

# Facing Away: Mental Health Treatment with the Old Order Amish

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*Mental health treatment of the Old Order Amish is a relatively new phenomenon. Increasingly however, members of this sequestered Christian sect are either voluntarily seeking treatment or finding themselves ordered into treatment. Because they resist acculturation, many of the models of cross-cultural treatment are less than fully applicable; and because their pursuit of counseling is relatively recent, there is little information available to guide the therapist working with these clients. This article provides a practical approach to the more salient experiences and difficulties that arise in treatment of the Old Order Amish.*

## FACING AWAY: MENTAL HEALTH TREATMENT WITH THE OLD ORDER AMISH

The Old Order Amish face the paradox of living a sequestered lifestyle in an interlocking modern society. Their reliance on horse and buggy as the primary mode of transportation, their resistance to using external power sources in their homes, an education usually limited to the eighth grade, and their plain form of dress all serve to mark them as “a peculiar people,” a label they gladly accept (Hostetler, 1993; Kraybill, 2001). Their rapidly expanding numbers—approximately 175,000 in 28 United States and Canadian provinces, a roughly 200% increase in 25 years (Nolt, 2003)—also brings increasing attention from the very world they attempt to avoid, an unwelcome but necessary acculturation (Berry, 19995).

The Old Order Amish (condensed to “Amish” in this article, although in point of fact, there are several groups of “plain people” who use this generic term) are marketed by the tourist industry as being “frozen in time.” In reality, the Amish accept change slowly, and they adapt modern technology to suit their needs. Historically, they have been slow to accept mental health services. The reasons for such resistance vary, both for

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individuals and for Amish communities (see, for example, Egeland, 1986; Jakubaschk et al., 1994). However, several common concerns predominate in their resistance to mental health care. Concerns about the mental health field itself include perceived cultural biases and misinformation about them among "English" (their term for non-Amish) therapists. Concerns arising from a theological/social perspective include the traditional emphasis on bishops or ministers as the source of counseling (or in some communities, lay Amish who serve in a counseling role) and the possibility that counselors outside the community may hold agnostic or atheistic views. The Amish also emphasize the "untrained mind," placing a premium on humility; "excessive" education or deep thought can become a source of pride and thus is viewed as unnecessary for the simplicity required to live a Christian life. Worse, excessive education may be viewed as an effort to emulate the omniscience of God (Hostetler, 1993; Weyer et al, 2003).

The Amish have long been willing, however, to take from the world that which they consider good, separating themselves from that which is bad (Igou, 1999). For this reason, they seek the services of qualified medical and allied health professionals (Wittmer, 1995; 2001). Increasingly, they either seek mental health services on their own or sometimes find themselves (or their youth) court ordered into involvement with such services. At the same time, little information is available in the mental health literature about clinical work within the Amish culture. Although detailed, thorough, and excellent sociological studies of this "peculiar people" abound (e.g., Bennett, 2003; Emery, 1996; Kraybill, 2001, 2003; Reiling, 2002; Savells, 2003), a literature review found only one article on mental health needs (Cates & Graham, 2002).

The current article addresses several pragmatic aspects of mental health work with the Amish. Cross-cultural theory and models are a necessary starting point; however, the large majority of these do not address the unique demands of work with a population that neither plans, nor desires, to be assimilated, but intends to remain sequestered. The following outline, then, does not attempt an overarching theoretical approach. It should be considered as a broad "case study," perhaps of a community or lifestyle, rather than an individual. The descriptions of individual clients are designed to maintain anonymity.

One additional caveat. The Amish are bound by basic principles of belief, largely referenced in the *Ordnung*, a set of rules for living (Hostetler, 1993; Nolt, 2003). However, this is at best a loose overarching hierarchy that guides all Amish; many of the rules for daily living and

behavior remain at the community level. For this reason, principles that guide customs in one area may not apply fully or completely in another. Likewise, principles that guide behavior at the time of the writing of this article may change by the time it sees print. For these reasons, this outline should be seen as a broad description, and not as a blueprint for work with Amish clients.

