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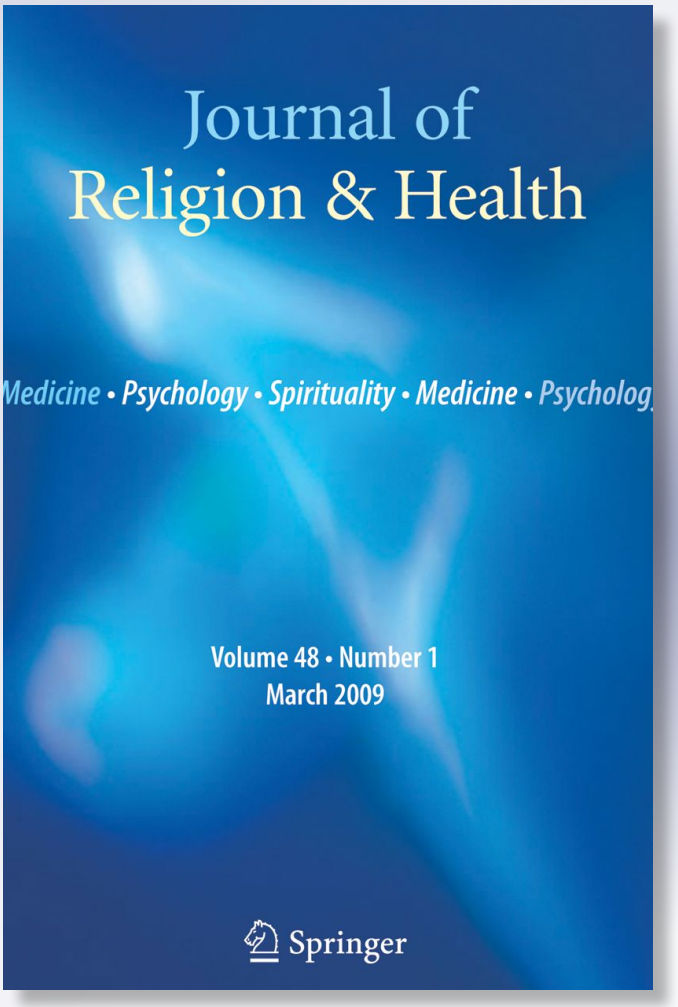

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ORIGINAL PAPER

Health Beliefs and Practices in an Isolated Polygamist Community of Southern Utah

Anne Catherine Miller · Katrina Karkazis

Abstract Short Creek is a largely closed and isolated community on the border between Utah and Arizona, made up of the sister towns of Hildale, Utah, and Colorado City, Arizona. Beginning from childhood, the 6,000 or so members of the Fundamentalist Church of Jesus Christ of Latter-Day Saints (FLDS) are brought up in a lifestyle of plural marriage, meaning a marriage among one man and more than one woman, and are surrounded by their peers in "the covenant." A lifestyle of plural marriage is likely to affect the health of community members, but its effects have not been studied because of the community's isolation and distrust of outsiders. This paper addresses several questions that arise in contemplating the health of the Short Creek community: What are the health beliefs in this community, and what are their historical bases? Where do families seek medical care, and for what or at what threshold of illness or injury? What is the attitude of care providers serving this community, and how are the providers viewed by the community? More broadly, this paper examines the ways in which polygamy configures health. In order to meet this objective, this paper aims first to provide a brief account of this community's history and demographic profile, followed by a discussion of health care in this community and how it is affected by the practice of plural marriage, with the data comprised of qualitative interviews with health care providers to the community. The goals of this project are to gain a rich, historically nuanced understanding of the health of community members, and to identify directions for further academic and policy research. Our findings indicate that health in this community is shaped by limited resources, an attitude of health fatalism, and a profound insularity and corresponding isolation from the outside world.

Keywords Polygamy and health · FLDS and health · Isolated religious communities and health · Rural communities and health

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Epidemiology and Context

According to the US Census Bureau (2010), 4,821 people live in Colorado City, Arizona. It is a young community, 67 % of its members are 19 years old or younger. The community is 47.8 % male, and 99.5 % White. Hildale, Utah has 2,726 people in residence, with a similar distribution. The overwhelming majority of community members are members of The Fundamentalist Church of Jesus Christ of Latter-Day Saints (FLDS), a group that split from the modern Mormon Church in the early twentieth century. The practice of polygamy, combined with its firm commitment to isolation from outsiders, sets this community apart from other religious communities.

