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FAMILY INTEGRATION AND PSYCHOLOGICAL WELL-BEING AMONG OLDER ADULT BEACHY AMISH

by

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Table of Contents

		Page
	List of Tables	v
	Acknowledgements	vi
	Vita	ix
	Abstract	xi
I.	INTRODUCTION	1
II.	SURVEY OF THE LITERATURE	6
	The Amish	6
	Cultural Gerontology	19
	Family Integration	25
	Psychological Well-Being	39
III.	HYPOTHESES	50
IV.	METHODS	54
	Subjects	54
	Procedure and Assessment Instruments	57
V.	RESULTS	64
	Family Integration	64
	Psychological Well-Being	71
	Family Integration and Psychological Well-Being	74

Results Related to other Variables 76

Qualitative Results 77

VI. DISCUSSION 83

Discussion of the Results and Comparisons with Other Groups 83

Cultural Themes 92

Methodological Issues 102

Future Research and Theoretical Issues 108

Conclusion 119

VII. REFERENCES 122

VIII. APPENDICES 133

Appendix A: Structured Interview 133

Appendix B: Modified Family Adaptability and Cohesion Evaluation Scale 142

Appendix C: Life Satisfaction Index Z 144

Appendix D: Geriatric Depression Scale 146

Appendix E: Item Response for Cohesion Subscale 148

Appendix F: Item Response for Adaptability Subscale 149

Appendix G: Item Response for Life Satisfaction Index Z 150

Appendix H: Item Response for Geriatric Depression Scale 151

List of Tables

		Page
Table 1:	Percent of Contact Between Older Adults and at Least One Child	66
Table 2:	When Older Adults Last Saw at Least One Child	66
Table 3:	Time of Journey to at Least One Child's Home	66
Table 4:	Mutual Aid Patterns Shown in Percentages	68
Table 5:	Reported Levels of Family Cohesion	70
Table 6:	Reported Levels of Family Adaptability	70
Table 7:	Means and Standard Deviations of Reported Psychological Well-Being . . .	73
Table 8:	Correlation Coefficients for Measures of Family Integration and Psychological Well-Being	75
Table 9:	Correlation Coefficients for Measures of Family Integration, Psychological Well-Being and Demographic Variables .	78
Table 10:	Comparison of Mutual Aid Patterns Between the Amish Sample and a U.S. National Sample	88

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ABSTRACT OF THE DISSERTATION

Family Integration and Psychological Well-Being
Among Older Adult Beachy Amish

by

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The aim of this study was to examine family integration and psychological well-being among Beachy Amish older adults and to evaluate Amish society as a positive model of psychological aging. The present study focused on two dimensions of family integration (association and affection) and two dimensions of psychological well-being (life satisfaction and depression). By employing a social network sampling procedure, 60 Beachy Amish persons, age 55 or older, were selected as subjects. A structured interview was conducted with each subject; in addition,

each subject completed several self-report measures. The results revealed that the Amish subjects have high associational integration as measured by intergenerational contact, residential proximity, and familial mutual aid, and high affectual integration as measured by reported familial cohesion and adaptability. Psychological well-being, as measured by reported life satisfaction and depression, was also found to be high. When Amish associational integration was compared with non-Amish samples, the results showed that the Amish were similar in the frequency of intergenerational contact and residential proximity, but showed greater mutual aid. An important finding of this study was that mutual aid, affectual integration, and psychological well-being were significantly correlated. Mutual aid was found to be significantly correlated with both affectual integration and psychological well-being, and affectual integration was found to be significantly correlated with psychological well-being. These quantitative findings were discussed in terms of qualitative observations, important cultural themes, and methodological and theoretical issues. The qualitative and quantitative results suggest that Amish society appears to serve the interest of older adults and is a positive model of psychosocial aging.

INTRODUCTION

As the number of elderly persons in the United States and around the world continues to increase, new models of familial integration and care for the elderly will need to be evaluated and adopted. The rapid increase in the number of older persons in the United States is well documented; however, less research has examined cross-cultural familial models for the integration of and care for elderly family members. The purpose of this study is to (a) examine one particular sub-cultural group and (b) to propose it as a positive model of familial integration of aged members. Investigation of alternative models seems particularly important since the number of elderly persons are increasing and the family is the primary social institution which has usually accepted or been assigned the role of integrator and care-giver. Another reason this investigation seems particularly important is that social and behavioral research has not given much attention to the variety of cultural models of familial integration of the elderly which exist or how the existing models might be modified for future

needs. Researchers have seemingly taken a status quo or ethnocentric approach with regard to issues related to familial integration of aged members. Past research has tended to be limited to familial integration in majority U.S. culture. The descriptive results have then been used in a prescriptive manner. Such an approach sees U.S. majority cultural patterns as "normative" rather than only one model among many. Thus, in one sense the current study is an attempt to add to the small but growing literature which has attempted to report possible alternative models of familial integration of aged members. As the number of older persons rapidly increases and as the number of four and five generational families increases, traditional U.S. majority cultural patterns of integration of the elderly may not be satisfactory. Such models may not serve the best interests of either the family or the aged individual, and new models may have to be adopted. One service which social and behavioral science researchers may provide to the larger society is the investigation and presentation of alternative models of familial integration of aged members which best serve the interests of both family and aged individuals.

In this study the familial integration of Amish older adults is investigated. Amish society is examined because (a) it is uniquely different from U.S. majority

culture and so adds to the literature regarding additional models, and (b) it may have positive components which can be used in the development of alternative models of familial integration in other societies. The purpose of this study is not to make Amish society prescriptive or normative. Nor is it to romanticize Amish society or the Amish aged. Amish society has created a unique social construction of reality. The Amish have attempted to be "in," but not "of" the "world," and have been selective in their acceptance of Western cultural patterns, world views, social institutions, and technology. While the Amish are geographically and historically a Western society, they have also attempted to be faithful to their religious ideals and so have created a unique social reality. An important component of their unique social reality is the centrality of family integration. This uniqueness makes the Amish an especially good group to examine the familial integration of aged family members.

Familial integration of aged members in this study is defined as the degree to which kinship patterns, relationships, and processes encourage and maintain associational and affectional interactions between younger and older family members. Family associational integration patterns to be examined between older adults and their children in this study include: (a) frequency of contacts, (b) patterns of living arrangements and

residential proximity, and (c) exchange of resources, or mutual aid patterns. The affectional aspects of family integration will be examined by investigating the level of (a) family cohesiveness, and (b) family adaptability as reported by older adults. In addition to examining familial integration of older Amish, this study will also explore the psychological well-being of older Amish and how familial integration and psychological well-being may be related. For this study, psychological well-being will be investigated by evaluating the level of reported life satisfaction and depression among older Amish.

This study will allow for a general description of familial integration and psychological well-being, which is not reported elsewhere in the literature and will allow for the testing of several general hypotheses. The initial hypotheses of this study are that the Amish will show a high level of familial associational and affectional integration, as well as psychological well-being. In addition, it is hypothesized that a positive relationship will be found between (a) associational and affectional integration, (b) associational integration and psychological well-being, and (c) affectional integration and psychological well-being.

In summary, the rationale for this study is to (a) provide descriptive data regarding family integration and psychological well-being among older adult Beachy

Amish, and (b) to examine Amish society to determine if it is a positive model of psychosocial aging.

SURVEY OF THE LITERATURE

The Amish

History of the Amish. The subjects in this study are members of a small religious sect known as the Amish. Despite perceptions of the Amish as a traditional, static folk culture, there is change and adaption among the Amish. One example of this is the variety of "Amish" groups which currently exist. The current study includes subjects from several small Amish groups who have split from the larger Old Order Amish in the last twenty to eighty years. Before further identifying the Amish of this study it is helpful to briefly discuss the Old Order Amish. The Old Order Amish are the largest and most socially, religiously, and technologically conservative and traditional group of Amish. This group takes their name from Jakob Ammann, who was a leader in the Swiss Anabaptist church fellowship, and who split from the Anabaptists between 1693 and 1697, and founded his own group who became known as the Amish. While the Amish concurred with the Anabaptists on most doctrinal issues such as adult baptism, separation of church and state, the church as a "new community," the

priesthood of believers, and pacifism, a major reason for the split was in regard to the "ban" and the degree of "shunning." To use the ban was to excommunicate a person from the church for some deed or belief deemed wrong by the church. Shunning is the practice of not associating with those who have been disciplined or banned by the church. Amman held more firmly to the practice of banning and took a stronger position of total shunning than did the larger Anabaptist community, hence the separation.

The migration of Old Order Amish from Switzerland to Pennsylvania started as early as 1727 and continued for about 100 years until no Amish remained in Europe. While the Amish settled in many areas of the United States they came and remained primarily in Pennsylvania, Ohio, and Indiana. One of the largest Amish settlements is still in Lancaster County, Pennsylvania. It is estimated that the total number of Amish in the United States is approximately 85,000 people.

Characteristics of the Amish. In attempting to define the nature of Amish society, Hostetler (1968) uses Redfield's (1950) ideal of the "little community." While Hostetler (1968) believes that the Amish have similarities to "folk," "primitive," and "peasant" societies, he finds them different in several important ways. The little community is usually seen as a rural sub-culture within a more modern state; hence it is unique in regard to more

traditional folk or peasant societies. However, it is similar with folk societies in that it is small, largely isolated, homogeneous, oral communication-centered, and takes on "Gemeinschaft" features. Hostetler (1980) lists four ways in which he believes the Old Order Amish fit the model of the "little community":

1. Distinctiveness. Simply by seeing an Amish person one can see that he or she is distinctive. Distinctive features can be noted thoughout their lifestyle. The distinctiveness is based on religious convictions and traditions. The influence of religion permeates family interactions and patterns, economic transactions, social structures, the limited use of technology and modern luxuries, and style of clothes. Another distinctiveness is the common use of Pennsylvania Dutch or low German.

2. Smallness. The social life of the Amish is centered in small networks. Of course, one such network is the family; the other primary group is that of the church district made up of thirty to forty households who live in close geographic proximity. Large bureaucracies or highly structured social institutions are not encouraged or desired, but rather intimate relationships are fostered.

3. Homogeneity. Hostetler (1968) states that "The Amish community is homogeneous in the totality of its culture and psychology. Ways of thinking and behaving are much alike for all persons in corresponding positions

of age and sex" (p. 15). Commonness of thinking is stressed. The Amish receive a similar level of education, have similar occupations, and have a similar amount of wealth, or at least all members have economic security. Homogeneity is evident in first and last names of the Amish. Often children receive names similar to their grandparents, and there are about only forty common last names within the Amish community. Homogeneity is evident in the internal and external Amish farm and home by the commonness in architectural styles.

4. Self-sufficiency. The Amish attempt to be self-sufficient in most areas of life. The Amish are largely economically, nutritionally, educationally, socially and religiously self-sufficient. The Amish are also self-sufficient in that they refuse to accept federal farm subsidy, compensation payments or Social Security benefits or any other type of governmental aid. Hostetler (1968) states that "Amish security requires a high degree of personal relations and responsibility in times of stress, fire, sickness, old age, or death. Amish life is not segmented into cliques, clubs, or special interest groups, but approximates a cradle-to-the-grave arrangement as an integral whole: the community provides for all or most of the activities and needs of the people in it" (p. 21).

The Amish groups included in this study are the Beachy Amish, the New Order Amish and several Amish-

Mennonite fellowships. These groups are all similar in that they split from the Old Order Amish, but still want to be identified as "Amish." While little research has been conducted among the new and smaller Amish groups, there is at least some evidence to suggest these groups have similar qualities of the "little community" as identified with the Old Order Amish and as outlined by Hostetler (1980). While there are many similarities between the newer Amish groups and the Old Order Amish, the new Amish groups have tended to be more evangelical in their religious faith and practice, as well as more accepting of modern technology. For example, the newer Amish groups not only stress the traditions of the church and the importance of maintaining an integrated religious community, but they have also tended to stress the importance of a "personal" spiritual experience. They stress the importance of a personal salvation experience, and that this is important or at least as important as maintaining traditional Amish values and practices. The newer Amish groups have attempted to maintain a balance between the traditions and practices of the historic Amish community, as well as an evangelical individual spiritual experience. With regard to technology, the new Amish groups have accepted the use of telephones into private homes, but some groups, such as the New Order Amish, do not all use electricity in their homes. Also, many New

Order Amish continue to use horses and buggies, whereas most of the other newer Amish groups own and use automobiles. However, none of the newer Amish groups have televisions in their homes. It is not uncommon, however, for them to have a radio.

The largest and oldest of the newer Amish groups in Lancaster County are known as the Weavertown Amish (later Beachy Amish). This group includes nearly two-thirds of the total subjects for this study. The Beachy Amish have been named or assigned themselves several names since their beginning in about 1910 (Lapp, 1963). The various names have included (a) Church House Amish (they often met in church buildings instead of private homes as the Old Order Amish have done), (b) Amish-Mennonite (in many respects they identify with both Amish and Mennonite religious faiths and practices), (c) Peachy Amish (two ministers named S.W. Peachey and C.D. Peachey from Belleville, Pennsylvania, helped to organize the group), and (d) Weavertown Congregation (the Peachey Church in 1928 bought a church house outside of Bird-In-Hand, Pennsylvania in an area known as Weavertown). While the group is today officially known as Beachy Amish, many persons (both within and outside of the group) and authors continue to use one or several of the names listed above. Just as the Old Order Amish separated from the Anabaptists over the issue of the ban and shunning, the Beachy Amish in

Lancaster County withdrew from the Old Order Amish due to a controversy concerning shunning (Lapp, 1963). The controversy concerned the degree to which a particular person should be shunned. A number of persons could not agree to the more severe practice of shunning in this particular case and so in about 1910 thirty-five families split from the Old Order Amish. As noted above, the group was first called the Peachey Church, taking the name of several of its first organizers. In 1928 the group bought a church house and became known as the Weavertown Amish-Mennonite congregation. In 1958 the Weavertown congregation joined an affiliation of other groups which had also split from the Old Order Amish. This new group was known as the Beachy Amish-Mennonite Affiliation. The name Beachy is derived from Mose Beachy who helped to organize many of the new congregations. The Weavertown congregation grew from about 85 persons in 1910 to 200 members in the early 1960's. During the 1960's, the Weavertown congregation parented two new congregations which still exist today; they are Pequea and Mine Road. All three congregations maintain active and close ties among each other. The Mennonite Yearbook (Horsch, 1983) lists Weavertown as having 192 members, Pequea as having 152 members and Mine Road as having 107 members.

The New Order Amish are a second group included in this study. The New Order Amish are a small group who

began to emerge in the 1960's in Pennsylvania and Ohio. This group wished to relax the restrictions on the use of technology such as telephones, tractor-driven farm machinery, and power-driven generators for cooling milk tanks. The New Order Amish groups formed an affiliation, but unlike the Beachy Amish do not permit the use of automobiles or meet in church buildings for religious services. The New Order Amish have tended to remain a small group. A primary reason for this is that several groups have withdrawn from the New Order Amish and formed their own congregations. These groups tend to meet in church buildings and have automobiles and in many respects are similar to the Beachy Amish even though they are not officially affiliated with the Beachy Amish. Some of these groups or persons in the groups identify themselves as "New Amish," while others identify themselves as "Amish-Mennonite." The New Amish or Amish-Mennonite congregations included in this study are Gap View, Summit View, and Groffdale. In summary, subjects for this study include persons from the (a) Weavertown, Pequea, and Mine Road congregations of the Beachy Amish-Mennonite affiliation, (b) Honeybrook and Quarryville Districts of the New Order Amish, and (c) Gap View, Summit View, and Groffdale congregations of the new Amish-Mennonite groups.

Studies of the Amish. While several extensive sociological-anthropological studies (Gangel, 1971;

Hostetler, 1980; Hostetler & Huntington, 1971; Kollmorgen, 1942; Schreiber, 1962) have been completed, few studies of psychological well-being and/or family life have been conducted with the Amish. Even fewer studies have been conducted with older Amish. The social and behavioral Amish studies to date have also tended to include Old Order Amish; few studies have concentrated on the smaller and New Amish groups. In short, little is known about psychological well-being, family integration, or the elderly among Old Order Amish or other Amish groups, such as the Beachy Amish. Having noted the paucity of research, several studies will be discussed which have touched on issues germane to the present study. Based on anthropological research, Hostetler and Huntington (1971) outlined what they believed to be six life span developmental categories among the Old Order Amish: infancy, little children (pre-school children), school children, young people, adulthood, and old people. It is with the last category that, of course, the current study is most concerned. Hostetler and Huntington (1971) note that the Biblical reference, "Honor thy father and mother, that thy days may be long upon the land which the Lord thy God giveth thee" (Exodus 20:12), guides much of the attitude and behavior toward Amish aged. The aged are held in high regard, and respect tends to increase with age. Not only do the Amish have respect, but also authority. For example,

church leaders are appointed for life, hence the aged are important in the leadership of the church. Older men are approached for their knowledge in farming practices and older women for homemaking functions.

Retirement in Amish society is gradual and voluntary. Usually between 50 and 70 years of age the older people give responsibility of the management of the farm and household to one of their children. The change of management and responsibility is determined by the needs and abilities of both the parents and the children. For example, the health of the parents may be a large factor in such a transition. When the transition occurs the older people continue to help their children and grandchildren on the farm.

When the Amish couple retires they often move into the "Grossdaadi Haus" or grandfather house, which is a separate dwelling on the farm grounds often connected to the main farmhouse. When the older couple moves into the grandfather house, the son or daughter moves into the main farmhouse and raises his or her family. Thus, the Amish aged have privacy and can determine their own pace of life, but they are also close to their families. The older couple may assist their children, take up part-time jobs, travel, and care for those who are sick.

Economically, most Amish have saved enough money so that they can retire in comfort. The Old Order Amish aged

receive no governmental assistance. When the aged become unable to care for themselves they are not admitted to nursing homes or other institutions, but are cared for by their families. Bryer (1979) outlines how the Amish care for dying persons and their families. The family and church members provide a large support base for the aged and those near death.

In one of the few studies of Amish aged, Roth (1981) explored the effects of modernization among a group of Old Order Amish and Mennonite elderly in Kansas. He used an anthropological format and interviewed ten Amish and ten Mennonite older people to evaluate the relationship between modernization and status. In general, Roth found that Mennonites were more "modern" than the Amish and that the Amish elderly had a greater level of status than did the Mennonite elderly. Roth explored status by evaluating the relative influence of the elderly in matters related to family and church. The Amish aged were found to live in closer residential proximity to their children than did the Mennonites, and were also found to exchange resources more frequently with their children than did the Mennonites. Roth's research findings are consistent with other researchers' (Hostetler & Huntington, 1971; Backman, 1961) observations that Amish aged enjoy a high level of respect and status within Amish society.