### THE THERAPIST'S ROLE WITH AN AMISH CLIENT

The "client" vs. "patient" distinction in mental health has subsided somewhat in recent years, as the terms—at least in common usage—once again overlap. Still, their original meaning, distinguishing a collaborative versus professional-patient participation in the therapy process is an important consideration here. Because the Amish value the "untrained mind," and because much of their health care experience is with the medical field, their initial presentation may be as a "patient" who takes a more passive role. Cues from the therapist that the relationship is collaborative and that the therapeutic work will proceed as a mutual process, may be readily accepted by some Amish clients. For others though, the awareness that they will take an active role in their therapy may produce anxiety. The therapist needs to remain alert to this possibility and of the potential need to explain, in greater-than-usual detail, the process of the therapeutic encounter, its purposes, and the roles of therapist and client.

Building rapport and establishing empathy with Amish clients are also unusual processes. No degree of intimacy, and no level of emotional closeness crosses the emotional and psychological fences that the Amish maintain to separate themselves from the world (Igou, 1999). An observant therapist becomes attuned to the emotional distance, the measured response, and the caution with spontaneity that often characterizes interactions with these clients. While the Amish are able to maintain strong emotional ties with English friends (and even therapists), invisible (at least to outsiders) barriers to full relationships are always present. Often, the greatest rapport occurs as the client develops a respect, rather than the more commonly anticipated emotional closeness, for the therapist.

Ironically, the nonjudgmental attitude toward behavior and beliefs that therapists offer may serve to increase emotional conflict for an Amish client. Although our dominant culture values independence and freedom, in contrast, the Amish value submission and conformity (Wittmer, 1995; 2001). In order to maintain that conformity, the Amish maintain a strong self- and church discipline. If a community member is seen as too rebellious or too "worldly" (often, too eager to accept or promote change),

s/he may be pressured to conform or face community disapproval. A therapist's acceptance of a variety of worldviews is uniquely permissive and may challenge the conformity that the client attempts to maintain. As a result, the client must find a niche for the therapist that includes this unusually "open" attitude. Because the Amish are unlikely to express this conflict openly unless questioned, it may initially be difficult to see the quandary in which the client is placed. Such nonjudgmental empathy can allow a client to actively explore the reasons for a set of beliefs and confirm them; however, it can also create an experience of guilt and confusion, at least during a transition phase.

David was a young adult male who had recently joined the Amish church and was struggling with the use of alcohol. Prior to his decision to be baptized, David had used alcohol heavily, and he continued to binge drink on weekends. During sessions, the therapist easily identified David's sadness as a sense of loss over the "worldly" life he had left behind, although David remained committed to pursuing the Amish lifestyle. Although David was willing to use cognitive-behavioral techniques and Alcoholics Anonymous meetings to manage his alcohol abuse, he nevertheless was unwilling to work on his emotional issues outside the sessions (for example, sharing his sense of grief with his family or friends). When gently confronted with this by the therapist, David indicated he believed that these feelings would not be accepted by his community.

David felt that he had the support of his bishop and his church to help him abstain from alcohol use. However, he felt that the church community would not accept his feelings about losing the freedom of his adolescence prior to baptism into the church. Therapy involved time to discuss the confusion created by the therapist's permission to grieve. Comfortable in the church, he sometimes felt that he was betraying his beliefs by openly expressing his emotions in sessions. The therapist acknowledged the divergent nature of counseling and Amish life, and encouraged David to work with his issues in a manner that was comfortable for him.

As noted above, at age 16 Amish teens enter a period in which they are allowed to "run around" prior to joining the church (Reiling, 2002). This period, known as *rumspringa* (though the Amish dislike this word as an English-imposed term), is also a period of difficulty for Amish parents. No longer in school, loosened from parental control, yet not subject to the strict discipline of the *Ordnung* since they have not yet joined the church, some (although certainly not all) of these youth choose to "go wild." This can be a period of increased alcohol, tobacco, and illicit drug use, as well as experimentation with sexual behaviors. Amish youth are most likely to face

problems with law enforcement during this time. Later problems with substance abuse and dependence frequently begin in this unregulated time.