It may be useful briefly to compare the FLDS to other isolated religious groups, including the Amish, who face similar challenges as a consequence of insularity and isolation, meaning that they have limited contact with mainstream society. The medical care providers for the FLDS who were interviewed, and whose comments we return to later, argued that tailoring their care to the FLDS is no different than tailoring their care to the unique needs of another of these communities. One care provider explains, "Whether you're working with the Navajo or [the FLDS population], you need to know what the cultural issues are with them."

Each community has particularities that must be accommodated in providing appropriate medical care; this paper will draw out those particularities of the FLDS. A care provider contrasted working within this community to his experience of treating the Amish who do not use health insurance and rather pay for treatments collectively and thus carefully evaluate the necessity of each procedure. He explained, "I haven't noticed [concerns about cost] as much with the Colorado City population. They're not concerned about the cost of it, they're more concerned about not wanting it to be done." Here, he refers to the FLDS belief in health fatalism, where health outcomes are believed to reflect God's will. Some of these particularities are common to other rural or isolated religious communities, while others are directly related to polygamy or the beliefs of the FLDS. This paper attempts to draw the distinction between the two.

Although scholars have studied only minimally the health of the Short Creek community, polygamist populations elsewhere have been studied, and mental health has been a topic of particular concern. One study of Turkish polygamist groups shows a higher level of somatization disorder, where emotional stress is converted into physical illness, among polygamous women, with the highest rates being among the most senior wives (Ozkan et al. 2006). Similarly, studies of the Bedouin-Arab tribes of Israel show lower levels of self-esteem among more senior wives as compared to their junior counterparts (Al-Krenawi 1999). These are important issues to examine in considering the health of this community; however, societal stigma and prevailing attitudes about mental illness make this very difficult, as discussed later. Nevertheless, examining health care as it relates to an illegal practice that promotes persecution and estrangement from the outside world is valuable to broader explorations of trust in the medical system, as well as providing valuable insight into the particular health care needs of this community.

Methods

This study employs two methodologies: a historiography of health and healing in these communities, and a series of qualitative interviews with health care providers who serve this community.

The historiography was completed using materials at the Stanford University libraries and through the InterLibrary Loan program, visiting the General and Special Collections at the University of Utah and Brigham Young University, and contacting scholars of these communities. ACM also searched modern news sources, including JSTOR and current newspapers for terms including "isolated religions communities and health," and "polygamy and health." The body of scholarship on this community is minimal, especially as it pertains to their health and medical beliefs and practices (Divett 1981; Bush 1976, 1979, 1986, 1993; Bradley 1990; Schwab 2010).

Building upon this historiography, the second phase of the study utilized qualitative and open-ended interviews with health providers both within the community and in nearby areas. The interviews focused on the health care providers' perspectives on providing health care and health knowledge, in both the preventative and episodic capacities. Our Institutional Review Board for Medical Subjects approved this study. The data include eleven in-depth, semi-structured interviews with physicians and other health care workers conducted in March and April 2011 by ACM. Nine of these interviews were done in person; two were conducted over the phone because of scheduling conflicts. The interviews lasted 30–60 min each. The interviews were semi-structured and topics for questions included health beliefs, health values, and processes of obtaining health care.

These eleven individuals account for a large proportion of the local health care providers in the Short Creek Area include eight male physicians, and a female nurse practitioner, midwife, and nutritionist, all of whom work in St. George and the neighboring communities. These individuals were identified through the literature and through recommendations from other clinicians. The clinicians interviewed displayed a commitment to serving this community, with longevity of service ranging from 9 months to 28 years.

At the start of the study, we hoped to gain access to interview some of the clinical care providers who live and work in Colorado City. Unfortunately, the current community climate of crisis due to the recent indictment of their leader, Warren Jeffs, made this impossible. We instead pursued more interviews with care providers with extended exposure to community members. The possibility of completing interviews with the community care providers exists in the future and would provide an extremely valuable perspective building upon this study.

Because of the sensitive position of this community, the care providers who serve its members have worked to establish a trusting relationship. This relationship is precarious, and so in conducting this study, we endeavored to ensure the anonymity of interview subjects. Their identities are not necessary to understand the value of their comments and insights, and so, following anthropological convention, all interviewees are referred to simply as "care providers."

