Definition of Health and Health Promotion Behaviors Among Midwestern Old Order Amish Families

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OBJECTIVES: To investigate health beliefs and behaviors among Old Order Amish. METHODS: 87 Old Order Amish adults. Open-ended questions and quantitative measures - Health Promoting Lifestyle Profile (HPLP), Multidimensional Health Locus of Control (MHLC), and Perceived Social Support (PSS) scales. Hermeneutic analysis of qualitative data. Comparison of means of quantitative measures across gender and generation using ANOVA. RESULTS: Support for multidimensional concept of health, 2) Dominance across generations of exercise/physical activity and nutrition as health-maintaining behavior, 3) Definition of health as ability to continue working to provide for family, 4) Work-related physical activity most frequent health-maintaining behavior; 5) Internal-HLOC consistently scored most highly; 6) Chance-HLOC scores were higher than powerful others-HLOC scores; 7) HPLP - nutrition ranked among highest and exercise ranked lowest; and 8) PSS-family scores were higher than PSS-friends scores. CONCLUSIONS: Strong Amish family support system makes family involvement in health maintenance essential, 2) Findings important for clinicians working with persons who prefer natural remedies to complex scientific options, 3) Evidence that health/illness of culturally-diverse rural persons may be unique, and 4) Need for further examination of cultural appropriateness of measures in research with diverse groups.

KEY WORDS: Health Behaviors; Internal-External Control; Lifestyle; Religious Beliefs; Social Support.

The aim of this multi-generational, ethno-religious minority research project was to explore health promotion and well-being among three generations of one ethnically-diverse group – Old Order Amish. Although many studies document health promotion activities among the general population (e.g., Collins, et al. 2001; Kaufman, 1996; Miller, 1991), relatively few investigators have focused on such behaviors among members of diverse subgroups (DeSantis, 1989; 1993). The discrepancies in life expectancy, morbidity, and mortality among different ethnic groups (Arnold, 1993; Ma & Henderson, 1999) may relate to differences in lifestyle or health-promoting behaviors (Foster, 1992; Geronimus, 2000). Indeed, as an ethnic and religious minority group, the Amish experience of health in the U.S. may be quite different from that of the majority population and other population subgroups.

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The overall goal of the larger research project was to examine factors influencing the health, well-being, and health promotion practices of community-based, ethnically-diverse rural older adults. The specific aims of the reported research were to: 1) examine and compare open-ended responses to health definition and health maintenance practices among three generations of Old Order Amish, and 2) compare and contrast the variables of health locus of control, health-promoting lifestyle, and perceived social support among the three generations.

AMISH HERITAGE

The Old Order Amish are descendants of the 16th century Swiss Anabaptists, a group that espoused baptism of adult believers and opposed infant baptism. In the early 1700's, to escape religious persecution, the Amish broke away from the Mennonites and immigrated to the U.S., settling in Pennsylvania. Today, the Amish seek to maintain a separateness from the world by maintaining a simple lifestyle without material luxuries, a distinctive style of dress that is similar to the 16th century European peasants, an agricultural way of life, travel by horse and buggy, and absolute pacifism (Bomar, 1989; Fuchs, Levinson, Stoddard, Mullet, & Jones, 1990; Hostetler, 1993; Kraybill, 1989; Palmer, 1992). Not opposed to technology per se, they are opposed to “becoming worldly,” and carefully maintain their separateness by keeping technology at a less accessible distance (Hostetler, 1993). For example, use of a telephone belonging to a neighbor or business, or located in a covered shelter at the end of a lane and shared by more than one family, might not be prohibited in the Amish community.

The religious and cultural beliefs of the Amish result in many health perceptions and behaviors that differ significantly from the dominate American culture (Adams & Leverland, 1986; Brubaker & Michael, 1987; Buccalo, 1997; Palmer, 1992; Schweider & Schweider, 1975; Wiggins, 1983). For example, the Amish voluntarily abstain from participation in the government social security system, choosing to maintain separateness from the world by relying on a cash economy and “self-insurance” through community support in case of natural disaster or major health crisis (Glenn, 2001).