Jonah was a fifteen-year-old Amish male referred to therapy for sexually abusing a female Amish neighbor. Because of the nature of his offense, therapy was relatively long-term. Over time, it became clear that Jonah was identifying with his "English" therapist and was using him as a model for his own life. The boy felt uncomfortable with the Amish, and was actively seeking an entrance into "the world." As with most Amish, when Jonah turned 16 years old, he would enter a period in which he would be granted increased freedom in his life (often called by the Amish as "entering the devil's playground"). He would be free to make his own choices until he chose to be baptized into the church or leave the Amish entirely.

In this case, the therapist chose to speak with Jonah's mother and described the situation. The therapist was frank, expressing his own concerns. First that Jonah might well "go English" or "run wild," and second, that Jonah's parents (and the broader Amish community) might see this as the therapist's fault. Jonah's mother, however, was sufficiently concerned about her son that she wanted him to remain in treatment with the therapist, and she was willing to take the risk involved. Therapy included a modified sex offender protocol, but the therapist also examined the realities of Amish life versus life in "the world" with Jonah.

### THERAPIST ACCOMMODATIONS WITH AMISH CLIENTS

Therapists avoid the indulgence of self-disclosure. There are numerous, highly appropriate reasons for this: to avoid "bootlegging" therapy, to maintain the focus of attention on the client, to avoid a sense of collegiality in therapy, among others. Still, Amish clients live in communities in which cohesion and intimacy are the norm. Self-disclosure is anticipated, expected, and even encouraged. Members of an Amish church anticipate open confession of their sins. *The Budget*, a primary Amish publication distributed throughout all communities, includes information on the health and well being of individuals (Wittmer, 2001). As a result, the therapist's lack of self-disclosure may seem odd to an Amish client, although s/he client will rarely comment on this fact. The Amish client may see a therapist as unwilling to share because "English" are "of the world;" of greater concern, a client may perceive a therapist as withholding secrets, particularly when such honesty is requested. The information disclosed by the therapist need not be excessively intimate. Divulging marital status,

number of children, or original home location may suffice to give clients a sense of therapist "self-disclosure."

One of the areas of greatest difficulty for a therapist may be broaching the subject of morality or spirituality. We speak of Amish "culture;" more accurately, they comprise a Christian sect (Kraybill, 2001; 2003). To work with the Amish is to work with a people who have actively chosen this lifestyle as a manifestation of what they believe is Christ's teaching. Clothing, grooming, and transportation set the Amish apart; yet there is no effort to impose their beliefs on a therapist. Indeed, it is much more common for the therapist to inadvertently impose her/his beliefs on the Amish client. The Amish generally accept the broader Christian faith, and do not see themselves as the only "true" believers; those few fundamental Amish who do ascribe to this belief are unlikely to seek mental health services unless ordered to do so.

Therapist self-disclosure in regard to spiritual beliefs is a difficult issue. The Amish are fundamental Christians, their values "conservative" by the standards of the world; they are not open to change. If the therapist makes the choice to share her/his spirituality as a means of furthering the therapeutic relationship, such disclosure can serve a positive purpose. If the therapist's beliefs deviate too far from mainstream Christianity, however, such disclosure can form a barrier in therapy as well. Whichever spiritual beliefs may be held, a therapist who is uncomfortable working with clients who espouse strong, fundamental Christian principles may be uncomfortable working with the Amish. For those who do choose to share a spiritual belief, little is required beyond a simple explanation (e.g., "I consider myself a Christian/Catholic/Baptist," etc.). A statement such as, "My thoughts and prayers go with you" supports the Amish way of life.

### **PRACTICAL CONSIDERATIONS**

The majority of Amish speak "Dutch" (a German dialect) in the home; once children attend school, even a parochial (Amish) school, they learn English (Hostetler, 1993). The Bible in an Amish home is Luther's translation, written in German; therefore, the Amish speak Dutch and English, and read German. Currently, among some Amish communities, there is a fear that English is overused and that Dutch will become a lost language for the younger generation. In these communities, this may result in a "backlash," or insistent return to the old ways. More affluent communities may emphasize moving Amish children to parochial schools and away from public schools.

For many Amish clients English is still a second language since Dutch continues to be the language of choice in the home and is the language of greatest comfort and familiarity. For this reason (and depending on an individual's level of involvement with "the world"), an Amish client may experience difficulty with English idioms, slang, and phrases, or have trouble with self-expression. Again, clients are unlikely to share such problems readily. However, over long associations, the Amish in conversation will say "What's a word for that in English?" or "There's no exact translation for that," acknowledging the language barrier.