The most comprehensive study to date which has

examined psychological well-being among the Old Order Amish is a study by Egeland and Hostetter (1983) in which they examined the incidence and prevalence of psychiatric disorders among the Amish of Lancaster County from 1976 to 1980. The study was epidemiological in nature and was not limited to hospitalized Amish. While the study was not limited to older people, and statistics for older people were not reported, the research by Egeland and Hostetter (1983) is helpful in gaining a general understanding of the psychiatric disorders encountered by the Amish. From 1976 to 1980, Egeland and Hostetter identified 112 active cases of mental illness out of a population sample of about 12,000 Amish. Using the criteria from the DSM III, 71 percent of the 112 cases received a diagnosis of a major affective disorder, 9 percent received a diagnosis of a specific affective disorder, and the remaining 20 percent were diagnosed as having thought disorders (i.e. schizophrenia, paranoid disorder, and atypical psychosis). While affective disorders appear to be the most common psychiatric disorder among the Amish, Egeland and Hostetter note that "the rate for major affective disorders (among the Amish) is about one percent, which is half the usual rate of mood disorders in other populations" (p. 56). Egeland and Hostetter's research suggests that the rates for mental illness in general and affective disorders in particular are below the average for many other populations.

Investigation of psychological well-being in this study seems especially warranted since affective disorders are the most commonly diagnosed psychiatric disorders among the Amish. Thus, measures of life satisfaction and depression were included in this study.

Few empirical studies have investigated Amish family life, and in particular the family life of Amish aged. The family is an important social institution within Amish society (Huntington, 1976). Hostetler (1980) gives several examples of how the family plays a central role; for example, the size of each church district for the Old Order Amish is measured by the number of families, not the number of baptized individuals, and directories and maps made by the Amish list families and households rather than individuals. The family is seen as a primary institution for socializing children into Amish society (Hostetler & Huntington, 1971; Huntington, 1976). Hostetler (1980) states that the family is not only a powerful force in socializing of children but the family is also an important force (unit) throughout the life span of the individual Amish person. In many respects, Amish youth are socialized not to leave the family and live an independent life, but rather are socialized to relate as individuals within a family context throughout the life span. Hence, the family is a primary institution for people of all ages. One aim of the present research

is to document how Amish aged are indeed part of the family system within Amish society.

In summary, the Amish are made up of a variety of groups, but still are common enough in their religious faith and practice for there to be a distinctive social construction of reality known as "Amish." No studies could be located which primarily concentrate on the family integration and psychological well-being among the elderly of any Amish group. Thus, a primary purpose of the present study is to provide descriptive information regarding family integration and psychological well-being and to provide a foundation for future research in Amish studies and family integration.

Cultural Gerontology

While there has been increased interest in the anthropology of aging or cultural gerontology, few studies have actually been reported (Gutmann, 1977; Keith, 1980). This paucity of research is particularly true of the examination of psychological and familial issues related to the anthropology of aging (Clark, 1967). For example, in a recent text on cultural gerontology (Holmes, 1983), only a few pages are given to personality and aging and little attention is given to the family; in fact, family is not listed in the index. The few studies which have been completed have tended to focus on three basic approaches as outlined by Holmes (1980):

1. Status and role studies relating particularly to economic and modernization factors.

2. Self or societal conceptions and attitudes toward aging and old age.

3. Applied pragmatic approaches which attempt to discover ways in which our society and our aged may better cope with the problems associated with advanced age (p. 36).

Simmons' work published in 1945 was the first extensive study of the role and status of the aged in various cultures. While Simmons' (1945) research is 35 years old it still stands as a primary work in the field. Simmons used 109 variables to examine the treatment of elderly in 71 societies. The data used by Simmons was indexed with the Human Relations Area File at Yale University. Simmons found that the aged maintain status when they continue to control knowledge, traditions, special skills, and have property rights. Simmons found that the aged of agricultural societies tend to have a higher status than the aged of either non-technological or highly technological societies.

More recently, Press and McKool (1972) have shown similar results in their anthropological findings of Meso-American societies. Press and McKool found that the aged are at a disadvantage in societies where there are diverse economic systems, discontinuity in father-son

economic interests, and a high level of bureaucratization. In another study, Maxwell and Silverman (1970) found that societies in which the aged control useful information there is a higher level of status and positive treatment. General agreement has been found between the aforementioned studies; that is, the way in which a society is structured has an impact on the aging process. However, Holmes (1980) points to some exceptions. For example, Israel, Russia and Ireland have given a high level of status to the aged, but yet are considered industrialized nations. Holmes (1980) points to the importance of understanding the historical development of each society and the values the society has been built on. For example, a society built on Buddhism may develop quite differently than a society based on Judeo-Christian assumptions.

In a study of societal attitudes toward the aged, Bengston and Smith (1968) found that when young men from Argentina, Chile, India, Pakistan, Israel, and Nigeria were interviewed little relationship was found between traditional and modern societies and their attitudes toward older people. Smith, Homberg, and Hughes (1961) found that personal and societal attitudes toward aging may be a function of the concept of time within the society. Their study suggests that societies in which time is accurately measured may have a less favorable attitude toward aging. Societies which tell people the

precise time they must leave the labor force seem to have higher levels of anxiety about aging. In societies not as concerned with accurate measurement of time less anxiety is reported and a more positive attitude toward aging seems to exist.

In a major study, anthropologists Clark and Anderson (1967) investigated the aging process of San Francisco aged. They found that weak kinship ties, rapid technological change, high levels of personal independence, and economic productivity tend to decrease the possibility for well-being among the aged. Shelton (1965) who studied the Ibo aged in Nigeria found a "virtual absence of psycho-senility or even a sense of indolence or disengagement." Shelton challenges the biological-decremental position of disengagement theory and suggests from his research that the cultural context must be examined to understand the aging process. Shelton posits that deterioration need not be associated with aging. He found in Iboland that the aged have important roles in religious life and have received unlimited support from the extended family. Arth (1968a; 1968b) also studied the Ibo, but differed in his interpretation. Arth found hostility and ambivalence toward the aged, and disagreed with Shelton's definition of "psycho-senility," and believes Shelton's informants to be speaking about cultural ideals, not reality.

Gutmann (1974) has directed his research towards similar interests as the present study. He was particularly interested in the psychological dimension of aging in various cultures. Gutmann, using the TAT, studied five societies, Kansas City, Navajo, Lowland and Highlands Maya, and Druze, to determine the psychological orientation of the old. His findings indicate that the younger men tend to have an active mastery orientation, whereas the aged tend to have passive and magical mastery orientation. Gutmann is careful, however, to say that while this internal shift appears to have some universal scope, the move from active to passive mastery does not support disengagement theory. For example, Gutmann found that the Druze make the shift to a magical and passive mastery orientation, but do not necessarily withdraw socially.

This brief review of most of the major cross-cultural studies helps to set the stage for discussion of how social-cultural factors may affect psychological processes. While the studies are few and not all relate directly to the focus of the present study, they do help to formulate a theory of aging and how social-cultural factors and psychological processes might interact. We can summarize by stating that the type of society seems to have an impact on the status and attitude toward the aged and aging. While this seems fairly well established, it is less established that the type of society may have

an effect on psychological well-being.

The anthropological study of family integration and aging has also received little attention. As noted above, Holmes (1983) gives little attention to the family; likewise, Keith (1982), in another book on the anthropology of aging, devotes little attention to the family. However, in one review of ethnicity and aging, Gelfand (1982) lists several studies which have examined family life. Several studies of residential proximity among several U.S. ethnic groups have been conducted. Sanford (1978) found that among aged Blacks, 12 percent had children who lived in the same county or immediate neighborhood. Ishizuka (1978) found that among elderly Japanese, 20 percent live with their children. In a study by Valle and Mendoza (1978) of elderly Mexican-Americans, 32 percent were found to be living together with their children and over one-third had children or grandchildren in close proximity. The anthropological studies of family life and aging have largely included ethnic groups of U.S. culture (such as those listed above) or with industrialized Western societies (Shanas et al., 1968). Few studies have been truly "cross-cultural," and even fewer studies have examined psychological well-being and family integration. While Cowgill and Holmes (1972) and Keith (1980) assert that there is variation in patterns of aging between various societies, little is known about

the relationship between family integration and psychological well-being between different societies or cultures. An aim of the present study is to contribute to the literature of family integration and psychological well-being within cultural gerontology.

Family Integration

Over 30 years ago, Beard (1949) asked the provocative question, "Are the aged ex-family?" While advances in answering that question have been made in the past several decades in many respects the question still remains a valid one. Many changes have occurred within the family in the last thirty to fifty years. These changes have caused some to ask: How is the family to be defined, and who is included as family? Sussman (1977) has suggested that a helpful way to define the family is to simply ask people whom they include as "family." Changes in who is perceived as family have been largely brought about by an extended life span and socio-cultural changes (Strieb & Thompson, 1959; Townsend, 1968).

While the life span has increased and socio-cultural changes have occurred, Troll, Miller and Atchley (1979) report that the family is alive and well. Studies of families and the elderly have largely confirmed that, despite the changes, the aged are part of family life. Before discussing the family literature it is helpful to

note that much of the research to date has been interested in understanding whether the elderly are integrated into, or isolated from the family. Disengagement theory (Cummings & Henry, 1961) has been used as a heuristic in researching the aged and family relations. Research guided by this approach has assumed that if disengagement theory were correct, then the elderly would be isolated from rather than integrated into the family. To date, the investigation of this question has been conducted by examining family composition and interaction of family members. This has usually taken a more quantitative orientation rather than a qualitative approach. Little research has looked at the emotional or more qualitative aspects of relationships between the elderly and their families. Bengston and DeTerre (1980) have identified several major constructs for understanding family integration or family solidarity. They have defined such features as family composition, living arrangements, residential proximity, and family integration (type and frequency) as "associational solidarity." The emotional or qualitative aspects of family relations are listed as "affectual solidarity." Bengston and DeTerre also list a third construct, "consensual solidarity," which is concerned with life values and norms or expected standards of behavior.

The present paper will focus primarily on the first

two dimensions of family life; those of associational integration and affectual integration. For the purposes of the present project, associational integration will include the following components: (a) family composition, (b) living arrangements, (c) family interaction, (d) mutual aid, and (e) residential proximity. Affectual integration will include family cohesion and family adaptability.

Family Composition. It has often been assumed that the normative family of the past was the three generation extended family and that this arrangement provided security and status for older family members. Modern historical and sociological research of the past several centuries of Western nations is questioning this long-standing assumption (Anderson, 1977; Hareven, 1978; Troll et al., 1979). For example, research findings indicate the frequency of contact between generations may have been less a century ago than at present. More to the point of family composition, however, Bane (1976) found that in colonial America the average number of persons in a household was about five or six persons. In more recent times, Bane reports the average size of a household dropped from 5.6 persons per household in 1850 to 4.1 persons per household in 1930. Bengston and DeTerre (1980) state that in 1977 the average number of persons per household was 3.39 members.

Shanas (1973) in a study of seven countries and Harris (1975) in a nationwide study of the U.S., reported that approximately 80 percent of all older people who were married also had children. In another report, Shanas (1975) stated that four out of five older subjects listed one or more surviving children. Troll et al. (1979) reported that about 10 percent of those over 65 also have children who are also over 65. A similar finding was reported by Shanas (1981) who found that four out of five of those persons who had children also had grandchildren, and of the respondents over the age of 80, about three-fourths had great-grandchildren.

Shanas et al. (1968) and Shanas (1979) reported in a study of three countries (including the U.S.) that 40 percent of those over 65 were either widowed, separated or divorced; widowhood was the most common status for women. In summary, it appears that aged family members may not live in the same household with other family members, but the extended family to which aged members belong has been increasing in the past several decades.

Living Arrangements. Bengston and DeTerre (1980) point to several studies which document the fact that historically the three-generation family household has usually been the exception rather than the rule, at least in Western societies. While Poster (1980) has challenged these findings, it is generally assumed that the three-

generation household was not as common as has often been thought. In more recent times, Lopata (1973) has pointed out that when several relatives from several generations do live together it is usually during a family crisis rather than a permanent arrangement. Carter and Glick (1976) found, however, that living arrangements do vary with race, income, and ethnic background. For example, Yelder (1979) pointed out that Black families are more likely to have three generations in the same household than white families. Kobata (1979) reported that three-generation households are common among Japanese-American families.

Troll et al. (1979) and Troll (1971) reported that most surveys show that older people prefer to live alone. This wish is consistent with the statistical data of most U.S. aged who live in a separate dwelling apart from their children. Shanas et al. (1968) found in Denmark, Britain, and the U.S. that most elderly either live with their spouse or alone. For example, in the U.S., 79 percent of those married live only with their spouse and of those widowed or divorced 49 percent live alone.

Residential Proximity. How close do elderly live to their children or other relatives? Shanas et al. (1968) found that 84 percent of all those over the age of 65 in Denmark, Britain, and the U.S., live less than an hour away from one of their children. Lopata (1973)

found the modal distance between adult children and their aged mother to be one hour. Some researchers have questioned the findings of Shanas et al. (1968) with regard to residential proximity. Adams (1968) found that in his study only one-third of the young adults live near their parents. It should be noted the methodology was different than in the study by Shanas et al., in that the aged parent was asked to list the closest child, and Adams asked the adult child how close he/she lived to their parents. One explanation to the variation is what Bultena and Wood (1969) found: that aged parents may migrate to live near one of their children when they retire. Supporting Adams' findings was a study by Peterson (1979) which reported some 40 percent of all older people have no close living relatives. In addition, Payne (1975) reported that among a group of Black aged only 50 percent had active family relationships.

Family Interaction. Numerous studies have investigated the type and frequency of contact among families (Adams, 1968; Hill, Foote, Aldous, Carlson & MacDonald, 1970; Litwak, 1960; Rosow, 1967; Shanas et al., 1968; Sussman, 1965; Sussman & Slater, 1963; and Troll, 1971). The findings related to the type and frequency of contact tend to parallel that of residential proximity in that they indicate there is a great deal of contact between generations. Troll et al. (1979) report that most of

the research in this area reveals that aged parents and children see each other rather often. When parents and children cannot have face-to-face contact it appears that many communicate by letter-writing or using the telephone.

In Shanas et al.'s (1968) study of three Western nations, 84 percent of the U.S. respondents had seen at least one of their children within the last week and 90 percent within the last month. In another study, Shanas (1973) reported that 52 percent had seen one child in the last 24 hours and 78 percent had seen one within the last 7 days. Harris (1975) in a national study of the U.S., found 55 percent of the elderly persons had seen a child within the last several days, and 81 percent within the last several weeks. In a study of rural and urban aged, Bultena (1969) found that 12 percent had contact daily, 20 percent reported contact for one or more times a week, but not daily, 17 percent reported contact one or more times a month but not weekly, and 51 percent several times a year or less. While there is some variation in the percentage of each of the studies, on the whole they suggest that many older people have frequent contact with their children.

Mutual Aid. Mutual aid is the exchange of resources between generations. The resources can take the form of assistance in everyday activities or emotional and financial support. Lopata (1973) and Hill et al. (1970)

have noted that the exchange of resources is often important in times of family crisis. Sussman (1977) has noted how the family is often the primary and first social institution to care for persons in need. Thus, as Troll et al. (1979) pointed out, the aid between generations is often considered an important variable in understanding the family life of the aged.

Troll (1971) and Sussman and Burchinal (1962) have found two patterns of mutual aid: the one type of aid flows from the old to the young; the second type flows in both directions, from old to young and young to old. While Riley and Foner (1968) found that the percent of aged parents who help their children is slightly higher than the percent of children who give help to their parents, in general they found the pattern of exchange to be bi-directional.

In a study of older people in Louisiana, Bracey (1966) found that less than 15 percent of the elderly received regular help with homemaking activities from their children. Bracey (1966) reported the most frequent aid with homemaking activities had to do with shopping, housework, cooking, and advisory help with money matters and home repairs. Of the same sample only 9 percent stated they received regular financial aid and only 4 percent stated they received occasional money gifts. In another study, Atchley (1976) found that only about 3

percent of his retired sample reported financial gifts from family or friends. Shanas et al. (1968) found that in the U.S. sample only 4 percent of the aged parents received regular money gifts from children and 35 percent received occasional money gifts from children. Shanas and her associates report that 60 percent of the U.S. sample reported giving some type of help to their children and 50 percent reported giving some type of help to their grandchildren. In addition, Shanas et al. found that 69 percent of the aged received some type of help from their children and other relatives. The types of help given included emergency help, home repairs, housekeeping, and financial aid.

Affectual Integration. Much of the research investigating family integration has concentrated on associational integration (Bengston & DeTerre, 1980). Troll et al. (1979) have noted that research on family integration has been too narrow in its approach and has been primarily focused on quantitative aspects of family integration rather than the qualitative dimension. In the past several decades many researchers have assumed that associational integration is a good way to measure "family integration." Many researchers have assumed that if there is a high level of interaction, close residential proximity, and much mutual aid between generations one can assume older persons to be integrated into

the family.

Research which has explored the affectual integration of the aged into the family has challenged the assumption that associational integration alone is a good measure of family integration. For example, Adams (1968) found no correlation between affectual attitudes toward one's parent and the frequency of interaction with parents. Angers (1975) and Brown (1974) observe that positive or negative ratings of affect of immediate family members had no relationship with the amount of contact between family members. Thus, only examining associational aspects of family integration is problematic in that it does not measure all aspects of family life and in particular does not measure how family members actually feel about each other as they interact.

Studies which have looked primarily at affectual aspects of integration revealed that most parents and children report positive feelings for each other (i.e. family) (Troll et al., 1979). This seems to be true at most points along the family life cycle, but seems to be especially true during the later states of the family life cycle. Johnson and Bursk (1977) reported a significant correlation between the two responses of aged parents and adult children when they were asked how they felt about each other. The aged parents and adult children tended to have positive feelings toward each

other and both parties tended to rate their relationship more positive if the parents had adequate financial resources and were in good health. In another study of affectual integration, Rosow (1967) found that role loss among older parents did not necessarily increase dependency on adult children or on the neighbors of the adult parents.

The present study will examine two dimensions of affectual integration: family cohesion and family adaptability. Cohesion is concerned with the degree to which persons report feeling integrated or isolated from the family. Adaptability is concerned with the degree to which persons report their family can change as new or problematic situations are confronted. The present project will explore the degree to which older persons feel cohesion within the family and to what extent they believe the family is adaptable.

