esteem and an interest in life.

Mental illnesses are characterized by alterations in thinking, mood or behaviour associated with significant distress and impaired functioning.²

Cultural Competence

Cultural competence is having the knowledge, skills, attitudes and other personal attributes that are required by providers to deliver appropriate care and services in relation to the cultural characteristics of their clients. Cultural competence includes valuing diversity, knowing about cultural mores and traditions of the populations being served, and being sensitive to these while caring for individuals.³⁻⁷

Cultural competence is more than an awareness of a range of customs, ethnicities and languages. It can also address religion, which plays an important role in people's lives and in their health care needs.^{3-7,12}

When applied, cultural competence addresses:

1. Communication issues, including disclosure and decision-making about family involvement
2. Understanding of customs surrounding how to deal with depression and mental illness
3. Understanding of attitudes related to medication, treatment & counseling
4. Privacy issues related to mental illness
5. Spiritual matters, as well as religious issues, including rituals and working with ministers who assist family members to make decisions.^{13,15-17,21}

It is not realistic for health professionals and social service providers to understand the entire breadth of cultural or religious beliefs in relation to health & illness. However, it is reasonable to expect that providers will develop an understanding of populations that they often see while also building the skills needed to identify situations where they need further assistance, and the knowledge of pathways to access this assistance.

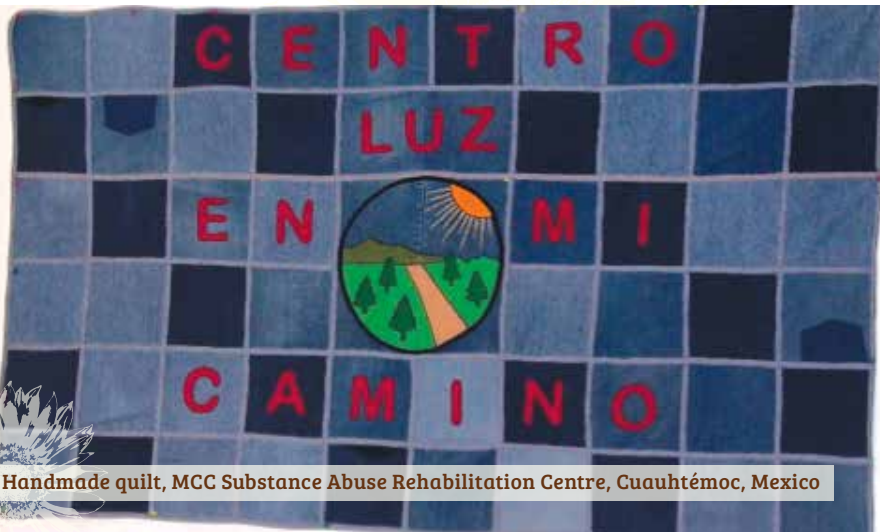
Cultural Safety

Cultural safety is based on cultural awareness, sensitivity and competence. In addition cultural safety includes a reflective process that helps the provider create a safe environment for the patient while also ensuring shared respect and learning.^{3,7-10} “Cultural safety” is a useful concept when working with individuals who hold religious perspectives and related lifestyles that are different from those of mainstream society. Assumptions and invalid conclusions can be drawn when working with such groups, which can then lead to the development of inappropriate care.^{3,7-10}

Five principles are necessary to help to ensure cultural safety^{8,11}

1. Protocols: respect for cultural forms of engagement.
2. Personal Knowledge: understanding one’s own cultural identity and sharing information about oneself to create a sense of equity and trust.
3. Process: engaging in mutual learning; checking on cultural safety of the service recipient.
4. Positive Purpose: ensuring the process yields the right outcome for the service recipient, according to that recipient’s values, preferences and lifestyle.
5. Partnerships: promoting collaborative practice.

Cultural safety builds on valuing diversity and differences, avoiding assumptions, and clear communication. Cultural safety is practice which respects, supports and empowers the cultural identity and wellbeing of individuals, so that they can express their identity while having their cultural needs met.



Handmade quilt, MCC Substance Abuse Rehabilitation Centre, Cuauhtémoc, Mexico

Recommendations for Working with the Low German Mennonites^{1, 12-19}

- Know which LG Mennonite group(s) live in your local community; be respectfully curious and become aware of their beliefs and practices related to healthcare.
- In general, the lives of LG Mennonites focus on faith, family, home, and work.
- Be aware and respectful of the LG Mennonite churches' doctrine, and communicate with respected LG Mennonite individuals and families to learn about working with the ministers.
- Be aware that some churches are concerned about their members' interactions with outsiders.
- Initiate conversations by talking about topics that may be of interest to LG Mennonites.
- Make yourself available to answer questions and give detailed explanations, but expect that families may need to have a minister with them when they talk to outsiders.
- Give straightforward answers: e.g. depending on the person's health issues, give the options for medical treatments & counseling.
- Keep in mind that the concerns among LG Mennonite families are often similar to those of the mainstream population.
- When presenting information, be sensitive about the words you use; for example, avoid expressions like "no hope."
- Using pictures and flip charts may help the LG Mennonites to understand the information you provide.
- Know that the LG Mennonites appreciate your work.



Background Context

Durango Colony, Mexico

This document is based upon a research study that was developed and conducted by a research team at the University of Lethbridge that included clinical personnel in participating health regions in Alberta (Alberta Health Services), Manitoba (Southern Health-Santé Sud and Eden Health Care Services) and Ontario (Canadian Mental Health Association).