In the initial stages of interviewing an adolescent Amish sexual offender, the therapist prepared to ask a routine set of questions about masturbation. On prior occasions, the therapist used the word masturbation and several slang expressions for it. The boy had never heard any of these terms. Once the therapist described the act, the boy readily admitted masturbating several times per week. When asked, "What do you call that in Dutch?" the boy puzzled a moment and replied, "I don't think we *have* a word for that in Dutch." Subsequent checking by the therapist confirmed that it was unlikely that a word to describe such behavior would be familiar to the boy. In his community, many sexual acts might be described, but were unlikely to be named.

Transportation is also an important consideration for the Amish. The use of "English taxis," usually vans driven by non-Amish who rent their services for trips farther than a horse and buggy can reasonably accommodate, is common, but can also be expensive. For this reason providing as many services as possible in one trip or (if multiple therapists are seeing Amish clients) arranging for as many client visits as possible at one time, defrays clients' transportation costs. For the same reason, cancellations are difficult, and clients need as much notice as possible. Cell phones are increasingly common (although often used only for outgoing calls; incoming calls are received on voice mail). In some areas Amish even have landline phones into their homes. However, many communities still rely on "phone booths," in which several families share voice mail on one line in a booth some distance from their houses (Kraybill, 2001). In these cases, a message may not reach a client immediately.

The mental health ethical obligations regarding confidentiality can also be different from the Amish perception. Some clients may prefer that no one know that they, or members of their family, are receiving mental health services. In these cases, the client or family may be hiding services from their bishop or church hierarchy. However, some clients prefer that this

information be shared with their church leaders. A bishop leads the Amish church district; beneath him in the hierarchy are ministers, and beneath them hierarchically are deacons. If a client approves the suggestion, a "courtesy call," to visit a bishop at his home, can make significant inroads into the Amish community. Otherwise, again if the client approves, a letter or phone call/voice mail to the bishop can serve as a respectful recognition of the Amish hierarchy. The Amish clergy are also the frequent "first line" of treatment for mental health problems, and will be the source of "aftercare" when the client is terminated from a mental health center. For this reason, too, it becomes important for the therapist to network with the client's bishop and ministers.

The following vignette highlights the "community" approach to mental health that sometimes characterizes work with the Amish. The client's church—in Amish belief, a group of people, and not a building—felt integrally involved with his treatment and progress. Thus, involving them in an understanding of his behavior, and opening his treatment to their questions was an appropriate, if unusual step.

Adam, an Amish man with a family of five children, suffered a closed head injury after being kicked in the left temporal region by a horse. Sequelae included poorly controlled seizure activity, impulsivity, and inappropriate sexual comments and behavior toward women in the church and community. Therapeutic intervention included work with both Adam and his wife, and a "team" approach with his bishop and ministers, who visited him on a regular basis, both to provide support and gently confront his behavior. After a time, Adam requested that his counselor meet with his church community (approximately fifty adults) to explain his condition and the causes for his behavior. This meeting was arranged through the bishop, and the meeting was held in the absence of Adam and his wife, again at their request, to assure that the church members would feel comfortable asking questions.

Amish clergy are no different from clergy of any religious group in their willingness to accept "advice" from therapists on the management of clients. Adam's bishop—as well as others—actively seek the advice of counselors on how to manage some issues in their churches. Others are willing to work alongside therapists, but feel no need to share views. Still others prefer to avoid the counseling process, and encourage their church members to do so as well. The therapist does well to read the situation, and provide education and supervision to church leaders as appears appropriate.

### THE DIFFICULTIES OF AMISH LIFE

No more and no less than any other group of human beings, the Amish face the problems associated with misplaced aggression, addiction, and sexually inappropriate behavior. However, in a patriarchal and hierarchical system that sequesters itself from the world, these problems may be "hidden" in a way that disturbs non-Amish mental health providers. Our insistence on the ability to speak freely, on equality of gender, and on a system in which agents outside the family maintain authority to deal with the protection of threatened children or adults, is often at odds with Amish life in which the church handles discipline for such behaviors. But discipline works best for obvious infractions that are confessed and that involve behaviors that are neither compulsive nor repetitive in nature. For behaviors that are blatantly denied, or for behaviors that feel out of control for the individual, spiritual discipline may be less effective.