This rarely-studied group has approximately 150,000 believers in 20 states and Canada today and a strong presence in the Midwest (Harden, 1996). Communities of Amish exist in every state with a major agricultural base. Birth control measures are not routinely practice, resulting in large families and rapid growth of the Amish population (Brubaker & Micheal, 1987; Smith, 1961). The Amish represent a young and extremely fast-growing population subgroup, the fastest growing rural group in the U.S. As an ethnic subgroup within the vulnerable rural U.S., it is important that researchers and practitioners better understand Amish health perceptions and health promotion practices to help them optimize health and health care access.

Because formal education is limited by religious beliefs, the Amish rely on non-Amish, known as the “English,” for health care needs not met by self-care practices (Hostetler, 1993). Folk medicine such as the use of liniments, vitamins, reflexology, midwives, and therapeutic touch are routinely practiced (Hostetler, 1980; Trier, 1991). “Pow wowing,” a practice of sympathy curing or faith healing using words, charms, and physical manipulations, to heal is common (Hostetler, 1980, p.274; 1993).

Although the use of modern medical technology is not prohibited by religious beliefs, the Amish are cautious and conservative in action (Hostetler, 1993) and may refuse health services if approval has not been granted by the community leaders (Wenger, 1991). For example, Amish families and communities vary in receptivity to the practice of immunization for communicable diseases, leading to increased vulnerability to epidemics (Trier, 1991). The Amish are at risk because they travel into the non-Amish community for periodic shopping and visits to relatives in distant Amish communities. Although the Amish account for less than 0.5% of the national population, they experienced nearly all rubella reported in the U.S. in 1991 (Briss, Fehrs, Hutcheson, & Schaffner, 1992), a clear example of their unique vulnerability.

With scant data (e.g., Troyer, 1988) on incidence, prevalence, mortality, and morbidity specific to the Amish population, Amish health risks related to cardiovascular disease, diabetes, cancer, and other diseases prevalent in the dominant population are largely unspecified. The unique combination of Amish lifestyle and genetic factors may lessen or increase the impact of certain risk factors.

METHODS

Cultural Beliefs

Cultural beliefs of individuals define health
Table 1. Demographic and Historical Summary of Participants by Generation

<table>
<thead>
<tr>
<th>Variable</th>
<th>Total (N=86)</th>
<th>Generation a</th>
</tr>
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<tbody>
<tr>
<td></td>
<td></td>
<td>Young (n=43)</td>
</tr>
<tr>
<td>Age (years)</td>
<td>X</td>
<td>x (range)</td>
</tr>
<tr>
<td>Males</td>
<td>46.41</td>
<td>25.67 (18-39)</td>
</tr>
<tr>
<td>Females</td>
<td>8.04</td>
<td>8.25 (8-9)</td>
</tr>
<tr>
<td>Total</td>
<td>8.09</td>
<td>8.26</td>
</tr>
<tr>
<td>Chronic Conditions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Males</td>
<td>1.84</td>
<td>0.75</td>
</tr>
<tr>
<td>Females</td>
<td>2.31</td>
<td>1.04</td>
</tr>
<tr>
<td>Total</td>
<td>2.08</td>
<td>0.90</td>
</tr>
<tr>
<td>% female</td>
<td>59%</td>
<td>63% (n=27)</td>
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</tbody>
</table>

a Generations: Young = 18-39 years, Middle = 40-59 years, Older = 60+ years

and illness and when and how they will seek access to health care (Tripp-Reimer, Johnson, & Rios, 1995). For instance, cultural groups within the U.S. do not always view health as a primary value. Group members experience conflicts between their own particular cultural values and those of the larger society (Yeatts, Crow, & Folts, 1992). The significance or meaning of health and health care for individuals and families of varying backgrounds must be understood if health care professionals are to help these clients to optimize their health (Lask, 1991). Understanding the viewpoint of the minority elderly is particularly important so that their cultural heritage and beliefs be maintained while their health and independence are maximized.