Ethical approval was granted by these agencies as well as the University of Lethbridge (U of L). This research study focused on mental health beliefs and practices among Low German Mennonites, and is one study in a series that has been conducted with this group.¹⁴⁻¹⁹

For the mental health study, discussions and interviews were conducted with LG Mennonite individuals and ministers, along with care providers such as nurses, social workers and physicians, as well as service providers in Alberta, Manitoba and Ontario. Details about our research methods can be found elsewhere.¹⁵

To ensure a full understanding of the topic at hand, we also spent time reading documents related to mental health among diverse groups. We discovered that there were very few documents available that talked about religious or cultural diversity when it comes to mental health, or addressed how to accommodate such diversity in the care experience.

The cultural guidelines are based upon the findings from our study to assist health care and social service providers during their interactions with Low German Mennonites.



Heritage Home, Manitoba

Several ideas are interwoven in this document:

1. Health & social service providers strive to deliver high quality care within the environment within which they work,
2. Evidence is an important aspect of providing care to clients,
3. Belonging to a cultural or religious group is an important part of many people's everyday lives, and
4. Clients and health & social service providers interact in a variety of clinical situations; clients' preferences and the evidence and expertise of providers play a role in determining what type of care is delivered.

We therefore hope that this booklet helps to:

1. Create an environment within which care is provided in a compassionate, safe, competent, and ethical manner that meets cultural safety standards for the LG Mennonites; and
2. Emphasize the responsibility of all health care and social service providers, and all health care and social service managers and decision makers, as they work toward enhancing the quality and safety of care of their patients²⁰ within the multicultural context in which we all live.



Development Process

Bustillos Valley, Chihuahua, Mexico

This document was developed in collaboration with the advisory members of the research team.

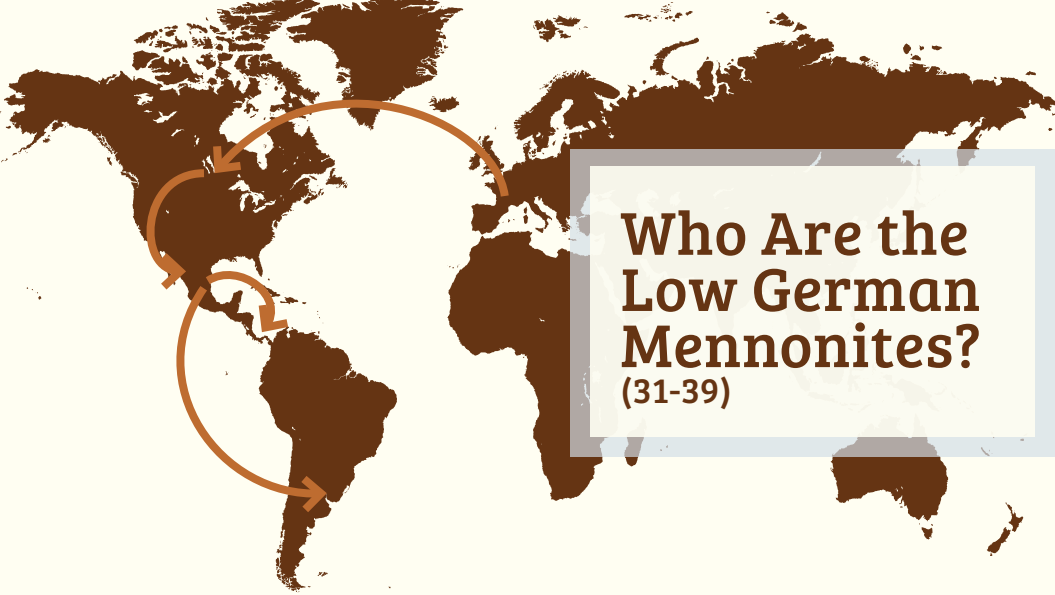
It was also reviewed by individuals who work with, and care for, the Low German population in Alberta, Manitoba and Ontario as well as by other relevant individuals such as health & social service providers external to the research project. Finally, it was reviewed by mental health care experts who are unfamiliar with the LG Mennonites.

The process of discussion, writing, review and editing has led to a deeper understanding about the links between religious affiliation and beliefs and practices in the everyday life of the LG Mennonites. We believe that it has resulted in a document that is useful and usable by those who work with this population.

A note about the title page of this document: The sunflower is a common symbol for the LG Mennonites who enjoy sunflower seeds at social gatherings. The stylized picture representing the LG Mennonite couple making a choice when they come to Canada has been a mainstay in all of our research projects. It has become the background for the web page devoted to the research related to this population. It is hoped that this document will become a work in progress and will be revised as necessary to help ensure that care for the LG Mennonites is conducted in a thoughtful and caring manner while considering their unique beliefs and practices.

Summary of Recommendations^{2, 12-13, 15-16, 23-29 (1, 20-23, 24-30)}

	Individual Providers	Organizations
Education	<p>Make a commitment to learn about the Low German Mennonites that you care for</p> <p>Attend workshops that discuss LG Mennonites to learn about this group of people</p>	<p>Provide inservices and workshops for HSSCPs, especially new staff members, about the Low German Mennonite population, as well as topics such as cultural safety</p>
Practice	<p>Address your personal beliefs related to mental health, and reflect on how they impact on the care of your clients</p> <p>Become familiar with and apply cultural safety protocols</p> <p>Be aware of potentially low levels of literacy of the LG Mennonites and use simple language to give detailed information</p> <p>Use charts and pictures to help your clients to understand complicated issues</p> <p>Set individual practice goals to deliver respectful care for the LG Mennonites; be aware of the presence of stigma among this group</p> <p>Be sure to take care of yourself to be emotionally able to care for your clients</p> <p>Ask for suggestions from the LG Mennonites in a way that explains that their suggestions will help the healthcare providers to improve the quality of their services</p>	<p>Create an expectation that care will be provided that meets cultural safety protocols</p> <p>Be familiar with the size of the LG Mennonite population living in the local area</p> <p>Collaborate with organizations that work with LG Mennonites</p> <p>Support face-to-face communication and community visiting; be prepared to spend time listening to what the LG Mennonites are sharing</p> <p>Provide translation services</p> <p>Provide participatory learning opportunities for the LG Mennonites</p>
Policy	<p>Be familiar with your employer's policies about the care of all diverse groups including the LG Mennonites</p>	<p>Develop policies within the organization that match the language recommended within the cultural safety literature</p>