The interviews were analyzed using grounded theory or inductive reasoning (Pelto and Pelto 1990; Rubin and Rubin 2004; Ryan and Bernard 2000). After first generating a list of themes from the interview transcripts, the themes were then categorized to become a set of codes by ACM and KK. Three interviews were coded and reviewed by both researchers to ensure inter-rater reliability prior to coding the remainder of the interviews (by ACM). There are no disclosures or conflicts of interest; neither author is a member of this community nor has any interests there.

Through this study, we do not intend to further stigmatize this community and its health beliefs. To the contrary, we have endeavored to be sensitive to its unique issues and background, and hope that this project will provide a meaningful contribution to outsiders' understanding of this community in order to serve them better. A second aim is to open the discussion of the particular health challenges faced by this community, and thus how to improve health for community members.

Background and History of the Community: "All would be equal"

The Church of Jesus Christ of Latter-Day Saints was founded in 1830 in upstate New York. Some of its members, known colloquially as the "Mormons," "LDS," or "the Church," began practicing polygamy roughly 20 years later. This practice was the root of much conflict and suspicion from outsiders and the government, and was abandoned as an official church practice in 1890 (Woodruff 1890).

However, some Church members believed that the practice was necessary for exaltation in a future life, and so did not accept LDS Church President Wilford Woodruff's (1890) *Manifesto* prohibiting plural marriage. In 1926, a group of dissenters migrated to Short Creek, a rural and desolate area straddling the Utah-Arizona border, about 40 miles southeast of St. George, Utah, the nearest metropolitan area, where they felt they could practice plural marriage without persecution. Governor George W. P. Hunt of Arizona, upon visiting the remote area, commented, "Hell, if I had to live in this place, I'd want more than one wife myself" (Stegner 1942).

In Short Creek, the migrants were able to establish a society based on their belief in polygamy. This society, as a former community member writes, "eventually became a United Order, where all possessions and acquisitions were owned [collectively] so there would be no rich or poor, but all would be equal" (Bistline 1994). In addition to living the law of the United Order, now called the United Effort Plan (UEP), they also obey "the principle" of plural marriage. The members of the UEP are termed the FLDS and are not formally or informally aligned with the modern Mormon Church (LDS).

This illegal lifestyle of plural marriage remains a source of consternation for the LDS and has caused repeated skirmishes and disagreements with state and local governments that have sought to curb this practice. Among the most prominent was the 1953 "Short Creek Raid" directed by the Arizona government in which most men in the community were taken prisoner, while the women and children were removed and sent to live with non-polygamous families outside of the community. However, local media devoted wide coverage to the raid where the photos of women and children being forced out of their homes generated a public outcry that forced the government to abandon their objective (Zent 1997).

Partially owing to this Short Creek debacle, no large-scale or government-directed raids have been conducted since in Utah or Arizona, with law enforcement officials choosing a "hands-off approach to Hildale-Colorado City" (Zent 1997). In an effort to erase the stigma associated with the name "Short Creek," the community recognized the state border and officially split into two communities, called Colorado City and Hildale.

The community now exists largely without outside government or religious interference, but the religious leaders of the community command supreme authority over the lives and beliefs of their followers. FLDS historian Hales notes, "The UEP [gives] FLDS leaders total control over homes and property [all property is owned and allocated by the Church], and the Law of Placing [the assignment of wives based on divine inspiration gives] them control over families and marriages" (Hales 2008, pp. 98).

Beliefs and Practices that Frame Health

Religious beliefs and practices pervade everyday life for those in Colorado City. This is especially true with regards to health care, where community beliefs are grounded on and

guided by community values of "keeping sweet," insularity from the outside world, and fatalism.

"Keeping sweet" is the prevailing sentiment in family life for the FLDS. It is emblazoned on rocks and Jeffs has repeatedly stressed its importance in guiding thoughts and social interactions. One care provider explains, "They have a saying out there, 'be sweet,' where you aren't allowed to show sadness." Women are taught from childhood that their responsibility is to marry and have children, and the care providers note that the women generally seem to be content with that lifestyle. This may be tautological; however, because they have no choice but to be content. They learn that complaining disturbs the spirit of God, and so they should just "keep sweet."