Family cohesion is not a new concept in family study (Olson, Sprenkle, & Russell, 1979); however, little research has been conducted which included an elderly generation. Family cohesion for purposes of this study will be defined as "the emotional bonding members have with one another and the degree of individual autonomy a person experiences in the family system" (Olson et al., 1979, p. 5). When there is extreme family cohesion there is enmeshment in the family system and limited individual

autonomy. When there is little family cohesion there is disengagement from the family and high individual autonomy. Olson et al. (1979) posit nine concepts related to cohesion: emotional bonding, independence, boundaries, coalitions, time, space, friends, decision-making, interests and recreation.

Family adaptability, for purposes of this study, will be defined as "the ability of the marital/family system to change its power structure, role-relationship, and relationship roles in response to situational and developmental stress" (Olson et al. 1979, p. 12). It is assumed that extreme adaptability results in chaotic family systems and little adaptability results in a rigid family system. Olson et al. (1979) posit six concepts related to adaptability: family power, structure, negotiation styles, role relationships, relationship roles and feedback.

Olson et al. (1979) have developed a "circumplex model" of understanding family systems which allows for examination of family cohesion and family adaptability as two separate dimensions or together as one dimension of family life. There are 16 possible types of marital and family systems derived from the circumplex model. For example, Olson et al. (1979) assume that the four most balanced (functional) types of family life are "flexible-connectedness," "structural-connectedness,"

"flexible-separateness," and "structured-separateness." (For the other 12 types see Olson et al., 1979.) While Olson assumes these four types to be the most balanced or functional for family life, this has not been examined among aged family members or families who have elderly members, nor has this been examined among various cultural groups. Thus, we do not know empirically which type or types of family system(s) tend to be the most supportive and integrative for older family members. Little is known about how family cohesion and family adaptability (as defined here) relate to associational factors or psychological well-being among the elderly. Another important point to be raised in response to Olson et al's. work is whether other cultures would assume the four "balanced" systems selected by Olson et al. to be the most "balanced" or functional in their particular cultural situation. Olson et al.'s model may be helpful as a tool to describe family integration, but not necessarily a good method to determine what should be prescriptive across different cultural situations.

Conclusion. Several studies show that associational integration is not necessarily correlated with affectual integration and that in general a positive relationship seems to exist between most aged parents and their children. While numerous studies have examined aspects of associational integration, the validity of using only

associational features as measures of family integration has been questioned. Studies do show, however, that there is generally more interaction (type and frequency), mutual aid, and residential proximity between generations than has often been assumed by professionals or the society at large. While several studies have investigated the impact of both associational integration and affectual integration, most studies of family relations among the elderly have not explored both associational integration or affectual integration in the same study. Most of the integration studies have tended to focus on associational patterns.

The present study will explore specific aspects of associational integration (residential proximity, frequency of contact, living arrangements, and mutual aid) and two dimensions of affectual integration (family cohesion and family adaptability). Investigation of family cohesion and adaptability as well as associational aspects of family life will allow for a more comprehensive study of family life, and an examination of both associational and affectual integration within the same sample. In addition to examining associational and affectual integration as two dimensions of family integration, the present study will examine the relationship of associational and affectual integration with psychological well-being. While several studies have explored family

integration and psychological well-being, most of these studies have only examined associational integration and its relationship with psychological well-being.

Psychological Well-Being

Psychological well-being has been the subject of much research within gerontology (Larson, 1978). However, there are two factors associated with psychological well-being which have largely been unexplored: sociocultural forces and family integration. Few empirical studies have examined the psychological well-being of older persons cross-culturally or attempted to understand how family integration is related to psychological well-being. Thus, little is known about the effects sociocultural forces and patterns of family integration may have on the psychological well-being of older persons.

While psychological well-being is a broad construct and can include many dimensions of mental health, the present investigation will explore two dimensions: depression and life satisfaction. This study will concentrate on the more affective aspects of psychological well-being, or what others have termed subjective well-being or morale. Depression was selected for study as one dimension of psychological well-being for several reasons. First, depression is the most common affective and functional disorder among U.S. majority culture elderly (Blazer, 1982). Secondly, depression is the most

common mental disorder among the Old Order Amish (Egeland & Hostetter, 1983). Because depression is known to be a common affective problem it is especially important to explore how reported depression may be related to patterns of family integration. Life satisfaction was selected for study for the following reasons. First, life satisfaction allows for a global assessment of affective psychological well-being, whereas depression is a more focused aspect of psychological well-being. Second, little is known about how family integration and reported life satisfaction are related. The present study will allow for a global assessment (life satisfaction) and a specific assessment (depression) of psychological well-being.

Depression. Depression is the most common psychopathology among the elderly (Birren, Butler, Greenhouse, Sokoloff, & Yarrow, 1963; Granick & Patterson, 1971; Pfeiffer, 1977; Pfeiffer & Busse, 1973; Straker, 1963; Zarit, 1980). This appears to be true for both clinical and community groups of elderly. Depression is especially common if mild levels of depression are included with severe levels of depression. Kay, Beamish and Roth (1964) and Stenbeck, Kumpulainen, and Vauhkonen (1979) found 20 to 25 percent of the elderly subjects they surveyed were mildly depressed.

While depression has been defined differently by many researchers and clinicians, it is now generally

assumed that depression is a constellation of several characteristics. The most generally accepted characteristics of depression are dysphoria and negative affect, psychomotor retardation, and somatic symptoms such as sleep disturbance, fatigue, loss of appetite and weight. A final commonly accepted characteristic of depression is cognitive distortions, such as dysfunctional assumptions, or low self-evaluation. Most clinicians agree that depression is a constellation of these characteristics rather than simply negative affect (Stenbeck, 1980; Zarit, 1980).

Numerous etiological explanations have been given regarding depression among the elderly. The most common explanations are: (a) genetic and biochemical theories, (b) psychosocial aging and adaption, (c) personality dynamics, (d) significant life changes and stress, and (e) cognitive style and processes. While it is beyond the scope of the present project to discuss or investigate the etiology of depression among the elderly, the present project is especially interested in exploring the relationship between depression and family integration. Thus, the present study is not an etiological study of depression, but rather is interested in examining how depression, as one aspect of psychological well-being is related to family life.

Little is known about the sociocultural factors

related to the onset of depression. Several comprehensive literature reviews on depression in later life list few, if any, references on family or sociocultural studies of depression among the elderly (Pfeiffer, 1977; Zarit, 1980; Zung, 1980). One exception is a review by Stenbeck (1980) in which he discusses the social and cultural factors related to depression. Stenbeck states that the many social and personal losses associated with advanced age may contribute to depression. He also states that negative cultural attitudes toward the aging process and the aged may contribute to lowered self-esteem and depression among the elderly; however, these appear to be Stenbeck's impressions since no studies are cited supporting his perspective.

While not directly addressing issues related to family and socio-cultural patterns and depression, numerous authors have discussed closely associated constructs, such as social stress (Blazer, 1980), significant life events (Stenbeck, 1980), life changes (Zarit, 1980), and life stress (Zung, 1980), as they relate to depression. These authors all assume that social and life stresses and changes play an important role in the etiology of depression. The social and life stresses and changes identified as possible contributors to depression are: loss of a loved one, loss of a job, loss of health, loss of membership or status in a group, failure of plans or

personally significant pursuits, upsetting events, migration, and loss of income. It is generally assumed that the greater the social stresses or life changes, the higher the possibility of depression.

Blazer (1980) points out, however, that an interaction exists between social stress and social support. By this he means that the possibility of a person becoming depressed is not only based upon the level of stress or number of stressors, but is also dependent upon the level of support that is available to the person. Thus, a person faced by several losses or stressful events may be able to cope with the difficulties because of a strong social support network. Whereas, a person with few social stresses or changes, but also with few social supports, may become greatly depressed.

Little is known about how the family (as social support) helps older members to resolve or cope with social stresses or changes. For research purposes the present project assumes that the family is an important (primary) social support for older people, and that the family is an important factor in helping older people adjust to social and life stresses and changes. The present study will explore the balance of social stress and social support, and reported depression by examining reported depression among Amish aged and the degree to which they are integrated into the family. It is assumed

that the family is an important social support for Amish aged and the more family integration the greater the social support resources available to the older person. Because of the social supports available through family integration, the older person is better able to cope with social stresses and changes, and thus will report little depression.

Life Satisfaction. The concept of "life satisfaction" has received wide acceptance in gerontological research (Lohmann, 1977). Instead of life satisfaction some have termed the concept, morale (Lawton, 1972), or affect balance (Bradburn, 1969). However, as Larson (1978) has pointed out, the varying terms have fairly consistent meaning. Larson (1978) prefers to call them "measures of subjective well-being." Subjective well-being has also been described as level of satisfaction, happiness, mood, affective state, and life satisfaction.

The first measure of subjective well-being was developed by Cavan, Burgess, Havighurst and Goldhamer (1949) to assess old people's adjustment to specified areas of life: work, health, religion, etc. Further adaption by Neugarten, Havighurst and Tobin (1961) led to measuring strictly internal constructs independent of the external situation. In an attempt to measure only internal subjective well-being several measures emerged: Life Satisfaction Index A and B (Neugarten et al., 1961),

the Philadelphia Geriatric Center Morale Scale (Lawton, 1972), the Bradburn Affect Balance Scale (Bradburn, 1969), and the Kutner Morale Scale (Kutner, Fanshel, Togo & Langer, 1956). Some of these measures have since been revised and have received additional statistical evaluation. For example, Morris and Sherwood (1975), and Lawton (1975), subjected the PGC Morale Scale to factor analysis and found three stable replicable factors: agitation, attitude toward own aging, and lonely dissatisfaction.

From Larson's (1978) listings of the studies using various subjective well-being scales, the Life Satisfaction Index (A or B) has been the most widely used. For example, some 15 studies used the Life Satisfaction Index, whereas the PGC Morale Scale and Kutner Scale were used in only two studies. Clearly the Life Satisfaction Index has been the measurement of choice by researchers. The Life Satisfaction Index has been used in varying geographic settings and with several sub-cultural groups, as well as a national sample (Harris, 1975).

The Life Satisfaction Index was first developed by Havighurst (1963) to measure the following: zest for life, resolution and fortitude, congruence of goals and achievements, positive self-concept, and positive mood tone. This first scale was a rating scale in which an interviewer would rate the subject (this is known as the Life Satisfaction Rating Scale). In 1963, Havighurst

went on to devise two self-report questionnaires which have been known as Life Satisfaction Index A and B. Further analysis and restudy have largely confirmed the use of Life Satisfaction A (Adams, 1969). Wood, Wylie, and Sheafer (1969) found that Index A could be reduced from 20 to 13 questions with similar results. This short version is known as the Life Satisfaction Index Z.

A general trend in life satisfaction research has been to understand the relationship between the degree of life satisfaction and such variables as health, socio-economic status, age, sex, social interaction, and marital status (Larson, 1978). The research indeed suggests that variables such as level of education, occupational status, marital status, and forms of social interaction appear to be related to life satisfaction (Larson, 1978). However, there is an important problem that Larson points out in his review of the literature:

> These statistics do not indicate a direction of causality. . . . For several of these variables, such as health and social activity, the relationship may be one of reciprocal interdependence (p. 117).

While Larson's caution is important, others such as George (1978) believe research findings give general support to the following relationships: that higher well-being is reported for those having higher socio-economic

status, good health, and those who are married (Edwards & Klemmack, 1973; George & Maddox, 1977; Spreilzer & Snyder, 1974). Additional support for the correlates of life satisfaction have been revealed through more advanced methods of data analysis. Markides and Martin (1979) used a path analysis to develop a causal model of life satisfaction among the old. They found that sex, activity, and health are the primary predictors of life satisfaction, while income and education were not found to be direct predictors. Some of the analysis did suggest, however, that activity, education and income were indirect predictors of life satisfaction.

While life satisfaction has received a great deal of attention within gerontological research (Lohmann, 1980), two areas of study in life satisfaction have been particularly neglected. Little is known about the relationship of life satisfaction and cultural variation, and life satisfaction and family integration. Few studies have actually examined varying cultures or sub-cultures with regard to life satisfaction. Two exceptions are Bilk and Havighurst (1976) who studied seven different ethnic and residential groups in Chicago, and Ragan, Bengston, and Solomon (1975) who compared Blacks, Mexican-Americans, and Whites living in Southern California. Bild and Havighurst found few differences, while Ragan et al. found differences in life satisfaction among the

three groups.

While several studies have investigated marital status and life satisfaction (Cavan et al., 1949; Maddox & Eisdorfer, 1962; Martin, 1973; Messer, 1967), few studies have investigated family integration. While the findings have not been uniform, many studies point toward a positive relationship between marital status and life satisfaction (Lohmann, 1980). While some attention has been given to the relationship between marital status and life satisfaction, only limited attention has been given to the family and life satisfaction. Glenn and McLanahon (1981) state, "To our knowledge there is no direct evidence pertaining to the effects of off-spring on the psychological well-being of older adults. . . ." (p. 411).

Several studies have taken a narrow perspective of "family life" and investigated the frequency of interaction between adult children and aged parents (Arling, 1976; Blau, 1973; Edwards & Klemmack, 1973; Lee, 1979; Mancini, 1979). These studies have, for the most part, not found a positive relationship between life satisfaction of aged parents and frequency of interaction with adult children. Family integration as a predictor of life satisfaction defined broadly, has not been explored. For example, except for frequency of contact, little is known about the relationship between life satisfaction and (a) patterns of mutual aid, (b) residential proximity,

(c) family cohesion, and (d) family adaptability.

An aim of the present research is to investigate the relationship between associational and affectual aspects of family integration and life satisfaction. Contrary to many of the studies listed above, it is assumed that associational and affectual family integration will be positively related to life satisfaction among Amish aged. Since family is such an important social institution within Amish society, it is assumed that greater integration into the family will result in greater reported life satisfaction.

HYPOTHESES

The broad aim of the present study is to investigate family integration and psychological well-being among Amish older adults. The purpose is to expand the number of models of familial integration of the aged that have been studied and proposed as alternatives by psychologists and gerontologists. The specific aims of the study are:

1. Examine two dimensions of family integration (associational and affectual) among Amish older adults.
2. Examine two dimensions of psychological well-being (depression and life satisfaction) among Amish older adults.
3. Examine the relationship between family integration and psychological well-being among Amish older adults.

Hypotheses Related to Family Integration

I. Associational family integration will be found to be particularly strong among Amish older adults.

A. Frequency of contact between older adults and their children will show a high level of interaction.

B. Older adults will show a pattern of close residential proximity to their children.

C. Mutual aid patterns will be particularly strong between older adults and their children.

II. Affectual family integration will be found to be particularly strong among older adults and their children.

A. Amish older adults will report a high level of family cohesiveness.

B. Amish older adults will report a high level of family adaptability.

Hypotheses Related to Psychological Well-Being

I. Amish older adults will not report high levels of depression.

II. Amish older adults will report high levels of life satisfaction.

Hypotheses Related to Family Integration and Psychological Well-Being

I. Family associational integration will be highly related to psychological well-being.

A. Increased frequency of contact between older adults and their children will be negatively related to depression.

B. Increased frequency of contact between older adults and their children will be positively related to life satisfaction.

C. Increased residential proximity between older adults and their children will be negatively related to depression.

D. Increased residential proximity between older adults and their children will be positively related to life satisfaction.

E. Increases in mutual aid patterns between older adults and their children will be found to be negatively related to depression.

F. Increases in mutual aid patterns between older adults and their children will be positively related to life satisfaction.

II. Family affectual integration will be highly related to psychological well-being.

A. Reported family cohesion will be negatively related to depression.

B. Reported family cohesion will be positively related to life satisfaction.

C. Reported family adaptability will be negatively related to depression.

D. Reported family adaptability will be positively related to life satisfaction.

Hypotheses Related to Other Variables

In addition to testing the hypotheses listed above, the relationship between family integration and psychological well-being and other selected variables will be explored. For example, demographic characteristics, physical well-being, and community involvement will be examined to see how they may be associated with family integration and psychological well-being.

METHODS

Subjects

The inclusion criteria for this study are adult members, age 55 or older, of the Beachy Amish church or other related Amish groups who had at least one child. To help reduce possible confounding factors due to geographic or regional differences among various Amish groups, only Amish living in Lancaster and Chester Counties in Pennsylvania were considered as potential subjects. Subjects were selected using a natural network sampling technique. In particular, two methods were used to recruit subjects: (a) Several Amish and Mennonite leaders, familiar with the Beachy Amish and other Amish groups, were asked to give the names of persons who might be subjects for the study, and (b) each subject included in the study was asked to list the name or names of persons who they believed might be interested in being subjects. When names were acquired by either method the potential subjects were contacted by phone and asked to participate in the study. From these two methods approximately 100 persons were listed as potential

subjects. Of these persons, 96 were actually contacted, with 20 refusing to participate and 16 not fulfilling the criteria, such as being below the age of 55 or being childless. The subjects included in this study were the first 30 men and 30 women to fulfill the inclusion criteria and who completed the structured interview. The mean age of the subjects was 65.07 (SD = 8.73) with the ages ranging from 55 to 89 years. Of the 60 subjects one was widowed, one was married but whose wife was not included as a subject, and 29 were couples. The mean number of years married was 42.20 (SD = 10.52). The mean number of children per subject was 5.97 (SD = 2.88), with a range of 1 to 13 children. The mean number of grandchildren per subject was 14.22 (SD = 10.35). The mean number of living siblings per subject was 6.65 (SD = 3.69). Primary life-long occupational status of the 60 subjects includes 26 farmers, 25 homemakers, 5 carpenters, and 4 businesspersons. However, current occupational status includes 9 farmers, 27 homemakers, 8 carpenters, 6 businesspersons, 4 in other positions, and 6 retired. Many subjects reported that between age 50 to 60 they "moved from the farm" and began a second career. It was not uncommon for subjects to manage the family farm until age 50 to 60 and then turn its management over to a child, and then take up a second occupation. The second career often continues into late life as there were few subjects

who reported completely stopping work of some kind. With regard to living situation, one subject lived alone, 31 lived with their spouse, and 28 lived with their spouse and at least one child. The mean number of years living in the current home or residence was 17.79 (SD = 14.38) with a range of 1 to 50 years. Fifty percent of the subjects live 7 miles or less away from the farm where they grew up, and 94 percent lived 25 miles or less away from the farm where they grew up (M = 13.03 miles, SD = 20.99).