Who Are the Low German Mennonites? (31-39)

Low German (LG) Mennonites are a conservative religious group that migrated from Eastern Europe to Canada, as well as other countries including Mexico, Bolivia, Belize, Paraguay and Argentina.

Some LG Mennonites adhere to religious principles based upon a literal interpretation of the Bible.

They are sometimes referred to as “*Kanadier*” Mennonites (signifying the Canadian migration) or “Mexican” Mennonites, but many prefer to be called “Low German Mennonites.” They speak *Plautdiestch*, a variation of High German that varies from one locale to another.

Sometimes the term “conserver” is used to include the *Kanadier* descendants in Canada and also those who have subsequently emigrated from other countries. Regardless, they are all part of the Anabaptist groups that

emphasize adult baptism, pacifism and literal interpretation of the Bible. They originated from the Old Colony Mennonites who had settled in Canada in the 1880s but left in the 1920s to set up a new home in Mexico. Those who left wanted to retain a lifestyle that followed their interpretation of the Bible, which emphasized a physical and spiritual separation from the world and from those in the world who were deemed to be non-Christian. This group eventually moved to other countries such as Belize, Bolivia and Paraguay.

Religious practices are an important part of their lives, with Sundays and the yearly religious holidays strictly maintained. Religious points of view are steeped in tradition and reinforced



A Mennonite School in AB

from the ministers who preach according to their interpretations of the Bible.

The LG Mennonite community represents a range of religious values and perspectives from conservative to more liberal. The use of electricity and modern technology varies by colony and religious background for the LG Mennonites who are in southern locales. Some individuals believe that using such equipment will negatively influence their relationship with God and threaten them as a group. Within some of these families, there are traditional roles for women and men. Women are often responsible for the domestic work, including cooking and cleaning, and the men work in the fields or within their business.

In these locations, they work predominantly in the agricultural sector. Some of them have invested many years and hard work to have a successful life in these countries.

However, LG Mennonites are returning to Canada for a variety of reasons. For some, there are more economic opportunities here and for others, the difficulties within the churches have led to their departure from Latin America. In recent years the ongoing violence related to the drug wars in Mexico have also prompted their migration.

In Canada, the LG Mennonites primarily live in Alberta, Manitoba, Ontario and Nova Scotia. In total, approximately 100,000 LG Mennonites are in Canada. Most of the LG Mennonites in the USA live in Kansas, Texas and Oklahoma.

Returning to Canada has meant a number of adjustments and changes for this group. In Manitoba, they are returning to a historical and social context with which they are familiar. For example, the original villages in southern Manitoba (e.g., Choritz, Reinland, Schoenwiese) remain largely intact, providing a connection

to the LG Mennonites' history and the unique way that the villages were designed in Europe and then transposed to a Canadian context. In these communities, for example, houses were attached to the barn, allowing for easy access to the animals particularly when the weather was inclement.

In Alberta, there are no examples of village structure that represents this historical context. Instead, the LG Mennonites often live in small towns (particularly if the men work as long-distance truck drivers, welders or mechanics) or on land owned by a feedlot operator for whom they work. If they have been successful, they may have purchased their own land.

There is a range of beliefs and lifestyles among the LG Mennonites who live in Canada but it would be inappropriate to generalize within the groups and from one group to another. Due to the traditional religious value of living 'separate and apart' from the world, different

communities may display varying degrees of hesitation to contact health and social service providers. For those who are more conservative, their children are usually home schooled within a Christian curriculum because there are concerns about mingling with non-Mennonite and non-Christian groups, as well as about children being exposed to a curriculum that includes topics such as human sexuality or the scientific explanation for the creation of the world. However, those LG Mennonites who move to Canada from southern locales have a limited education, and thus are not well prepared to assist their children succeed in the home schooling process. In some areas of southern Alberta, special education programs have been developed to assist the LG Mennonite children succeed academically. For example, the Burdett school in southern Alberta offers German language and Mennonite culture/religion classes to their LG Mennonite students, who constitute about 90% of the student population.



A Local Bakery in a LG Mennonite Community in AB



Mennonite Heritage Village, LaCrete, Alberta

Some LG Mennonites are more liberal and take part in mainstream society and use modern conveniences. This group may allow their children to go to school with non-Mennonite children, and do not object to continuing their schooling beyond junior high or high school. In these groups, married, baptized women may decide to no longer wear their kerchief, and they may allow their children to wear other clothing styles beyond the usual home-made simple skirt and blouse. Some of these individuals and families take the risk of being thought of as “too modern” by other members of their community. They may find themselves separated from their fellow LG Mennonites as a result.

In many cases, there is limited interaction between LG Mennonites who are conservative and those who are liberal. Differences in opinion about how to act and live can divide friends and families.



