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Conservative Anabaptists Descriptions of Delay, Comfort in Connectedness, and Ease in Cultural Tension when Seeking and Responding to Healthcare

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Abstract

Conservative Anabaptists description of delay in health seeking behaviors, comfort in connectedness, and ease in cultural tension when seeking and responding to healthcare.

Matthew Hottle

Background: Conservative Anabaptists are a large ethnic religious population that continues to grow in the United States. This includes groups of Amish, Mennonites, Hutterites, and Brethren populations residing in rural areas. These groups are known to experience adverse health related outcomes such as community acquired infections, advanced cancer diagnosis, and undiagnosed chronic conditions such as hypertension, diabetes, and heart disease. Therefore, the concept transcending health values has been developed to better understand how conservative anabaptists describe seeking and responding to healthcare.

Purpose: The purpose of this study is to (1) gather empirical evidence about the concept of transcending health values (2) use the evidence to contribute to the body of knowledge of nursing. The research question was, "How do Conservative Anabaptists describe the delay in health seeking behaviors, comfort in connectedness, and ease in cultural tension when seeking and responding to healthcare?"

Method: The study used qualitative directed content analysis guided by the core qualities of transcending health values: delay in health seeking behaviors, comfort in connectedness, and ease in cultural tension. Fourteen participants were recruited from a conservative Anabaptists Beachy Amish Mennonite congregation by flyers placed in church mailboxes. To obtain data, two focus groups of 7 individuals each were completed using a semi structured interview script The focus groups were tape-recorded, transcribed verbatim. The data were analyzed using directed content analysis by coding based on the three predetermined categories, specific descriptors identified, condensed to meaning unites, and lifted to themes.

Results: Ten themes were derived from predetermined categories. Delay in seeking healthcare is waiting to allow the body to heal itself, following a chain of natural remedies and over the counter medications, seeking guidance from within the community and obtaining medical care only when necessary. Comfort in connectedness is expecting the medical environment to be unfamiliar, uncomfortable, and cold, being unheard and treated like a number, yet desiring to be understood. It is also being open to personal perspectives and ways of thinking by providers and giving time and personal attention to one another. Ease in cultural tension is trusting those who are humble and open, and partnering to share care responsibilities.

Conclusions: Findings from the study were congruent with previous literature about delay in health seeking behaviors, comfort in connectedness, and ease in cultural tension. Findings were also coherent with theoretical and conceptual frameworks and grounded in the discipline of nursing. Implications for future research, practice, and policy include measures to support conservative Anabaptists in receiving culturally competent healthcare and to provide empirical evidence for those caring for this community. Additional studies are needed to further explore transcending health values in other settings and more diverse populations.

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Dedication

This work is dedicated to my family. My wife Aimee who supports me in all I do. Throughout this journey she has listened to me, cared for our children, kept our house running. You are levelheaded and steady, which is exactly what I need. You sacrificed for us. Thank you, Ich liebe dich.

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Chapter 1: Introduction

Conservative Anabaptists, including Amish, Brethren, Hutterites, and Mennonites, are the large ethnic religious groups, residing in many rural areas. These populations are forecasted to double every year (Travelsted et al., 2022). Those residents experience extreme health and poverty inequities and limited access to healthcare. Globally, this religious group continues to grow with more than 200 different groups with 800,000 members in 17 countries mainly in rural areas (Kraybill, 2010). Health disparities are the main issues within this population. As the population continues to grow, especially in rural areas, there is an increasing number of healthcare providers that are needing information about conservative Anabaptist health practices, to be able to provide culturally sensitive informed care (Anderson & Potts, 2022). Conservative Anabaptists often delay care and utilize Complementary Alternative Medicine (CAM) that can lead to adverse outcomes (Garritt-Wright et al, 2020)

Statement of the Problem

Adverse health related outcomes are observed among conservative Anabaptists because of delay in seeking healthcare. Conservative Anabaptists are more interested in pragmatic services that meet their needs when there is an acute problem, rather than utilizing screenings or preventative services, and a use of Complementary Alternative Medicine (Anderson and Potts, 2020). Further, there are embedded perceptions about health care that can impact healthcare decision making. This group generally believes that good health comes from God and healthcare providers can only partially influence outcomes (Weller, 2017). Due to religious reasons many conservative Anabaptists do not use health insurance which could lead to delayed healthcare seeking behaviors. (Rohr et al., 2019). Other distinctive cultural aspects of the conservative Anabaptist community may include barriers like low health literacy, limited education, access to media, and other religious beliefs. Due to the rurality of living environments, these populations

must travel long distances for healthcare services that may include horse and buggy, a paid taxi, and time off work (Katz et al, 2011).

Background

Adverse health outcomes have been observed in the Amish population, including community acquired infections, advanced cancers, and undiagnosed chronic conditions such as hypertension, diabetes, and heart disease (Culturevison: Getting to know the Amish, 2018). Conservative Anabaptists have a higher rate of undiagnosed chronic illness, including hypertension, diabetes, and heart disease. The prevalence rates for diabetes, hypertension and hypercholesterolemia in conservative Anabaptists are lower than their average American counterparts. However, most conservative Anabaptists are less likely to be aware that they were affected. If they were affected, they were less likely to be treated with medication for the diagnosis (He et al, 2020). This group utilizes natural and herbal remedies to treat medical conditions and only seeks out medical care for emergencies. (Culturevison: Getting to know the Amish, 2018). Although Conservative Anabaptists may utilize conventional modern medicine, there is still an extensive use of complementary and alternative medicine such as alternative health practitioners, folk medicine, and spiritual practice (Hostetler, 1993)

Community acquired infections are another adverse health outcome experienced by this group. There have been several outbreaks of vaccine-preventable diseases in under vaccinated Amish communities, including polio, rubella, and measles. There are several community groups that do not vaccinate their children against many preventable childhood diseases for religious or philosophical reasons. Vaccination for these diseases are not generally prohibited in this group, it remains that there are lower levels of routine childhood vaccination rates in many conservative Anabaptist communities (Fry et al, 2001).

The diagnosis of advanced cancers has been observed in this group. Conservative Anabaptist tend to be cautious about receiving preventable services due to the idea of communal living and the pressure of costly screening tests that may burden the community and may replace the will of God. Due to this thought many times when cancers are diagnosed, they are already advanced. This is especially true for prostate, female breast, and colon cancers which translates to poorer health outcomes (McBride et al, 2018).

Although not prohibited, many conservative Anabaptists avoid modern medicine when at all possible. They report distrust in the American medical and pharmaceutical industry, and feeling culturally disoriented in medical settings, with the potential for personal and community loss of control (Anderson & Potts, 2020). These cultural values and beliefs lead to delays in seeking and acting on care directives, and subsequent poorer health outcomes. (McBride & Gesink 2017; Katz et a 2011; Fry et al. 2001).

Disciplinary Perspective

The focus of the discipline of nursing is caring in the human health experience (Newman, 1991). This problem fulfills the focus of nursing and the human-environment-health relationship due to the interconnectedness of human health with the multidimensional environment of the conservative Anabaptist population. The healthcare environment of conservative Anabaptists includes two distinct cultures: modern healthcare culture and Anabaptist culture. It is important to understand how the two health cultures relate to each other. The multivariable dimension of this dyad includes but is not limited to religion, finances, community relationships, fear, and influences of outcomes, along with how it influences their health, healing, and well-being. There is a gap between the two distinct cultures that includes how they relate to each other in the environment they are embedded.

Purpose

The purpose of this study was to obtain descriptions from conservative Anabaptists about how they seek out and act on healthcare directives. The purpose statement addresses the problem through a description of the experience by getting the unique views of this population on adverse health outcomes that may come from delays in seeking and responding to healthcare directives.

Research Question

This study described the experiences of Conservative Anabaptists and gathered empirical evidence for the concept *transcending health values*. The question guiding this descriptive qualitative study was "How do Conservative Anabaptists describe the delay in health seeking behaviors, comfort in connectedness, and ease in cultural tension when seeking and responding to healthcare?" A qualitative descriptive design, using focus groups to collect data, was used to answer this research question.

Theoretical Framework

The theoretical base that framed the study was Choi's (2018) theory of cultural marginality. This theory was developed to help understand when there is a straddling of two distinct cultures. The concepts of the theory of cultural marginality are across-culture conflict recognition, marginal living, and easing cultural tension. Across-cultural conflict recognition is defined as the start of acknowledgement and understanding of two different conflicting cultures. The conflict starts to come out when there are value systems in place that may cause conflict with an individual's own cultural values. Marginal living as a concept for this theory is defined as a passive betweenness in the pushing/pulling tension between two cultures while forging new relationships in the midst of old and living with simultaneous conflict/promise This passive

betweenness is described as living in two worlds where they feel like they do not belong. Easing cultural tension is defined by four patterns of easing tension. Those response patterns are assimilation, reconstructed return, poise and integration. Assimilation is a process where the individuals are incorporated into the dominant culture. Reconstructed return is when after the encounter of the new culture individuals return to their own culture. Poise is attentive fit on the margin regardless of the emotional conflict or struggle. Integration is when the individual creates a third culture by combining the old and new cultures. There is not one pattern that is a panacea for easing cultural tension but knowing the patterns will help to understand the struggle that many people of different cultures may face Choi, (2018).

