

ABSTRACT

THE HEALTH BELIEFS AND PRACTICES OF THE AMISH

By Amy Schroeder

The Amish are a large religious and cultural group with roots in Ohio, Indiana, and Pennsylvania. Smaller communities of Amish can be found throughout 27 states, including Wisconsin. The population of Amish continues to grow due to large families. In depth research has been completed in regards to the Amish culture in the largely populated areas of the country, but there is a lack of information about the health beliefs and practices of the Amish, specifically in Wisconsin. Additionally, very few qualitative studies have been completed about the Amish. Studying the Amish culture is part of providing culturally competent care. Understanding their beliefs and practices will allow healthcare providers to give the best possible care, and increase the likelihood of trusting relationship with the provider. Creating an agreed upon plan of care will not only increase patient satisfaction, but also increase compliance.

The purpose of this study is to explore the health beliefs and practices of the Old Order Amish from a rural area of Wisconsin.

The theoretical framework for the study is Leininger's Cultural Care Diversity and Universality theory (Leininger & McFarland, 2002). This model discusses the cultural variables that impact a person's being and the culturally competent care provided by a healthcare system. The research question is as follows: What are the health beliefs and practices of the Amish?

The study was conducted via personal interviews with Amish adult men and women. A purposeful sampling technique was used. The names of the participants were selected from the directories of the church districts within the settlement. The sample size was ten participants. The participants were asked open ended questions regarding their beliefs related to health. Responses were further explored with probe questions. Colaizzi's phenomenological analysis was used to interpret the data collected (Speziale & Carpenter, 2007).

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by

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CHAPTER 1

INTRODUCTION

The Amish are a group of Anabaptists who emigrated from Europe to the United States in the 1700's. The members of the Amish are religious, hard-working persons who believe "worldliness" keeps one from being close to God. Because of this conservative belief, they choose to live a more simple life by avoiding the use of modern conveniences and technology (Igou, 2009). "The Amish live by a code of conduct known as *Ordnung* that forms their behavior, speech, and manner of dress; it is a set of rules and regulations for living the Amish faith" (Weyer et al., 2003, p. 141).

Differences between the Amish and non-Amish or "English" cultures are many. The Amish do not believe in birth control and have low infant mortality, which leads to a rapidly growing population. The formal education system includes grades one through eight. "Excessive education is considered an effort to mimic omniscience, a state only God enjoys" (Graham & Cates, 2006, p. 61). Tobacco and alcohol use is rare. The Amish may be best known for their farming tradition, and the horse and buggy method of transportation. This transportation method provides some limitation with travel or access to healthcare facilities. The Amish people do not use insurance; this is a determining factor in health care practices (Weyer et al., 2003). "Folk remedies are highly valued and passed along from mothers to daughters, as a skill required of all good homemakers" (Donnermeyer & Friedrich, 2006, p.41).

Each culture, and subgroup of the cultures, has their own beliefs on health and healthcare practices. Healthcare providers need to understand the culture of the people they care for in order to build a trusting relationship with mutual respect for each other. According to Black (2008), "In delivering appropriate and culturally competent health

care, providers and educators must increase their understanding of beliefs and practices and values that are relevant to different cultural groups" (p. 10).

Analysis of Pertinent Literature

Research is available about the Amish culture; however, few studies focus on their health beliefs and practices. The overwhelming majority of research on the Amish has pertained to a particular aspect of the Amish culture. In addition, it has often been done among the Amish in Iowa, Indiana, Ohio, and Pennsylvania. There is a gap in knowledge about the Amish in Wisconsin, yet Wisconsin is a rural state with a large Amish population. In a search of Amish health, indexed by the Cumulative Index of Nursing and Allied Health Literature (CINAHL), only four articles were found regarding the health beliefs and practices of this distinctive population. The analysis of pertinent literature will explore what is known about the Amish culture.

Blair and Hurst (1997) conducted a qualitative study in Ohio by collecting field work observations and systematic interviews with five Amish leaders and four healthcare professionals. The researchers concluded with a few prominent themes. It was learned that the term "Gelassenheit" means "submission" or "yielding to a higher authority," and "to be mindful of those around you," is a strong lesson in Amish culture. In the medical field, this is demonstrated when a provider respects the values of the Amish culture.