Health Clinic, Durango

Mental Health Beliefs among the LG Mennonites

We have included this brief summary of information generated from the discussions and interviews with the LG Mennonites. More details can be found elsewhere.¹⁵

LG Mennonites, like other groups, support and care for their family members and friends who are unwell (15-17). Their religious beliefs and behaviours are a very important part of their lives and when someone is mentally ill, religion plays a significant role. For example, some LG Mennonites see mental illness as serving a purpose in one's life. Being mentally unwell can bring other insights and reflections forward to the person who is unwell. This can lead to being closer to God, a goal that is important in a LG Mennonite's life.

The discussion that is presented here is not meant as a generalization about how LG Mennonites think and believe. Instead, it is offered as a way to provide a greater

understanding of this particular group of people to the wide variety of individuals in care and service provision that interact with them.

Kinds of mental health problems:

"Narfenkrankheit:" or Narfun trouble—or sickness of nerves or nerve troubles are words that are commonly used to discuss mental health issues. Others include: weak nerves or broken nerves. Such conditions are found in both women and men of all ages. For the LG Mennonites, *Narfenkrankheit* is the equivalent of depression; some individuals are considered susceptible to having weak nerves. For many of the LG Mennonites, depression is something that is considered to be within the person's control and therefore they believe it

can end if the person so desires. There is limited understanding or acceptance that an individual cannot make themselves be active or do things when they are depressed.

Postpartum Depression: most often referred to as the “baby blues” without understanding that this type of depression is much more severe and needs treatment through medication and counseling. May be thought of by LG Mennonites as the woman being “lazy.”

Psychotic Illness: Even though LG Mennonites may not have a full understanding of genetics and mental illness, some believe that mental illness “runs in the family”. Examples of mental illness that occur among LG Mennonites include schizophrenia and bipolar depression. Some LG Mennonites see psychosis as a result of Satan’s power over them because they have spiritually strayed. When this occurs it is more challenging to care for the unwell individual.

Spiritually unwell: If the individual has committed an act that is considered to be a “sin” (e.g., adultery) they may become distressed

and mentally unwell but in this case, they are also spiritually unwell. Many LG Mennonites believe that it is important that such individuals seek forgiveness for their sin—this includes seeking forgiveness from God and may include seeking forgiveness from another person. Individuals who do not repent are considered prone to developing mental illness. Sin can also be “inherited” from family members; such individuals who may be labelled by the community as sinful.

Suicide does occur among the LG Mennonites, in southern locales as well as in Canada. Some ministers interpret this action as sinful and a sure sign that the individual will be eternally damned. The family of the individual who has died by suicide needs support and reassurance, particularly if the individual has been buried differently due to the suicide—outside of the graveyard, for example. While this occurs infrequently in Canada it is more common in Mexico. Hence, individuals who arrive in Canada may be dealing with a variety of issues from their past that negatively impact their everyday health.



Mennonite Heritage Village, Steinbach, MB

Other related factors

Substance abuse of alcohol, prescription and illegal drugs also occurs among LG Mennonites, and heightens any mental health problems that are already in existence. The LG Mennonites see individuals who engage in substance abuse as straying from God and allowing Satan into their hearts.

Life challenges such as drinking within the home, being stressed, and dysfunctional family relationships all contribute to mental health difficulties. For many LG Mennonites, these issues are private and are not to be discussed with others, in part to reduce gossip in the community.

Seeking Assistance

- For some LG Mennonites, prayer is the most important part of their healing and can be done in the privacy of their home.
- Some LG Mennonites are comfortable with seeking the advice provided by physicians if their family member has been diagnosed with a mental health issue such as depression.
- Their minister also plays a large role in providing guidance in making decisions about health care. However, the lack of understanding of mental illness of some ministers means that the family does not always feel supported by the church. Mental illness can be seen as something that is “controllable,” and hence the afflicted individual may be blamed for not changing and becoming better on their own. There can be a lack of understanding of the need for medication to help rectify the chemical imbalance in the brain of the individual who is ill.

Caring for someone who is mentally ill

- Family members are most often the ones involved in the care of Mennonites who are mentally unwell.
- In some situations, mental illness is considered shameful and it can be difficult to receive support from community members. The unwell individual may be kept hidden from the community and the family members may feel isolated.
- The LG Mennonites are comfortable with non-Mennonites caring for their family members who have a mental illness but prefer that they have Christian beliefs.
- Health providers should not be surprised if family members ask about their religious beliefs.

Use of Alternative Medicines

- LG Mennonites use over-the-counter medicines in Mexico and other countries. Examples are “*Wunder Oil*” which can be used for improving one’s health or for treatment of any number of disorders.
- It is not uncommon for the LG Mennonites to share medication including medication for mental illness; therefore completing a thorough history is particularly important.
- “Bonesetters” or “chiropractors” are lay healers within the LG community that can assist individuals with various health ailments. They may treat arthritis pain or even set broken bones. They may treat physical symptoms of mental health issues (e.g., headaches, sleeplessness) which are not understood by the person.



Application to Practice

An LG Mennonite Church in AB

Learn from the past. Support for the present. Hope for the future. “Culture, ethnicity and religion weave the fabric of each person’s particular response to treatment and healing.”⁴⁰

Protocols for Cultural Safety and the LG Mennonites

One way to enhance cultural safety for LG Mennonites is to complete a cultural competence self-assessment such as the checklist suggested by the Central Vancouver Island Multicultural Society.⁴¹

This checklist includes questions related to:

Awareness: e.g., “I am aware of my discomfort when I encounter differences in race, colour, religion, sexual orientation, language and ethnicity.”

Knowledge: e.g., “I will recognize that my knowledge of certain cultural groups is limited and commit to creating opportunities to learn more.”

Skills: e.g., “I can act in ways that demonstrate respect for the culture and beliefs of others.” The checklist helps to identify your areas of strength and weakness and therefore identify the areas that need further development.