The concepts of the theory correspond with the concept *transcending health values* and align with the purpose of the study. *Transcending health values* is when there is a delay in health seeking behaviors that is aided with comfort in connectedness, leading to ease in cultural tension (Hottle, 2023). The core concepts of transcending health values are congruent with the concepts of the theory of cultural marginality. Integration of the concepts from *cultural marginality* and core qualities of *transcending health values* are the human health experiences of seeking and responding to healthcare, with conflict across cultures, and marginal living, that can lead to a delay in health seeking behaviors. An ease in cultural tension can occur through comfort in connectedness.

Significance

The human environment-health relationship is defined by Smith (2019) as the "interconnectedness of human health with the multidimensional environment" (pg. 11). Florence Nightingale postulated the importance of the environment on the wellbeing and healing of a patient (Nightingale, 1969). There are environmental influences that change the human-

environment-health relationship. These include but are not limited to physical, social, cultural, political, economic, and philosophical dimensions. The interrelationship is crucial to the focus of the discipline of nursing (Smith, 2019).

The phenomenon of concern within the discipline of nursing that emerges from the theoretical and empirical work of nursing includes several areas of inquiry (Smith, 2019) The area of inquiry that this research will contribute to is the environments that facilitate health, healing, and well-being. This area of inquiry includes how physical social, cultural, political and economic environments impact health, healing and wellbeing (Smith, 2019).

The significance of this study is that the findings will contribute to the discipline of nursing centered on how a particular cultural group, conservative Anabaptists, describes the human-health-environment relationship related to healthcare. By using a descriptive qualitative research design the participants will describe their lived experiences regarding the healthcare and human-environment-health relationship. The focus of the discipline of nursing, caring and the human health experience, human-environment-health relationships, and environments that facilitate health, healing, and wellbeing constitute the foundation of the study.

Summary

Adverse health related outcomes are observed among conservative Anabaptists because of a delay in seeking healthcare. This study seeks to understand how conservative Anabaptists describe health seeking behaviors using a qualitative descriptive study. The research question was: “How do Conservative Anabaptists describe the delay in health seeking behaviors, comfort in connectedness, and ease in cultural tension when seeking and responding to healthcare?” This is a unique subculture of the United States population that is growing in many states. The theoretical underpinnings of this research topic was using the concept transcending health values

and the theory of cultural marginality. The results of this study may enlighten many healthcare providers to understand how this population seeks out, receives, and experiences healthcare and treatment.

Chapter II is a comprehensive review of the literature on conservative Anabaptist health seeking behaviors. In Chapter II, the primary topic discussed is the gap in the literature related to health seeking behaviors in the conservative Anabaptist population.

Chapter 2: Review of the Literature

Adverse health related outcomes are observed among conservative Anabaptists because of delay in seeking healthcare. Conservative Anabaptists are more interested in pragmatic services that meet their needs when there is an acute problem, rather than utilizing screenings or preventative services, and a use of Complementary and Alternative Medicine (Anderson and Potts, 2020). Further, there are embedded perceptions about health care that can impact healthcare decision making. This group generally believes that good health comes from God and healthcare providers can only partially influence outcomes (Weller, 2017).

This literature review was guided by the research question, "How do Conservative Anabaptists describe the delay in health seeking behaviors, comfort in connectedness, and ease in cultural tension when seeking and responding to healthcare?" and the emerging concept *transcending health values* (Hottle, 2023). This literature review was organized as follows: conservative Anabaptist culture, resistance to modernism, separatists, healthcare decision making, complementary alternative medicine (CAM), and theorical approaches to studying conservative Anabaptists.

To identify healthcare preferences and adverse health outcomes to the conservative anabaptist community the databases that were searched were: Medline, CINAHL full text, APA Psych Info. The type of search was advanced. Keywords used to include any Boolean operators or symbols: Anabaptist, Amish, barriers, healthcare, healthcare values, adverse outcomes, healthcare decision making.

Conservative Anabaptist Culture

Conservative Anabaptists are groups of Christian denominations, which also include Amish, Mennonite and Brethren churches, and their history dates to 16th century Europe. During that time, they were persecuted for their religious beliefs and most immigrated to North America.

This group is typically identified by the plain lifestyle that includes a selective use of technology, being self-sustaining, work mostly trade or skill jobs, non-resistant beliefs, and not using medical insurance. This population promotes community living and over individualism.

Further, there are embedded perceptions about health care that can impact healthcare decision making. Conservative Anabaptists are more interested in pragmatic services that meet their needs when there is an acute problem, rather than utilizing screenings or preventative services (Anderson and Potts, 2020). This group generally believes that good health comes from God and healthcare providers can only partially influence outcomes (Weller, 2017). Due to religious reasons many conservative Anabaptists do not use health insurance which could lead to delayed healthcare seeking behaviors. (Rohr et al., 2019). Other distinctive cultural aspects of the conservative Anabaptist community may include barriers like low health literacy, limited education, access to media, and other religious beliefs such as the importance of community over self and the will of God. Due to the rurality of living environments, these populations must travel long distances for healthcare services that may include horse and buggy, a paid taxi, and time off work (Katz et al, 2011). In conservative Anabaptist culture, men make most major decisions, including medical decisions (Weller, 2017).

Resistance to Modernism

There are many different accepted practices within the various sects of conservative Anabaptists. The boundaries that each church group set up within the church can affect to what extent certain modern technologies are accepted. This ranges from the use of electricity, computers, vehicles, and insurances. However, there is an overall resistance to modernism and separation from the world (Gertz, 1985). Due to this resistance to modernism, there can be limited information on healthcare services, transportation to and from healthcare settings, and

financial burdens that can impact this groups healthcare needs. This resistance can lead to poorer health outcomes for this population.

Separatists

Conservative Anabaptists or plain Anabaptists are by nature separatist from the lager modern society and remain community-oriented within their own religious groups. This group desires to remain different and separate from the world, choosing to be different and choose disconnection and controlled interactions with outsiders (Weller, 2017). This group will often live in clustered communities of likeminded individuals. The local community is very close with the social and spiritual community in which they belong. (Anderson & Donnermeyer, 2013). Anabaptist communities are often considered "separatist and community-oriented," referring to those outside of their tradition as "English". Thus, finding comfort in community (Kraybill et al., 2013). Many conservative Anabaptists remain separate from the outside world due to the feeling of a corrupt and materialistic mindset of the modern world. There are many conservative Anabaptist groups who still speak Pennsylvanian German a southern German dialect where the faith originated to remain separate (Choy, 2020). This separatist mentality can affect the way conservative Anabaptists feel about conventional medical treatment and delay their health seeking behavior.

Healthcare Decision Making

Conservative Anabaptists have embedded perceptions about health, such as good health comes from God that impacts their decision-making process. This group tends to value quality of life than longevity, so aggressive treatment sometimes is not pursued (Weller, 2017). Garrett-Wright et al (2020) conducted research to explore the understanding of Anabaptist patients' health care beliefs and preferences as well as lessons learned from providers who have experience delivering health care for this culturally diverse population. They used a qualitative

descriptive approach to collect data with a sample of health care providers. The participants were interviewed, and themes were identified during the analysis of the interviews. The team discovered seven themes in their study regarding Anabaptists healthcare decision making that include "1) Anabaptist communities place value on negotiating their prescribed plan of care, 2) community members take greater responsibility for their health outcomes as compared to mainstream communities, 3) there is increased value placed on direct communication, active listening, and presence in the relationship between the patient and HCP, 4) there is a tendency to delay care until later in the course of illness, 5) community members are cautious in using mainstream treatments and desire to use natural products when possible, 6) there is a general aversion to legal action, and 7) community members express appreciation for health care that is provided to them" (pg. 17). These themes gives insight into the conservative Anabaptists healthcare preferences and decision making.

When seeking healthcare conservative Anabaptists can feel that they are not part of the healthcare decision making process. There are instances where conservative Anabaptists feel that they lack the communication from the medical staff to make decisions regarding healthcare. This is especially true regarding costs and expected benefits of the procedure (Rohr et al., 2019). The importance of clear communication and a trusted healthcare provider that will listen to them is imperative.

Patriarchal

Conservative Anabaptists are patriarchal in orientation. The head of household generally makes most of the decisions about healthcare and finances (Weller, 2017). Hegemonic masculinity is predominant in conservative Anabaptists culture. Conservative Anabaptists masculine predominance in relationship to the surrounding American society include their focus on: Christianity, pacifism, competition and success of business, and egalitarianism (Strikwerda,

2020). Men in this group determine the form of social interactions and women operate within those interactions (Graybill, 2022). This group is led by men such as bishops and deacons of the congregation that help them with decisions regarding religion, dress, and healthcare options (Weller, 2017).