Participant Recruitment and Characteristics

Participants were Midwestern conservative Old Order Amish adults who were voluntarily participating in a health screening program offered in a local Amish schoolhouse. After initial contact via the health screening program, family members were invited to participate in the present study. Additional recruitment was conducted through snowball sampling. Potential participants were given letters of information about the present study via mail or personal delivery at health screening sites. Potential participants were screened to ensure they met inclusion criteria: over age 18, verbally facile, and membership in the Amish community. Upon consenting to participate, interviews were scheduled.

As demonstrated in Table 1, participants averaged eight years of formal education (range = 6 to 9 years) in the one-room schoolhouses where lessons were taught in both English and German. This level of education is consistent with what is widely expected in Amish communities (Kachel, 1989). The age range of all participants was 18 to 78 years with a median age of 40 years. Although 73% of the respondents of all ages were married, 100% of respondents over the age of 60 years were married. Fifty-two percent of the participants were female. Respondents over age 60 reported an average of 3.3 chronic health conditions. For comparison purposes, participants were classified into three generations: young (18-39 years), middle (40-59 years), and older (60+ years).

Ensuring Culturally Appropriate Measurement

When approaching research with non-mainstream populations (i.e., non-European American, middle-class, Christian-oriented), it is essential to consider the cultural appropriateness of data collection procedures including choice of instruments and method for collecting data from participants. Sedlacek (1994) argues that there is often a belief among researchers that what is good for one must be good for all. Because humans are inherently diverse, it is impossible for every research instrument to provide unbiased measurement of all people. Related to this is the use of traditional approaches to data collection and analysis that
urement of all people. Related to this is the use of traditional approaches to data collection and analysis that may be biased toward mainstream interpersonal norms of interaction. For example, Land and Hudson (1997) found that face-to-face interviewing was a more effective method of data collection for studying Hispanic cultures than mailed surveys that are often perceived as more impersonal. Although this method was more time-consuming and costly than mailed surveys, the cultural value of personalismo of the participant population warranted this modification in methodology.

In consideration of these issues regarding multicultural research, the primary author made several efforts to incorporate culturally appropriate procedures into data collection. First, the entire interview tool was reviewed by professional caregivers from agencies serving this Amish community. Second, pilot work was completed with an elderly Amish couple who assessed and evaluated the cultural appropriateness and sensitivity of the interview tool. Third, because some members of the Amish community may be uncomfortable with the use of modern technology, the use of audio-taping was not included in the present procedures. Rather, interviewers took detailed notes during the interviews and followed each interview with written field notes.

**Instruments and Interview Protocol**

All participants took part in a face-to-face interview lasting between one and two hours on average. The interview was conducted by trained graduate nursing research assistants who read the items to participants who were unable to read or who had apparent difficulty completing the forms. Some participants, however, preferred to complete the interview on their own with face-to-face verification by a research team member. Because several tools were checklists, and most were designed specifically for use with older participants, interview fatigue was minimal. Data were collected using completed quantitative measures, notes taken during the interviews, and post-interview field notes. Up to three generations were interviewed in the first wave of data collection due to the extended family networks and geographical proximity of multiple generations of family members.

The interview was composed of open-ended and semi-structured questions dealing with affective experiences (Lawton, 1988), health practices, and health perceptions; and scales measuring psychological variables of perceived control (Reid & Ziegler, 1981), health locus of control (Wallston, Wallston, & DeVellis, 1978), health-promoting lifestyle (Pender, Walker, Sechrist, & Stromberg, 1988), perceived social support from family and friends (Procidano & Heller, 1983), self-rated health, and morale (Lawton, 1975). Descriptive data in the areas of health care practices and self-rated well-being were collected using two Likert-scale items, and open-ended questions focusing on the type and frequency of health-promoting behaviors (i.e., “Tell me about five things you do to stay healthy. For each of these things you listed, tell me how often you do it.”) and on health definition (i.e., “Tell me what being healthy means to you?”). For the present study, analyses were focused on responses to the open-ended questions and the measures of health locus of control, health-promoting lifestyle, and perceived support from family and friends.