This lifestyle, along with the division of family roles, has myriad effects on health. According to our interviews, the mother plays a dominant primary role in the child's life, coming to all health care visits and bearing responsibility for the overall care of the child. However, she does so often with help from her sister-wives, the other wives in the plural marriage. The system allows for distribution of responsibility, where some sister-wives work outside the home and others are principally responsible for running the household, and also alleviates some of the pressures of motherhood. A mother has a much stronger support network with other women in the house and can call on them for emotional or physical help with her duties and stresses. One care provider explains, "In our society… you have a lot of women who don't have a lot of support structure around them…and I think it creates a lot of depression and anxiety that doesn't exist in their society." Whether it is true that the depression does not exist in their society, or whether it is simply masked by a commitment to "keeping sweet" is unclear.

The fathers are also involved in caring for their children. A father is the main breadwinner, and the ultimate decision-maker on all matters for the family, including health decisions. The fathers are less involved in the actual childcare not because of lack of interest, but because they are busy working and have so many children among which to divide their time.

Community relationships are also defined by insularity due to a profound distrust of outsiders. In 2000, FLDS prophet Rulon Jeffs died and was replaced by his son, Warren. Many of those I interviewed mark Warren Jeffs' takeover as a turning point in the community and its increasing conflict with and insularity from the outside world. Warren Jeffs made several isolating changes in the community including banning television and Internet access, as well as instituting private, religious schools for FLDS children. In 2006, Jeffs sent several hundred people to Texas in a large exodus, under what he claimed was God's direction to help his people find more "protection" from the outside (Hollenhorst 2011).

With this further isolation has come further distrust of the outside world (outsiders are called "outlanders"), and so the cycle continues (Dillon 1992). In 2008, roughly 450 children were taken from the community by Texas state authorities on suspicion of child abuse. They were later returned to their families, but Warren Jeffs' 2011 conviction for sexual assault of a minor comes from allegations raised at this time (Hollenhorst 2011).

Isolation, or insularity, is also based on the fundamental FLDS principle of self-reliance. This stems from the idea that each person is responsible for his own salvation, and consequently, his own welfare in this life. FLDS Church members are encouraged to become self-reliant and to take care of problems within the family, resulting in a tiered path to seeking health care through the family, the community, and finally, the outside world. The mechanism seems to work fairly well: a care provider comments, "They do a good job of taking care of their own, they really do." This is difficult to correlate with their prevalent use of Medicaid and other social services, but is an example of their pragmatic fatalism, discussed later.

Their separatism and isolationism have many effects on health and health care, most of which are not yet quantified. The story of the "lost boys" is one such occurrence. According to the teachings of Warren Jeffs and other FLDS prophets, men must marry more than one wife in order to achieve salvation (Jeffs teaches that this number should be at least three). The surplus of young men generated by this practice, escalated by the fact that there is very little immigration or conversion into this community, is countered by sending the boys away under the pretext of having disobeyed some commandment or societal rule (Hales 2006). Some estimate that upwards of 1,000 boys have had this experience (Borger 2005). These young men face significant challenges in adapting to a life other than that of plural marriage, as well as being outcasts from their religion, community, and family. The health effects of this uprooting remain to be explored.

Health fatalism is the third driving characteristic in the community's attitude toward health. They have a general attitude of fatalism, or a belief that whatever happens is God's will, which extends from medical incidents to natural disasters. This belief causes them to regard medical conditions such as infertility or genetic disorders with a degree of futility. The attitude quoted repeatedly in the interviews was one of "That's just the way it is." However, they do also recognize their children and their bodies as blessings from God, and so do their best to seek enough medical care to keep them healthy. This pragmatic fatalism, while a seeming contradiction, is a survival mechanism, a way to sustain the community with so little immigration and so little access to in-community health care.

Although not unique to this community, this fatalistic attitude is especially pronounced with regard to genetic disorders and conditions. Many care providers noted an increased number of children born with congenital conditions and malformations such as cleft palate and other anomalies. One attributed this to what he slightly facetiously termed a "shallow gene pool, no lifeguard," meaning consanguinity, or marriages among people that are closely related.

As a result of these intermarriages, the community also has high incidences of several genetic illnesses. Two of these have been well documented: fumarase deficiency and pyruvate kinase deficiency (Kerrigan et al. 2000; Christensen et al. 2010). Fumarase deficiency is a degenerative neurologic disorder that causes unusual facial structure, frequent epileptic seizures, episodes of coma, and possible early death. Unfortunately, Arizona is home to about half of the worldwide sufferers of this condition with up to 20 reported cases due to the high degree of inbreeding and crossbreeding in the population, according to pediatric neurologist Dr. Theodore Tarby (Kerrigan et al. 2000).