Caring Community

It is very important and part of the Anabaptist culture to care for one another. This is a factor to consider in the healthcare decision making process for the conservative Anabaptist. Grandizio et al (2015) states that Conservative Anabaptists have decreased hospital stays due to strong familial and social support within the community. This can have positive results on patients' recovery limiting follow up appointments and decreasing costs for the population. This group also values spiritual and community connections, they also prefer a sense of connectedness and consistency of relationships in their healthcare providers (Garrett-Wright et al., 2020).

Follow-up care

Conservative Anabaptists have been known to not continue plans of care and follow-up after a healthcare visit. The more conservative the group the less pre and post care they will seek due to the preconception that you only go to the doctor when you are sick (Weller, 2017). There are many socioeconomic variables such as lack of insurance, transportation, and time off work to consider with this population. Due to this, this group has a lower attendance to outpatient follow-up care (Grandizio et al, 2015).

Complementary and Alternative Medicine

This population has a strong proclivity to complementary and alternative medicine (CAM). CAM is the popular mane for healthcare practices that have not been traditionally used as part of conventional medicine. The usage of alternative health practitioners, folk medicine, and spiritual practices prevail especially for chronic illnesses (Anderson and Potts, 2020). A

survey completed by Rohr et al. (2019) found that only around 36% of conservative Anabaptists sought out doctors as an important source of information on health issues. Although not prohibited, many conservative Anabaptists avoid modern medicine when at all possible due to distrust the American medical and pharmaceutical industry, they tend to feel culturally disoriented in medical settings, and there is a loss of personal and community (Anderson & Potts, 2020). The usage of CAM treatments may benefit in some situations; however, it can lead to a delay in seeking conventional medical treatment when necessary (Weller, 2017)

Adverse Outcomes

Conservative anabaptists experience adverse outcomes due to their healthcare practices. These adverse outcomes include outbreaks of community acquired infections, chronic illness that may go untreated, and advance stage of diseases at time of diagnosis. These adverse outcomes lead to poor healthcare consequences.

Vaccination Preventable Diseases

There have been several outbreaks of vaccine-preventable diseases in under vaccinated Amish communities, including polio, rubella, and measles. Due to genetic preconditions conservative Anabaptists may have immunocompromised conditions and lower vaccination coverage, Conservative Anabaptist children have an increased risk of vaccine preventable diseases that require hospitalization more often than the general population (Williamson, et al. 2017). There are several community groups that do not vaccinate their children against many preventable childhood diseases for religious or philosophical reasons. Although vaccination for these diseases are not generally prohibited in this group, it remains that there are lower levels of routine childhood vaccination rates in many conservative Anabaptist communities (Fry et al, 2001). Generally, conservative Anabaptists access medical care on a “need to only” basis (Medina-Marino, 201). Vaccination of persons is not extensively viewed as a need.

Chronic Illnesses

Conservative Anabaptists have a higher rate of undiagnosed chronic illness, including hypertension, diabetes, and heart disease. The high fat and sugar diet of this culture leads to higher hyperlipidemia rates and contributes to cardiovascular disease (Weller, 2017). In comparison to the general American culture, conservate Anabaptists are less likely to be aware that they were affected by a chronic illness such as diabetes or hypertension. If they were affected, they were less likely to be treated with medication for the diagnosis (He et al, 2020).

Since most conservative Anabaptists communities are geographically and socially isolated the increase of genetic conditions prevail (Ferkol et al., 2013). Conservative Anabaptist have a high rate of genetic conditions such as Maple Syrup Urine Disease (MSUD), Ellis-van Creveld syndrome, and pyruvate kinase deficiency. This is due to the "founder effect" where the current population are descendants of a few original immigrants to the United States (Weller, 2017). Genomic clinics are becoming more common in areas with high conservative Anabaptist populations. Although, there is increased interest in learning more about genetics within this population, there are hesitancies about screenings (Anderson Potts, 2020).

Advanced stage of disease at diagnosis

It is difficult to compare health status of conservative Anabaptists and other groups due to the limited data collected amongst these groups (Farrar et al, 2018). However, it is known that conservative Anabaptists have lower cancer screening rates than their non-Anabaptist counter parts. This attributes to the groups higher rates of late-stage diagnosis of certain cancers such as: colorectal, female breast, and prostate cancers documented (Katz et al., 2011). This leads to poorer prognosis of cancer diagnosis.

Conservative Anabaptist tend to be cautious about receiving preventable services due to the idea of communal living and the pressure of costly screening tests that may burden the

community and may replace the will of God. Due to this thought many times when cancers are diagnosed, they are already advanced. This is especially true for prostate, female breast, colon cancers which translates to poorer health outcomes (McBride et al, 2018).

Theoretical Approaches in Research

Theoretical grounding in conservative Anabaptist studies have been limited. The early Anabaptist researchers such as Hostetler and Kraybill gathered information to inform the medical community (Anderson & Potts, 2020). In turn, these early publications have gathered information without social or cultural theory, but merely descriptions of culture and practices. (Reschley, 2020).

The French sociologist Pierre Bourdieu formulated the terms *habitus, field,* and *capital* to theorize interactions on the internal and external human experiences (Reschley, 2020). This social theory was used in the context of historical development of Amish agriculture. This framework can help trace Amish habits of thought and behavior and help to interpret internal and external habits. The use of theory in this population has been beginning and it is imperative that more methodologically rigorous, social scientific theoretical contributions come into use to inform health research (Anderson & Potts, 2020).

Guiding Theory for this Study

Theory is very important for the grounding and foundation of a study. This study uses the theory of cultural marginality to add to the framework of the study. The concepts of the theory of cultural marginality are across-culture conflict recognition, marginal living, and easing cultural tension. Across-cultural conflict recognition is defined as the start of acknowledgement and understanding of two different conflicting cultures (Choi, 2018) The conflict starts to come out when there are value systems in place that may cause conflict with their own cultural values.

Marginal living as a concept for this theory is defined as a passive betweenness in the pushing/pulling tension between two cultures while forging new relationships in the midst of old and living with simultaneous conflict/promise. Conservative Anabaptists live in the margins of two distinct cultures they are trying to reconcile their preserved culture with modern ways This passive betweenness has been described as living in two worlds where you feel like you don't belong (Choi, 2018)

Conservative Anabaptists are in this betweenness described by Choi. They are currently straddling two distinct cultures: conservative Anabaptism and modern American. The use of modern medicine with complimentary alternate medicine (CAM) are both accepted but, preference to (CAM) persists.

Synthesized Literature

Conservative Anabaptists are a unique subpopulation within the United States that is rapidly increasing. This group has variance in practices among the individual groups within each congregational unit. Conservative Anabaptists are living in the margins of two distinct cultures. Their health practices are influenced by many factors that include finances, trust, community, and religion. There are many adverse health outcomes due to how this group seeks and responds to healthcare. Those adverse health outcomes include delayed health seeking behaviors, acquired infections that are preventable, chronic illness, and poor health outcomes. Research in this population has been limited and theory to ground research is imperative.

Summary

There is body if knowledge of research on conservative Anabaptists that address their healthcare practices. The problem being researched is that adverse health related outcomes are observed among conservative Anabaptists because of a delay in seeking healthcare. The

literature was searched to find evidence of this problem. The literature was then placed into a matrix to help organize the material. The adverse outcomes of: community acquired infections, chronic health conditions, and poorer health outcomes were identified. The use of the concept "transcending health values" and the "theory of cultural marginality" was used to perform a descriptive qualitative research design to answer the question "How do Conservative Anabaptists describe the delay in health seeking behaviors, comfort in connectedness, and ease in cultural tension when seeking and responding to healthcare?". Due to the communal practices of this population and the importance of community a focus group methodology was utilized to perform the study.

Chapter 3: Method

The purpose of this study was to obtain descriptions from conservative Anabaptists about how they seek out and act on healthcare directives. The research question guiding this study was, "How do Conservative Anabaptists describe the delay in health seeking behaviors, comfort in connectedness, and ease in cultural tension when seeking and responding to healthcare?" Chapter three describes the method used in this study including the research design, human subjects' protection, sample, procedures for data collection, and plan for data analysis.

Research Design

The approach to answer this research question was a descriptive qualitative research design using a focus group for data collection. This study utilized focus group interviews, as described by Krueger (1988), which the purposes of a focus group to (1) collect qualitative data from a focused discussion, and (2) gather insights into attitudes, perceptions, and opinions of participants. Focus group designs are defined as "group discussions organized to explore a specific set of issues. The group is focused in the sense that it involves some kind of collective activity, crucially, focus groups are distinguished from the broader category of group interview by the explicit use of the group interaction as research data" (Kitzinger 1994, p. 103).

This method of data collection is preferred in this cultural group because of their preference for group consensus on issues. Conservative Anabaptists regard their community as very important and are conscious of the need to avoid the appearance of individualism and want to present as a united front and with cohesiveness (Savells & Foster, 1987). The guiding research question "How do Conservative Anabaptists describe the delay in health seeking behaviors, comfort in connectedness, and ease in cultural tension when seeking and responding to

healthcare?" is a question that is seeking descriptions from this population. Using this design and methodology a rich set of data can be obtained.