The primary source of income was reported as wages, with savings being second. Subjects reported their current financial status as: just enough to get by--6 subjects; comfortable--41 subjects; more than enough--9 subjects; well-to-do--1 subject, and 3 did not report their financial status. However, when asked about how their financial status had changed since they were age 50, 7 (17%) reported it to be worse, 23 (38%) subjects reported it to be about the same, and 29 (48%) subjects reported it to be better. Sixteen subjects (27%) rated their physical health as excellent, 31 (52%) subjects rated it as good, and 11 (18%) rated it as fair, and 2 subjects did not respond. Within the last 3 years only 11 subjects had been hospitalized at least once; however, of the 11 only 2 had been hospitalized more than once. When asked to compare their current health with when

they were age 50, 12 (20%) stated it was worse now, 33 (55%) stated it was about the same, 12 (20%) stated it was better, and 3 subjects did not respond.

The religious affiliation of the 60 subjects was as follows: Forty-four subjects are members of the Beachy Amish Church; 8 are members of the Gap View Amish-Mennonite Church; 2 are members of the Groffdale Amish-Mennonite Church; 2 are members of the Summit View Amish-Mennonite Church, and 4 are members of the New Order Amish Church. The 16 non-Beachy Amish subjects were included to increase the total N of the study. As reported above, these related Amish groups are very similar to the Beachy Amish. The natural network sampling procedure used among the Beachy Amish did not refer new names after the first 30 to 40 subjects had been interviewed. After the first 35 to 40 subjects interviewed, the names of few potential persons were referred who had not already been interviewed or had refused to participate in the study. To supplement the number of subjects, other Amish groups very similar to the Beachy Amish were included.

Procedure and Assessment Instruments

Procedure. The procedure for collecting the data was to conduct a structured interview and to have two self-report measures completed by each subject. The structured interview was conducted in the subject's home.

When both spouses were present and included in the study, the interview was conducted with both the husband and wife present. Each spouse was encouraged to give independent responses. While the presence of both husband and wife during the interview may have limited the independence or freedom of responses, early attempts to interview the husband and wife separately were not fruitful. Interviewing both spouses together improved subject compliance and was more consistent with Amish social values. In addition, independent responses by both spouses to the interview questions were frequent. Thus, in general the procedure to interview husband and wife together did not appear to hinder collection of accurate data. With regard to the self-report measures, each subject (spouse) was requested to complete the measures without consulting their spouse or other family members.

Structured interview. A structured interview (see Appendix A) format was used to gather the data regarding demographics, family integration and associational patterns. The interview format was used for several reasons. First, Amish older adults are not familiar with objective psychological measures often used in psychological and gerontological research. Secondly, the interview allowed for greater freedom in exploring issues related to family life and psychological well-being. The

structured interview format also encouraged a more informal and cooperative atmosphere and attitude among the subjects. The interview sessions often appeared to be experienced more as a family visit than as a "research procedure." The structured interview used in this study was a modification of other instruments developed to examine family life among the aged. The formulation of items having to do with family associational integration was based on the work of such people as Shanas et al. (1968) and Harris (1975) and included questions related to living arrangements, frequency of contact, mutual aid patterns, residential proximity, and family composition. Items were included that would allow for the comparison of Amish aged with other subjects. Also included in the interview were items which asked the subject to compare current associational family integration with past associational integration. Subjects were asked to state whether selected aspects of associational integration had gotten better or worse, or had stayed about the same since they were age 50. In addition, a wide range of demographical health items were included.

FACES. As noted above, few scales have been developed to measure the affectual integration of older family members (Bengston & DeTerre, 1980). One measure, the Family Adaptability and Cohesion Evaluation Scales (FACES), has been used to assess affectual integration in marital

and family systems, but has not been used with an aged sample (Olson, personal correspondence). A modification of the FACES was used in this study. FACES is an 111 item self-report scale designed to describe and evaluate the level of cohesion and adaptability reported by family members regarding their family of origin (Olson et al. 1979). FACES is based on the assumption that there are four levels of family cohesion (disengaged, separated, connected, and enmeshed) and four levels of family adaptability (chaotic, flexible, structured and rigid). FACES has been developed as a "circumplex" model in which the two dimensions (cohesion and adaptability) can be used to identify 16 types of marital and family systems. The clinical and construct validity for FACES has been demonstrated as well as the internal consistency reliability for the total scores of adaptability ($r = .75$) and cohesion ($r = .83$).

A modified version of the FACES (see Appendix B) was used for the following reasons: (a) The original 111 item instrument was found to be too lengthy for subjects unfamiliar with such measurement techniques, (b) the instrument was developed for middle-aged parents and their adolescent children, hence some items do not apply to aged parents and adult children, and (c) not all items were relevant to Amish culture. To achieve a high degree of subject compliance and effectiveness, the FACES was

modified in the following ways: (a) It was administered in a structured interview format. Each item was read and the subject was asked to respond by indicating whether the statement was true all the time, most of the time, some of the time, or none of the time, (b) a stimulus answer card was presented with the four alternatives to facilitate a response; and (c) the FACES was shortened to a core of 24 items with several alternative and additional items used when it seemed appropriate. Sixteen of the 24 items were selected by using half of the moderate intensity level items as identified by Olson et al. (1979) for both the cohesion and adptability subscales. Eight items were selected from the Edwards Social Desireability Scale which are included in the FACES. This modified form of the FACES allows for the examination of individual items as well as the calculation of a total score for cohesion and adaptability.

Life satisfaction. Two dimensions of psychological well-being, life satisfaction and depression, were examined. These two dimensions of well-being were measured using self-report measures. At the conclusion of the structured interview each subject was given the two measures, instructions for completing them, and a stamped, addressed envelope to return the measures when they had completed them.

Life satisfaction was measured using the Life

Satisfaction Index Z (LSIZ) (see Appendix C) modified by Wood, Wylie, and Sheafer (1969). The LSIZ is a modification of the Life Satisfaction Index A (LSIA) originally developed by Neugarten, Havighurst, and Tobin (1961). The LSIZ is a 13 item questionnaire which the subject simply records a yes, no or unsure response for each item. Use of the LSIZ will permit comparison with other studies where the same index was used. Lohmann (1977) found the LSIZ to be highly correlated with the LSIA (.941) and the modified Philadelphia Geriatric Center Morale Scale (.806) as well as other measures of life satisfaction.

Depression. Few measures of depression have been designed specifically for the aged. The scales often used to measure depression among young people have not been found to be good measures of depression among the elderly. For example, the Zung Self-Rating Depression Scale (SDS) has been criticized by numerous researchers and clinicians (Blumenthal, 1975; Eisdorfer & Cohen, 1978; Gallagher, Thompson & Levy, 1980; Kane & Kane, 1981) for emphasizing the importance of somatic symptoms as a manifestation of depression. Somatic complaints among the elderly are not as strongly associated with depression as with younger people. The MMPI Depression Scale has also been found to have problems of reliability when used with older people (Harmatz & Shader, 1975; Zemore & Eames, 1979). Another common criticism of the widely used depression scales is

that they are difficult for many elderly to complete.

The present study employed the Geriatric Depression Scale (GDS) (Brink, Yesavage, Lum, Heersema, Adey, & Rose, 1982) (see Appendix D) which, as the name implies, has been developed especially for the elderly. The GDS is a 30-item depression measure and has several advantages over other depression scales. The advantages are: (a) Items which might increase defensiveness among the elderly have been avoided (e.g., questions about sexual activity), (b) the answer format is very simple (yes/no), and (c) the GDS does not include questions regarding somatic symptoms. Another important advantage of the GDS is that its reliability and validity have been demonstrated. The coefficient alpha for internal consistency was found to be .94; the split-half reliability coefficient was also .94. The test-retest reliability coefficient was .85. Validity was assessed by demonstrating that the GDS accurately classified subjects as normal, mildly depressed, or severely depressed, based on the Research Diagnostic Criteria (RDC) for a major affective disorder. In addition, evidence for convergent validity was found. The correlation between the GDS and the SDS was found to be .84 and the correlation between the GDS and the Hamilton Rating Scale for depression was .80 (Brink et al., 1982).

RESULTS

The general hypotheses of this study are that (a) Amish older adults will show a high level of familial associational and affectual integration, as well as psychological well-being, and (b) that familial integration will be found to be positively related to psychological well-being. The results of this study will be reported by discussing (a) familial integration, (b) psychological well-being, and (c) the relationship between familial integration and psychological well-being.

Family Integration

The aim of the hypotheses related to familial integration was to examine associational and affectual integration patterns among Amish older adults. It was hypothesized that both associational and affectual integration would be found to be high.

Associational integration was measured by examining the frequency of contact, residential proximity, and mutual aid patterns between familial generations. The results support the hypotheses related to associational patterns that there is a high level of familial integra-

tion. Regarding frequency of contact, Table 1 shows that 41 percent of the subjects report some kind of contact (face-to-face, phone or letter) once a day with at least one child; 25 percent report some type of contact several times a week; and 21 percent some type of contact once a week with at least one child. Thus, over 87 percent of the subjects report some type of contact with at least one child at least once a week. Table 2 suggests that the contact between generations is often face-to-face. For example, 53 percent of the older adults had face-to-face contact with one of their children on the day before, or the day of the interview, and an additional 24 percent saw at least one child in the last 2 to 7 days. Hence, in the last week, 77 percent of the subjects reported face-to-face contact with at least one child. Taken together, Table 1 and Table 2 indicate that there is a high level of contact between familial generations.

Since frequency of contact was found to be high, it is not surprising that residential proximity between familial generations, another measure of associational integration, was found to be close. Table 3 shows that 32 percent of the older adults live in the same household with at least one child, 25 percent live within a 10 minute journey from at least one child, and 19 percent live at least in an 11 to 30 minute journey from at least one child. In short, 76 percent of the older adults in

Table 1

Percent of Contact Between Older Adults and at Least One Child

Everyday	Several Times a Week	Once a Week	Once a Month or More	Once a Year or More	Never
41	25	21	12	1	0

Table 2

When Older Adults Last Saw at Least One Child*

Today or Yesterday	Within 2 to 7 Days	Within 8 to 30 Days	Month or More
53	24	10	13

*Expressed in Percentages

Table 3

Time of Journey to at Least One Child's Home*

Same Household	0 to 10 Minutes	11 to 30 Minutes	31 to 60 Minutes	60 Plus Minutes
32	25	19	3	21

*Expressed in Percentages

this study live within a 30 minute journey of at least one child.

The final measure of associational integration is that of mutual aid between familial generations. There appears to be a great deal of mutual aid between older adults and their children in this study, as documented on Table 4, which shows the frequency of aid between the generations on numerous items. The type of aid most regularly given by parents to at least one child is financial assistance (25%), closely followed by advice on farm and business matters (24%). The types of aid most occasionally given by parents to at least one child are advice on how to deal with life's problems (67%), and financial assistance (66%). Table 4 shows that parents report giving both material aid (financial assistance, caring for grandchildren, running errands, and so forth), as well as non-material aid (advice on various matters). While the pattern of providing aid is bidirectional between parents and children, Table 4 shows that in most areas the parents provide more aid than their children. The most striking area in which the children provide more aid than their parents is in regard to regular help with home repairs. When the mean number of ways in which parents and children aid each other was calculated, either occasionally or regularly, it was found that the mean number of ways children aid their parents is 3.3, whereas

Table 4

Mutual Aid Patterns Shown in Percentages

	Children Aid Parents			Parents Aid Children		
	Don't Currently Help	Help Occasionally	Help Regularly	Don't Currently Help	Help Occasionally	Help Regularly
1. Help out when someone is ill.	93*	2	5	84*	7	9
2. Take care of grandchildren.	--	--	--	31	59	10
3. Give advice on running a home.	69	24	7	27	61	12
4. Give advice on raising children.	--	--	--	44	52	4
5. Shop or run errands.	46	34	20	35	48	17
6. Help out with money.	76	19	5	9	66	25
7. Help with home repairs.	40	42	18	50	41	9
8. Give advice about business matters	71	17	12	31	45	24
9. Give advice on how to deal with life's problems	52	37	11	23	67	10
10. Help with housekeeping.	67	24	9	60	29	11

*Most subjects reported they would help if the need arose.

the mean number of ways that parents report aiding their children is 6.00. Thus, the older adult subjects report giving almost twice as much aid as they report receiving.

In summary, the results of the associational measures (frequency of contact, last seen, residential proximity, and mutual aid) of integration support the hypotheses that high levels of familial associational integration will be found among Amish older adults.

Affectual integration was measured by examining familial cohesion and adaptability as reported by the subjects. The results support the hypotheses that affectual integration would be high among Amish older adults in this study. Table 5 shows that most older adults report their family to be very cohesive. For example, 78 percent of the subjects' scores fell in the "connected" family typology according to Olsen et al. (1979). The mean score on the FACES Cohesion Subscale was 50.20, which implies that the subjects perceive their family of procreation to be much more enmeshed than disengaged. With regard to reported family adaptability, the results suggest that there is more heterogeneity with regard to adaptability than cohesion among the subjects. Using Olsen et al.'s (1979) family topology, Table 6 shows 52 percent of the subjects perceive their family of procreation as "flexible," 27 percent see their family as "structured," 15 percent see their family as "chaotic"

Table 5

Reported Levels of Family Cohesion*

Levels of Cohesion	Total Sample N=30	Sex		Age	
		Males N=30	Females N=30	Under 64 N=34	Over 65 N=26
Disengaged	0	0	0	0	0
Separated	2	3	0	0	4
Connected	78	77	80	77	80
Enmeshed	20	20	20	23	16

*Expressed in Percentages

Table 6

Reported Levels of Family Adaptability*

Levels of Adaptability	Total Sample N=60	Sex		Age	
		Males N=30	Females N=30	Under 64 N=34	Over 65 N=26
Chaotic	15	10	20	17	12
Flexible	52	57	47	53	52
Structured	26	23	23	21	32
Rigid	7	10	10	9	4

*Expressed in Percentages

and 7 percent see their family as "rigid." The mean score for the FACES Adaptability Subscale was 24.89.

The results reveal that a majority of subjects do not fall outside Olsen et al.'s classification of a functional family system. Thus, the older adult Amish subjects in this study tend to report a good to high level of affectual integration. Additional confirmation of the hypotheses of high affectual integration is an examination of the responses for each item on the modified version of the FACES (see Cohesion Subscale-Appendix E; Adaptability Subscale-Appendix F) used in this study which suggests positive familial integration.

In summary, the hypotheses related to familial associational and affectual integration are supported. The Amish older adult subjects in this study report high levels of contact, residential proximity, and mutual aid between familial generations, as well as cohesion and adaptability. The results of this study suggest that Amish older adults are well integrated into family life.

Psychological Well-Being

Psychological well-being is examined on two dimensions: reported life satisfaction and depression. It is expected that the subjects in this study will report high life satisfaction and low depression. Results support these hypotheses related to psychological well-being in that the subjects report being satisfied with life and

report little depressed affect. With regard to life satisfaction, the subjects had a mean score of 20.34 (see Table 7) out of a possible total positive score of 26. Examination of Appendix G, which shows the responses to each item on the LISZ, reveals that each item is answered in the direction of the most life satisfaction most of the time. The principal exception is the second item in which 53 percent of the subjects were not sure whether they had "gotten more of the breaks in life than most of the people" they knew. However, overal life satisfaction appears to be high.

When depression is examined the results reveal that little depression was reported by the subjects. Table 7 shows that the mean score for the GDS was 4.52 which is well below the cut-off score (10) for clinically significant depression. It was also found that female subjects reported more depression than the male subjects, and the older subjects more than the younger subjects. While the mean scores suggest little depression, when the mean frequency breakdown is examined 14 percent of the subjects were found to be mildly depressed as classified by the GDS. However, no subjects were found to be moderately or severely depressed. Appendix H shows the responses to each item on the GDS. Each item is answered in the non-depressed direction except for Item 30 which asked, "Is your mind as clear as it used to be?"

Table 7

Means and Standard Deviations of Reported Psychological Well-Being

	Total Sample		Sex				Age			
			Male		Female		55-65		66-89	
	M	SD	M	SD	M	SD	M	SD	M	SD
Life Satisfaction (LISZ)	20.34	3.26	20.32	3.16	20.36	3.59	20.43	3.48	20.36	3.26
Depression (GDS)	4.52	3.91	3.71	2.80	5.32	4.69	2.90	3.03	6.60	3.96

In summary, the hypotheses related to psychological well-being are supported, and in particular Amish older adults were found to report high life satisfaction and low depression.

Family Integration and Psychological Well-Being

The aim of this study is not only to describe, but to begin to examine the relationship between family integration and psychological well-being. It is hypothesized that family (associational and affectual) integration will be positively related to psychological well-being (depression and life satisfaction).

Only one type of associational integration, mutual aid patterns, is significantly related to reported life satisfaction and depression, as Table 8 shows. Reports of parental aid to children are significantly related to life satisfaction ($r = .25$) and depression ($r = -.37$). However, aid from children to parents was not found to be related to depression or life satisfaction.

Associational patterns of mutual aid were found to be significantly related to affectual integration (see Table 8). The subjects' report of their children aiding them is significantly related to reported cohesion ($r = .51$) and adaptability ($r = .31$). Reports of parental aid to children are significantly related to reported cohesion ($r = .26$) and adaptability ($r = .42$).

Other associational integration patterns, such as

Table 8

Correlation Coefficients for Measures of Family Integration and Psychological Well-Being

	Contact with Children	Face-to Face Contact	Proximity	Children Give Aid	Parents Give Aid	FACES-C	FACES-A	LSIZ	GDS
Family Integration									
Contact with Children	1.00	.61***	.65***	-.17	.10	-.07	-.18	.01	.18
Face to Face Contact		1.00	.73***	-.14	.03	-.08	-.02	.08	.06
Residential Proximity			1.00	.09	.18	-.02	-.01	.01	.02
Mutual Aid									
Children Give Aid				1.00	.51***	.31**	.34**	.21	-.15
Parents Give Aid					1.00	.26*	.42***	.25*	-.37**
Cohesion (FACES-C)						1.00	.54***	.09	-.32**
Adaptability (FACES-A)							1.00	-.01	-.29*
Psychological Well-Being									
Life Satisfaction (LISZ)								1.00	-.30*
Depression (GDS)									1.00

*** $p \leq .001$
** $p \leq .01$
* $p \leq .05$

residential proximity, frequency of contact, and last seen are not significantly associated with reported life satisfaction or depression.