Pyruvate kinase deficiency was only recently noticed among members of this population. A rare disorder where patients lack an enzyme in glycolysis (the biochemical process through which glucose is converted into cellular energy) it causes a neonatal hemolytic jaundice similar to glycogen-6-phosphate-dehydrogenase deficiency. It occurs in the Caucasian population at a prevalence of about 1 in 20,000 live births, yet four neonates from this community were diagnosed with the disorder within a 5-year period, a troubling prevalence of 1 in 250 live births (Christensen et al. 2010).

The health sequelae of consanguinity are common to other isolated communities, but are particularly prominent in this community, because of the high number of both marriages and children, and also because of a lack of recognition that the congenital anomalies are linked to consanguinity. Similarly, the insulated nature of the community makes the anomalies seem more common, and therefore less concerning. Although most of those I interviewed believed that the health care providers in the community recognize the health effects of consanguinity, there does not seem to be much discouragement of the practice from the religious establishment. Major cultural changes such as marrying outside the

community, having fewer children, or having fewer wives could drastically improve the situation; however, significant progress could be made by community members making more of an effort to marry outside of small family circles.

These beliefs about consanguinity stem from FLDS beliefs about reproduction and children that are based on "the principle" of plural marriage. The plural family is thought to be an essential subunit that will continue into the next life. They teach that the number of children is strongly tied to one's salvation. The care providers explained that there is a "real status that is bestowed with a lot of kids," and that is not uncommon to see women who have twelve, fourteen, or up to eighteen children. An expert on the FLDS and American religious communities explains:

> A girl growing up in the shadow of Short Creek's red butte knew the boundaries of her world. She and the other women of Short Creek were geographically and socially isolated, living in the rigid gender-marked world of patriarchy…Bearing children to a righteous husband as one of his several wives was, in these women's views, not only the husband's will but also God's will (Bradley 1990, pp. 16).

This belief frames and directs the community's general attitude toward health, showing a certain degree of fatalism and a commitment to bearing and raising children.

Because of the high societal value of multiple children, infertility and miscarriage are very emotionally difficult for FLDS women. However, invasive medical infertility treatments, such as in vitro fertilization, are not sought after because they are viewed as "unnatural." This is evidence of another incidence of conflicting beliefs in this community: an overwhelming desire to have children that is sometimes at odds with a belief that whatever happens is God's will.

When asked about birth control attitudes among community members, many care providers replied, "what's birth control?" This reflects the outside perspective that birth control is very seldom used in this community, perhaps understandably as the number of children is tied to salvation. Joseph Musser, an early FLDS prophet and thought-leader, taught that sexual intercourse should occur only for the purpose of procreation, and that "Birth control is a divine principle, but God must be the controller. Self-control, on the part of individuals, is the great requirement" (as quoted in Siegmeister 1942, p. 185). Families practice some limited forms of family planning, where, "if there are several wives, the wife who is trying to get pregnant will spend more time with her husband at the time of fertility," explains one care provider. This is in addition to natural family planning mechanisms, such as breastfeeding, which is an integral part of FLDS culture.

Barriers to Seeking Health care

Health beliefs of those living in Colorado City stem from those of early Mormonism. The early Mormons, led by Joseph Smith, often lived on the frontier. Smith supported Thomsonian medicine, a type of naturopathic medicine that was codified by Samuel Thomson. The basis for Thomson's medical philosophy came from the Book of Genesis (1:29–30), where God gives Adam the things of the earth for his use and his health. The Thomsonians, and the early Mormons, believed in exclusively using herbs for healing.

Some scholars might therefore have expected a "near-exclusive reliance on herbalists and midwives" in today's FLDS community (e.g., Bush 1993), but the care providers interviewed believe that naturopathic traditions are viewed as complementary to allopathic medicine. Although there is some anecdotal evidence that some community members do

first turn to herbal remedies, the care providers did not see this as a major hindrance to seeking timely allopathic care. This is another example of pragmatic fatalism, where health beliefs have evolved to incorporate modern medical practices.