Human Subjects Protection

Respect for persons

Informed consent was obtained with adequate information about participation in the investigation, and voluntary agreement. It is important to give this population a valid reason for obtaining data (Savelles & Foster, 1987). The purpose of informed consent is to protect the rights and welfare of persons participating in the research. The participants are providing legal documentation that they have received all information necessary to make an informed decision and give their permission to proceed with the study (De Vine, 2022).

The participants voluntarily consented to participate. The informed consent included sufficient information for the participant to understand the process, their rights, and risks and benefits of the study. The participants were afforded the rights of privacy and confidentiality for the information that was shared. The participant had the right to withdraw from participating without being penalized.

Privacy and confidentiality

The focus group was conducted in a fellowship hall with a door that closes so that only participants and PI will hear what is happening. The focus group was conducted in a place, where at the time of the meeting, there was limited flow of people not involved in the meeting. The focus group sessions were spaced far enough apart that there was no overlap in participants to avoid privacy issues. The participants were able to share as much or as little information without coercion.

During the focus group there was a tape recorder to record the conversations and the PI took handwritten field notes. The recording was transcribed. Then, the audio was deleted. The

transcription and the field notes were saved on a password protected computer. Focus group members will know each other and hear each other during the focus group however, a conversation about privacy was conducted before the interview process.

Risks/benefits - beneficence

There may be a minimal risk in disclosing information to this group. However, they can choose to participate and choose what to say. The knowledge gained from this study may benefit future persons from this community by informing the healthcare community on how to meet the needs and provide culturally competent care for this population.

The purpose of the study was to do good for the participants and the community they are representing. The risks for this study were justified by potential benefits of furthering the healthcare community's knowledge of conservative Anabaptists and how they seek and respond to healthcare. The study design utilized helped to minimalize the risk and allow the participants to be comfortable giving them the freedom to share openly without judgment and free of bias.

Justice

This study did not exploit vulnerable persons. Everyone knowingly consented to exactly what was being asked of them. This study did not exclude anyone who may benefit from this study. Anyone who wished to participate had the opportunity to do so. Each member of the congregation being studied had equal opportunity to participate. A flyer was placed in every head of household church mailbox with instructions how to contact the PI.

Sample

This study used convenience sample of members of a conservative Anabaptist community in rural Appalachia. Flyers were placed in all the mailboxes of the Mt View Mennonite Church. The interested parties contacted the PI for the date and time of the focus group meeting, which was held in Mt. View Mennonite Church fellowship hall. In qualitative

research, the participants were enrolled until achieving interview data saturation (no new topics or information is brought up). Across qualitative studies, samples between 10-15 participants have resulted in saturation of data (Turner-Bowker, et al., 2018).

Inclusion criteria included adult men or women, who are 18 years or greater, of conservative Anabaptist members who speak English were enrolled. Exclusion criteria was those who had a background or currently working in healthcare facilities and those with a disability (i.e., severe dementia) that precluded their ability to join the focus group discussion.

Interview Script

The theoretical framework for this study was an integration of the concept *transcending health values* (Hottle, 2023) and Choi's (2018) *theory of cultural marginality*. The concept *transcending health values* was developed to define a phenomenon that was experienced through practice with conservative Anabaptists. This concept includes three core qualities which are delay in health seeking behaviors, comfort in connectedness, and ease in cultural tension (Hottle, 2023). The interview script (Appendix 2) was based on the three concepts from *transcending health values concept.*

Procedures for Data Collection

The recruitment occurred through flyers being placed in head of household's church mailboxes at Mt. View Mennonite Church. The flyer had information about the focus group and how to contact the primary investigator (PI). Informed consent was obtained with adequate information about participation in the investigation, and voluntary agreement. It is important to give this population a valid reason for obtaining data (Savelles & Foster, 1987). The PI, who is a member of this community, conducted the focus groups. This is to ease the participants and allow them to openly discuss without fear. A semi structured interview script was followed using

the three predetermined categories from *transcending health values* concept (See Table 1). The three categories are comfort in connectedness, ease in cultural tension, and delay in health seeking behavior (Hottle, 2003). There was an audio recording and field notes obtained by the PI. When there were no new subjects brought up the focus group the time was completed. The focus group lasted between 60 - 90 minutes. The focus group was in the church basement/fellowship hall with a door that closes to limit people from entering or passing through. Then, each participant received a $50 gift card at the completion of the focus group. When the focus group was concluded, and the audio recording was transcribed verbatim, directed content analysis was performed.

Plan for data analysis

Analysis of focus group data followed directed content analysis (Hsieh & Shannon, 2005). After data collection was obtained a verbatim transcription of the data were reviewed based on the pre-determined categories (delay in health seeking behaviors, comfort in connectedness, and ease of cultural tension) from the concept transcending health values. Six steps in the process of analysis were followed: (1) Transcribe the focus group conversations verbatim (2) researchers read the scripts to get an understanding of the whole (3) code the data based on the predetermined categories of, delay in health seeking behaviors, comfort in connectedness, and ease in cultural tension (4) identify specific descriptors from the participants own words for each of these categories (5) group specific descriptors into meaningful groups to form meaning units (6) shorten meaning units to condensed meaning units (7) abstract condensed meaning units to themes.

Summary

This qualitative study used directed content analysis to describe how conservative Anabaptists describe seeking and responding to healthcare. Human subject protection was considered when completing this study. There was IRB approval, respect for persons, confidentiality, beneficence, and justice observed. Recruitment occurred primarily from a community of conservative Anabaptist's in rural Appalachia though flyers and word of mouth. Then, data collection utilized a semi-structured, tape-recorded focus group interview derived from the three core qualities of *transcending health values.* Data analysis included the coding of data, identifying specific descriptors from the data, grouping data into meaning units, and lifting meaning units to themes that describe this experience. Human subject protection was considered when completing this study.

Chapter 4: Results

This chapter reports the results of Conservative Anabaptists Descriptions of Delay, Comfort in Connectedness, and Ease in Cultural Tension when Seeking and Responding to Healthcare. The research question guiding this study was, "How do Conservative Anabaptists describe the delay in health seeking behaviors, comfort in connectedness, and ease in cultural tension when seeking and responding to healthcare?" The sections in this chapter are participant demographics, recruitment and analysis, the themes identified through directed content analysis, and synthesis of results.

Participant Demographics

Fourteen members of a Beachy Amish Mennonite congregation participated in this study. Of the fourteen participants five were male (ages range 20 - 71), nine were female (age range 23 - 78). Five of the participants were residents of Pennsylvania, and nine were residents of Maryland.

Recruitment and Analysis

Each participant was recruited via a flyer placed in all the head of household mailboxes at a conservative Anabaptist congregation. The flyer introduced the investigator, described the purpose of the study, recruitment plan and eligibility. The interested participants then contacted the investigator by phone call or text. Each participant was screened for eligibility, and then given a date and time to participate in one of two focus groups.

Eighteen individuals contacted the investigator with interest in participating. Two were disqualified due to having previous healthcare experience, one previously was an orderly, and one previously was a nursing assistant. Two withdrew before the focus group, leaving a total of fourteen participants divided into two focus groups. Both focus group sessions were on the same day, one was at 9 am and one was at 11am.

The focus groups were conducted in the fellowship hall of the participants church in an area that was private and that had doors that would close for privacy. Refreshments were served and participants socialized before the session. Each focus group lasted between 60-75 minutes. The script using the predetermined categories was read starting with delay in health seeking behaviors then, moving to the next question, allowing each participant the opportunity to respond.

In answering the research question, "How do Conservative Anabaptists describe the delay in health seeking behaviors, comfort in connectedness, and ease in cultural tension when seeking and responding to healthcare?", the following analysis process was used. Each focus group was tape recorded and then transcribed verbatim. The transcriptions were read to get an understanding of the whole. Data were then coded and grouped into clusters with similar meaning within each of the predetermined categories of delay in health seeking behaviors, comfort in connectedness, and ease in cultural tension. Meaning units within the text associated with codes were extracted and condensed to preserve core meanings, and then organized into subcategories. Subcategories were then organized and abstracted to higher level themes. Finally, the investigator identified specific descriptions in the participants own words that supported each of the themes (Hsieh & Shannon, 2005).

When asked "How do Conservative Anabaptists describe the delay in health seeking behaviors, comfort in connectedness, and ease in cultural tension when seeking and responding to healthcare?", ten themes that describe delay in health seeking behaviors comfort in connectedness, and ease in cultural tension were found.

Themes

Delay in health seeking behaviors

Table 1 describes the four themes related to delay in health seeking behaviors along with the condensed meaning units from the participant descriptions that support the theme.