Other prominent themes noted to influence the approach to healthcare include the core aspect of strenuous work, the consideration of the cost factor in preventative care, and the degree of conservatism in an Amish group. The more conservative groups were even less likely to seek preventative care. Certain health problems are more common in the Amish population, such as occupational and sports related activities,

rubella outbreaks, cystic fibrosis, whooping cough, and genetic diseases. Mental illness is also common. Positive health factors include limited use of tobacco, alcohol, or drugs, and an increased recognition for mental illness and affective disorders. The researchers also discovered the tendency to wait to seek a provider unless it is of an urgent matter, the use of home remedies, and the vulnerability of this diverse group. Variation was noted among medical insurance practices, but in general, the Amish are taught not to impose on each other for support.

Another research study regarding the general health beliefs and practices of the Amish was performed by Armer and Radina (2006). This research was a combination of open-ended questions, as well as, quantitative measures designed to explore health promotion among Old Order Amish. Participants consisted of 87 Old Order Amish adults. The emerging themes regarding the definition of health include the importance of being healthy, the ability to work hard, a sense of freedom to enjoy life, family responsibility, and both physical and spiritual well-being. The prominent health maintenance behavior was the work-related physical activity.

Gerdner, Tripp-Reimer, and Sorofman (2002) conducted a secondary analysis of data from a series of ethnographic studies conducted between 1979 and 1991, which consisted of 41 participants. Results of the study revealed that the devotion to the Amish community, church and religious beliefs are entwined in the daily life of Old Order Amish. Ninety-five percent reported using folk remedies, often for minor trauma, respiratory conditions, or health promotion. The services of a physician were primarily utilized for serious health conditions and emergencies. Many participants discussed use of chiropractors, osteopathic physicians, or reflexologist. Herbal based remedies were also a common finding in this study. The author suggests providing a more holistic

perspective of healthcare beliefs and practices and recognizes that as a critical component of culturally competent care.

Weyer et al. (2003) wrote about a case study involving a dying elderly Amish woman in Ohio. A description of the home visit was provided, which highlighted the unique aspects of Amish culture. The author alerted the reader of the fraud and exploitation that occurs in the Amish population in relation to their healthcare. Unfortunately, Amish people may be targeted by salespeople who use scientific terms and quote Bible scriptures to convince a person of their cure (Weyer et al., 2003). Although the Amish often use home remedies to treat their ailment, they will seek out western medicine when necessary. Transportation and cost of services are mentioned as barriers to medical care.

This literature review illustrates a gap in knowledge regarding the health beliefs and practices of the Amish. Only four studies were available about a growing population of people who have immigrated to the United States over 200 years ago. Only two of these studies included a qualitative aspect of research and none of the research was done in Wisconsin. An understanding of the health beliefs and practices of the Amish culture must be developed to give culturally congruent care. In addition, the actions which would support the culture need to be explored as a guide for healthcare providers.

Significance to Nursing

Although various sectors of Amish exist, this study focuses on the general health beliefs and practices of the Old Order Amish because it is the largest sector and comprises the accessible population in Wisconsin. It is important to study this diverse

population for a number of reasons: the number of Amish continues to increase, their healthcare practices are unique, and providing culturally congruent care is a critical aspect of nursing.

As a result of prohibited use of contraception, low infant mortality rates, and encouragement of large families, the population of Amish is increasing rapidly (Weyer et al, 2003). Large families of seven to ten children are common. Meyers (2009) reported, "By 2008 the estimated figure had increased from 127,800 in 1990 to 231,000 in 2008" (para. 3). Another source stated "demographic data indicate that the number of Old Order Anabaptists in the United States is doubling about every 20 years, making them perhaps the fastest-growing segment of an otherwise generally declining farm-based population" (Gilliam, Jones, Field, Kraybill, & Scott, 2007, p. 12). Wisconsin ranks fourth in the highest population of Amish people, with an estimated 15,525 people (Amish Population by State, 2009). This rapid growth speaks to the increased probability of healthcare providers in rural settings caring for Amish patients.