How do the FLDS pay for health care? They have limited health insurance with a large proportion of people on Medicaid, which tends to cover major medical expenses while covering less dental health care, less psychiatric care, and fewer preventative and screening medical services. Community members, while refusing government intervention in so many aspects of their lives, including state governance and legal systems, do not have any qualms in accepting government aid such as welfare. Some care providers mentioned that there is a saying, "bleed the beast," which refers to taking advantage of state and federal welfare programs in an effort to weaken the government, which some community leaders see as the enemy. However, many community members legitimately qualify for the aid. This is another example of pragmatism yielding a way to sustain their community, but also shows that they are not characterized wholly by self-sufficiency, as are many Utopian or religious communities (Fogarty 1990, p. 176).

In 2007, Kramer wrote that the UEP was valued at over $400 million, representing the entire wealth of the community. However, community members see very little of this wealth. Since residents do not own land (they rent from the UEP), many of them are eligible for welfare funds. Only the first wife is legally wedded to the husband (the rest of the weddings are religious ceremonies only), and so the other wives and their children are, for legal purposes, unwed mothers and dependents. They can therefore collect welfare benefits, although many families already qualify for these benefits on income alone (Dillon 1992).

Comprising parts of both Arizona and Utah further complicates the health insurance system. Some providers in St. George accept only Utah Medicaid, and so provide large amounts of free health care to Arizona residents who come to Utah for care (one health care provider estimates that for the Intermountain Medical Group, the outpatient arm of Intermountain Healthcare in the region, the value is about $400,000 annually for pediatric services alone).

There are other challenges to allopathic medical care in Short Creek, however, including a profound lack of resources. The community clinic, called Hildale Family Medical Center, is located on the Hildale side of the community. Its personnel include one family practice physician and several allopathically trained nurse practitioners and nurse midwives, all of whom are FLDS. The community has no mental health services (although this is a shortage that extends throughout Southwestern Utah), nor any pediatric or specialist services. This general lack of resources extends to the availability of facilities and medical imaging. Although these barriers to health care are common to rural communities, they are compounded in this community by insularity.

However, the community has adapted to the challenges it faces in providing care. While some outsiders may be concerned that this reliance on mid-level practitioners is to the detriment of the community, most care providers interviewed felt that they system works very well to fit the needs of the community. The addition of the two community general practitioners approximately 12 years ago was welcomed, but since the departure of one of the physicians (Physician B, who was sent to Texas in 2006), the remaining physician (Physician A) has become, according to one interviewee, "overwhelmed" and refers to outside physicians even more frequently. This translates into more challenges with access to care, as his patients must wait longer for appointments.

Despite their long history of insularity, residents of Colorado City and Hildale frequently seek outside medical care. The FLDS have a group of physicians who regularly

treat members of their community, and with whom they have developed a certain level of trust. This working relationship has developed over time, often through care providers from St. George who initiated the relationship and secured trust through visiting the community. The longevity of service among the care providers has allowed the relationships to strengthen with experience and time. However, some care providers feel that some community members have become more distrustful in recent years, perhaps due to the increased scrutiny and community unrest that have resulted from the leadership of Warren Jeffs. (It remains to be seen how the recent conviction and imprisonment of Jeffs for sexual abuse will impact the community. With the loss of their leader, it is possible that the community will become either more or less isolated, but will likely be more fearful of increased stigma).

Their attitudes toward these outside medical practitioners display health fatalism. Despite believing some treatments to be unnatural, or not God's will, many care providers note that community members appear to trust health care practitioners more than other patients. Medical malpractice lawsuits are rarely pursued in this community. One care provider explains, "they [also] are very unlikely to sue because they look at life as, well, that's the way it is, that's God's will, if something happens." Many of the care providers I interviewed felt a strong sense of loyalty and friendship with the community, something that has been able to develop away from the confines of mutual distrust.

However, once a community opinion is established, it is very difficult to change. For example, the community did not accept immunizations in the past. Although the community care providers now stress the importance of this prophylaxis, there are still many community members who refuse vaccinations. The care providers I interviewed did not understand the exact reasoning for the refusal, but speculate that this is another instance of medical care being seen as unnatural. Fortunately, this community is isolated enough to have avoided any serious outbreaks of disease. The care providers noted an increased incidence of children with *Haemophilus influenzae*, chicken pox, and pneumococcal pneumonia, all diseases that are preventable with vaccines.