Table 1. Themes of Delay in Health Seeking Behaviors and Associated Condensed Meaning Units

Theme 1	Waiting to allow body to heal itself.	• Dr. not necessary for something that resolves itself. • Usually revolves itself. • God designed our bodies to heal themselves. • Time and rest you need to take into consideration. • Wait until it gets better • The body is created to heal itself • I support my body in healing itself
Theme 2	Following a chain of natural remedies and over the counter medications	• Natural remedies first • Try over the counter. • Go to cupboard. • Home remedies • Over the counter medicine • Herbs • Natural stuff first
Theme 3		• Recommendation for other friends • Recommendation from naturalists • Ask a nurse at church. If they think it's wise to go to the doctor, I

	Seeking guidance from within the community	would take that a little more seriously. • I ask the lady that I get my herbs from she's studying, knows what she's doing. • Friends who have a lot of studies • Go to friends. • Ask my mom
Theme 4	Obtaining medical care only when necessary	• Delay hospital as long as possible • Only if out of my control • When I know something is wrong • When it's beyond me

Delay in health seeking behaviors is defined as waiting until illness is serious after using alternative methods of treatment to seek healthcare (Sieren et al., 2016). When participants discussed questions related to delay in health seeking behaviors they responded with items like, allowing time for the body to heal itself, using herbs and over the counter medications, seeking advice from individuals inside the community, and getting help only when needed. This resulted in four themes in this category. Comments included:

Theme 1 Waiting to allow body to heal itself.

- "Our bodies are created to heal themselves…give my body a chance to do what God created it to do."
- "I think God designed our bodies to heal themselves and sometimes time and rest is what you need to take into consideration."
- "If I get a cold, I'm going to just have a cold. If it gets bad then, I might start taking some medicine."

Theme 2 Following a chain of natural remedies and over the counter medications.

- "I usually do herbs, natural stuff and then Tylenol or ibuprofen after that."
- "I go to my cupboard of natural remedies first."
- I probably try natural remedies first and then if they don't take care of it, then I might try over the counter medicines and usually it resolves itself. But, if it doesn't then, I would go see a doctor."
- "It's sort of a chain, you know, the hospital is your last."

Theme 3 Seeking guidance from within the community.

- "I would tend to consult someone like a nurse from our church."
- "When it didn't seem to resolve, I talked to a nurse at church, who told me to go back to urgent care."
- "I also have friends who have a lot of studies or my mom."

Theme 4. Obtaining medical care only when necessary.

- "I don't feel it's necessary to pay to see a doctor for something that will resolve itself."
- "In my mind, it wasn't bad enough. I'm not one of those people, any little thing go straight to the doctor's office".
- "I got to the point that it was so serious that I didn't have a choice, except to go to the ER."

Comfort in connectedness

Table 2 describes the four themes related to comfort in connectedness along with the condensed meaning units from the participant descriptions that support the theme.

Table 2. Themes of Comfort in Connectedness and Associated Condensed Meaning Units		
Theme 5	Expecting the medical environment to be unfamiliar, uncomfortable, and cold	• Feeling awkward there.

		• Don't feel at home there. • Don't expect it to be comfortable. • Don't get a warm fuzzy felling at the doctor. • Pushed into a cold room. • Pushed me out in the hall.
Theme 6	Being unheard and treated like a number, yet desiring to be understood	• Felt somewhat treated like a statistic rather than individual. • They were looking at statistics. • They were looking at statistics not looking at me as an individual. • Feel like they don't hear you. • Like to be heard and understood.
Theme 7	Being open to personal perspectives and ways of thinking by providers	• Provider that understands my perspective, where I'm coming from • Choosing someone who will hear me. • Choosing someone who understands my way of thinking. • Someone more open to my thinking
Theme 8	Giving time and personal attention to one another	• A doctor who you know breezes in and out does not make you feel comfortable. • Feeling like they do not hear you. • Waiting and just getting more frustrated. • Frustrated waiting for doctor

Comfort in connectedness is defined as finding comfort in community and familiarity (McBride & Gesink, 2018). When the participants were asked questions related to comfort in connectedness, they described the medical environment and the desire to be heard and understood. The condensed meaning units drawn from their stories included things like expecting medical settings to be cold and uncomfortable, a desire to be heard and understood, not wanting to be treated as a statistic, and providers valuing spending time with them. As a result, four themes emerged from the category.

Theme 5: Expecting the medical environment to be unfamiliar, uncomfortable, and cold.

- "I just feel awkward there. I don't feel at home there… it's not where I'm used to going to, it's not familiar."
- "I don't expect it to be … comfortable or fun… It's not that …they make me feel like I shouldn't be there, but I'm there because I need to be."
- "I didn't know what was going on. I was just out in the hallway…. then pushed into a cold room. They didn't even go in the room; they just pushed me in. It was pitch black and cold."

Theme 6: Being unheard and treated like a number yet desiring to be understood.

- "I felt somewhat treated like a statistic rather than an individual."
- "I felt like they were looking at statistics and saying you need to deliver …because of our statistics, not looking at me as an individual."
- "I'm sitting there waiting, waiting, waiting, waiting and just getting more frustrated… it would be nice to know what is going on".
- "I like to be heard and understood….I like them to understand my perspective and where I am coming from."

Theme 7: Being open to personal perspectives and ways of thinking by providers.

- "The reason I chose my provider was I felt he was someone that would understand my way of thinking. He always takes time, and he is interested."
- "I tend to choose midwives. Someone who will hear me and understand where I am coming from".

Theme 8 Giving time and personal attention to one another.

- "I'm sitting there waiting, waiting, waiting, waiting and just getting more frustrated… it would be nice to know what is going on".
- "I like to be heard and understood…. I like them to understand my perspective and where I am coming from."
- "A doctor who breezes in and out, like in a mad rush. It does not make you feel comfortable or relaxed. You feel like he doesn't hear you.

Ease in cultural tension

Table 3 describes the two themes related to ease in cultural tension along with the condensed meaning units from the participant descriptions that support the theme.

Table 3. Themes of Ease in Cultural Tension and Associated Condensed Meaning Units

Theme 9	Trusting those who are humble and open	• He prayed with us. • Knowing they're Christian. • Having similar beliefs would make a difference. • Personal attention • Makes you think, well, he really does care about my health. • He (the doctor) always takes time and he's interested. • Taking time to show interest.

		• Personalities of healthcare staff can affect my experience.
Theme 10	Partnering to share care responsibilities	• My voice was heard. • Could give my opinion. • May not have agreed. • They were gracious and OK with it. • They gave me a little grace. • She was concerned about me. • She would wake up at night thinking about me. • Care for me and my baby • I like to be heard and understood. • To understand my perspective where I'm coming from • Someone who will hear me and understand. • Where I am coming from • That goes two ways.

Ease in cultural tension is defined as decreasing stereotyping, discrimination, and health inequities to aid ease in cultural tension (Blanchet Garneau et al., 2018). During this conversation participants stated things about trusting people who share similar beliefs, providers who are humble, and being able to partner with the provider. Through these descriptions two themes were identified. Participants shared thoughts such as:

Theme 9. Trusting those who are humble and open.

- “I thought he is humble enough to admit that he missed it…. doctors have a lot of knowledge. I am glad we have doctors, but you know, they aren’t God either.”
- “They are subject to making mistakes too…doctors are human too.”
- “He said it is your privilege to try something natural if you want and I was so pleased he said that. I am grateful I could do all natural”.
- “I felt like things were offered and not pushed on me, and my voice was heard. I could give my opinion, and they may have not agreed with it but they were gracious”.

Theme 10. Partnering to share care responsibilities.

- “I have to remember that I chose them to take care of me and it’s that I have to work with them.”
- “I do realize when I have a problem I am going to go back and see them again”.
- “It’s not fair they care about me, it’s not fair more me to say I want my way and ignore what they say. Simply because they are doing their job.”

Synthesis of Results

By utilizing directed content analysis, data were analyzed and categorized using the concept *transcending health values.* When asked “How do Conservative Anabaptists describe the delay in health seeking behavior, comfort in connectedness, and ease in cultural tension when seeking and responding to healthcare?”, ten themes that describe delay in health seeking behavior, comfort in connectedness, and ease in cultural tension were found. Conservative Anabaptists describe comfort in connectedness in health care by: (1) expecting the medical environment to be unfamiliar, uncomfortable, and cold. (2) being unheard and treated like a number yet desiring to be understood (3) being open to personal perspectives and ways of thinking by providers (4) giving time and personal attention to one another. Conservative

Anabaptists describe delay in seeking healthcare from professionals by: (5) waiting to allow the body to heal itself (6) following a chain of natural remedies and over the counter medications (7) seeking guidance from within the community (8) obtaining medical care only when necessary. Conservative Anabaptists describe ease in cultural tension as: (9) trusting those who are humble and open, and (10) partnering to share care responsibilities.

Chapter 5: Discussion

A qualitative descriptive design was used to get descriptions from Conservative Anabaptists about seeking and responding to healthcare. Using a directed content analysis, guided by the concept *transcending health values*, descriptions of delay in health seeking behaviors, comfort in connectedness, and ease in cultural tension were analyzed. This chapter will present the discussion related to study findings and will include the following major topics: the study, findings, findings related to the literature, integration of findings with theory and concept, contribution to the knowledge base of nursing, trustworthiness, implications of findings for further research, nursing practice, and policy, limitations, and conclusion.