The Amish are known for a few of their unique lifestyles. One hallmark tradition is their use of horse and buggy. This impacts the frequency of healthcare visits, as well as the nature of the visit. According to Weyer et al., (2003), "When the Amish do seek medical attention, they often have severe symptoms and increased risk of mortality secondary to delay in seeking care... Compared to the non-Amish, Amish people are less likely to seek medical attention for minor aches or illnesses and more apt to follow folk remedies and drink herbal teas" (p.143). When making appointments for healthcare visits, the time of day, season of the year, and length of time an appointment may require, are all taken into consideration.

Folk medicine and home remedies are often used. "The Amish have always considered health care preferences from a more holistic view than most non-Amish in American society" (Donnermeyer & Friedrich, 2006, p.43). Graham and Cates (2006), reported, people in the Amish community "may identify chiropractors as primary physicians, and often begin diagnosis of, or treatment for a disorder with herbs, minerals, vitamins, foot reflexology or iridology, the specific remedy often chosen on the basis of traditional and personal experience" (p. 64). Healthcare providers need to recognize the common use of folk remedies and ask questions accordingly in order to provide safe care. In addition, they may tailor their delivery of care in order to provide care that supports the Amish culture.

Another unique aspect of Amish health practices is the strong belief in self-sufficiency, which prevents the Amish from using insurance or assistance of other sorts. This can lead to financial constraints and the desire to minimize the use of healthcare systems. Healthcare providers who are cognizant of the monetary aspect of healthcare are appreciated.

Additionally, as healthcare providers, being culturally competent is important. With increased cultural competence, a healthcare provider will gain better understanding of the patient's worldview, as well as, how it guides his being and decisions. "Culture is directly related to health promotion, disease prevention, early detection, access to healthcare, trust and treatment compliance" (Polacek & Martinez, 2009, p. 98). Ultimately this lifelong process of acquiring cultural competence will influence the approach provided in the healthcare field.

Madeleine Leininger developed a theory based on this process -- Cultural Care Diversity and Universality Theory (Leininger & McFarland, 2002). The central goal of

this theory is to provide culturally congruent care to person's of diverse culture. Understanding and recognizing the culture of each patient and using this information to shape the nursing care is the heart of her theory.

Problem Statement

Although the available literature contains valuable information about the Amish culture, the number of qualitative studies was minimal. Commonalities were found in all, which discussed the importance of religion, the avoidance of modern technology, the symbolic dress, farming history, and horse-drawn vehicles. Yet distinction still occurs between localities. Powell (2009) stated, "the Ordnung varies from community to community and order to order, which explains why you will see some Amish riding in automobiles, while others don't even accept the use of battery-powered lights" (para. 1). Literature regarding the Amish population in Wisconsin is not available, and qualitative studies about the healthcare beliefs and practices of the Amish culture in Wisconsin are limited.

In addition, the Amish population is growing, which increases the likelihood of healthcare providers caring for Amish patients. Because the Amish have different health beliefs, there is a responsibility to understand the culture and provide culturally sensitive care. Research focusing on the health beliefs and practices of the Amish is needed as a resource to be used by healthcare providers.

Purpose of the Study

The purpose of this qualitative, exploratory study was to obtain an understanding of the health beliefs and practices of the Amish culture in Wisconsin.

Research Question

What are the health beliefs and practice of the Amish culture in Wisconsin?

Definitions of Terms

Conceptual Definitions

Health beliefs: The personal convictions that influence health behaviors (Mosby's Medical Dictionary, 2009)

(Health) practice: Methods, procedures, processes, and rules used in a particular field or profession (Practice, 2010).

Amish culture: A person of Amish faith, with integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and/or institutions of racial, ethnic, religious, and/or social groups (Lipson & Dibble, 2008)

Operational Definitions

Health beliefs: The self-stated views or opinions of the Amish, as obtained by oral interviews.

Health practices: The actions of the Amish people, as stated through oral interviews relating to health.

Amish culture: Men and women of the Old Order Amish, 18 years of age and older, living and practicing Amish beliefs.

Assumptions

For the purpose of this study, the following assumptions were made:

1. People of Amish culture have varying beliefs regarding health care.

2. Amish men and women understand and speak the English language.
3. Amish men and women will be honest in regards to their beliefs and practices related to health.