Mennonite Heritage Village, Steinbach, MB

Personal Knowledge

- Caregivers should reflect on and be aware of their own attitudes and feelings about mental health and illness.

Process

- Assess individuals' preferences for information.
- Understand and apply the basic principles of communication when discussing mental health issues.
- Educate the family about the signs and symptoms of stress and mental health conditions with attention to their faith and spiritual practices, and other specific needs unique to their family.
- Evaluate the family's comprehension of what is occurring during this phase.
- Ensure that the family and the patient understand the benefits of mental health services and counseling.

Positive Purpose

- Values, beliefs and experiences greatly shape individuals' decision-making,³⁵⁻¹² and need to be considered and assessed when working with religious groups.
- Help patients to find their spiritual comfort and emotional strength. The individual may need to atone for their past behaviors in order to achieve better mental health. This may involve their minister, other family members, others from their church community, or even pastoral care from the hospital.
- Help the family make decisions about the care of their relatives. Family members may want to discuss the situation with their minister. The minister may need assistance in understanding the clinical situation as well as the importance of taking medication and having counseling. The patient may want to talk with their minister before they make decisions about their care.

This decision-making process takes time. The clinical staff who are caring for the patient need to give that person and their family time to reflect and make a decision, which then needs to be honoured by the clinical staff.

- Introduce information gradually, using non-medical terminology, and assess if it is being understood.
- Offer the family the opportunity to have a minister in attendance, to assist with prayer and other rituals.³⁹

Partnerships

- If possible and desired, communicate assessment findings to individuals and the family on an ongoing basis.
- Low German family members can be supported by clinical staff to “be there” for their loved one by praying with them, talking to them, or doing things such as singing with them. Clinical staff are also encouraged

to spend time with the patient: simply sitting with them can be enough—silence is a way of communicating. The patient’s privacy also needs to be respected to ensure that they are given enough time to be alone and reflect on their circumstances^{15-17,28}

- Support the patient within their community. The patient’s community may provide a range of supports including visits, provision of food, singing, praying, laying of hands, interpretation and translation, and direct care. Correct translation can be assured if medical terms are clarified beforehand.^{15-17,28}



An MCC Thrift Shop in AB



How Providers Can Help Individuals and Family Members Engage in Decision-Making about Mental Health Care

Here are some specific actions that may be applied to work with the Low German Mennonites:

- Assess individuals' and family members' perceptions about their situation and options.
- Help the family to clarify their values if that is desired; otherwise confirm that their minister will be involved with this process.
- Provide timely information in a manner that family members can comprehend, by using concrete examples and lay language.
- Assess the individuals' and family members' competence for decision-making and their confidence in the minister who is providing guidance about decisions.
- Be prepared to deal with questions and comments about mental illness being caused by Satan or sin.
- Offer clear, thorough information to the family members and their minister if the individual and family so desire.
- Acknowledge and address emotions, and provide grief support when there is a suicide.
- Provide consistent care providers and counselors.
- Listen and respond to family members' comments; because LG Mennonites tend not to complain, be specific in asking them questions so you can discern if there are concerns.
- Validate the importance of hope within the context of uncertainty if this is supported by their religious beliefs—encourage them to talk with the minister to clarify these issues.
- Facilitate ongoing communication between individuals and family members.

References

1. Mental Health Commission of Canada. (2009). *Toward recovery and well being: A framework for a mental health strategy for Canada*. Retrieved on January 25, 2016, from <http://www.mentalhealthcommission.ca/English/document/241/toward-recovery-and-well-being>.
2. Public Health of Canada. (2015). *Mental Illness*. Retrieved on January 25, 2016, from <http://www.phac-aspc.gc.ca/cd-mc/mi-mm/index-eng.php>
3. Baba, L. (2013). *Cultural safety in First Nations, Inuit and Métis public health: Environmental scan of cultural competency and safety in education, training and health services*. Prince George, BC: National Collaborating Centre for Aboriginal Health.
4. Kirmayer, L. (2012). Rethinking cultural competence. *Transcultural Psychiatry*, 49(2), 149-164.
5. Leavitt, R. (2002). Developing cultural competence in a multicultural world: Part 1. *PT Mag Phys Ther*, 1-9.
6. Ryder, A. G., & Dere, J. (2010). Canadian diversity and clinical psychology: Defining and transcending 'cultural competence'. *Coll. Alberta Psychol. Monit*, 35, 6-13.
7. Registered Nurses' Association of Ontario. (2007). *Embracing cultural diversity in health care: Developing cultural competence*. Toronto, ON: Registered Nurses' Association of Ontario.
8. Brascoupé, S., & Waters, C. (2009). Cultural safety: Exploring the applicability of the concept of cultural safety to Aboriginal health and community wellness. *Journal of Aboriginal Health*, 7(1), 6-40.
9. Native Mental Health Association of Canada and Mood Disorders Society of Canada. (2010). *Building bridges 2: A pathway to cultural safety, relational practice and social inclusion – schedules "A" to "E" to main report*. Retrieved on January 25, 2015, from http://www.mooddorderscanada.ca/documents/Publications/BUILDING%20BRIDGES%202_SCHEDULES%20A-E.pdf
10. Richardson, S., & Williams, T. (2007). Why is cultural safety essential in health care?. *Medicine and Law*, 26(4), 699-707.
11. Ball, J. (2007). Supporting Aboriginal children's development. In *Early Childhood Development Intercultural Partnerships*. Retrieved on January 25, 2016, from www.ecdip.org/capacity/.
12. Ysseldyk, R., Matheson, K. Anisman, H. (2010). Religiosity as identity: Toward an understanding of religion from a social identity perspective. *Personality and Social Psychology Review*, 14(1), 60-71.
13. Koenig, H. G. (2005). *Faith & mental health: Religious resources for healing*. West Conshohocken, PA: Templeton Foundation Press..
14. Kulig, J., Babcock, R., Wall, M., & Hill, S. (2009). Being a woman: Perspectives of Low German-Speaking Mennonite women. *Health Care for Women International*. 30(4), 324-338
15. Kulig, J. & Fan, HY., (2016). *Mental health beliefs and practices among Low German Mennonites: Application to practice*. Lethbridge, AB: University of Lethbridge. 978-1-927770-06-1.
16. Kulig, J. & Fan, HY., (2013). *Death and dying beliefs and practices among Low German-speaking Mennonites: Application to practice*. Lethbridge, AB: University of Lethbridge.