The results indicate that affectual integration is significantly related to reported depression, but not to life satisfaction. Table 8 shows that reported cohesion ($r = -.32$) and adaptability ($r = -.29$) are significantly related to depression; however, neither cohesion nor adaptability was found to be significantly related to life satisfaction.

In summary, the results indicate that reported parental aid to children is significantly associated with reported life satisfaction and depression, as well as reported familial cohesion and adaptability. In addition, reported familial cohesion and adaptability are significantly related to reported depression but not to life satisfaction. The significant relationships are in the expected direction; for example, increased parental aid to children is associated with increased life satisfaction and decreased depression. Increased cohesion and adaptability is associated with decreased depression.

Results Related to Other Variables

Other variables sometimes found to be significantly related to family integration and psychological well-being among elderly samples were examined. Age, sex, reported physical well-being, number of children, and

number of friends were correlated with instruments of associational and affectual integration, and depression and life satisfaction, in an effort to understand how they might be associated. Table 9 shows that age more than any of the other variables is related to family integration and psychological well-being. Age is significantly and positively related to frequency of all types of contact ($r = .28$), face-to-face contact ($R = .36$), and reported depression ($r = .56$), and is significantly related to parental aid to children ($r = -.39$) and reported cohesion ($r = -.27$). In summary, age appears to emerge as a more salient factor than other selected demographic features.

Qualitative Results

In addition to the quantitative results presented above, several qualitative results will be presented. The qualitative results are ethnographic information, participant observations, and clinical research impressions gathered during the research process. The qualitative results are presented to help give a broader presentation of the data than is possible in a strict quantitative format. This is especially important in cross-cultural research.

Numerous observations or experiences obtained while collecting the data are listed here:

1. The subjects did not understand why the study included inquiries about their own individual families.

Table 9

Correlation Coefficients for Measures of Family Integration, Psychological Well-Being and Demographic Variables

	Sex	Age	Reported Health	Number of Children	Number of Friends
Contact with Children	.02	.28*	-.09	.22	-.12
Face-to-Face Contact	-.02	.36**	.00	.02	-.09
Residential Proximity	.02	.13	-.03	-.08	.11
Children Give Aid	.42***	-.16	-.11	.07	.09
Parents Give Aid	.23	-.39**	.11	.23	-.02
Cohesion (FACES-C)	.01	-.27*	-.00	.15	.10
Adaptability (FACES-A)	.00	-.15	.17	-.08	.08
Depression (GDS)	.21	.56***	-.25	-.15	.25
Life Satisfaction (LISZ)	.00	-.03	-.08	.04	-.15
Sex	1.00	-.21	-.17	-.02	-.03
Age		1.00	-.19	-.19	.38**
Reported Health			1.00	-.02	.03
Number of Children				1.00	.03
Number of Friends					1.00

*** $p < .001$
** $p < .01$
* $p < .05$

They perceived the research task as my wanting to know about Amish family life in general, not their family in particular. So, they had a hard time understanding why individual families would need to be interviewed in order to gain a better understanding of Amish family life in general. This would appear to be related, in part, to the emphasis on social and communal values in contrast to individualistic values.

2. The subjects did not see the importance of the research questions. They did not perceive family life or psychological well-being within their own family or within Amish social life to be problematic. It did not appear to be an issue about which they were concerned.

3. Likewise, the subjects did not perceive aging within Amish society to be particularly problematic. They did not report and did not appear to be concerned about facing any discontinuities that might emerge as they grow older.

4. The subjects reported little concern for the future with regard to who might care for them or assist them if they become frail or dependent.

5. The subjects reported frequent intergenerational contact, both within the family and in the larger social context. For example, two subjects (a couple) had just returned from a several week van trip with a youth group. The subjects reported that it was very common for young

people to invite older people to accompany them on such trips.

6. Numerous subjects reported various types of family gatherings which are oriented toward mutual aid (however, these types of aid were not included in the quantitative results section). One example is "sisters day" in which the sisters from one family or origin gather about once a month for the day to help each other with a homemaking project, e.g., make a quilt, preserving fruits and vegetables, or work on a project for international relief. Another gathering which some subjects reported was a "family night" in which their children met together several times a month to help with home repairs or home-making projects. Other types of aid reported by numerous parents were helping children build homes or assist in repairs around the house or farm. This was especially true for children moving out of state or children moving to a new Amish settlement.

7. After rapport was established and the subjects understood the nature of the research questions, they appeared to enjoy discussing and describing their family life. They seemed to like the opportunity to discuss family history and sometimes even family values and changes. Even some painful family crises and decisions were shared openly. Most subjects readily acknowledged and showed ongoing acceptance toward their children who

were no longer Amish. In other situations, parents admitted to problems with their children, but stated, "They are still our children and part of our family." An indication of the subjects' openness to such discussions was the recurring need for the investigator to redirect the conversation toward answering questions from the structured interview.

8. The subjects appeared to underreport affectual integration. Humility is an important Amish virtue; thus, to compliment one's own family is to break an important cultural ideal. They often seemed embarrassed about and almost apologized for their positive feelings toward their families.

9. The subjects who were married appeared to have stable relationships. Before giving a final answer, husbands and wives often openly consulted with each other. While male subjects frequently consulted with their spouses, the male subjects appeared to have more control over the final answer than the female subjects.

10. Several Beachy Amish leaders (i.e., bishops, etc.) reported that only 2 or 3 Beachy Amish were currently in a nursing home. One or two of the subjects had no children and one chose to go to a nursing home. All Amish leaders and subjects reported that this was unusual, and that most older people are cared for at home.

These qualitative or ethnographic results would

appear to support the quantitative results that familial integration and psychological well-being are high among Amish older adults.

DISCUSSION

Discussion of the Results and Comparisons With Other Groups

The broad aim of this study was to investigate family integration and psychological well-being among Amish older adults. The results of the study suggest that Amish older adults are well-integrated into family life and have high psychological well-being, and that Amish society may indeed serve the interest of Amish older adults and be a positive model of family integration.

The hypotheses for this study were organized into three areas: (a) family integration, (b) psychological well-being, and (c) the relationship between family integration and psychological well-being. In general, the hypotheses that Amish older adults would report high familial integration were supported. In particular, associational family integration, as measured by frequency of contact, residential proximity with children, and mutual aid between parents and children, were found to be high among Amish older adults. For example, 77 percent

of the subjects report face-to-face contact in the last 7 days with at least one child, and 79 percent report living within an hour's journey of at least one child. With regard to mutual aid, parents report giving at least 6 of the 10 types of aid at least occasionally. The hypotheses related to affectual family integration were also confirmed. With regard to cohesion, 98 percent reported their family as being connected or enmeshed; and with regard to adaptability, 52 percent described their family as flexible. These results would support the hypotheses that affectual integration is strong among Amish older adults.

The hypotheses that psychological well-being would be high among the Amish was also supported. The mean LSIZ score for reported life satisfaction was 20.34 out of a possible positive score of 26. As was hypothesized, Amish older adults did not report high levels of depression. The mean GDS score for depression (4.52) was well below the cut-off (10.00) for clinically significant depression.

While the hypotheses that family integration and psychological well-being would be high among Amish older adults were supported, the hypotheses related to the relationship between family integration and psychological well-being show a less consistent pattern. For example, it was hypothesized that family associational integration

would be highly related to psychological well-being. The results show that mutual aid was significantly correlated with reported life satisfaction ($r = .25$) and depression ($r = .37$), whereas the other variables of associational integration (contact and residential proximity) were not found to be significantly correlated. It was also assumed that affectual integration would be related to psychological well-being. The results show that reported depression was significantly correlated with cohesion ($r = -.32$) and adaptability ($r = -.29$), but were not found to be significantly correlated with reported life satisfaction. In summary, these hypotheses were supported: (a) parental aid to children correlated significantly with reported life satisfaction and depression, and (b) reported depression correlated significantly with reported familial cohesion and adaptability. Thus, in some important ways family integration and psychological well-being were found to be related.

Comparison with Non-Amish studies. To further explore the hypotheses of this study, it is helpful to compare these results with the results from non-Amish studies. In several ways the Amish subjects in this study are similar to non-Amish. A comparison of the results of this study with the results from non-Amish studies will be made in these areas: (a) associational integration, (b) affectual integration, and (c) psycho-

logical well-being.

Comparison of associational factors, such as contact and residential proximity show that the Amish are similar to non-Amish samples. For example, the Amish subjects in this study appear to have approximately the same number of contacts and similar residential proximity with their children as found with numerous non-Amish samples. In a national U.S. sample of elderly subjects, Shanas et al. (1978) reported that 75 percent of the subjects had face-to-face contact with at least one child in the past 7 days. This finding is similar to the current study in which 77 percent of the Amish reported face-to-face contact in the past 7 days.

In another national sample, Harris (1975) reported that approximately 80 percent of the elderly subjects had face-to-face contact in the last week or two. In contrast to the studies listed above, Bultena (1969) reported that only 38 percent of a rural and urban elderly sample had face-to-face contact with at least one child in the last 7 days. These studies show that the Amish subjects show equal or greater face-to-face contact as other samples of older adults.

With regard to residential proximity, the Amish subjects report living similar distances from their children as non-Amish samples. One of the highest levels of residential proximity was noted by Shanas et al.

(1968): 84 percent of the elderly in three industrial societies lived less than an hour from one of their children. Seventy-nine percent of the Amish subjects in this study reported being within one hour from at least one child. Other studies (Adams, 1968) suggest that only one-third of the elderly may live close to their children. For example, Sanford (1978) found that among aged Blacks, only 12 percent had children who lived in the same county or neighborhood. However, this is lower than has been reported in most studies. For example, in another U.S. national sample, Shanas and Sussman (1981) reported that 52 percent of the elderly subjects live within a ten minute journey of at least one child. In the current study, 57 percent of the Amish subjects lived within a ten minute journey of at least one child. Thus, the available data suggest that with regard to both face-to-face contact and residential proximity, the Amish subjects of this study report similar patterns of associational integration as has been found in non-Amish samples.

Comparison of mutual aid patterns between Amish and non-Amish samples show some notable differences. For example, Table 10 contrasts the ways in which Amish subjects in this study and elderly subjects in a U.S. national study (Harris, 1975) report giving aid to their children. The Amish subjects give significantly more aid than the subjects from the national study in most areas.

Table 10

Comparison of Mutual Aid Patterns Between the Amish Sample and a U.S. National Sample (Shown in Percentages)

	AMISH SAMPLE		U.S. NATIONAL STUDY*		
	Ways in Which Parents Aid Children		Ways in Which Parents Aid Children		
	Do Help	Don't Help	Do Help	Don't Help	Not Applicable
1. Help out when someone is ill.	16	84**	68	19	13
2. Take care of grandchildren	69	31	54	28	17
3. Give advice on running a home	73	27	21	70	9
4. Give advice on raising children	56	44	23	67	10
5. Shop or run errands	65	35	34	54	12
6. Help out with money	91	9	45	44	11
7. Home repairs	50	50	26	60	14
8. Give advice about business matters	69	31	20	70	10
9. Give advice on how to deal with life's problems	77	23	39	52	9

*Harris (1975)
**Most subjects reported they would help if the need arose.

While comparison of associational integration between Amish and non-Amish samples is possible because of widespread use of similar measurement instruments, it is more difficult to contrast affectual integration and psychological well-being. Few studies have examined these two variables in the same study or used the same measures as were employed in this study. In general, it appears that when quantitatively compared, the Amish are at least similar to other samples of non-Amish older adults with regard to reported affectual integration and psychological well-being. For example, in a review of several studies on older adults' rating of family relationships, Troll et al. (1979) found that most older adults were very positive toward their children. The Amish at least show a similar pattern, if not a more significant trend, in that 98 percent of subjects reported cohesive relationships with their children. Qualitative observation would suggest that affectual integration is indeed high among Amish older adults. With regard to psychological well-being, both the qualitative and quantitative results would suggest that when contrasted to non-Amish groups, the Amish subjects score higher. Blazer (1982) reported a mean LSIZ score of 17.4 for a group of elderly subjects compared to the Amish subjects' mean LSIZ score of 20.34. None of the Amish subjects reported a moderate to severe depression on the GDS and

only 14 percent reported being mildly depressed. This exceptionally low rate of reported depression is unexpected since depression is one of the most common psychiatric disorders among the elderly (Blazer, 1982), and depressive disorders are the most common psychiatric disorders among the Amish (Egeland & Hostetter, 1983). These findings are consistent with qualitative observations. Information gained from the structured interview, informal discussion, and clinical research observation, would suggest that none of the subjects were suffering from a reactive or major depressive disorder.

Having contrasted the level of associational integration, affectual integration, and psychological well-being between the subjects of this study with other samples, the relationship between family integration and psychological integration will be discussed in greater detail. In reviewing the literature on familial contact, affection and morale (life satisfaction), Weishaus (1979) has noted that few, if any, studies have found a significant relationship between increased familial contact and affection and life satisfaction. Likewise, in this study, more frequent contact between Amish older adults and their children does not necessarily imply greater affectual integration or psychological well-being. Furthermore, the frequency of contact and residential proximity is not associated with mutual aid patterns.

More frequent contact or close proximity was not found to be associated with greater mutual aid between parents and children.

The relationship between mutual aid and affectual integration or psychological well-being has not been noted in other studies. This is especially surprising since in this study these variables are significantly related. Indeed, the finding that parental aid to children is significantly correlated with affectual integration, life satisfaction, and depression, is the most striking finding of this study. Not only do Amish subjects engage in more mutual aid than non-Amish subjects, but aid was also found to be related to affectual integration and psychological well-being. This finding supports the hypothesis that family integration and psychological well-being are related. The unique finding is that family integration is more related to mutual aid than any other type of associational integration. In addition, mutual aid, affectual integration, life satisfaction, and depression are all related. For example, reported depression and affectual integration were also found to be significantly correlated.

Having reviewed the results in terms of their support for the hypotheses and how the results compare with non-Amish studies, the discussion to this point reveals that mutual aid, affectual integration and psychological

well-being are interrelated and suggests that the Amish are a positive model of family integration.

Cultural Themes

Social and individual behavior occurs in a context. Behavior does not occur in isolation, but is interrelated with the broader cultural context. This study has focused primarily on describing and understanding family integration and psychological well-being among Beachy Amish older adults without discussing how family integration and psychological well-being are related to the larger cultural context. In an effort to further understand the findings of this study and place them in the broader context of Amish society, they will be discussed in terms of how they relate to several cultural themes within Amish society.

One cultural theme that relates to the finding of this study is that of social support and sharing. Based on religious faith, the Amish have long held to the ideal of helping and assisting those who are in need. The Biblical command to "love one's neighbor as one's self" is seen as an important expression of Christian faith. Therefore, Amish provide material and non-material aid to those in need (both within and outside Amish society). There are many ways in which Amish attempt to care for those in need, or to make sure that "their own" are cared for from within Amish society. Amish society looks

within its social boundaries for its aid and support; it does not look to external structures, such as government, for assistance. Hence, Amish society has developed structures for support and sharing with those in need. The emphasis on the religious ideal of social support and sharing has several important implications for Amish older adults.

First, Amish older adults have been socialized to support and share with others, and in particular to aid their families. The socialization process is based on the models of previous generations and on religious faith. The injunction to provide support and aid to one's family is particularly strong; not to care for one's family would invoke negative social reaction. Thus, Amish older adults not only give aid to their children because of a familial bond, but because it confirms a social and religious ideal. It does not seem unexpected, then that the findings of this study would suggest that parental aid to children is high and that it is positively related to affectual integration and psychological well-being; or in short, when parents aid their children they feel affectually close to their children and feel good about their own emotional well-being. This may also help interpret why frequency of contact and residential proximity were not connected with affectual integration or psychological well-being. It is an important religious

ideal to provide aid to children, regardless of the frequency of contact or proximity.

A second implication of the theme of support and sharing for this study is that Amish older adults are socialized to expect that they will be aided when the need arises. Amish older adults are aware that just as they aided others, so others will aid them. A predominant characteristic of support and sharing in Amish society is that no one will lack material goods and if possible, non-material aid. The social support and sharing network and religious ideals are so strong that Amish older adults need to give little concern to whether they will be cared for or provided with the essentials of life. The first line of aid is the nuclear family, followed by the extended family, which is followed by the church community. There is a peace about the future that is experienced in few other Western cultures. This security about aid in the present or future would appear to be one factor related to the subjects' report of high psychological well-being.

A final implication related to the theme of support and sharing is that Amish older adults are recipients of a tradition of mutual aid, as well as models of mutual aid, to younger generations. The Amish older adult has witnessed and participated in the mutual aid of older generations and is also concerned with passing on the

traditions or theme of sharing and support to younger generations. Thus, aiding children is a means of perpetuating an important religious and social ideal. In return, the older adult is afforded his/her security in future years. In summary, it would appear that the major findings of this study, that mutual aid is high and is related to affectual integration, is consistent with Amish religious and social ideals regarding support and sharing.

A second cultural theme that would appear to be related to the results of this study is that of familism, or the emphasis that the family is given in Amish society. As already noted, Hostetler and Huntington (1971) have stated that the family is a primary institution within Amish society. The family is a primary socializer and caregiver at all ages in the life cycle. Both the qualitative and quantitive results of this study would suggest that this is the case. It is then not surprising that a society in which family is believed to be important would show high familial mutual aid and affectual integration. Troll et al. (1979) have noted that mutual aid is often considered to be a "critical variable in determining extended family status" (p. 88). If extended family status is seen as one indicator of the importance of the family within Amish society, the findings regarding mutual aid in this study would be consistent. In short,

mutual aid would be expected to be high in a society in which familism is emphasized. Also not unexpected is the finding that 98 percent of the subjects report their families as cohesive. This again, would be consistent with the theme that familism is important in Amish society. Familism as a theme in Amish society is consistent with the results of this study, that mutual aid and affectual integration are high among the subjects and their children.

A third cultural theme which has implications for the results of this study is age-integration. Amish society tends to practice and reinforce a pattern of age-integration, rather than age-separation. Age-integration is defined as the tendency for a society to value all age groups equally and to value the continuity and progression of individuals throughout the life cycle, as well as to value continuity between generations. Amish society has age-graded tasks (Hostetler & Huntington, 1971); however, all age grades are seen as valuable and so have a significant role and status. This is unlike U.S. majority culture in which older people do not have a well-defined and significant role or status. In Amish society all age groups are perceived as necessary for the maintenance of Amish social reality. For example, children are valued and socialized to become "Amish" because they are the hope for future generations; older people are valued

because they have contributed much to the maintenance of Amish society, and because they continue to model and reinforce the traditions of the past. Because of age-integration, there are fewer problems attributed to a "generation-gap," but rather increased intergenerational continuity. Amish older adults are not seen as a "burden" by either Amish society or Amish families. Care for an aged parent is seen as an honor and privilege. Qualitative results would suggest that Amish do not perceive care of older parents as a "duty"; rather it is framed in the context of an honor and the ebb-and-flow of ontogenetic and family development. Another aspect of age-integration is that there are few social markers to define "old" within Amish society. The most pronounced marker is turning the management of the farm over to a child and moving out of the main farm house. Nevertheless, retirement as a social or economic change is not understood or defined in the same terms as in U.S. majority culture. Many in Amish society continue to work in farm/rural-related businesses, or are self-employed in a small business late into life. In a sense, "retirement" never occurs.