Summary

The Amish population is growing rapidly, and Wisconsin is the state with the fourth highest Amish population. States with the largest population growth in 2007 -- 2008 were Pennsylvania, Indiana, New York, Ohio, and Missouri. Although Wisconsin was a high growth state in recent years, during this time period its population has remained static (Amish Population by State, 2009). The probability of encountering the Amish in need of healthcare in a rural community is to be anticipated. Providers must be cognizant of the health beliefs and practices in order to provide culturally competent care to the Amish.

CHAPTER II

THEORETICAL FRAMEWORK AND REVIEW OF LITERATURE

The purpose of this qualitative exploratory study is to obtain an understanding of the health beliefs and practices of the Amish culture. This chapter is a discussion of the theoretical framework that guided this investigation. An overview of Leininger's Cultural Care Diversity and Universality Theory (1993) and its relationship to the study will be presented. In addition, the review of the literature relevant to health beliefs and practices of the Amish will provide support for the study (Reynolds & Leininger, 1993).

Theoretical Framework

This study was designed to gain better understanding of the health beliefs and practices of Amish people. Leininger believed there was a connection between culture and care, and she felt patients had a right to have their sociocultural backgrounds understood (Reynolds & Leininger, 1993). According to Reynolds and Leininger (1993), several assumptions were formulated as grounds to support Leininger's theory including:

1. Care is the essence of nursing and a distinct, dominant, central and unifying focus.
2. Culturally based care is essential for well-being, health, growth, and survival and to face handicaps or death.
3. Culturally based care is the most comprehensive and holistic means to know, explain, interpret, and predict nursing care phenomena and to guide nursing decisions and actions.

4. Transcultural nursing is a humanistic and scientific care discipline and profession with the central purpose to serve individuals, groups, communities, societies, and institutions.
5. Culturally based caring is essential to curing and healing, for there can be no curing without caring, but caring can exist without curing.
6. Culture-care concepts, meanings, expressions, patterns, processes, and structural forms of care vary transculturally with diversities and some universalities.
7. Every human culture has generic care knowledge and practices and usually professional care knowledge and practices, which vary transculturally and individually.
8. Culture-care values, beliefs, and practices are influenced by and tend to be embedded in the worldview, language, philosophy, religion, kinship, social, political, legal, educational, economic, technological, ethnohistorical, and environmental context of cultures.
9. Beneficial, healthy, and satisfying culturally based care influences the health and well-being of individuals, families, groups, and communities within their environmental context.
10. Culturally congruent and beneficial nursing care can only occur when care values, expressions, or patterns are known and used explicitly for appropriate, safe, and meaningful care.
11. Culture-care differences and similarities exist between professional and client-generic care in human cultures worldwide.

12. Cultural conflicts, cultural imposition practices, cultural stresses, and cultural pain reflect the lack of culture-care knowledge to provide culturally congruent, responsible, safe, and sensitive care.
13. The ethnonursing qualitative research method provides an important means to accurately discover and interpret *emic* and *etic* embedded, complex, and diverse culture-care data.

As a way of displaying the theory in a graphic representation, Leininger created the Sunrise Model (Appendix A). The Sunrise Model was developed as a conceptual holistic research guide to work through the factors that potentially influence the well-being of people. The model is symbolized as a rising sun. "It conceptually depicts the world view, religion, kinship, cultural values, economics, technology, language, ethnohistory, and environmental factors that are predicted to explain and influence culture care" (Reynolds & Leininger, 1993, p. 26).

The outermost layer of the model is the worldview. "Worldview refers to the way an individual or group looks out on and understands their world about them as a value, stance, picture, or perspective about life or the world" (Leininger & McFarland, 2002, p. 83).

The next layer of the sun is composed of seven cultural and social structure dimensions. These are "the dynamic, holistic, and interrelated patterns of structured features of a culture" (Leininger & McFarland, 2002, p. 83). The elements include technology, religion, kinship, cultural values, politics, economics, and education.

Each of these elements is connected to the environmental context, language, and ethnohistory. Environmental context "refers to the totality of an environment, situation, or event with related experiences that give interpretative meanings to guide

human expressions and decisions with reference to a particular environment or situation” (Leininger & McFarland, 2002, p. 83). The ethnohistory of a culture is “the sequence of facts, events, or developments over time as known, witnessed, or documented about a designated people of a culture” (Leininger & McFarland, 2002, p. 84).