Community Particularities and Their Health Effects

There are some benefits to being part of the FLDS community, and several ways in which the community system works to allow for quality health care, despite the challenging circumstances. As explained earlier, the community commitment to self-reliance means that they will exhaust community resources before seeking outside care. An excellent example of this conditional insularity is with prenatal care and childbirth. The midwives of the community have decades of high-volume birth experience, yet they do not hesitate to refer for outside care whenever a birth is expected to be complicated in any way, including for pre-eclampsia, for breeching, and for women with gestational diabetes. One care provider explains, "They risk-out early. If the midwives are seeing anything that they're concerned about, they have a very low threshold to refer those to maternal-fetal medicine for evaluation." There is one St. George obstetrician/gynecologist who holds a clinic in Colorado City each month.

Seeking outside care also happens in the case of an emergency. The Emergency Medical Services (EMS) are known for their rapid response time and excellent training, necessary because they are so far from a hospital (an hour-long drive to St. George). They serve a population of about 20,000, including some of the other rural communities nearby and the Piute Indian Reservation, showing a dedication to improving health for the area, not just

for their own community. A care provider notes, "I've laughingly said that if I get into an auto accident here, I would hope that it's actually that group [FLDS EMS] that ends up taking care of me. They are that good." This dedication to providing quality in-community care is based on their desire to take good care of their own.

The health outcomes of the community clinic remain to be quantified, and there is some evidence that the patients are disadvantaged by receiving care at such an altitude of 4,990 feet, with a very dry climate. One care provider explained, "Well, the main difference [in providing care to this community] is the severity of their illness. They're a lot sicker when they come in." This is partly due to the higher elevation, so respiratory illnesses are more likely to progress to hypoxia, while it is also due to the community insularity and reluctance to seek outside care.

Care providers noted several common medical complaints among members of this community. The first is a high incidence of pediatric trauma, including fractures and cuts. One care provider noted that for the roughly 6,000 residents of Colorado City, "we see more pediatric trauma from that community than from the [rest of] Washington County," a population of about 90,000, according to the US Census (2010). This high incidence is explained by the large number of children in the community, and by the lifestyle where manual labor is emphasized. A care provider explained, "Kids watching kids, kids doing things that a 100 years ago people let them do. You know they're kind of stuck back a 100 years ago," meaning that children are allowed more responsibility for housework and manual labor than is typical in modern America. Because there are so many children in any one family, older children are often responsible for watching the younger children. While this may strike observers as being against the norm, it would not have been surprising to see this activity in the 1930s when this community moved into isolation.

Although there have been several media reports of a high prevalence of child abuse in this community, only a few care providers hinted at a suspicion of such. One care provider mentioned that the high incidence of pediatric trauma could be partly due to child abuse, but may also include some degree of child neglect. This provider mentioned that when child abuse is reported, there is an internal committee in the community that is responsible for following a protocol to confirm the claim. In this provider's experience, reporting the suspicion usually led to no tangible outcome, except that the child often would not be brought back for the appropriate follow-up care. This was exactly opposite of the intended consequence of reporting the suspicion, and so complicated the relationship of the physician's legal obligations with his goals of improving the health of his patients.

The large number of children also has significant health effects on their mothers. With such high numbers of pregnancies, the women have corresponding numbers of premature abortions, as well as early onset of those conditions associated with being multi-gravida. They have a higher incidence of pre-elampsia, and of gestational diabetes. A long-term care provider explains that these women have earlier onset of pelvic floor disorders. He says, "I have a lot of patients in their early thirties and their late twenties that have bladder prolapse or uterine prolapse, where you don't tend to see that in the other population until their forties or fifties."

Some care providers noted a higher incidence of anemia among women and children in this community. One long-term care provider described this phenomenon as being a combination of living as part of a poor, rural community where they do not eat enough protein, along with having a high birth rate and having children in quick succession, which can often cause excess blood loss and anemia. Many women who are diagnosed with anemia are not concerned because of the prevalence of anemia among women and children of their acquaintance. This is a reflection of the insularity and lack of outside education in the community.

The community experience is influential in shaping the individual interaction with the health care provider specifically and the system more generally. Often, a family becomes what one care provider termed a "frequent flier," in that they have several children that are treated by a particular care provider or for a particular condition. This allows the family's relationship with the care provider to strengthen and deepen, and helps the new patient and family members to be able to anticipate the hospital experience, as well as developing some familiarity with the care providers and treatment methods. Similarly, families share their experiences with other community members who are seeking medical care, helping to alleviate some of the worry that can come from the unknown.