In the Amish community, as with any group, both physical and sexual abuses occur with too great a regularity. The size of families, cultural choice to ignore certain pseudosexual behaviors in preadolescence (discussed below), and sexual behaviors during the adolescent *rumspringa* period may allow a greater forbearance of some behaviors than would be true in the broader society; however, this is a difficult, and culturally intertwined, determination. The level of cohesion among Amish communities and the sense of unease that often exists toward "the world" also mean that services, such as those provided by social service agencies investigating child physical and/or sexual abuse or spousal abuse, are viewed with skepticism. The normal avenues of approach—investigation, removal from the home, expectations for parenting classes, therapy, etc.—may work well with the "English." For the Amish, however, such approaches may work with one child or family, but effectively shut down avenues of reporting from the broader community.

The issues of accountability and victim status in cases of sexual offenses may also be perceived differently among some Amish families. We make a clear distinction between victim and perpetrator, even if sexual behavior had an element of "consensual" activity involved. For the Amish, a victim who actively participated in a sexual encounter, regardless of circumstances, may share some level of responsibility and be deemed guilty of the sin of adultery. The therapist who encourages the victim to see herself (or himself) as blameless creates an awkward paradox. While the victim may feel comfort and support from the therapist, within the community and the family, s/he may receive a much different message. Ultimately, as can occur

with a non-judgmental approach, such support may actually increase confusion and guilt. Unless the victim clearly was incapable of giving consent, strongly coerced, or otherwise forced into sexual activity, the therapist support will highlight the paradoxical lack of support for a "blameless" role that is found from the community.

Laura was an adolescent female coerced by an older Amish neighbor to have intercourse; she eventually became pregnant. The incident was reported to the Child Protective Services team and investigated; counseling services were arranged. The incident was widely known in the community in which she lived and in surrounding communities. Laura received compassion and support from adults in her life, which included the rekindling of a relationship with a teacher to whom she had grown quite close while in school. However, the community made it quite clear that Laura had committed adultery and must request forgiveness for her part in the sin.

Counseling with Laura needed to acknowledge her status in the community. The pressure from several other mental health professionals on her therapist was strong: they emphasized that Laura needed to learn that she was a victim, that she in no way was to blame, and that asking forgiveness and seeing herself as committing adultery was a way for a patriarchal society to continue to dominate. However, none of these arguments acknowledged the reality that Laura desired to continue living in an Amish community, and that those from whom she most needed approval were committed to a worldview in which she needed to ask forgiveness for her sin. As a compromise, counseling focused on Laura's need to be forgiven for her adultery and her role as a victim at the hands of a perpetrator. It was a paradox within "English" beliefs, but one that Laura seemed able to accept.

Amish boys engage in a pseudosexual game called "cows 'n bulls." Normally played by preadolescent and adolescent males, approximately ages six through twelve (although these ages may vary widely), the game involves either simulated or actual anal intercourse. It serves as a rite of passage for many, but because the Amish are reluctant to acknowledge that the game exists, it is difficult to determine the extent to which it is detrimental to development or the extent to which it is a harmless, culturally sanctioned form of sexual play. However, there are clearly times when the game becomes aggressive.

One Amish young adult, in discussing the physically abusive behavior that led to his referral, admitted that at approximately ten years of age he had been anally raped by four older boys during a "cows 'n bulls" game. He

did not see himself as a victim, but rather as accountable for the outcome, because he had gone with the boys with the intent of playing the game. Therefore, in his perception, he had sinned equally with his abusers. The therapist agreed with the boy's belief system to the extent that he had sinned in planning to play the game. However, the young man eventually was able to reframe the incident to understand that he had been sinned against in being raped, an important cognitive shift that helped him take responsibility for his own aggressive behaviors in his marriage.

The issues here were similar to those presented with Laura; however in this case, the victim began to identify with the perpetrators, and he became aggressive with his wife. Helping him to see the point at which actual, physical force changed the situation was important in moving him beyond a sense of guilt and in reframing distinctions in acceptable and unacceptable behaviors.