The Study

Conservative Anabaptists are groups of cultural religious communities that are known to have poorer health outcomes (McBride &Gesink 2017; Katz et al 2011; Fry et al, 2001); however, the current literature underrepresents their experiences with seeking and responding to healthcare. The concept of *transcending health values* was developed from practice experiences where it was observed that delays in health seeking behaviors, when aided with comfort and connectedness, could lead to ease in cultural tension (Hottle, 2023). The purpose of this study was to (1) gather empirical evidence about the concept of *transcending health values*, and (2) use the evidence to contribute to the body of knowledge on how to assist conservative Anabaptists healthcare needs. The research question was, “How do Conservative Anabaptists describe the delay in health seeking behaviors, comfort in connectedness, and ease in cultural tension when seeking and responding to healthcare?

Findings

Ten themes constitute the results of this study. These themes were (1) waiting to allow the body to heal itself, (2) following a chain of natural remedies and over the counter medications, (3) seeking guidance from within the community, (4) obtaining medical care only when necessary, (5) expecting the medical environment to be unfamiliar uncomfortable, cold, (6) being unheard and treated like a number, yet desiring to be understood, (7) being open to personal perspectives and ways of thinking by providers, (8) giving time and personal attention to one another, (9) trusting those who are humble and open, (10) partnering to share care responsibilities. Themes were organized by predetermined categories of delay in health seeking behaviors, comfort and connectedness, and ease in cultural tension.

In order to draw conclusions based on the themes, a synthesis statement was created for delay in health seeking behaviors, comfort and connectedness, and ease. The table that follows provides synthesis statements from the themes in the predetermined categories. The synthesis statements are the findings of the study from which conclusions can be drawn. See table 4 below.

Table 4: A synthesis of the themes that are the findings of the study.

Delay in Health Seeking Behaviors	Delay in health seeking behaviors is:
(1) waiting to allow the body to heal itself, (2) following a chain of natural remedies and over the counter medications, (3) seeking guidance from within the community, (4) obtaining medical care only when necessary	Prioritizing self-knowledge and community wisdom prior to seeking traditional healthcare.

Comfort in Connectedness (5) expecting the medical environment to be unfamiliar uncomfortable, cold, (6) being unheard and treated like a number, yet desiring to be understood, (7) being open to personal perspectives and ways of thinking by providers, (8) giving time and personal attention to one another	Comfort in connected is: Experiencing caring in the healthcare setting, in spite of it being distressing.
Ease in Cultural Tension (9) trusting those who are humble and open, (10) partnering to share care responsibilities.	Easing cultural tension is: Trusting and valuing service to others.

Findings Related to Literature

The current literature related to Conservative Anabaptists descriptions of healthcare has been limited to genetics, cultural health practices, and barriers of care. As this population continues to grow, there is a need to better understand their experiences with seeking and responding to healthcare (Anderson & Potts, 2020). However, the qualitative evidence related to these healthcare experiences is currently under-described. The findings from this study describe how Conservative Anabaptists seek and respond to healthcare and give a voice to this population. The themes derived from the predetermined categories of delay in health seeking behaviors, comfort in connectedness, and ease in cultural tension strengthen the existing literature while adding new knowledge to the discipline of nursing.

Delay in Health Seeking Behaviors

A major finding of this study is that a delay in health seeking behaviors is prioritizing self-knowledge and community wisdom prior to seeking traditional healthcare. This major finding adds supporting evidence to the existing knowledge base describing how conservative Anabaptists prioritizing self-care and input from their community prior to seeking traditional healthcare. It is not uncommon for conservative Anabaptists to delay in seeking healthcare. It is well documented in the literature that this group has a predilection for CAM and have a distrust for the American medical and pharmaceutical industry (Anderson & Potts, 2020). The participants of this study stated that when experiencing illness, they would wait to allow their body to heal itself and use a chain of natural remedies and over the counter medications. Many participants in this study spoke about using herbs, natural remedies, and fearing modern pharmaceuticals due to side effects. There are many conservative Anabaptists that look to individuals within their community who have healthcare knowledge and CAM knowledge first before seeking modern treatments (Anderson & Potts, 2020).

There is further evidence to support that this population will only seek medical assistance when necessary and not for routine exams or screenings (Sierene et al, 2016, Lehman, 1994). Participants in this study felt that they only receive medical treatment when they deem the necessity of it. Many of the participants responded that they would only go to the doctor or emergency room if they felt the problem was out of their control.

There is a trust that comes from advice from friends and family within conservative Anabaptist groups (Schweider & Schwieder, 1975, Wiggins, 1983). The participants in this study shared how they would go to a nurse in their church group or ask advice from friends and family. There is a long-standing appreciation that this population cares for one another within

community and family settings. There is a self-reliance and collaboration within the community is important to this population (Hess, 2018).

Comfort in Connectedness

A major finding of this study is that comfort in connectedness is experiencing caring in the healthcare setting, in spite of it being distressing**.** This major finding adds supporting evidence to the existing knowledge base describing how conservative Anabaptists describe that comfort can be experienced when interacting with caring healthcare professionals. Conservative Anabaptists groups are part of a cultural community (McBride & Gesnick 2018), that report comfort with traditional healthcare when there is patient/provider collaboration (Kahn et al, 2013). This group respects the advice of medical providers who show understanding, interests, and acceptance of complementary alternative medicine. Participants in this study stated many times that they had a desire to be heard and understood. They desired time and attention from the medical providers, and those who did so made them feel more comfortable and understood. Conservative Anabaptists find comfort in connectedness important due their value on community. The participates described a desire to be heard and understood and appreciated providers who spent time with them.

The participants of this study described expecting the medical environment to be uncomfortable, unfamiliar, and cold. Conservative Anabaptists prefer treatments that are perceived as natural and not in an unfamiliar, institutional setting. This population is comfortable bringing healthcare services such as births and eldercare into their homes (Anderson & Potts, 2020). It is important for the healthcare provider to understand that with open communication, time spent, and collaboration, conservative Anabaptists may feel more comfortable in traditional

healthcare settings. They describe better experiences, feel more relaxed, and are more willing to return for future visits.

Ease in Cultural Tension

A major finding of this study is that easing cultural tension is trusting and valuing service to others. This major finding adds supporting evidence to the existing knowledge base describing how conservative Anabaptists describe that easing cultural tension by trusting and valuing service to others. In this study participants spoke about how they appreciated and trusted providers who were humble and open to discussion. This population wants to establish trust and clarity in all interactions. This community desires character traits or trustworthiness, integrity, humility, engagement, and cooperativeness (Anderson & Porter, 2020). Once the reputation of a provider is known whether good or bad, it will spread throughout the community. To build trust in this population the provider must show respect and interest (Fisher 2002).

Humility and trustworthiness are two-character traits that this population highly values. The participants expressed how they had more respect, or trusted a provider that would admit their mistakes. This helps to establish a trusting relationship between provider and patient. In turn this causes an ease for the conservative Anabaptist. This ease will allow this population to seek healthcare and have a positive relationship with the provider.

When this population finds ease in their healthcare provider, they have a willingness to cooperate and will partner with the healthcare team. Participants in this study shared how they have a responsibility to the provider as a patient, especially if the provider has shown care and compassion to them. When conservative Anabaptists find aggressive or pushy healthcare providers, they will passively resist the services and providers will have negative responses to recommended treatments (Anderson & Potts, 2020).

Integration of Findings with Concept and Theory

Transcending health values is prioritizing self-knowledge and community wisdom in seeking healthcare, experiencing caring in the healthcare setting in spite of it being distressing, and trusting and valuing service to others. Prioritizing self-knowledge and community wisdom in seeking healthcare relates to transcending health values by the individual finding comfort and connectedness from those within their community. Participants in this study described several instances where they searched for specific medical treatments and sought out medical guidance from within their community. Experiencing caring in the healthcare setting, in spite of it being distressing is described by the participants by acknowledging that the medical environment may be unfamiliar, awkward and cold but, when they felt heard and understood they felt more comfortable. Trusting and valuing service to others relates to transcending health values by descriptions of a desire from the participants to want to work in partnership with health care providers.

The concept *transcending health values* has a coherence with the theory of cultural marginality. The concepts of the theory of cultural marginality are across-culture conflict recognition, marginal living, and easing cultural tension. Integration of the concepts from *cultural marginality* and core qualities of *transcending health values* are the human health experiences of seeking and responding to healthcare, with conflict across cultures, and marginal living, that can lead to a delay in health seeking behaviors. An ease in cultural tension can occur through comfort in connectedness. The theory's three concepts of marginal living, across-culture conflict recognition, and easing cultural tension align with the findings of this study. The findings mirrored the concepts of the theory of cultural marginality and aligned with what the participants described.

Marginal living as a concept for this theory is defined as a passive betweenness in the pushing/pulling tension between two cultures while forging new relationships in the midst of old and living with simultaneous conflict/promise. This passive betweenness has been described as living in two worlds where they feel like they do not belong. In this study the findings of prioritizing self-knowledge and community wisdom prior to seeking traditional healthcare is living on the margin outside of the traditional healthcare system. Wanting to seek out care where they feel comfort and connected to the healthcare providers giving advice is a way of forging new relationships outside of the conservative Anabaptist culture. The participants of this study sought out information that they had acquired through their own research, and through advice they found within their community. When needing to seek traditional healthcare, relationships could be established when a connection occurs between the conservative Anabaptist and the traditional healthcare provider when participants felt they were being listened to and valued for their health beliefs.