Health locus of control was measured using Wallston and Wallston’s (1981; Wallston et al., 1978) 18-item Multidimensional Health Locus of Control (MHLC) Form A. This measure contains three 6-item scales measuring dimensions of health locus of control: internal (IHL C), powerful others (PHLC), and chance externality (CHLC). The IHL C consists of questions concerning how strongly individuals feel they are in control of their health status (e.g., “If I take care of myself, I can avoid illness”). The alpha coefficient for this scale has been reported as .767 for Form A. The PHLC scale includes questions assessing individuals’ perceptions of powerful others’ (i.e., doctors, nurses, etc.) control over their health (e.g., health professionals control my health). The alpha coefficient for this scale has been reported as .673 for Form A. The CHLC measures individuals’ beliefs that their health status is largely based on chance or fate and that they or anyone else has little control over whether they will get sick or become well again (e.g., “No matter what I do, if I am going to get sick, I will get sick”). The alpha coefficient for this scale has been reported as .753 for Form A (Wallston et al., 1978). The MHLC has been frequently used with older (e.g., Fried, van Doorn, O’Leary, Tinetti, & Drickamer, 2000; Johansson, Grant, Plomin, & Pedersen, 2001), multicultural (e.g., Barroso et al., 2000) and rural populations (e.g., Winstead-Fry et al., 1999).

Health-promoting lifestyle was measured using Pender and colleagues’ (Pender et al., 1988; 1990) 48-item Health Promoting Lifestyle Profile (HPLP). The HPLP is composed of six subscales: stress management (a = .702), interpersonal relationships (a = .800), health responsibility (a = .814), self actualization (a = .904), nutrition (a = .757), and exercise (a = .809). The alpha reliability for the complete HPLP has been reported as .922 (Walker, Sechrist, & Pender, 1987). The HPLP has...
been frequently used with older (e.g., Conn, 1998; Pullen, Walker, & Fiandt, 2001), multicultural (e.g., Duffy, Rossow, & Hernandez, 1996; Nies, Bluffington, Cowan, & Hepworth, 1998; Peltzer, 2002) and rural populations (e.g., Pullen et al., 2001).

Perceived social support was measured using Procidano and Heller’s (1983) Perceived Social Support-Family (PSS-Fa) and -Friends (PSS-Fr) 20-item scales. The PSS-Fa assesses perceptions of actual, available support from one’s family members (e.g., my family is sensitive to my personal needs; my family gives me the moral support I need). The alpha coefficient for this scale has been reported as .90. The PSS-Fr evaluates perceptions of actual, available support from friends (e.g., “My friends are sensitive to my personal needs;” “My friends gives me the moral support I need”). The alpha coefficient for this scale has been reported as .88 (Procidano & Heller, 1983). The PSS sub-scales have been used with multicultural populations (e.g., Way, Coal, Gungold, Pahl, & Bissessar, 2001).

DATA ANALYSES

Hermeneutic analyses (Packer, 1985) were used with qualitative data from the open-ended questions regarding definition of health and health promotion practices. Initial coding of responses to the open-ended questions were organized into categories followed by thematic analysis (Lincoln & Guba, 1985). The unit of analysis was the complete thought determine by both a natural pause in the individual’s train of thought and the identification of ideas and topics that could stand alone as independent entities. For example, if a participant said, “I walk each day, eat good food, and try to take vitamins,” the concepts of walking, eating, and vitamins were coded as three separate units of analysis. Coding in this fashion is consistent with qualitative content analysis described by Germain (1993).

Means were calculated for the quantitative variables and subscales of interest. Due to potential problems with dependence of responses secondary to multiple familial relationships (41 of the 87 participants were related to one or mother other participants), ANOVA and MANOVA were used to compare means across generation.