Age-integration as a cultural theme has important implications for the results of this study. In particular, the subjects perceive themselves to be part of the continuity of life, and part of an ongoing ontogenetic

and historical process, rather than simply being "old." Hence, age-integration would appear to be associated with high psychological well-being and with feeling affectually integrated into one's family. As a result of age-integration, the individual Amish older adult's self-worth is affirmed and the boundaries between generations are reduced. The reduction in boundaries between generations contributes to the exchange of aid and increased affectual integration and greater psychological well-being.

A fourth cultural theme which has implications for the results of this study is the history of the Beachy Amish. A primary reason that the Beachy Amish were formed was in reaction to the shunning of an Old Order Amish church member. Today, the Beachy Amish do not practice the "ban" as the Old Order Amish do. Qualitative observations would suggest that because the Beachy Amish have experienced or witnessed the emotional and social trauma associated with shunning they have reacted by taking a position of openness and acceptance. While the Beachy Amish continue to maintain a strong "Amish" identity they also are accepting of other persons' decisions not to be "Amish" and continue to relate to those with whom they disagree. Because Beachy Amish have reacted to the use of shunning as a primary mode of social and religious control, they have adopted other modes of control. One

of the modes of control used by the Beachy Amish is acceptance and openness. The reaction against shunning not only has implications for Beachy Amish society as a whole, but also has implications for individual families. The ideal of acceptance rather than shunning is practiced in the family as well as the church. It emphasizes and symbolizes an approach that Beachy Amish parents take toward their families. One implication of this approach to family life is that Beachy Amish older adults in this study did not "shun" children who did not remain or become Beachy Amish. Little variation was noted between Amish and non-Amish children with regard to exchange of mutual aid, or affectual integration. With a number of subjects it appeared that they purposefully attempted to give equal or more aid and enhance affectual integration with their non-Amish children, as with their Amish children. However, the general point is that the parents attempted to show little deference between their Amish and non-Amish children. The tendency, or theme within Beachy Amish society and family life to accept rather than shun its members helps to explain not only the high level of mutual aid, but also the increased familial affectual integration.

A fifth cultural theme is that the Amish are a small, rural sect surrounded by a large, urban, technological society. Amish society is a different social

reality than U.S. majority society. One of the characteristics of being a minority sect is that everyone in the sect becomes important for the survival of the group, and people learn to live together even when there are disagreements. Because of the restricted social and geographic environment in which most Amish live, it is necessary and important to include every age group and person in some aspect of social life; hence, older people are valued for what they contribute to social processes and structures, as well as what children contribute. The minority status and restrictiveness not only increases the status of persons within Amish society, but also forces persons to become more cohesive. For example, because of limited mobility, intermarriage, lack of contact with non-Amish, and the primary focus of social activities being church-related, it is necessary for Amish individuals to develop intimate and healthy relationships with a limited pool of persons. The skill of learning to develop relationships in a restricted environment encourages families to develop cohesive and adaptable relationships. The results of this study suggest that Amish older adults report their families as being both cohesive and adaptable. One reason for this would appear to be because of the minority sect status of the Amish and the need to develop close and meaningful relationships with a small pool of people. The Amish

family appears to be one setting in which this occurs, and would appear to occur throughout the family life cycle. In summary, the minority sect status of the Amish contributes to the status of older adults and places individuals and families in a context in which they must learn to relate meaningfully and in a healthy manner to a limited number of people. The minority sect status of the Amish would appear to be one explanation of why familial mutual aid is high (since there is only a limited number of social sources from which assistance can come), familial affectual integration is high (families must learn to live together because of a limited social context), and the psychological well-being is high (older adults have valued status because they are seen as important to social maintenance).

In conclusion, five cultural themes (social support and sharing, familism, age-integration, reaction to shunning, and minority sect status) have been identified and discussed in terms of how they might influence or be related to the findings of this study. These themes have been outlined to place the results in a broader cultural context and to see if the results of this study are consistent with the larger social forces and reality within Amish society. The focus of discussion has been primarily on what implications or impact these cultural themes might have on family integration and psychological

well-being among Amish older adults. While additional research is needed, the results appear to be related to larger cultural themes.

Methodological Issues

Several important methodological procedures employed in this study will be outlined, along with discussion of some issues which have implications for future studies with the Amish. Strict adherence to experimental or quasi-experimental psychological research methodology was not appropriate or practical for this study. The following are several methodological procedures employed in this study in an attempt to be more appropriate and practical within the context of Amish society. First, a social network sampling procedure was employed instead of a random sample procedure. Practically, the random interviewing of older Amish would be difficult and time-consuming. However, more importantly, the random sample approach is not consistent with Amish social reality and practices. One example of this is that often potential subjects would suggest that it would be more valuable for the investigator to interview an Amish leader rather than to interview themselves. The potential subjects appeared to assume that the Amish leadership was more knowledgeable than they, and that the leadership would adequately represent them. Also, subjects were often surprised and sometimes found it difficult to understand

why the investigator was interested in their individual family experience. Their comments often reflected the opinion that discussion with several Amish leaders would yield as much information as interviewing 60 subjects. Thus, the subjects thought more in terms of the larger social-community experience than in terms of the experience of individual families. In this sense the subjects were not reductionistic in their perception of behavior, and in fact had difficulty understanding how interviewing 60 persons helped the investigator understand family life or older adults as a "whole" within Amish society. The social network sampling procedure was not only employed because it was more consistent with Amish social reality, but because a primary method to make contact or gain acceptance within Amish society is through social networks. A "random" impersonal process would violate important Amish social assumptions and practices and would not prove to be effective.

A second methodological procedure was with regard to the actual collection of data. Because of the "relational" nature of Amish society, data were gathered via a structured interview. In addition to being relational, the Amish are not socialized to use questionnaires, check list, scales, etc., thus most of the data were collected using verbal procedures. A final methodological procedure employed in this study was that the

investigator's spouse accompanied him on many of the interviews since many of the subjects invited her to attend. There was interest in the investigator's marital status by many subjects, and the presence of his spouse appeared to play a meaningful role in helping the subjects to feel relaxed and be more responsive. The subjects responded better if the research interview was perceived as a "family visit." These three methodological procedures were important in attempting to make the research more representative and practical within Amish society.

Some of the methodological issues encountered in this study which may be helpful in conducting research in the future are listed below. A predominant methodological issue in the study of Amish society is that it is a unique social reality. Thus, the use of measures and procedures developed for investigation of older adults in U.S. majority culture (also a unique social reality) with Amish older adults, raises important questions. The methodology of U.S. majority culture cannot be automatically adopted and used in the context of Amish society. Language, meanings, and processes take on different expressions within the two societies. Thus, a basic question is whether the methodology employed in studies of U.S. majority aged are relevant in Amish society. This concern guided the development of the research hypotheses as well as data gathering procedures of this study,

and should be considered for future studies.

A second methodological issue is that Amish were not socialized to analyze, problem-solve, or answer the types of questions that U.S. majority culture psychological researchers have been trained to ask. For example, conceptualizing or thinking in "psychological terms" (at least in terms familiar to U.S. majority-trained psychologists) is not employed or emphasized within Amish society. For example, individual psychological well-being or intrapsychic activity are discussed and valued less than wholesome relationships with each other and "with God." Extended education is not seen as important to being a "good" Amish person. Being a moral and humble person, and having good interpersonal relationships is much more important in Amish society than being able to abstract, analyze or intellectualize. Thus, questions must be asked that are meaningful and relevant to Amish society.

A third methodological issue is that rapport was important to accomplishing the research task. This issue is closely related to the issue raised above that the Amish are more interested in relationships than cognitive pursuits. Several examples of the importance of rapport are as follows: First, it was not uncommon for potential subjects to ask the investigator after the study had been explained, "and who are you?" A brief description

that the investigator was a student and a Mennonite was important information, and seemed more important than the actual focus of the study. Another example of the necessity for rapport was the inclusion of the investigator's spouse (as noted above) to project the sense of a "family or friendly" visit. In addition, it was important for the investigator and his wife to give a short family and church history. Since the investigator's spouse is also a Mennonite and has several cousins who are Beachy Amish, the necessary rapport to conduct the study developed quite rapidly. Development of rapport was necessary to establish the investigators as "legitimate," since there has been a history of reporters and "outsiders" who have at times exploited or misrepresented the Amish. Also, because of the personal nature of the information that was gathered, the development of rapport was crucial.

A final methodological issue is that Amish assume that practice is more important than theory. For the Amish it is more important to model Christian love or community than it is to discuss or theologize about what constitutes Christian love or community. This is based on at least two assumptions. First, the Amish believe that they should be a model of Christian community, "a light set on a hill," and so attract people to Christian faith by their example. Secondly, to discuss

one's virtues leads to pride and the tendency to feel secure in personal achievement rather than in depending upon God for security. In short, modeling and humility are important characteristics or ideals within Amish society. These two ideals run counter to assumptions employed in the use of traditional research methodologies. The Amish tend to say, "Don't ask me questions; see how I live." Also, the Amish probably tend to underreport because of their emphasis on modeling and humility. For example, the Amish had difficulty answering such questions as, "My family is as happy as any family can be when we are together," or, "My family is as perfect as any family can be." The responses often suggested that they believed their family was "perfect," but it was difficult for them to actually say it. Their responses were often in the nature of,"I think our family is pretty close and we get along well, but I don't want to say we're better than other families," or, "It feels like we are a close family, but there's always room for improvement." Certainly the ideals of modeling and humility have important methodological implications with regard to research design and interpretation of data.

Four methodological issues have been discussed which have implications for this study, as well as future studies with the Amish. The issues raised include the use of methodology and procedures in Amish society that

have been developed for use in U.S. majority culture, relationship-centered versus cognitively-centered society, need to develop rapport, and issues related to modeling and humility. Research design and methods that emphasize "relational" procedures would probably be most meaningful and effective among Amish subjects.

Future Research and Theoretical Issues

A topic for future research is the extension of the current investigation regarding intergenerational mutual aid within Amish society. One component of this investigation should be centered on further exploring and detailing the actual mutual aid practices between children and parents. For example, parental aid to the youngest children versus oldest children, parental aid to sons versus daughters, sons versus daughters aid to parents, which types of aid increase or decrease as parents age, etc. However, an important extension would be the investigation of mutual aid over the family life cycle and particularly in parental late life. The results of the present study suggest that parental aid to children decreases with age; this should be further examined. Probably more important, however, is whether parental reports of familial affectual integration and psychological well-being decline when parental aid to children declines. Since the present sample is a relatively "young-old" group (M age = 65), it is difficult to

project the relationships among these variables as the subjects grow older. One question is: What happens as the subjects grow older and are unable to give aid, or their children do not need (either real or perceived) parental aid? Does this impact affectual integration and psychological well-being for the aged parents? If several of the cultural themes (age-integration, familism, minority sect status) outlined above are correct, the implication is that as Amish older adults age they would not experience decreased affectual integration or low psychological well-being. However, because Amish individuals (including older adults) have been socialized to support and share with others (as outlined above in the theme on social support and sharing), older adults may experience a contradiction between wanting to fulfill a religious and cultural ideal and practice of aiding, but may not have the physical or material resources to accomplish the task. Thus, what happens to reported affectual integration and psychological well-being?

Research along this line would not only have implications for understanding Amish society, but may be helpful in developing a model of psychosocial aging, useful in other societies as well. Social gerontologists continue to search for models which help to describe and understand psychosocial aging; hopefully, examination of Amish elderly can be helpful in this task.

Before outlining several components of a proposed model of psychosocial aging, several other models of psychosocial aging will be discussed. One of the most controversial and earliest models is known as the disengagement theory (Cumming & Henry, 1961). Disengagement theory posits that the elderly and society mutually and "naturally" disengage from each other. Troll at al. (1979) have noted that most research studies indicate that the elderly do not "disengage" from their families, and that disengagement theory does not apply to older families or society in general. Just as the review by Tross et al. (1979) did not find disengagement to be the norm, the present results suggest that disengagement is not true for Amish older adults and their families. The level of mutual aid and degree of affectual integration reported in this study would suggest that most Amish older adults are very much "engaged" rather than disengaged.

Activity theory, which is many respects is the opposite of disengagement theory, posits that the elderly should and can remain active as long as possible. Activity theory holds that "successful" aging occurs when the older person maintains a high level of personal activity and "engagement." Old age is seen as a continuation of adulthood. Meaning in life is derived from maintaining activity. While the results of the present

study could be interpreted as lending support to activity theory, it also raises some questions.

Using activity theory the correlations between parental aid to children, affectual integration, and psychological well-being would appear to support the assumption that continuation of the parental role and activity into later life are associated with "successful" aging (if affectional integration and psychological well-being are considered measures of successful aging). However, it is difficult to assume that continuation of the parental role and activity alone are primarily responsible for Amish older adults' well-being. While activity theory may appear to be helpful in describing the social behavior of older adults, it is not comprehensive in its understanding of forces within Amish society.

Some of the questions raised by activity theory in relation to the present study are the following:

First, activity for activity's sake is not valued in Amish society. Activity is not meaningful in-and-of itself. Hence, not all activity is meaningful or is perceived to have the same qualitative aspects. The Amish place a high value on activity associated with supplying one's daily needs, and recreational or leisure time activity is not seen as important. Thus, what happens when an older person can no longer perform

meaningful activity as defined by Amish society?

Another way in which Amish social experience would contradict the activity model is that while the Amish not only assume that meaningful activity is important, they also assume that the "person" or individual is important. Thus, the person is valued more than what they can produce. Unlike U.S. majority culture which places great emphasis on the production potential of individuals, the Amish do not determine worth or importance based strictly on the ability to produce. While the Amish emphasize work and meaningful activity, they do not ascribe ultimate worth to it. Thus, activity theory might have value as a model of aging in a society in which human worth is judged primarily on the ability to produce. However, in societies where other characteristics or values are also important, activity theory may not be a helpful model of psychosocial aging.

A third model of psychosocial aging is known as the social reconstruction syndrome (Kuyper & Bengston, 1973). The social reconstruction syndrome is based on Zusman's (1966) social "breakdown syndrome" in which a person's social environment and self-concept interact to create a vicious spiral of increasing incompetence and negative self-perception. The spiral is interactive in that (a) the person is susceptible to psychological breakdown, (b) is socially labeled as incompetent, (c) takes on a

"sick" role, and (d) perceives him/herself as incompetent or inadequate. Kuyper and Bengston (1973) suggest that the spiral of the social breakdown syndrome applies to many U.S. elderly persons, so that as the elderly grow older and confront bio-psychosocial changes, they are more susceptible to negative social-cultural stereotypes regarding the uselessness of the elderly and so take on the roles and self-identify of an "old" person. This process then places the elderly at even greater risk for the spiral to continue.

To counter this spiral, Kuyper and Bengston (1973) have proposed the social reconstruction syndrome. In this syndrome the elderly are still seen as vulnerable to biopsychosocial changes, but there are several means or ways to ameliorate or reconstruct the spiral of breakdown. The changes include (a) not defining self-worth in terms of "production," (b) improving social services to the elderly to help build up and maintain coping skills, and (c) development of self-determination and/or greater power among the elderly. In short, Kuyper and Bengston are advocating a reversal of the social breakdown syndrome. They assume that breakdown is normative for U.S. majority culture and that reconstruction is necessary.

While the social breakdown syndrome would not appear to be the normative experience for Amish older

adults, the social reconstruction syndrome does appear to be descriptive of Amish older persons and Amish society. The social reconstruction syndrome model would appear to be a more helpful model of psychosocial aging than either disengagement or activity theory with regard to examining Amish society. Two primary reasons why the social reconstruction syndrome model is more helpful are that, first, it attempts to examine the interaction of individual experience and social-cultural forces, and secondly, it assumes that individuals and societies can change. Neither the individual or society is assumed to be static or unchangeable. For example, this model does not assume that social breakdown is normative or universal but rather that interventions can be introduced which change the interaction between the individual and society.

Amish society seems to have few negative stereotypes about older people; hence, when older Amish are confronted by the bio-psychosocial changes of aging they are not perceived as useless or unimportant to society. The changes due to the aging process are perceived differently in Amish society than in U.S. majority culture. Amish social ideals and stereotypes attribute different "meaning" to the changes due to individual aging than are assumed in U.S. majority culture. The tendency in Amish society is to provide aid and support rather than negatively label or disengage from the older person.

The social reconstruction syndrome would appear to be the norm within Amish society and the social breakdown syndrome would appear to be abnormal.

A fourth model of psychosocial aging is modernization (Cowgill & Holmes, 1972). Cowgill and Holmes assume that social participation, status, and satisfaction in aging are negatively correlated with modernization. In short, the greater the level of modernization within a particular society, the less the elderly are respected, involved or satisfied. The model of modernization as described by Cowgill and Holmes is helpful in understanding the results of this study. The lower level of modernization within Amish society (as compared to U.S. majority culture) may explain the positive level of familial integration and psychological well-being among the Amish subjects. Roth (1981) found that in a study of modernization among Amish and Mennonites, the Amish elderly had greater social participation and status than did the Mennonites. Thus, even in groups as similar as Amish and Mennonites modernization seems to be an important force.

Modernization as a model of psychosocial aging, however, is limited in some important ways (Simić, 1978). First, to define or operationalize modernization is difficult. It has been defined differently by various researchers (i.e., based on per capita income, education,

urbanization and industrialization). Secondly, the model assumes that modernization is a homogeneous phenomenon. Finally, modernization is usually seen as having negative consequences for the elderly. In short, the modernization model tends to take a homogeneous, negative, static approach to understanding psychosocial aging.

Having reviewed some of the models proposed by other researchers for examining and understanding psychosocial aging, several components of a model for future study will be outlined.

Multi-level analysis. The first component involves the analysis of behavior from multiple levels. Such levels might include the biological, psychological and social dimensions of individual experience and the customs, history, institutions, and ideals at the social-cultural level. A comprehensive model of aging should be helpful in examining and understanding how biological functions associated with aging effect and are related to psychological factors as well as social-cultural dimensions.