17. Fan, H.Y. (2011). *Medical encounters in "closed religious communities": Palliative care for Low German-Speaking Mennonite people* (Master thesis), Lethbridge, AB.: University of Lethbridge.
18. Kulig, J., Wall, M., Hill, S. & Babcock R. (2008). Childbearing beliefs among Low-German-Speaking Mennonite women. *International Nursing Review*, 55(4), 420-426.
19. Hall, B. & Kulig, J. (2004). Health and illness beliefs among southern Alberta Kanadier Mennonites. *Journal of Mennonite Studies*, 22, 185-204.
20. Leavey, G., Loewenthal, K., & King, M. (2007). Challenges to sanctuary: The clergy as a resource for mental health care in the community. *Social Science and Medicine*, 65(3), 548-559.
21. Loewenthal, K. M. (2006). *Religion, Culture and Mental Health*. Cambridge: Cambridge University Press.
22. Marshall, A., Bell, J., & Moules, N. (2010). Beliefs, suffering, and healing: a clinical practice model for families experiencing mental illness. *Perspectives in Psychiatric Care*, 46(3): 197-208.
23. Scheyett, A. (2005). *The Mark of Madness: Stigma, Serious Mental Illnesses, and Social Work in Mental Health*, 3(4), 79-97.
24. Kirby, M., & Keon, W. (2006). *Out of the shadows at last: Transforming mental health, mental illness and addictions services in Canada*. Standing Senate Committee on Social Affairs, Science and Technology: Government of Canada.
25. Rhi, B. Y. (2001). Culture, spirituality, and mental health: The forgotten aspects of religion and health. *Psychiatric Clinics of North America*, 24(3), 569-579.
26. Marshall, A., Bell, J., & Moules, N. (2010). Beliefs, suffering, and healing: a clinical practice model for families experiencing mental illness. *Perspectives in Psychiatric Care*, 46(3): 197-208.
27. Mindell, A. (2004). *The quantum mind and healing: How to listen and respond to your body's symptoms*. Charlottesville, VA: Hampton Roads.
28. Mennonite Centre Committee. (n.d.). *Opening doors: Information and resources for service providers working with Low German speaking Mennonites from Latin America*. Retrieved on December 01, 2015, from http://mcccanada.ca/sites/mcccanada.ca/files/media/ontario/documents/opening_doors.pdf
29. Sullivan, L. W., & Mittman, I. S. (2010). The state of diversity in the health professions a century after Flexner. *Academic Medicine*, 85(2), 246-253.
30. Wright, L. M., & Bell, J. M. (2009). *Beliefs and illness: A model for healing*. Calgary, AB: 4th Floor Press.
31. Bensen, J. (1998). Protective retreat: Mexico's Mennonites consider a new migration. *World and I*, 13(8), 1-6.
32. DeLuca, S. A., & Krahn, M. A. (1998). Old Colony Mexican-Canadian Mennonites. In R. E. Davidhizar & J. N. Giger (Eds.), *Canadian transcultural nursing* (pp. 343-358). Toronto, ON: Mosby.
33. Hedges, K. L. (1996). *"Plautdietsch" and "Huuchdietsch" in Chihuahua: Language, literacy, and identity among the Old Colony Mennonites in Northern Mexico*. Ann Arbor, MI: UMI Dissertation Services.
34. Janzen, W. (2004). Welcoming the returning 'Kanadier' Mennonites from Mexico. *Journal of Mennonite Studies*, 22, 11-24.

35. Janzen, W. (1990). *Limits on liberty: The experience of Mennonite, Hutterite and Doukhobor communities in Canada*. Toronto, ON: University of Toronto Press.
36. Loewen, R., & Friesen, G. (2009). *Immigrants in prairie cities: Ethnic diversity in twentieth-century Canada*. Toronto, ON: University of Toronto Press.
37. Loewen, R. (2001). *Hidden worlds: Revisiting the Mennonite migrants of the 1870s*. Winnipeg, MB: The University of Manitoba Press.
38. Redekop, C. W. (1969). *The Old Colony Mennonites: Dilemma of ethnic minority life*. Baltimore, MD: The John Hopkins Press.
39. Sawatzky, H. L. (1971). *They sought a country: Mennonite colonization in Mexico*. Berkley, CA: University of California Press.
40. Spector, R. E. (1996). *Cultural diversity in health and illness: Guide*, (6th. ed.). Norwalk, Connecticut: Appleton & Lang.
41. Central Vancouver Island Multicultural Society. (n.d.). *Cultural competence self-assessment checklist*. Retrieved on January 10, 2016, from <http://www.coloradoinitiative.org/wp-content/uploads/2015/10/cultural-competence-self-assessment-checklist.pdf>



Case Example Preamble

Spanish Lookout, Belize

The case studies serve as analytic tools to help HSSCPs develop an understanding of the complex social, cultural and religious dimensions underpinning mental health issues among the LG Mennonites. The cases were drawn from real life stories collected during the interviews, which reflect a particular situation

and some of the LG Mennonites’ beliefs and practices related to mental health. Each case study is designed to encourage HSSCPs to critically examine all factors that affect the LG Mennonites’ mental health, and to develop a way of working with this group of people.