FINDINGS

Results and Discussion of Qualitative Analyses

The results of the content analysis of qualita-

tive data included responses to questions regarding individuals’ definitions of health and health maintenance behaviors. The brevity of participants’ responses to these open-ended questions may reflect a more parsimonious worldview or this brevity may possibly be related to responding to questions in a non-native language - German is the first language spoken among the Amish. This brevity of words may have implications for patient teaching and printed patient education materials. The emergent themes for both questions are presented below.

Definition of Health

In the categorization of the data on definition of health, six themes emerged: the importance of being healthy, the ability to work hard, a sense of freedom to enjoy life, family responsibility, physical well-being, and spiritual well-being. These themes were consistent across the age groups and validated in a letter by one middle-aged male participant who chose to respond to the research team in writing instead of in a formal interview (Appendix A).

The first theme, the ability to work hard, was consistently expressed by both young and old respondents. One reason for the prevalence of this belief may be that older adults in Amish communities are expected to and do maintain their functional roles throughout their life courses, even despite possible disabling conditions (Hewner, 1997; Roth, 1997). Another reason for this belief may be that in Amish communities all individuals over the age of five years who are in good health are expected to work (Roth, 1997). Specific service to the community as an indicator of being healthy, beyond simply the ability to work hard, was uniquely reported by two respondents. Thus, being able to work appears to be highly valued as a definition of individual health status among these Amish.

The second theme, the importance of being healthy, was apparent in responses such as: “very important” or “everything.” One respondent equated good health to “life itself.” Often there was a one-to-two-word global response. For example, one brief response to the definition of health question was simply two words: “feeling good.” One possible explanation for this response may be the importance of being able to work among the Amish. Being in poor health and unable to work may be stigmatized and therefore avoided.

The third theme, a sense of freedom to enjoy life, was evident when several respondents noted that being healthy meant “being able to do whatever you
want.” The concept of freedom may run contrary to traditional understandings of Amish communities as highly structured and rule driven. Rather, Kraybill (1989) argues such structure provides boundaries that allow for the development of a sense of meaning, belonging, and identity among the Amish. Statements such as these about personal freedom as an indicator of one’s health status may reflect individuals’ perceptions that they are not hindered by their health to fulfill their family and community obligations. That is, a woman’s ability to clean her family’s clothes, which she wants to do to fulfill her family role, is an indicator of her personal freedom and thus her health status. One individual wrote that being healthy meant being able to “enjoy the beauty of nature.” The ability to enjoy the outdoors and nature may be indicative of the agrarian-based lifestyle of the Amish (Roth, 1997). Another individual spoke of being able to travel to visit family because she was healthy. This sentiment may be a result of the salience of family among the Amish discussed below.

A fourth theme, family responsibility, dealt with being able to raise a family and to be able to provide for them. The central importance of the family has its origins with the religious beliefs of the Amish where the entire society is based around the family. Churches measure the size of their congregation by number of families rather than individuals and worship services are held in families’ homes or barns (Bachman, 1942; Kraybill, 1989). Most Amish adults marry and have families. The mainstream U.S. concepts of divorce and remarriage are forbidden (Roth, 1997). All of these factors work together to establish the salience of the family among the Amish. Thus, being able to provide for one’s family as an indicator of being healthy should be expected.

The fifth theme, physical well-being, was characterized by participants’ mentioning of having energy or feeling good. This theme may be related to others discussed above including being able to work and provide for one’s family. Quite simply, having the energy and feeling as though one is not ill are important to one’s abilities to be a contributor to the community and family. Thus, it appears that not only is individual ability important to health status but individuals’ perceptions of being physically able to contribute are also important.

A sixth theme, spiritual well-being, was evident when participants spoke of being healthy as being spiritually healthy. This occurred across the groups, as many spoke of worshipping in a simple setting such as a home in the community. Because of the centrality of spirituality and religion among the Amish (Hostetler, 1980), the mentioning of the concept of spiritual health among these participants is to be expected.