Across culture conflict recognition is defined as the start of acknowledgement and understanding of two different conflicting cultures. The conflict starts to come out when there are value systems in place that may cause conflict with an individual's own cultural values. In this study, participants acknowledged the unfamiliarity and uncomfortableness of the healthcare setting yet would seek care when needed. In spite of being uncomfortable, when they feel heard and understood, they are willing to participate in the healthcare process.

Easing cultural tension resolves across-culture conflict and has four response patterns of ease. Those response patterns are assimilation, reconstructed return, poise, and integration. The patterns of ease from these participants, regarding healthcare comes by choosing to trust those who are humble, open, and have a desire to partner and share care responsibilities. They do not

give up their cultural identification, but they allow themselves to be a part of the healthcare environment.

Contribution to the Knowledge Base of Nursing

The focus of the discipline of nursing is caring in the human health experience (Newman, Sime, & Corcoran-Perry, 1991). The human-environment-health relationship is an interconnectedness of human health with a multidimensional environment (Smith, 2019) The findings of this study support the interconnectedness of human health with the multidimensional environment of the conservative Anabaptist population.

The participants in this study described prioritizing self-knowledge and community wisdom prior to seeking traditional healthcare. This relates to the human-environment-health relationship due to the physical, social, and cultural responses to the healthcare environment, and its effects on the way the conservative Anabaptist seeks and responds to healthcare. Experiencing caring in the healthcare setting in spite of it being distressing is described in the integrative-interactive paradigm where human beings are seen as adaptable to the setting they are given within the environment (Smith, 2019).

It is essential to relate the findings to the focus of the concepts of discipline of nursing. By allowing this population to openly discuss these topics rich data were uncovered and the human-environment-health relationship was described. The findings of this study make a partial contribution to the nursing knowledge base through understanding how conservative Anabaptists seek and respond to healthcare.

Trustworthiness

A strength of this study is the trustworthiness of the findings. This study held fast to the criteria of trustworthiness to increase the confidence in the data, interpretation, and the methods

to assure the quality of the study, The criteria to help satisfy trustworthiness are credibility, transferability, dependability, and confirmability (Shenton, 2004). Credibility deals with how congruent the findings are with reality and helps to ensure that the study is truly measuring what was intended. Directed content analysis, a widely used research technique in qualitative studies, was utilized to analyze the data. A semi structured interview script that was guided by the concept *transcending health value*s and the theory of cultural marginality, was used to facilitate the focus groups. The facilitator of the focus group was coached by a professor with extensive qualitative research background. The facilitator utilized field notes and tape recorder during the focus groups. Then the data were transcribed verbatim and analyzed. The transcripts were read numerous times by both the investigator and mentors. The transcript texts were coded and placed into categories. Data were categorized by using transcending health values predetermined core qualities. The findings are supported by direct quotations from the participants, and evidence of congruence of findings.

Transferability addresses whether the study findings can be used in other situations. (Shenton, 2004). To ensure the transferability to other populations and situations or allow future research to repeat this work, a detailed description of the methods and procedures were provided. This included the eligibility criteria, recruitment techniques, data collection, and data analysis.

Dependability relates to the reliability of the study, if the study was repeated with the same individuals there would be similar results obtained (Shenton, 2004). To ensure a thorough description of the method used, a detailed description of the research design and implementation was included. A description of the operational details of data gathering, including the interview script and study processes are included. Finally, a reflective appraisal of the study is included in

the discussion, limitations, and a detailed audit trail (see Appendix 1) provides adequate evidence to support dependability of findings.

Confirmability is the "qualitative investigators comparable concern with objectivity" (Shenton, 2004, p. 72). It is important that the results are the experiences and expressions of the participants (Shenton, 2004). Confirmability has been preserved using an audit trail and support from the committee members experienced in the method. Extensive audit trails were maintained for each step in the data analysis process. Also, prior to planning the study, the researcher engaged in a bracketing practice of reflexivity by journaling personal thoughts and values about experiences with this culture of participants. A reflexive journal was written down describing thoughts, feelings and perceptions to re-examine the researcher's positions when issues are raised that might affect the research process. Bracketing requires recognizing and setting aside personal beliefs about the phenomenon under investigation or what one already knows about the subject prior to and throughout the research study (Carpenter, 2007).

Implication of Findings for Further Research

Findings from this study offer topics for future research. Based on the findings about easing cultural tension, a phenomenological study could examine descriptions of the lived experiences of conservative Anabaptists partnering with their healthcare providers. In addition, a qualitative study exploring healthcare providers descriptions of cultural competency in caring for conservative Anabaptists could add descriptive findings to guide interactions between patient and provider.

Existing literature and study findings describe the role of healthcare providers in meeting the needs of this population. For example, communities with an Amish midwife who promotes vaccination have higher vaccination rates (Fry et al. 2001). This study did not allow for

conservative Anabaptists who are practicing healthcare workers or have practiced as healthcare workers to participate. It would be informative to see how healthcare professionals who are conservative Anabaptists describe caring for conservative Anabaptists in the traditional health care setting.

The results of this study were limited to one geographical location and one congregation. More research is needed to gain descriptions from other conservative Anabaptist constituencies and geographical locations. The participants discussed their experiences seeking and responding to healthcare in their individual community that may be different in other conservative Anabaptist constituencies or geographical location.

Implication of Findings for Nursing Practice

The synthesis of themes can help to inform nursing practice when addressing the healthcare needs of conservative Anabaptists. Participants described only seeking medical care when they deemed it necessary, desiring in partnering to share care responsibilities, and wanting to be heard and understood. The findings of this study can serve as a guide in interacting with conservative Anabaptist patients. For example, the nurse can begin by asking how the patient cares for themselves and their families at home, followed by what unmet need brings them to seeking care in the traditional healthcare system. The nurse can then ask about comfort needs while receiving care, and seeking the patient's perspective on how traditional healthcare can augment their self-care. These types of interactions can guide clinicians to understanding the cultural values and beliefs of the patient and build trust in the nurse/patient relationship.

Implications of Findings for Policy

This research can help inform policy makers at the local organizational level and provide cultural sensitivity and awareness training in healthcare practices specific to the population.

Continuing professional education and development activities can be created to inform healthcare providers on conservative Anabaptists beliefs and values when seeking healthcare. Organizations can include hospitals, primary care practices, and community/public health departments.

Limitations

Despite directed content analysis is a well-established analysis approach to guide and interpret qualitative date, it can also serve as a limitation due to the risk of predetermined bias. This can threaten objectivity of the findings (Hsieh & Shannon, 2007). However, to reduce this risk the research used strategies such as trustworthiness, bracketing, reflexivity, and guidance from knowledgeable and experienced researchers.

Transferability of the study findings are limited due to collecting data in one congregation in a small rural area. There is the possibility that there may be differences in experiences other conservative Anabaptist populations from different Anabaptist constituencies and geographical areas. Future studies should include a sample of other groups of conservative Anabaptists to compare findings.

Conclusion

Findings related to the descriptions from conservative Anabaptists of the delay in health seeking behaviors, comfort in connectedness, and ease in cultural tension when seeking and responding to healthcare are grounded in the knowledge base of nursing and consistent with previous literature. The core qualities of delay in health seeking behaviors, comfort and connectedness, and ease in cultural tension within the concept transcending health values are coherent with the concepts and assumptions within the theory of cultural marginality. The findings offer implications for future practice, research, and policy changes to support

conservative Anabaptists healthcare needs. This information can further support *transcending health values* for its use in nursing knowledge development.

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Appendix 1: Audit Trail

Pre-determined Categories	Sub-categories with Codes	Specific Descriptors (In the words of the participants)
Comfort in Connectedness	**Medical environment is unfamiliar, uncomfortable, and cold** I feel awkward there (healthcare setting) Don't feel at home there (hospital) Not somewhere I'm used to going, not familiar Don't expect it to be comfortable. I don't get a warm fuzzy felling to a doctor. Pushed into a cold room Pushed me out in the hall pitch black in there and cold Never ever said a word to me	"I just feel awkward there. I don't feel at home there… it's not where I'm used to going to, it's not familiar." "I don't expect it to be … comfortable or fun… It's not that …they make me feel like I shouldn't be there, but I'm there because I need to be." "I didn't know what was going on. I was just out in the hallway…. then pushed into a cold room. They didn't even go in the room; they just pushed me in. It was pitch black and cold."
	Treated like a statistic and not an individual I felt somewhat treated like a statistic rather than individual. Looking at statistics Statistics not looking at me as an individual. My personal history That didn't feel nice (being a statistic) Something that annoys me (about not being known)	"I felt somewhat treated like a statistic rather than an individual." "I felt like they were looking at statistics and saying you need to deliver …because of our statistics, not looking at me as an individual."
	Don't feel seen or heard A doctor who you know breezes in and out does not make you feel comfortable, necessarily or replaced. You feel like doesn't hear you.	"I'm sitting there waiting, waiting, waiting, waiting and just getting more frustrated… it would be nice to know what is going on". "I like to be heard and understood….I like them to understand my perspective and where I am coming from."