The worldview, the cultural and social structure dimensions, environmental context, language and ethnohistory all influence the core of the sunrise model. This central part is the care expressions, patterns, and practices, along with holistic health, illness, and death.

The layers of the sun describe features of the culture and how each influences another area. Underneath the sun is the description of how nursing decisions are affected by the culture. The focus of this model is on the individuals, families, groups, communities, or institutions in diverse health contexts. The nursing care practices upon these groups should consider the generic (folk) care, as well as professional care-cure practices of a particular culture. Knowledge of the factors that create and influence the culture, as depicted in the sunrise model, will ultimately influence the next layer of the model.

The next layer is entitled “transcultural care decisions and actions.” This refers to the decisions and professional actions in the field of nursing. The three nursing modes of actions or decisions that the nurse considers are:

- Culture care accommodation and/or negotiation: The actions that help people of a culture to adapt to or negotiate with others for meaningful, beneficial, and congruent health outcomes.

- Culture care repatterning and/or restructuring: The actions that help clients reorder, change, or modify their lifeways for new, different, and beneficial health care outcomes.
- The culture care preservation and/or maintenance: Actions which help people of a particular culture to retain and/or maintain meaningful care values and lifeways for the well-being, to recover from illness, or to deal with handicaps or dying.

The care action and decision data come from the information obtained in the upper levels of the Sunrise Model. That obtained data will guide the actions and decision of the nurse. These three types of actions lead to the ultimate goal of Leininger's sunrise model which is to provide culturally congruent care for health, well-being, or dying.

Case Study Application to the Theory of Cultural Care Diversity and Universality

Eli and Ruth are an Amish couple who have been married for 10 years. Their world view is to maintain a sense of community among the Amish yet remain separate from the rest of the world. They have six children, ranging from age 8 to 1.

Their son Daniel often developed ear infections in the first 2 years of his life. The unique aspects of the Amish culture influence how Eli and Ruth decide to treat their son. First of all, religion has an impact, as they believe God is the ultimate healer. The cultural values, beliefs and lifeways lead Eli and Ruth to try various folk remedies and care for him at home before taking him to a doctor. Kinship and social factors were helpful for Eli and Ruth, as they took advice from others in the Amish community. They also used books on nutritional healing or another book written by the people in the

Amish community for natural remedies. Although Eli and Ruth tried to provide the best care possible, it was necessary to try another route. As suggested by others, they took Daniel to the chiropractor. They traveled by horse and buggy to the chiropractor, as they do not believe in the use of modern technology or the use of cars. The chiropractor could feel with his hands that the top of the vertebrae were out of place. This misalignment put pressure on Daniel's ears causing repeated infections. The chiropractor suggested going to a physician for antibiotics. Eli and Ruth hired a driver to take the family to a doctor. They live in a rural area, therefore the nearest doctor was about 20 miles away. The office visit was intimidating for Daniel because he was only 2 years old and was unfamiliar with this atmosphere. The office visit resulted in a confirmation of "otitis media," a prescription for antibiotics, and a bill for \$102.00. The Amish do not have any insurance; therefore, they pay this bill in cash. The doctor also cautioned the use of herbal remedies while Daniel was on the antibiotics, as to prevent drug interactions. Based on the reported history, the doctor also suggested Daniel to have "tubes" put in his ears to help drain the ears and prevent repeated infections. Eli and Ruth had thought about this suggestion and agreed to have the procedure performed.

During the weeks before taking Daniel to surgery, a member of the Amish community met with a hospital staff member to negotiate the cost of the surgery. The hospital staff demonstrated culture care accommodation when they reduced the cost of Daniel's procedure. The bill was still more than Eli and Ruth could handle; however, other members of the Amish community assisted with the cost. The nursing staff promoted culture care preservation when they placed Eli, Ruth, and Daniel in a quiet area of the outpatient surgery department. Instead of encouraging television, and

bringing balloons and toys to help keep Daniel calm, the staff allowed the parents to use their natural ways to care for their child, yet informed them of the options. Upon discharge, instructions were clearly written and questions were answered by the nursing staff, knowing it would be difficult to make any follow up phone calls regarding Daniel's recovery. Culturally congruent care was provided to the family, as the hospital staff had some knowledge of the Amish culture and was able to mold their care to support their health beliefs and practices.