Before reading the case examples on the following pages, answer the following questions:

1. Who are the Low German Mennonites? What language(s) do they speak?
2. In Canada, where do the Low German Mennonites live? How long have LG Mennonites been in your area?
3. In what countries did they originally live?
4. Nowadays, from what country does this group primarily migrate?
5. What are some of their major religious beliefs?

When reflecting on mental health, consider the following questions:

1. What do you fear most when talking about mental health and illness?
2. How would you define “mentally ill”? What is an example of a mental illness?
3. What are the needs of those who are mentally ill? What are the needs of their family members?
4. How would you define “culture”? How would you define “religious beliefs”? What are some examples of how culture and religion affect our behaviour?
5. Have you ever worked with ministers in providing care for those who are mentally ill? What were the benefits and challenges?¹

Case Example #1

Julia Wiebe was a 26 year-old mother of five, who had been married for eight years. She and her husband had previously lived in the Durango Mennonite Colony, about 130 kilometers northwest of the city of Durango in Mexico, but they had left recently because of a severe drought; they were now living near some cousins in a farming area in southern Manitoba.

When Julia arrived in Canada she was pregnant with her sixth child; the pregnancy was more difficult than her previous ones. Early on, Julia experienced severe morning sickness and “unexplained” fainting spells. Since pregnancy is seen as a normal life event in her community, Julia did not receive any special antenatal or postnatal medical care in any of her pregnancies. She gave birth to her sixth child at a local hospital. For the first week after the birth, Julia felt normal, but then she started experiencing “baby blues.” She felt anxious and sad for “no reason.” Also she cried very often when no one was around, and had trouble falling asleep. Julia’s husband and her cousins did not pay attention to these symptoms either because they had occurred with her previous deliveries. They believed that these symptoms were “normal;” and expected them to disappear.

Three months after the birth, Julia’s situation had still not improved, and she began to exhibit some unusual behaviours. She did not want to talk to anyone, including her husband, her in-laws or her friends. She also had difficulties managing domestic duties, such as cooking the meals and cleaning the house. Subsequently, Julia became what she described as very “lazy” with her children, and she only spent time with them when there were people in the house. She felt guilty and ashamed for not looking after her children properly; she did not want to be seen as a “lazy” or “bad” mother. One afternoon, Julia was discovered hanging from a rope in their living room. Her cousin called their neighbours for help to take Julia to the local hospital; she survived and was diagnosed with postpartum psychosis.

When reflecting on this case study, consider the following questions:

1. What were your feelings as you read through the story?
2. What did you want to do for Julia and for her family members?
3. What is “hope”? What gives you hope? What, if anything, makes Julia question hope? What makes you question hope? What gives Julia hope? What is the role of other family members in helping Julia have hope?
4. Julia and members of her community considered her to be ‘lazy.’ How would you address this issue with them?

- 5. Apply the five principles of cultural safety to this case example:
 - i) Protocols: How would you find out about Julia's attachment to her church community?
 - ii) Personal knowledge: How can you share your perspectives of mental health with Julia?
 - iii) Process: What questions and comments can you make so that you and Julia can learn together about each other's perspectives of mental illness?
 - iv) Positive purpose: How will you conduct an assessment of the care provided to Julia and her family?
 - v) Partnerships: Identify who you would collaborate with to help ensure that Julia receives the care she needs.
-

Case Example #2

Susie Martens is a 36-year-old mother of four children. She has been married to Peter Martens for eighteen years, and has lived in Leamington, Ontario for the past six years. Peter works as a vegetable packer and Susie is a part-time housekeeper for another family in the community. They met in Mexico when Susie was 16 years old and Peter was 17 years old. Susie lived with her parents and siblings before she was married. Peter lived with extended family after the age of 14, because his father was an alcoholic and very abusive. Although he lived in the same village in Mexico as his immediate family, he had no contact with them after he left home. Now that Susie and Peter live in Canada, they have even less contact with their families. Some of Susie's siblings do live in the same area and they see them on occasion, but Peter has no contact with the few relatives he has in Southern Alberta and Manitoba.

Susie had known that Peter drank even at the beginning, when they began to see one another. However, she thought it was "normal" because many teenagers in their church drank on Sunday afternoon, a practice that is common in both Mexico and Canada. She thought her husband's drinking was a "weekend habit" shared by many other young men in the LG Mennonite community.

While still in Mexico and after their second son was born, Susie noticed some changes. Her husband started drinking more often than before. At the same time, he became very argumentative, negative and angry. He only slept two to three hours every night, and was suffering from chest pain. They bought some pills over the counter from a local pharmacy near their village, which was recommended by their friends who had similar problems. The pills helped Peter to control his mood and anger, but he still drank excessively. Susie had tried to

talk to the pastor from the more conservative church that she and her families belonged to in Mexico. However, she was told that a good Christian wife is to obey her husband in everything. At the same time, Peter started being verbally and emotionally abusive to his wife and children. It seemed like he could not control his mood or temper.

After coming to Canada, Peter was still taking the pills, which seemed to be less effective than they used to be. His drinking behaviour had also not improved. Susie's siblings and relatives helped her to look after her children when she had to take care of her intoxicated husband. Susie became really desperate and felt that there was no hope for her husband. They eventually were convinced by their siblings and cousins to visit a pastor who had a reputation of helping church members in a similar situation.