Health Maintenance Behaviors

Participants were asked to report activities done regularly to stay healthy. The analysis of the self-reported health maintenance behaviors supports the notion of a multidimensional concept of health outlined in the MHLC. Mental, physical, psychological, and spiritual components of health behaviors were cited. This is consistent with findings among the other diverse groups of community-dwelling respondents (Armer & Conn, 2001; Huck & Armer, 1996).

Behaviors categorized as exercise/physical activity and nutrition dominated the responses. Work-related physical activity was the most frequent health-maintaining behavior cited by both males and females. In turn, health was frequently defined by the ability to continue working to provide for the needs of the family. One respondent listed five activities carried out regularly to maintain health—all of which were related to strenuous out-of-doors activities, such as hauling manure, milking cows, and doing shop work.

QUANTITATIVE ANALYSES

Quantitative findings were derived from participants’ responses on the Multidimensional Health Locus of Control scale (MHLC: Wallston & Wallston, 1981; Wallston, et al 1978), Health Promoting Lifestyle Profile (HPLP: Pender et al., 1988; 1990), and Perceived Social Support (PSS) -Family and -Friends scales (Procidano & Heller, 1983). Table 2 includes the means and standard deviations for the three generations on each of these scales.

The mean responses of the MHLC was statistically similar across the generations. Internal health locus of control (IHLC), the tendency to perceive responsibility for one’s health to lie with the individual, was consistently scored most highly by all generations. Respondents scored higher on the chance HLC scale, related to the perception of one’s state of health being strongly affected by chance or fate (i.e., forces outside one’s control), than the PHLC scale, related to the tendency to perceive one’s health to be related to actions of powerful others such as doctors, nurses, and family. Statistically, there were no significant differences across the generations on the MHLC scales.

On the HPLP, the nutrition subscale ranked among the highest and the exercise subscale consistently ranked the lowest of the six subscales. The three gen-

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erational groups ranked nutrition behaviors as first of six health-promoting behavior subscales. Exercise was ranked sixth by the young and middle generations and fifth among those over age 60. In contrast, nutrition and exercise behaviors were consistently the most frequently reported health maintenance behaviors in response to the open-ended question, and the most frequent behaviors carried out by respondents, across generation. In cross-generational comparisons of HPLP subscale scores, means were stable.

Perceived Social Support scores were consistent across generations. The three generations all scored higher on the PSS-Fa scale than the PSS-Fr scale. A statistically significant difference between group means was found. T-test revealed that this difference was marginal (p<.25) difference between the mean scores of the younger and older generations. The higher general scores on the PSS-Fa scale should be expected because, as discussed earlier, the Amish place a strong emphasis on the family. In addition, most participants were members of a multigenerational family unit with extended family members living in close proximity. In spite of reliance on non-Amish “English” for transportation outside of the close-knit Amish community, communication and support existed even among extended family members residing in Amish communities in other states.

Weddings and funerals were attended by these extended family members using hired “English” transportation. Letters were frequent sources of communication, as well. Within this Amish community, younger sisters helped care for the older sister’s newborn infant, and a younger brother might assist with milking chores during the later weeks of the pregnancy. Mothers assisted the young newly-married homemakers in canning fresh fruits and vegetables from the garden for the winter months. Adult children cared for frail elderly parents. In contrast, no significant group differences were found on the PSS-Fr. T-tests of individual group means revealed that the following differences between groups were approaching significance: young/older, middle/older. No significant differences were found between males and females on either the PSS-Fa or PSS-Fr.

**CONCLUSIONS**

Due to use of a convenience sample of rural Amish participating in community-based health promotion programs, generalization is limited. Caution must be taken in assuming that non-participating Amish adults are similar to those who chose to participate in health promotion programs and health-related research. By using open-ended, semi-structured, and structured interview techniques, health professionals concerned about the unique perspectives, needs, and choices of vulnerable populations like the Amish can increase understanding and better develop culturally and generationally-appropriate health promotion programs.