Conclusion and Directions for Further Research

Health for those living in Colorado City, Arizona and Hildale, Utah is shaped in significant ways by limited resources, health fatalism, a fear of the outside world, and a corresponding insularity. These themes, combined with a historical basis in naturopathic medicine, direct the way this community perceives and seeks healthcare. Although the community now embraces allopathic medical treatments, it still rejects those that are regarded as invasive or "unnatural," meaning that they are "meddling in things that shouldn't be meddled in." However, this holds true only for certain treatments or to a certain extent and defining this line will require further investigation.

Barriers to receiving health care include community insularity, geographical barriers, and lack of resources and access to specialty medical care. Health care in this community is based on the idea of insularity, where they do their best to "take care of their own." This comprises care first within their own family, then within the community clinic, and finally, if necessary, with an outside physician, often one with whom a community relationship has been established. Families seek care at a similar threshold to mainstream society, hindered by geographical barriers including a forty-minute drive to the nearest hospital.

Community members and their outside care providers generally have a very good relationship, based on a history of mutual trust and respect. However, when a community member feels mistrusted, as in the case of suspected child abuse, they respond with a policy of full avoidance. This defensive attitude is affected by their long history of distrust of the government and other authorities.

Some of their challenges in accessing health care are common among other isolated or rural communities. Difficulty accessing health care, including specialists and hospital services, is a common concern, as is an inability to pay for health care. However, these challenges are compounded in the FLDS community by a poor relationship with the outside world. Other communities may not be as hesitant to seek outside care because they do not have such an overarching fear of having another government raid, similar to 1953 or to the Texas raid in 2008, where families were separated. For a community where family and their lifestyle are so tied to their salvation, there is nothing worse. Their eternal, or fatalistic, outlook on life means that they do not fear death as much as they fear being separated or forced to live in a way that is contrary to their religious beliefs. At the same time, many in the community need and accept government aid, including Medicaid and food stamps. This dichotomy of accepting government aid but not government law has created a situation of constant tension with the government and of constant fear in the community. Some of these challenges could be alleviated, at least partially, by higher level or broad policy changes regarding the legal status of polygamy.

Some issues are particular to this community because of their lifestyle of plural marriage. Community particularities lead to a high incidence of pediatric trauma, a low immunization rate, and a high birth rate, with the corresponding problems associated with multi-gravida women. These problems are unlikely to be resolved by policy intervention or the alleviation of trust issues between the community and the outside world. The community also suffers from a high rate of genetic disorders and congenital malformations, most likely due to some community consanguinity. This is a problem faced by many isolated and small communities, but is particularly pronounced in this community since consanguinity does not seem to be purposefully avoided. Since there is very little immigration into the community, this consanguinity is only likely to deepen.

There are some health benefits of a polygamist lifestyle. The sister-wife system allows for significant support and sharing of responsibilities for the women of the community. This, combined with the prevailing notion to "keep sweet," or be content with one's lot in life, leads to a very low rate of reported depression or other mental illness in the community. Similarly, community members are committed to helping each other and "taking care of their own." They have developed excellent EMS and midwifery systems, and the community health professionals are very invested in improving the overall health of the community.

In summary, the FLDS community has many challenges in seeking and receiving health care. Some of these are common to other isolated, rural communities, while others are particular to their community lifestyle. Those tied to plural marriage are further complicated by the illegality of the lifestyle and the associated fear of government intervention. Similarly, it may be postulated that those tied to the illegality of polygamy, and not solely to its practice, may be alleviated by reconsidering the legal status of the lifestyle. Regardless of origin, community members in the Short Creek area have developed a working solution to circumvent their particular barriers to health care. This solution has improved the overall health of this population, but does not fully alleviate the problem.

The type of high-level policy intervention mentioned above is necessary to help this community feel more accepted and therefore more comfortable in seeking outside care, and thereby to make progress in alleviating many of their health concerns. However, past efforts to open a discussion on the subject have been thwarted by the historical and cultural stigma surrounding polygamy, as well as the overarching Western Republican preference for less government intervention. Additionally, changing the legal status of polygamy, or creating exemptions, is a complicated task. Society does not wish to condone the lifestyle, nor to promote its hierarchical structure or to legitimize the gender roles epitomized by the society. Without policy intervention, however, it is unlikely that there will be meaningful change in the community's relationship with the outside. Until that time, community members will continue to seek health care, hindered by mutual distrust and fear.

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