The Amish emphasis on humility and the untrained mind creates unique issues for the therapist. Humility may interfere with efforts to bolster client self-esteem and self-confidence. Praise must often be indirect; for example, remarking on a session, "There was some good work done today," rather than "You did a good job." Likewise the emphasis on the untrained mind can interfere with efforts to develop insight, or even cognitive-behavioral techniques that become too sophisticated in the level of analysis required from the client. In the same way, reports of "progress" to the therapist may be tempered; to report too much success or express too much satisfaction may be seen as expressions of pride.

### FORMER AMISH

In any area densely populated by Amish, there will also be those who have chosen not to remain within the Amish life. In one sense, they are not the subject of this article; yet, their experience often lingers, and is a pervasive influence on the people they become.

Those who leave the Amish (generally) are better accepted by the community if they leave during their late teens or early adulthood, prior to baptism into the church. Some may leave as children with their families, and have little choice in the decision; others may enter *rumspringa* and choose "the world" over Amish life. In either case, they are likely to leave close relatives within the Amish church. The extent to which those who leave are accepted and supported varies from community to community, church to church, and family to family, but all are likely to be both rejected and accepted to some degree.

If a baptized member leaves the church, s/he is placed "under the ban,"

or is excommunicated (Hostetler, 1993). Some districts use a time-limited ban (in which case it is applied more frequently); for other districts, the ban is for life (in which case, it is a rarer occurrence). For Amish "under the ban" the ability to interact with family and friends varies, depending on district, church, family, and reason for the ban, but the "ban" is less likely to be supported for those who leave prior to baptism.

Mary left the Amish when, after many years of marriage, she left an abusive relationship with her husband, who also abused alcohol. In doing so, she left adult children, sisters, brothers, and her parents behind. Although several relatives in the Amish still communicated with her, the remainder of her family refused contact. She described her past among the Amish, recalling how she would sit on the front porch of her home in the evening, listening to the traffic pass on a busy road nearby. "I used to think of that as my way out," she said. She never divorced her husband, and never became involved with anyone else romantically, but lives quietly on her own. She struggles with depression, and continues to have trouble acclimating into "the world," although she now professes to hate all things Amish.

Andrew, an adult male, left the Amish because of severe and unremitting depression. He sought help from his bishop and was told that sufficient faith would change his outlook. Eventually he left his wife and children, obtained a divorce, and began a relationship with an "English" woman. His depression was better managed with antidepressant medication, but continued. Andrew professed anger with his Amish background, and he felt it had "robbed" him of much of the life he could have lived. Yet, in many sessions, he talked of his experiences as an Amish boy and man and about the relationships he had developed within that community. When the therapist gently interpreted the possibility that he was grieving the loss of that life, he was able to acknowledge this.

Mary and Andrew demonstrate the quandary that occurs for many who leave the Amish. No matter how difficult it may have been, no matter how much better life may be now, former Amish often seem at odds with their past, casting a bittersweet glow over the world they have left. Large, extended families, strong community bonds, and the ingrained belief that the Amish sect is a calling all serve as emotional ties to a life now gone. The therapist does well to assess the status of any client who refers to her/himself as "former" Amish.

### **A BALANCED APPROACH TO TREATING AMISH CLIENTS**

Neither the "simple" people of tourism marketing myth nor the "mystics" that some would hold them to be, the Amish are a Christian sect,

who live their lives in a simple way. They face problems no different from any other human beings or human society. Only the culture in which they live is unique to those of us who prefer the complexities and nuances of the 21<sup>st</sup> century western world. Yet the Amish, too, are slowly, inevitably changing. As they do change, more are embracing the concept of mental health care or are finding themselves or their families ordered into treatment.

Treating Amish clients is both extremely challenging and extremely rewarding. The subtleties of working with a sequestered culture, the inevitable emotional distance, the expectations of a therapist that can differ so dramatically from what we normally anticipate from a client, all stretch one's competence and abilities. At the same time, the Amish tend to be a generous and caring people, more than willing to respect those who respect them, and consistently forgiving of the faults that we in the world bring to the table in our work with these truly "peculiar" people.

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