First, the strong family support system in the Amish community has implications for family influence on health-related decision-making. That is, it appears from these data that Amish individuals do not typically make health-related decisions in isolation. Rather, they may be more likely than mainstream U.S. individuals to rely on the views of their family members or community leaders when deciding on health care option. In the past, in traditional Amish communities, elders decreed what health actions were deemed appropriate for community members. In today’s Amish communities, elders may choose to defer health decision-making to the individual family, with health decision-making heavily vested in the father. Such health-related decisions may include such issues as use of childhood immunizations or having a home birth attended by a lay midwife versus birth attendance by a non-Amish professional midwife.

Successful health programs in the Amish community must be built on good communication with both elders and family leaders, with careful attention to identified community, family, and individual priorities voiced by these decision-makers. Thus, family involvement in health screenings, care planning, and caregiving is essential in order to ensure that the decisions made regarding the individual’s health care are based on accurate and appropriate information. Thus, family involvement in health screenings, care planning, and caregiving are essential in order to ensure that the decisions made regarding the individual’s health care are based on accurate and appropriate information.

The increased support for chance-HLC over power others-HLC across all ages offers insight into the Amish world view. The belief that many aspects of health-related outcomes are outside the control of powerful others, such as doctors and nurses, is consistent with the use of lay and folk remedies and healers who rely less on individuals’ unique abilities and more on fate and faith. This is important information for clinicians assessing and planning care for persons who prefer natural remedies to complex scientific options (Tripp-Reimer & Martin, 1988; Tripp-Reimer et al 1995).

The findings offer insight into health mainte-
nance activities chosen by Old Order Amish. The diversity of the range of health promotional activities reported supports the concept of a multidimensional definition of health by these persons. The importance of the ability to work and provide for family was clearly communicated by participants of all ages. Findings supporting the notion that health and illness experiences of culturally-diverse rural persons, such as the Amish, may indeed differ from other rural cultural groups as well as the dominant white, middle-class perspective.

Consideration of the cultural and generational appropriateness of tools designed to measure health promotion behaviors and perception is essential to the design and conduct of research aimed at increasing understanding of and guiding interventions for vulnerable groups. For example, the discrepancy between the HPLP rankings and the open-ended responses suggests aspects of exercise perceived by elders to influence health status may not be captured by the standardized HPLP subscale. The inversion of the powerful others and chance HLC scores has implications for understanding Amish perceptions of health and illness and what may be considered appropriate interventions for disease prevention and cure. These findings suggest the need to further examine factors influencing health and well-being among these diverse groups.

Further comparative analysis of definitions of health and health promotion behaviors among other diverse groups (e.g., urban/rural African American, Catholic nuns) is in progress (Armer & Radina, in review). These preliminary research findings increase understanding of health-promoting and health-maintaining behaviors among members of these culturally diverse rural groups.

APPENDIX A

Letter from Participant

We eat 3 full meals a day. Most of our food is home grown which includes a lot of whole wheat flour. We don’t watch our cholesterol but we do watch refined sugar and salt some.

We do have one day a week (Sunday) to relax from earthly work. Which we also attend church regularly and also is a day to sometimes visit friends or older people, sick, etc.

Most weekdays are about the same. We get up in the morning – 4:30 - 5:00 am and go to bed from 9:00-10:30. We try to keep us busy with some kind of work – for two reasons. There is always something that should be done to provide for the family and it’s better for us if we have some kind of work to keep our minds on. Of course we also take some time off to rest and relax like over the noon hour, etc. Sometimes, we also take an evening off to get together with our friends or parents and family members. Sometimes we also take the day off to go to a public sale, barn raising, quilting or the likes.

There is hardly ever that we see a Physician unless for a broken bone or something that we can’t handle at home. We don’t depend on drugs to keep us healthy.

We don’t take any special exercise. We don’t use any alcohol, tobacco, or illegal drugs.

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