	He doesn't show up. Waiting and just getting more frustrated. Nice to know what's going on (with doctor's delay) They didn't tell you why Don't like 15-minute timeframe (p9) Frustrated waiting for doctor **Desire to be heard and understood** Like to be heard and understood (x2) Not rushing ahead, but listening to me (x2 – page 8) Trying to work for me Understand my perspective, where I'm coming from I chose someone who will hear me Choose someone who understands my way of thinking A bit more open to my thinking	"A doctor who breezes in and out, like in a mad rush. It does not make you feel comfortable or relaxed. You feel like he doesn't hear you." "The reason I chose my provider was I felt he was someone that would understand my way of thinking. He always takes time, and he is interested." "I tend to choose midwives. Someone who will hear me and understand where I am coming from".
Delay in Health Seeking Behaviors	**A chain of natural remedies, followed by over the counter medications, and finally medical care if needed** Natural remedies first (x3) Try over the counter Go to cupboard Home remedies start taking some medicine.	"I usually do herbs, natural stuff and then Tylenol or ibuprofen after that." "I go to my cupboard of natural remedies first."

	Take a pill Take ibuprofen Over the counter Cold medicine Herbs Natural stuff Tylenol, ibuprofen Natural Ibuprofen; Tylenol is my go to	I probably try natural remedies first and then if they don't take care of it, then I might try over the counter medicines and usually it resolves itself. But, if it doesn't then, I would go see a doctor." "Its sort of a chain, you know, the hospital is your last."
	Wait and allow body to heal itself Dr. not necessary for something that resolves itself Usually revolves itself God designed our bodies to heal themselves. Time and rest you need to take into consideration. Wait until it gets better Body is created to heal itself (x3) I support my body in healing itself Let it run its course (x3)	"Our bodies are created to heal themselves…give my body a chance to do what God created it to do." "I think God designed our bodies to heal themselves and sometimes time and rest is what you need to take into consideration." "If I get a cold, I'm going to just have a cold. If it gets bad then, I might start taking some medicine." "I don't feel like it's necessary to pay to see a doctor for something that will resolve itself."
	Seek help from within the community first Recommendation for other friends Recommendation from naturalists Books Research Ask the doctor of the family. Google	"I would only go to the doctor if something either wouldn't go away or if it got really bad." "I would tend to consult someone like a nurse from our church."

	Ask a nurse at church. If they think its wise to go to the doctor I would take that a little more seriously. I ask the lady that I get my herbs from She's studying, knows what she's doing A lot of study because of my kids Start with books Friends who got a lot of studies Ill go to friends My mom **Seek medical care if necessary or for children** I would only go to the doctor if something either wouldn't go away or it got really bad. When I was really sick, I went to the ER and did what they I would be more likely for my kids. You can't tell for sure what's going on with them. Things can escalate pretty quickly more than an adult. I have no problems for my kids I fought more for it (for my child) If its bad enough to go you better listen Delay hospital as long as possible Only if out of my control (i.e. broken arm) When I know something is wrong (i.e. heart attack) Definitely beyond me Less likely to delay when it's with children (x2)	"When it didn't seem to resolve, I talked to a nurse at church, who told me to go back to urgent care." "I also have friends who have a lot of studies or my mom" "I have no problem for my kids. I get uncomfortable because I am not sure what they are going to do with that information if I decline something". "I would say I would be more likely for my kids. You can't tell for sure what's going on with them." "For me I can evaluate myself. But, with my daughter we want to make sure. With children things can escalate pretty quickly, more so than an adult".

	Children don't know, can't evaluate (x2 – script 2, p. 5)	
Ease in Cultural Tension	**Beliefs and personality of the provider is important** He prayed with us. Knowing they're Christian. Having similar beliefs would definitely make a difference. Personal attention Makes you think, well, he really does care about my health. He (the doctor) always takes time and he's interested. Taking time to show interest Personalities of healthcare staff can really affect my experience	"Before I went into surgery, he prayed with us." "Knowing that they're Christian, have similar beliefs, would definitely make a difference". "The personalities of healthcare staff can really effect my experience…if they are friendly enough you know, I feel heard."
	Providers are not perfect and trust those who are humble He said that he missed on the picture. He's humbled enough to admit that he admits that he missed it You know they aren't God either. They are subject to making mistakes just same as anyone else.	"I thought he is humble enough to admit that he missed it…. doctors have a lot of knowledge. I am glad we have doctors, but you know, they aren't God either." "They are subject to making mistakes too…doctors are human too." "He said it is your privilege to try something natural if you want and I was so pleased he said that. I am grateful I could do all natural".
	Allowed to have opinion about self He (doctor) was responsible and gave me options	"I felt like things were offered and not pushed on me, and my voice was heard. I could give my opinion, and they may have not agreed with it but they were gracious".

	Offered and not pushed (medical care) I could give my opinion	“I have to remember that I chose them to take care of me and its that I have to work with them.” “I do realize when I have a problem I am going to go back and see them again”.
	Mutual responsibility to care for one another My voice was heard. Could give my opinion. May not have agreed. They were gracious and OK with it. They gave me a little grace. She was concerned about me. She would wake up at night thinking about me. Care for me and my baby I like to be heard and understood. To understand my perspective where I’m coming from Someone who will hear me and understand. Where I am coming from That goes two ways. A doctor or nurses or whoever are listening to me. Actually, hearing me Taking into account what I am saying and not just rushing ahead.	“Its not fair they care about me, its not fair more me to say I want my way and ignore what they say. Simply because they are doing their job.”
	Actually listening Trying to work for me. He walked with me. Understand my way of thinking. I feel heard He said its your privilege to try something natural if you want. I was pleased	“The doctor walked with me to show me where the waiting room was.” “The doctor called to the house to see how I was doing. He took time to show interest”. “The doctor would personally come in each morning to see how he is doing…it makes you think he really does care about my health.”

	I was impressed that he offered that to me first (natural) **Spending time and personal attention is caring** Offered and not pushed (medical care) I could give my opinion Medical staff gracious Doctor spent time with me (x3) Doctor is interested in me Personal attention from doctor shows caring about health Walked with me, showed me Came into the room and sat down Came in every morning	

Appendix 2: Focus Group Script

Principal Investigator: Matthew Hottle, MSN, RN-PhD Candidate

Focus Group Protocol
Date/Time: TDB
Moderator: PI
Welcome, Intro:
*Thanks for coming today. I'm Matthew and I'm going to be the moderator for this group***.**

Informed Consent, Oral Notification of Taping:
Before we begin, I need to ask you to sign the informed consent document you have in front of you. Would anyone like me to read it out loud? Do you have any questions about it? **READ IF NEEDED AND ANSWER QUESTIONS – ASK THEM TO SIGN THE FORMS AND COLLECT THEM.**

We mentioned this before but just to remind you, this session is being audiotaped. We will be using these only for making the transcripts, which will not contain names. After that, the tapes will be destroyed. Does anyone have any questions or objections?

Ground Rules for Group:

Thank you for your willingness to participate. I want to go over some basic ground rules.
1)Everyone's opinion is important, and I am very interested in hearing all points of view. I am not evaluating you. I am trying to better understand your experiences.
2)It's OK to talk to each other.
3) You may feel free to get up and get a drink or go to the restroom at any point.
4)Everyone doesn't have to answer every question but, I would like to hear from each of you.
5) I may need to keep us on track from time to time and guide refocus the group.
6) Are there any questions before we get started?

Introduction of Participants:

Now I'd like to go around the table so each person can give me their first name and tell me in a few words about themselves but, no last names or other information that would identify you and keep it short, please.

Introduction of Subject of Group:

The primary reason we are here today is to talk about seeking and responding to healthcare

c). What guides that decision?
d). How do you move forward?

Delay in Health Seeking behaviors is defined as waiting until illness is serious after using alternative methods of treatment to seek healthcare (Sieren et al., 2016).

1). Can you recall a time when you delayed seeking healthcare and share that experience?
a). Tell me more about what you did and why you did it.
2). Where do you get information that determines when you delay seeking care?
a). How do you decide the information you seek is true?

Comfort in Connectedness *defined as finding comfort in community and familiarity (McBride & Gesink, 2018).*
1). What is most important to you when seeking a healthcare provider and why?
a). Why is this important to you?
b). Tell me more about how you make this decision.
2). What do you do first when experiencing an illness?
a). Can you give me an example?
1.) Will you tell me of a time when you were ill and how you moved through your recovery.
b). Then what do you do with that information?

Ease in cultural tension defined as decreasing stereotyping, discrimination, and health inequities to aid ease in cultural tension (Blanchet Garneau et al., 2018).

1). Can you describe of a time where you have experienced yourself as being out of place in the healthcare setting (not understood, discriminated)?
2). When you are in a healthcare setting is there anything that makes you feel more comfortable
a). Tell me more about that feeling.

Wrap-up
Are there any areas we did not talk about that you think are important for us to know about your health seeking behaviors.
Thank you

Again, thank you for coming. We learned a lot and it was a pleasure talking with all of you. Thank you for sharing your thoughts.

Final Arrangements
Give honorarium.