After a few visits, Peter eventually started sharing his stories with the new pastor. Peter began to understand that he used alcohol as a tool to deal with his loneliness, fear and uncertainty. He did not want to be an abusive person like his father, but he felt that he had no control over his own situation. He felt very guilty about mistreating his wife and children. He believed that he was useless as a man. The new pastor explained to Peter and Susie that they needed help from professional counselors, and assisted the couple to book the necessary appointments. At the same time, some donations and support, such as food and children's clothing, were provided by church members and the new pastor.

.....

After reading this case study, consider the following questions:

1. What questions do you still have about the family and its circumstances?
2. What approach would you take when working with Peter?
3. What are some ways to help Susie and the children deal with their current circumstances?
4. What are some ways to deal with the issues of domestic violence with Peter and Susie?
5. Apply the five principles of cultural safety to this case (i.e., Protocols, Personal Knowledge, Process, Positive Purpose, Partnerships). Give specific examples of how they can be used to assist in the care of this family.

We hope that you have found this resource useful in your practice when caring for Low German-speaking Mennonites. We would appreciate any feedback about the usefulness and accuracy of the material. Please contact Dr. Judith Kulig at Kulig@uleth.ca or 403-382-7119 if you want to share any comments or feedback. Thank you.

Bibliography

1. Bottos Canas, L. (2008). *Old Colony Mennonites in Argentina and Bolivia: Nation Making, Religious Conflict and Imagination of the Future*. Boston: Brill.
2. Burkholder, L. K. (1998). *Pennsylvania Mennonites in Mexico*. Morgantown, PA: Masthof Press.
3. Cultural Safety Working Group, (2011). "One Focus; Many Perspectives" *A Curriculum for Cultural Safety and Cultural Competence Education*. Ottawa: Mental Health Commission of Canada.
4. Hedges, K. L. (1996). "Plautdietsch" and "Huuchdietsch" in Chihuahua: *Language, literacy, and identity among the Old Colony Mennonites in Northern Mexico*. Ann Arbor, MI: UMI Dissertation Services.
5. Janzen, W. (2004). Welcoming the returning 'Kanadier' Mennonites from Mexico. *Journal of Mennonite Studies*, (22), 11-24.
6. Janzen, W. (1990). *Limits on liberty: The experience of Mennonite, Hutterite and Doukhobor communities in Canada*. Toronto, ON: University of Toronto Press.
7. Loewen, R. (2006). *Diaspora in the Countryside. Two Mennonite Communities and Mid-Twentieth-Century Rural Disjuncture*. Toronto: University of Toronto.
8. Loewen, R., & Friesen, G. (2009). *Immigrants in prairie cities: Ethnic diversity in twentieth-century Canada*. Toronto, ON: University of Toronto Press.
9. Loewen, R., (2001). *Hidden Worlds: Revisiting the Mennonite Migrants of the 1870s*. University of Manitoba Press, 2001.
10. Reinschmidt, K. M. (2001). *Old Colony and General Conference Mennonite in Chihuahua, Mexico: History, representations and women's everyday lives in health and illness*. Ann Arbor, MI: University of Michigan.
11. Seah, E. Tilbury, F., Wright, B., Rooney, R., & Jayasuriya, P. (2002). *Cultural Awareness Tool: Understanding Cultural Diversity in Mental Health*. Commonwealth Department of Health and Ageing and Multicultural Mental Health Australia. Parramatta BC.

Web Links

Books and References

www.Mennonitischepost.com
www.Biblegateway.com
(click on “Audio” versions then Reimer 2001)
<http://www.mennolink.org/books/confessionoffaith.html>

Language and Dictionary

Explanation of Plautdietsch:
<http://www.mhsbc.com/news/v11n03/p11.htm>
English/Platt German Online Dictionary:
<http://mennolink.org/>
Translator: [Dictionary.com](http://www.Dictionary.com)
Resources: [Languageresources.co.uk/German/English](http://www.Languageresources.co.uk/German/English)

Audio Programs

Internet Radio from Chihuahua, Platt German News Broadcast: [Mennoitaschihuahua.mx](http://www.Mennoitaschihuahua.mx)
Audio Platt German of N/T: [Sw-radioplattdeutsch.radio.de](http://www.Sw-radioplattdeutsch.radio.de)
[Sw-radiodeutsch.radio.at](http://www.Sw-radiodeutsch.radio.at)
Mennonite Community Services CHPD 105.9 De BrigjEkj Ran (I Run) Low German [http://ciamradio.com/ekj-ran-i-run-low-german/](http://www.ciamradio.com/ekj-ran-i-run-low-german/)

Health among the Low German Mennonites

www.mennonitehealth.com

Opening Doors website: <http://openingdoors.co/>

Health Links

Canadian Council on Health Services Accreditation (CCHSA): <http://www.cchsa.ca>
Canadian Patient Safety Institute (CPSI): <http://www.cpsi-icsp.ca>
History of the Mennonites: <http://history.mennonite.net/> <http://www.mhsc.ca/>
Organizations Involved with Mennonites
Mennonite Central Committee Canada Low German Programs: <http://canada.mcc.org/lowgerman>
MCC Alberta: <http://mccalberta.ca/whatwedo>

Mental Health Commission of Canada

<http://www.mentalhealthcommission.ca/>

University of
Lethbridge



Mennonite Health
University of Lethbridge
1 403 382 7119
4401 University Dr W,
Lethbridge, AB T1K 3M4
mennonitehealth.com

**A Hot
Design**

Design by A Hot Design
ahotdesign.com