Interaction. Not only should the model by multi-leveled in its analysis but it should be helpful in understanding the interaction among the various levels. Such interaction should not be seen as linear, but rather as more of a dialectical process in which the interaction is formed by previous interactions and

creates unique subsequent interactions.

Continuity and Discontinuity. The model should not only examine interaction within and between the individual and social-cultural context but how they are both continuous and discontinuous. The aging process should be examined for the ways in which it is a continuous and/or discontinuous process. An example of the continuity and discontinuity component is the degree to which cultural ideals and assumptions match with actual social patterns, structures and practices. For example, in what ways are Amish social ideals continuous and discontinuous with actual social practice? Also implied in this component is the importance of understanding the conflicts and paradoxes that exist within individual experience and the cultural context, as well as between the individual and cultural context.

Change. In addition to helping to explore the continuities and discontinuities, a model should help to describe and understand how change may be encouraged or prohibited (both individual and social-cultural change). For example, what are the continuities or discontinuities for Amish older adults when none of their children remain Amish? Or, how does Amish society respond to changes in the biological processes of aging? What would be the impact on familial integration and psychological well-being if Amish were employed in fewer farm-related

occupations or if there were other modifications in Amish social-cultural life?

Relative. Because of the assumption that change is normative, all models are seen as relative. Each society or sub-group within society should be seen as having a unique model of psychosocial aging. Thus, one model does not become "normative." Rather, each society is described in terms of its own social reality. The emphasis is on identifying and exploring social-cultural ideals and practices from within the context of the society under study, rather than assuming the ideals or practices of that context are universal or have the same meaning in other cultures. For example, "retirement" as a social ideal and practice is defined differently in various societies. This is not to imply that comparisons between societies cannot be made, but it does imply that the comparison process must start by assuming that each society has a unique model of psychosocial aging.

In recent years models of psychosocial aging similar to the one outlined above have been discussed (Baltes, Reese & Lipsitt, 1980; Riegel, 1976). However, little research has been conducted which examined familial integration and psychological well-being using such a model. The present study has attempted to incorporate several of the components of the model outlined above by (a) examining individual, familial, and societal

levels of Amish life, (b) by describing the interaction between individual older adults, their families and Amish society as a whole, and (c) assuming that Amish society is a model--that it is relative and not normative. Components of the model not included in the focus of this study, but still guiding this study were the assumptions that Amish society is continuous and discontinuous, and that it is changing, not static. Future investigations of Amish older adults should focus in greater detail on the continuities and discontinuities of the aging process within Amish society.

Conclusion

The aim of this study was to examine family integration and psychological well-being among Amish older adults. The purpose of the study was to provide descriptive information regarding family integration and psychological well-being and to explore whether Amish society provides a positive model of integration and care of older family members. The results revealed that the Amish have high intergenerational familial contact, close residential proximity and high mutual aid between generations. In addition, reported familial affectual integration and psychological well-being were also found to be high among Amish older adults. The high levels of family integration and psychological well-being confirmed the initial hypotheses. However, when familial

associational integration of the Amish subjects was compared with non-Amish samples, the results showed that the Amish were similar in frequency of contact and residential proximity, but showed greater mutual aid. The results also revealed that mutual aid was significantly correlated with familial affectual integration and reported psychological well-being. In addition, familial affectual integration and psychological well-being were found to be significantly correlated. Except for age, other demographic or reported health factors were not significantly related to family integration or psychological well-being.

The significant findings of this study were the strong correlations between mutual aid, affectual integration and phychological well-being. The correlations between these variables were not only found to be statistically significant, but were also found to be related to several cultural themes within Amish society. The results are discussed in terms of several relevant cultural themes. Several methodological issues were discussed which have implications for interpreting the present results, as well as guiding future research on family integration and psychological well-being among Amish older adults.

Amish society does appear to serve the interest of older adults and is a positive model for the integration

of older persons into family life. As noted in the Introduction, one service the behavioral and social sciences can provide to society-at-large as the aged population increases, is to explore positive models of integration and care of older persons. Amish cultural themes, as well as social and familial practice (as described in this study) would appear to have positive characteristics that serve the interests of older people in other societies.

REFERENCES

Adams, B.M. Kinship in an urban setting. Chicago: Markham Publishing Co., 1968.

Adams, D.L. Analysis of a life satisfaction index. Journal of Gerontology, 1969, 24, 470-474.

Anderson, M. The impact on the family relationships of the elderly of changes since Victorian times in governmental income-maintenance provision. In E.S. Shanas and M.B. Sussman (Eds.), Family, bureaucracy, and the elderly. Durham: Duke University Press, 1977.

Angres, S. Intergenerational relations and value congruence between young adults and their mothers. Unpublished doctoral dissertation, University of Chicago, 1975.

Arling, G. The elderly widow and her family, neighbors, and friends. Journal of Marriage and the Family, 1976, 38, 757-768.

Arth, M.J. An interdisciplinary view of the aged in Ibo culture. Journal of Geriatric Psychiatry, 1968a, 2, 33-39.

Arth, M.J. Ideals and behavior; a comment on Ibo respect patterns. The Gerontologist, 1968b, 8, 242-244.

Atchley, R.C. The sociology of retirement. New York: John Wiley & Sons, 1976.

Bachman, C.G. The Old Order Amish of Lancaster County. Norristown, Pa.: Pennsylvania German Society, 1961.

Baltes, P.B., Reese, H.W., and Lipsitt, L.P. Life-span developmental psychology. Annual Review of Psychology, 1980, 31, 65-110.

Bane, M.J. Here to stay. New York: Basic Books, 1976.

Beard, B.B. Are the aged ex-family? Social Forces, 1949, 27, 274-279.

Bengston, V.L., and DeTerre, E. Aging and the family relations. Marriage and Family Review, 1980, 3, 51-76.

Bengston, V.L., and Smith, D.H. Social modernity and attitudes toward aging. The Gerontologist, 1968, 8, 26.

Bild, B., and Havighurst, R.J. Senior citizens in great cities: The case of Chicago. The Gerontologist, 1976, 16, Part II.

Birren, J.E., Butler, R.N., Greenhouse, S.W., Sokoloff, L., and Yarrow, M. (Eds.), Human Aging: A biological and behavioral study. Washington, D.C.: U.S. Government Printing Office, 1963.

Blau, Z.S. Old age in a changing society. New York: Franklin Watts, 1973.

Blazer, D.G. The epidemiology of mental illness in later life. In E.W. Busse and D.G. Blazer (Eds.), Handbook of geriatric psychiatry. New York: Van Nostrand Reinhold, 1980.

Blazer, D.G. Depression in late life. St. Louis: C.V. Mosby, 1982.

Blumenthal, M.D. Measuring depressive symptomatology in a general population. Archives of General Psychiatry, 1975, 32, 971.

Bracey, H.E. In retirement: Pensioners in Great Britain and the United States. Baton Rouge: Louisiana State University Press, 1966.

Bradburn, N.M. The structure of psychological well-being. Chicago: Aldine, 1969.

Brown, A.S. Satisfying relationships for the elderly and their parents of disengagement. The Gerontologist, 1974, 14, 258-262.

Brink, T.L., Yesavage, J.A., Lum, O., Heersena, P.H., Adez, M., and Rose, T.L. Screening tests for geriatric depression. Clinical Gerontologist, 1982, 1, 37-43.

Bryer, K.B. The Amish way of death. American Psychologist, 1979, 34, 255-261.

Bultena, G.L. Rural-urban differences in the familial interaction of the aged. Rural Sociology, 1969, 34, 5-15.

Bultena, G.L. and Wood, L. The American retirement community: Bane or blessing? Journal of Gerontology, 1969, 24, 209-217.

Carter, H. and Glick, P.G. Marriage and divorce: A social and economic study. Cambridge: Harvard University Press, 1976.

Cavan, R.S., Burgess, E.W., Havighurst, R.J. and Goldhammer, H. Personal adjustment in old age. Chicago: Science Research Associates, 1949.

Clark, M. The anthropology of aging, a new area for studies of culture and personality. The Gerontologist, 1967, 7, 55-64.

Clark, M. and Anderson, B. Culture and aging: An anthropological study of older Americans. Springfield, Ill.: Charles C. Thomas, 1967.

Cowgill, D. and Holmes, L. Aging and modernization. New York: Appleton-Century-Crofts, 1972.

Cumming, E., and Henry, W.E. Growing old: The process of disengagement. New York: Basic Books, 1961.

Edwards, J.N., and Klemmack, D.L. Correlates of life satisfaction: A re-examination. Journal of Gerontology, 1973, 28, 497-502.

Egeland, J.A., and Hostetter, A.M. Amish study, I: Affective disorders among the Amish, 1976-1980. American Journal of Psychiatry, 1983, 140, 56-61.

Eisdorfer, C., and Cohen, D. The cognitive impaired elderly: Differential diagnosis. In M. Storandt, I. Siegler and M. Elias (Eds.), The clinical psychology of aging. New York: Plenum, 1978.

Gallagher, D., Thompson, L.W., and Levy, S.M. Clinical psychological assessment of older adults. In L. Poon (Ed.), Aging in the 1980's: Psychological issues. Washington, D.C.: American Psychological Association, 1980.

Gangel, K.O. The Amish of Jamesport, Missouri. Practical Anthropology, 1971, 18, 156-166.

Gelfand, D.E. Aging: The ethnic factor. Boston: Little, Brown and Co., 1982.

George, L.K. The impact of personality and social status factors upon levels of activity and psychological well-being. Journal of Gerontology, 1978, 33, 840-847.

George, K.K., and Maddox, G.L. Subjective adaptation to loss of the work-role: A longitudinal study. Journal of Gerontology, 1977, 32, 456-462.

Glenn, N.D., and McLanahan, S. The effects of offspring on the psychological well-being of older adults. Journal of Marriage and the Family, 1981, 43, 409-421.

Gutmann, D.L. Alternatives to disengagement: The old men of the highland Druze. In R.A. LeVine (Ed.), Culture and personality: Contemporary readings. Chicago: Aldine, 1974.

Gutmann, D.L. The cross-cultural perspective: Notes toward a comparative psychology of aging. In J.E. Birren and K.W. Schaie (Eds.), Handbook of the psychology of aging. New York: Van Nostrand Reinhold, 1977.

Haraven, T. The historical study of the life course. In T. Haraven (Ed.), Transitions: The family and the life course in historical perspective. New York: Academic Press, 1978.

Harris, L., and Associates. The myth and reality of aging in America. Washington: National Council on Aging, 1975.

Havighurst, R.J. Dominant concerns in life. In L. Schenk-Danzinger and H. Thomae (Eds.), Gegenwartsprobleme der entwicklungspychologie. Gottingen: Verlay fur Psycholgies Hogrefe, 1963.

Hill, R., Foote, N., Aldous, J., Carlson, J., and MacDonald, R. Family development in three generations. Cambridge: Schenckman Publishing Co., 1970.

Holmes, L.D. Trends in anthropological gerontology: From Simmons to the seventies. In J. Hendricks (Ed.), Perspectives on aging and human development: In the country of the old (Vol. 2). Farmingdale, New York: Baywood Publishing, 1980.

Holmes, L.D. Other cultures, elder years: An introduction to cultural gerontology. Minneapolis: Burgess Publishing, 1983.

Horsch, J.E. Mennonite yearbook and directory. Scottdale, Pa.: Mennonite Publishing House, 1983.

Hostetler, J.A. Amish society. Baltimore: Johns Hopkins Press, 1968 (2nd edition).

Hostetler, J.A. Amish society. Baltimore: Johns Hopkins Press, 1980 (3rd edition).

Hostetler, J.A., and Huntington, G.E. Children in Amish society: Socialization and community education. New York: Holt, Rinehart, and Winston, 1971.

Huntington, G.E. The Amish family. In C.H. Mindel and R.W. Habenstein (Eds.), Ethnic families in America. New York: Elsevier Scientific Publishing, 1976.

Ishizuka, K. The elder Japanese. San Diego: Center on Aging, San Diego State University, 1978.

Johnson, E.S. and Bursk, B.J. Relationships between the elderly and their adult children. The Gerontologist, 1977, 17, 90-96.

Kane, R.A. and Kane, R.L. Assessing the elderly: A practical guide to measurement. Lexington, MA: Lexington Books, 1981.

Kay, D.W.K., Beamish, P., and Roth, M. Old age mental disorders in Newcastle-upon-Tyne, Part I: A study of prevalence. British Journal of Psychiatry, 1964, 110, 146-158.

Keith, J. "The best is yet to be": Toward an anthropology of age. Annual Review of Anthropology, 1980, 9, 339-364.

Keith, J. Old people as people. Boston: Little, Brown and Co., 1982.

Kobata, R. The influence of culture on family relations: The Asian-American experience. In P.K. Ragan (Ed.), Aging parents. Los Angeles: University of Southern California Press, 1979.

Kollmorgen, W.M. Culture of a contemporary rural community: The Old Order Amish of Lancaster County. Washington, D.C.: U.S. Department of Agriculture, 1942.

Kutner, B., Fanshel, D., Togo, A.M., and Langner, T.S. Five hundred over sixty. New York: Russell Sage Foundation, 1956.

Kuypers, J.A. and Bengtson, V.L. Competence and social breakdown: A social-psychological view of aging. Human Development, 1973, 16, 37-49.

Lapp, F.E. History of Weavertown Church. Lancaster: Feldser Printing, 1963.

Larson, R. Thirty years of research on subjective well-being of older Americans. Journal of Gerontology, 1978, 33, 109-125.

Lawton, M.P. The dimensions of morale. In D. Kent, R. Kastenbaum, and S. Sherwood (Eds.), Research planning and action for the elderly: The power and potential of social science. New York: Behavorial Publications, 1972.

Lawton, M.P. The PGC moral scale: A revision. Journal of Gerontology. 1975, 30, 85-89.

Lee, G. Children and the elderly: Interaction and morale. Research on Aging, 1979, 1, 335-380.

Litwak, E. Occupational mobility and extended family cohesion. American Sociological Review, 1960, 25, 9-21.

Lohmann, N. Correlations of life satisfaction, morale, and adjustment measures. Journal of Gerontology, 1977, 32, 73-75.

Lohmann, N. Life satisfaction research in aging: Implications for policy development. In N. Datan and N. Lohmann (Eds.), Transitions of aging. New York: Academic Press, 1980.

Lopata, H.Z. Widowhood in an American city. Cambridge: Schenkman Publishing, 1973.

Maddox, G., and Eisdorfer, C. Some correlations of activity and morale among the elderly. Social Forces, 1962, 40, 254-260.

Mancini, J.A. Family relationships and morale among people 65 years of age and older. American Journal of Orthopsychiatry, 1979, 49, 292-300.

Markides, K.S., and Martin, H.W. A causal model of life satisfaction among the elderly. Journal of Gerontology, 1979, 34, 86-93.

Martin, W. Activity and disengagement: Life satisfaction in movers into a retirement community. The Gerontologist, 1973, 13, 224-227.

Maxwell, R.J., and Silverman, P. Information and esteem: Cultural considerations in the treatment of the aged. International Journal of Aging and Human Development. 1970, 1, 361-392.

Messer, M. The possibility of an age-concentrated environment becoming a normative system. The Gerontologist, 1967, 7, 247-251.

Morris, J.M., and Sherwood, S. A retesting and modification of the Philadelphia Geriatric Center Morale Scale. Journal of Gerontology, 1975, 30, 77-84.

Neugarten, B.L., Havighurst, R.J., and Tobin, S.S. The measurement of life satisfaction. Journal of Gerontology, 1961, 16, 134-143.

Olson, D.H., Sprenkle, D.H., and Russell, C.S. Circumplex model of marital and family systems: I. Cohesion and adaptability dimensions, family types, and clinical applications. Family Process, 1979, 18, 3-27.

Payne, B. The older male volunteer: Sex differences in the volunteer role. Washington, D.C.: ACTION, 1975.

Peterson, J.A. The relationships of middle-aged children and their parents. In P.K. Ragan (Ed.), Aging Parents. Los Angeles: University of Southern California Press, 1979.

Pfeiffer, E. Psychopathology and social pathology. In J.E. Birren and K.W. Schaie (Eds.), Handbook of the psychology of aging. New York: Van Nostrand Reinhold, 1977.

Pfeiffer, E., and Busse, E.W. Mental disorders in later life-affective disorders; paranoid, neurotic, and situational reactions. In E. Pfeiffer and E.W. Busse (Eds.), Mental illness in later life. Washington, D.C.: American Psychiatric Association, 1973.

Poster, M. Critical theory of the family. New York: The Seabury Press, 1980.

Press, I., and McKool, M. Social structure and status of the aged: Toward some valid cross-cultural generalizations. International Journal of Aging and Human Development, 1972, 3, 297-306.

Ragan, P.K., Bengtson, V.L., and Solomon, B. Life satisfaction, age identification and attitudes toward aging. Paper presented at the Annual Meeting of the Gerontological Society, 1975.

Redfield, R. The little community. Chicago: University of Chicago Press, 1950.

Riegel, K.F. The dialectics of human development. American Psychologist, 1976, 31, 689-700.

Riley, M., and Foner, A. Aging and society: An inventory of research findings. New York: Russell Sage Foundation, 1968.

Rosow, I. Socialization of the aged. New York: The Free Press, 1967.

Roth, D.E. Aging and modernization among the Yoder Amish and Hesston Mennonites. Unpublished master's thesis, Wichita State University, 1981.

Sanford, P. The elderly black. San Diego: Center on Aging, San Diego State University, 1978.

Schreiber, W. Our Amish neighbors. Chicago: University of Chicago Press, 1962.

Simić, A. Aging and the aged in cultural perspective. In B.G. Myerhoff and A. Simić (Eds.), Life's Career Aging: Cultural variations on growing old. Beverly Hills: Sage Publications, 1978.

Shanas, E. Family-kin network and aging in cross-cultural perspective. Journal of Marriage and the Family, 1973, 35, 505 - 511.

Shanas, E. Social myth as hypothesis: The case of the family relations of old people. The Gerontologist, 1979, 19, 3-9.

Shanas, E. and Sussman, M.B. The family in later life: Social structure and social policy. In R.W. Fogel, E. Hatfield, S.B. Kiesler, and E. Shanas (Eds.), Aging: Stability and change in the family. New York: Academic Press, 1981.

Shanas, E., Townsend, P., Wedderburn, D., Friis, H., Milhhoj, P., and Stehouver, J. Older people in three industrial societies. New York: Atherton Press, 1968.

Shelton, A.J. Ibo aging and eldership: Notes for gerontologists and others. The Gerontologist, 1965, 5, 20-23.

Simmons, L. The role of the aged in primitive society. New Haven: Yale University Press, 1945.

Smith, R., Holmberg, R., and Huges, C. Cultural differences and the concept of time. In R.W. Kleemeier (Ed.), Aging and leisure. New York: Oxford University Press, 1961.

Spreitzer, E., and Snyder, E.E. Correlates of life satisfaction among the aged. Journal of Gerontology, 1974, 29, 454-458.

Stenback, A. Depression and suicidal behavior in old age. In J.E. Birren and R.B. Sloane (Eds.), Handbook of mental health and aging. Englewood Cliffs, NJ: Prentice-Hall, 1980.

Stenback, A., Kumpulainen, M., and Vauhkonen, M.L. Depression in septuagenarians. Aktuelle Gerontologie, 1979, 9, 112-121.

Streib, G.F., and Thompson, W. The older person in family context. In C. Tibbetts (Ed.), Handbook of social gerontology. Chicago: University of Chicago Press, 1959.

Sussman, M.B. Relationships of adult children with their parents in the United States. In E. Shanas and G.F. Streib (Eds.), Social structure and the family: Generational relations. Englewood Cliffs, N.J.: Prentice Hall, 1965.

Sussman, M.B. Family, bureaucracy, and the elderly individual. In E. Shanas and M.B. Sussman (Eds.), Family, bureaucracy, and the elderly. Durham: Duke University Press, 1977.

Sussman, M.B. and Burchinal, L. Parental aid to married children: Implications for family functioning. Marriages and Family Living, 1962, 24, 320-332.

Townsend, P. Problems in the cross-national study of old people in the family: Segregation vs. integration. In E. Shanas and J. Madge (Eds.), Interdisciplinary topics in gerontology: Methodological problems in cross-national studies on aging. New York: Karger, 1968.

Troll, L. The family of later life: A decade review. Journal of Marriage and the Family, 1971, 33, 263-290.

Troll, L.E., Miller, S.J., Atchley, R.C. Families in later life. Belmont, CA: Wadsworth, 1979.

Valle, R., and Mendoza, L. The elder Latino. San Diego: San Diego State University, 1978.

Weishaus, S. Aging is a family affair. In P.K. Ragan (Ed.), Aging parents. Los Angeles: The University of Southern California Press, 1979.

Wood, V., Wylie, M., and Sheafor, B. An analysis of a short self-report measure of life satisfaction: Correlation with rater judgements. Journal of Gerontology. 1969, 24, 465-469.

Yelder, J. The influence of culture on family relations: The Black American experience. In P.K. Ragan (Ed.), Aging parents. Los Angeles: University of Southern California Press, 1979.

Zarit, S. Aging and mental disorders. New York: Free Press, 1980.

Zemore, R., and Eames, N. Psychic and somatic symptoms of depression among young adults, institutionalized aged, and non-institutionalized aged. Journal of Gerontology, 1979, 34, 716-721.

Zung, W. Affective disorders. In E.W. Busse and D.G. Blazer (Eds.), Handbook of geriatric psychiatry. New York: Van Nostrand Reinhold, 1980.

Zusman, J. Some explanations of the changing appearance of psychotic patients: Antecedents of the social breakdown syndrome concept. The Millbank Memorial Fund Quarterly, 1966,64.

Appendix A

STRUCTURED INTERVIEW ON FAMILY INTEGRATION

ID#_____ Date_____

Name _____

Address _____

_____

Congregation _____

1. What is your age? _____

2. In what year were you born? _____

3. Sex (1=male; 2=female)

4. Are you currently married?

   1=married
   2=widowed (year widowed _____)
   3=never married

5. In what year were you married to your current spouse?

   _____

6. Have you been married more than once?

   1=no
   2=twice
   3=three times
   4=four or more

   If married twice or more:

   a. When did you marry your first spouse?_____

   b. How many years were you married?_____

   c. How many years before you remarried?_____

   If married three times:

Appendix A continued:

a. When did you marry your second spouse?_____

b. How many years were you married?_____

c. How many years before you remarried?_____

7. What was your occupation for most of your life?

_____

8. Are you presently employed?

1=yes
2=no

9. When did you retire? (stop operating the farm)

1=haven't retired
2=list year or age retired_____
3=homemaker_____
4=work part-time

10. What is your current occupation?

_____

11. How many hours a week do you work at your present occupation?_____

12. How many hours a week do you work around the home or farm?_____

13. With whom are you living?

1=alone
2=spouse
3=spouse and children
4=children
5=other relatives _____
6=other _____

14. When did you move to your present house?_____

15. When did you move to your present farm?_____

16. How many miles away is the farm you grew up on?_____

17. How do you see your financial situation at this time?

Appendix A continued:

1=cannot make ends meet
2=have just enough to get by
3=comfortable
4=more than enough to get by
5=well-to-do

18. What is your primary source of income at the present time?

1=savings
2=wages
3=savings and wages
4=gifts from children
5=other income _____

19. How would you rate your financial situation now compared to when you were 50 years old?

1=worse
2=about the same
3=better

20. How would you rate your physical health at this time?

1=poor
2=fair
3=good
4=excellent (very good)

21. Is your health better or worse now than it was when you were 50 years of age?

1=worse now
2=about the same
3=better now

22. How many times have you been hospitalized in the last three years? _____

Reasons:

1. _____

2. _____

3. _____

4. _____

5. _____

Appendix A continued:

23. Do you have any physical conditions, illnesses or other health problems that you have had for several months or more:

1=yes (number _____)
2=no

Condition:

1._____

2._____

3._____

4._____

24. Are you taking any medications?

1=yes (number _____)
2=no

List:

_____

_____

Appendix A continued:

27. I would like to ask you some questions about each of your children. I would like to start with the oldest child first.

a. Is this child a natural or step-child?
b. Is this child a daughter or son?
c. Is this child married?
d. How often do you see this child (average)?
e. When was the last time you say this child?
f. What did you do together the last time?
g. How long a journey is it to this child's home?
h. Is this child a member of the Beachy-Amish church?

	Natural or Step	Sex	Marital Status	Frequency Contact	Last Seen	Activity	Residential Proximity	Beachy Member
1.								
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								
11.								
12.								
13.								
14.								
15.								

Appendix A continued:

28. Is the amount of time you spend with your children different now than when you were age 50?

    1=decreased
    2=about the same
    3=increased

29. How many grandchildren do you have?_____

30. How often do you see at least one of your grandchildren?

    8=daily
    7=several times a week
    6=once a week
    5=several times a month
    4=once a month
    3=several times a year
    2=once a year or less
    1=never

31. How many great-grandchildren do you have?_____

32. How often do you see at least one of your great-grandchildren?_____(use code above)

33. How many brothers or sisters do you have?_____

34. How often do you see at least one of your siblings?
    _____ (use code from No. 30)

35. Are your parents still living?

    1=mother living
    2=father living
    3=both living
    4=both deceased

36. How often do you see your parent(s)?
    _____ (use code from No. 30)

37. If you had an emergency (became ill) who would help you or care for you?

    1=spouse
    2=children & spouse
    3=children
    4=other relatives
    5=friend
    6=other

Comments:

Appendix A continued:

38. I would like to ask some questions about how you and your children might help each other.

    a. Do any or all of your children help in the following way...
    b. Is this help on a regular basis or only occasionally?
    c. Do you help any of your children in the following ways...
    d. Is this help on a regular basis or only occasionally?

	Children Help/Give Frequency	Parents Help/Give Frequency
+help out when someone is ill	_____	_____
+take care of small children	XXXXXXXXX	_____
+give advice on running a home	_____	_____
+give advice on raising children	XXXXXXXXX	_____
+shop or run errands	_____	_____
+give you/them gifts	_____	_____
+help out with money	_____	_____
+fix things around the house	_____	_____
+give advice on job or business matters (farm)	_____	_____
+give advice on how to deal with life's problems	_____	_____
+help with housekeeping	_____	_____
+other _____	_____	_____
+other _____	_____	_____
+other _____	_____	_____
+other _____	_____	_____

Frequency: 1=never/no help 3=regularly
2=occasionally 4=willing to help

Appendix A continued:

39. Do your children help you more or less than when you were 50?

    1=less
    2=about the same
    3=more

40. Do you help your children more/less than when you were age 50?

    1=less
    2=about the same
    3=more

41. Do your siblings help you, or do you help your siblings in any way?

    1=subject helps siblings
    2=siblings help subject
    3=help each other
    4=no help

42. How many close friends do you have?_____

43. How often do you see at least one of your friends?

    8=daily
    7=several times a week
    6=once a week
    5=several times a month
    4=once a month
    3=several times a year
    2=once a year or less
    1=never

44. Do you see your friends more or less often now than when you were 50 years old?

    1=less
    2=about the same
    3=more

45. How often do you attend church services?

    1=never
    2=less than once a month
    3=once a month
    4=several times a month
    5=weekly or more

Appendix A continued:

46. How often do you attend other church activities?

_____(use code from #49)

List activities_____

_____

_____

47. Do you attend church activities and services more or less often now than you did at age 50?

1=less
2=about the same
3=more

48. Do you hold any leadership positions in the church?

List:_____

49. Do you meet with or belong to any other types of groups (non-church)?

List:_____

_____

50. How often do you meet?

1=less than once a month
2=monthly
3=several times a month
4=weekly

51. Are you a leader in this group?

1=yes
2=no

52. Is your involvement in such groups more or less now than when you were age 50?

1=less
2=about the same
3=more

APPENDIX B

4 = True all the time
3 = True most of the time
2 = True some of the time
1 = True none of the time

_____ 1. Family members enjoy doing things alone as well as together.

_____ 2. Our family has a balance of closeness and separateness.

_____ 3. There are times when other family members do things that make me unhappy.

_____ 4. Family members feel comfortable inviting their friends along on family activities.

_____ 5. Family members seldom take sides against other members.

_____ 6. My family completely understands and sympathizes with my every mood.

_____ 7. Family members like to spend some of their free time with each other.

_____ 8. We respect each other's privacy.

_____ 9. Our family is not a perfect success.

_____ 10. In our family we know each other's close friends.

_____ 11. Family members discuss important decisions with each other but usually make their own choices.

_____ 12. There are times when I do not feel a great deal of love and affection for my family.

_____ 13. Although family members have individual interests, they still participate in family activities.

_____ 14. In our family, it's important for everyone to express his opinion.

Appendix B continued:

_____ 15. If I could be a part of any family, I could not have a better match.

_____ 16. Each family member has at least some say in major family decisions.

_____ 17. Punishment is usually pretty fair in our family.

_____ 18. I don't think anyone could possibly be happier than my family and I when we are together.

_____ 19. Family members discuss problems and usually feel good about the solutions.

_____ 20. In our family, everyone shares responsibilities.

_____ 21. Our family is as well adjusted as any family can be.

_____ 22. Family members make the rules together.

_____ 23. If one way doesn't work in our family, we try another.

_____ 24. I don't think any family could live together with greater harmony than my family.

Appendix C

Here are some statements about life in general that people feel differently about. Would you read each statement on the list, and if you agree with it put a check mark in the space under "AGREE." If you do not agree with a statement, put a check mark in the space under "DISAGREE." If you are not sure one way or the other, put a check mark in the space under "NOT SURE." PLEASE BE SURE TO ANSWER EVERY QUESTION ON THE LIST.

	AGREE	DISAGREE	NOT SURE
1. As I grow older, things seem better than I thought they would be.	____	____	____
2. I have gotten more of the breaks in life than most of the people I know.	____	____	____
3. This is the dreariest time of my life.	____	____	____
4. I am just as happy as when I was younger.	____	____	____
5. These are the best years of my life.	____	____	____
6. Most of the things I do are boring or monotonous.	____	____	____
7. The things I do are as interesting to me as they ever were.	____	____	____
8. As I look back on my life, I am fairly well satisfied.	____	____	____
9. I have made plans for things I'll be doing a month or a year from now.	____	____	____
10. When I think back over my life, I didn't get most of the important things I wanted.	____	____	____

Appendix C continued:

	AGREE	DISAGREE	NOT SURE
11. Compared to other people, I get down in the dumps too often.	_____	_____	_____
12. I've gotten pretty much what I expected out of life.	_____	_____	_____
13. In spite of what people say, the lot of the average person is getting worse, not better.	_____	_____	_____

Appendix D

Please read each statement on the list and CIRCLE the "Yes" if you agree with the statement and CIRCLE the "No" if you disagree with the statement. PLEASE BE SURE TO ANSWER EVERY QUESTION.

1. Are you basically satisfied with your life?. . . . . yes / no
2. Have you dropped many of your activities and interests? yes / no
3. Do you feel that your life is empty? yes / no
4. Do you often get bored? yes / no
5. Are you hopeful about the future?. . . . . yes / no
6. Are you bothered by thoughts you can't get out of your head? yes / no
7. Are you in good spirits most of the time? yes / no
8. Are you afraid that something bad is going to happen to you? yes / no
9. Do you feel happy most of the time? yes / no
10. Do you often feel helpless? . . . . . yes / no
11. Do you often get restless and fidgety? yes / no
12. Do you prefer to stay at home rather than going out and doing new things? yes / no
13. Do you frequently worry about the future? yes / no
14. Do you feel you have more problems with memory than most? yes / no
15. Do you think it is wonderful to be alive now? . . . . . yes / no
16. Do you often feel downhearted and blue? yes / no

Appendix D continued:

17. Do you feel pretty worthless the way you are now? yes / no

18. Do you worry a lot about the past? yes / no

19. Do you find life very exciting? yes / no

20. Is it hard for you to get started on new projects? . . . . . yes / no

21. Do you feel full of energy? yes / no

22. Do you feel that your situation is helpless? yes / no

23. Do you think that most people are better off than you are? yes / no

24. Do you frequently get upset over little things? yes / no

25. Do you frequently feel like crying? . . . yes / no

26. Do you have trouble concentrating? yes / no

27. Do you enjoy getting up in the morning? yes / no

28. Do you prefer to avoid social gatherings? yes / no

29. Is it easy for you to make decisions? yes / no

30. Is your mind as clear as it used to be?. . yes / no

Appendix E

Item Responses for Cohesion Subscale*

Cohesion Items	True None of the Time	True Some of the Time	True Most of the Time	True All of the Time
1) Family members enjoy doing things alone as well as together.	0	22	45	33
2) Our family has a balance of closeness as well as separateness.	5	18	49	28
3) Family members feel comfortable inviting their friends along on family activities.	3	10	42	45
4) Family members seldom take sides against other members.	42	25	13	20
5) Family members like to spend some of their free time with each other.	0	15	76	9
6) We respect each other's privacy.	0	3	22	75
7) In our family we know each other's close friends.	0	27	60	13
8) Family members discuss important decisions but usually make their own choices.	0	12	72	16
9) Although family members have individual interests, they still participate in family activities.	0	5	67	28

*Shown in percentages

Appendix F

Item Response for Adaptability Subscale*

Adaptability Items	True None of the Time	True Some of the Time	True Most of the Time	True All of the Time
1) In our family, it's important for everyone to express his/her opinion.	8	16	57	18
2) Each family member has at least some say in major family decisions.	3	22	49	26
3) Punishment is usually pretty fair in our family.	6	6	64	24
4) Family members discuss problems and usually feel good about the solutions.	0	24	64	12
5) In our family everyone shares responsibility.	0	0	64	36
6) Family members make the rules together.	24	30	43	3
7) If one way doesn't work in our family, we try another.	5	18	65	11

*Shown in percentages.

Appendix G

Item Response for Life Satisfaction Index Z*

Items	Agree	Disagree	Not Sure
1) As I grow older, things seem better than I thought they would be.	66	4	30
2) I have gotten more of the breaks in life than most of the people I know.	29	18	53
3) This is the dreariest time of my life.	7	91	2
4) I am just as happy as when I was younger.	88	5	7
5) These are the best years of my life.	46	20	34
6) Most of the things I do are boring or monotonous.	2	96	2
7) The things I do are as interesting to me as they ever were.	89	2	9
8) As I look back on my life, I am fairly well satisfied.	82	2	16
9) I have made plans for things I'll be doing a month or a year from now.	58	29	13
10) When I think back over my life, I didn't get most of the important things I wanted.	20	59	21
11) Compared to other people, I get down in the dumps too often.	3	88	9
12) I've gotten pretty much what I expected out of life.	71	4	25
13) In spite of what people say, the lot of the average person is getting worse, not better.	41	34	25

*Shown in percentages.

Appendix H

Item Response of Geriatric Depression Scale*

	Items	Agree	Disagree
1)	Are you basically satisfied with your life?	91	9
2)	Have you dropped many of your activities or interests?	13	87
3)	Do you feel that your life is empty?	2	98
4)	Do you often get bored?	4	96
5)	Are you hopeful about the future?	90	10
6)	Are you bothered about thoughts you can't get out of your head?	15	85
7)	Are you in good spirits most of the time?	97	3
8)	Are you afraid that something bad is going to happen to you?	0	100
9)	Do you feel happy most of the time?	96	4
10)	Do you often feel helpless?	8	92

continued

*Shown in percentages

Appendix H

Item Response of Geriatric Depression Scale*

	Items	Agree	Disagree
11)	Do you often get restless and fidgety?	8	92
12)	Do you prefer to stay at home, rather than going out and doing new things?	37	63
13)	Do you frequently worry about the future?	8	92
14)	Do you feel you have more problems with memory than most?	27	73
15)	Do you think it is wonderful to be alive now?	88	12
16)	Do you often feel downhearted and blue?	5	95
17)	Do you feel pretty worthless the way you are now?	10	90
18)	Do you worry a lot about the past?	3	97
19)	Do you find life very exciting?	85	15
20)	Is it hard for you to get started on new projects?	31	69

continued

*Shown in percentages.

Appendix H

Item Response of Geriatric Depression Scale*

	Item	Agree	Disagree
21)	Do you feel full of energy?	70	30
22)	Do you feel that your situation is hopeless?	5	95
23)	Do you think that most people are better off than you are?	6	94
24)	Do you frequently get upset over little things?	24	76
25)	Do you frequently feel like crying?	9	91
26)	Do you have trouble concentrating?	27	73
27)	Do you enjoy getting up in the morning?	88	12
28)	Do you prefer to avoid social gatherings?	15	85
29)	Is it easy for you to make decisions?	53	47
30)	Is your mind as clear as it used to be?	30	70

*Shown in percentages.