Review of Literature

The literature review for this study is divided into three categories: (a) health beliefs and practices of the Amish culture, (b) other research about Amish culture, and (c) cultural competence. In reviewing the literature, it is evident that each culture has a variety of health beliefs and practices, as well as, a desire for healthcare providers to be respectful of their beliefs. Recognizing one's weakness in cultural competence, as well as, a desire to improve it, is essential to health care in today's society.

Amish Health Beliefs and Practices

A well written qualitative research article on the health beliefs and practices was produced by Blair and Hurst (1997). The in-depth interviews were conducted with four area health professionals and five Amish leaders. Information was also obtained from Amish documents. The goal of the study was to provide information regarding the values that influence the approach to health care issues.

The researchers learned that the Amish are mindful of the people around them, and they are cognizant of the effect their actions have on those around them. The Amish appreciate a doctor who is respectful of their culture, and in general, local doctors

are preferred. The Amish value hard work; the ability of performing hard work is part of their definition of health. Cost is an influencing factor of healthcare and may inhibit preventative care measures. Some of the more common health problems for the Amish include, occupation and sports related injuries, cystic fibrosis, whooping cough, genetic diseases, and stress responses. The Amish are reluctant to seek healthcare and often wait until the last minute for assistance. Home remedies are commonly used. Healthcare providers who understand the Amish religious and cultural practices will be more like to care for Amish patients.

The health beliefs and practices of the Amish were also researched by Armer and Radina (2006), although in this study, a combination of qualitative and quantitative measures were used. Eighty-six participants were interviewed for qualitative analysis; hermeneutic analyses were used for this portion of the study. Tools for the quantitative study include the Multidimensional Health Locus of Control (MHLC), Pender's Health Promoting Lifestyle Profile (HPLP), and the Perceived Social Support-Family (PSS-Fa) and -Friends (PSS-Fr) scale. The alpha coefficient for each of the scales was reported: MHLC was .767, HPLP was .922, PSS-Fa was .90, and PSS-Fr was .88. Suggested further research includes analysis of health definitions and health promoting behaviors among other diverse groups.

The results of the research indicated that exercise or physical activity and nutrition are the most prominent health maintaining behaviors. A strong family support system in the Amish community influence the health related decision-making. Many aspects of health-related outcomes are believed to be outside the control of doctors and nurses and more in the power of faith.

A quantitative study was conducted by Gerdner et al., (2002) via secondary analysis of data. Descriptive statistics were used to analyze the quantitative data, and standard content analysis was used for the narrative data. The sample size of 41 Old Order Amish was appropriate. The study provided important information about the health beliefs and practices of the Amish in Iowa, and would be a good resource for healthcare providers.

For example, the majority of the participants in the research credited God with the “power to heal.” Ninety-five percent of participants reported use of folk remedies. Minor injuries and respiratory problems were the most commonly treated with folk remedies. Services from physicians were primarily reserved for acute illnesses or emergent situations. Payment for services was done with cash, as the Amish do not purchase health insurance.

Finally, a case study by Weyer et al., (2003) was included in the review of literature; although, this research was not very insightful. Limitations of the study include that the case study provided very little information about the Amish lifestyle. The sample size of one case study was small. Aspects of the Amish culture and the implications about the health practices were obtained from a literature review. This literature review revealed the Amish education system includes grades one through eight. Children are often working full time either at home or in a nearby shop by the age of 14. The Amish speak a mixture of German, English, and Pennsylvania Dutch. The elderly are an important source of information for the younger generations. Birth control is not practiced in the Amish community. Folk remedies are commonly used. The Amish define illness as the inability to function in the work role. Typically seeking healthcare is

delayed, which puts the Amish patient at increased risk or mortality. Transportation and cost are influencing factors in seeking healthcare.

Other Amish Research

One practice by the Amish, which may have great impact on their health status, is the lack of tobacco and alcohol use in the Amish communities. This specific aspect of the culture was studied by Freketich et al. (2008). The goal of this research was an effort to estimate the tobacco use among the Amish in Ohio. The method of this study was unique in that it involved interviews with the participants, as well as, verification through biochemical marker. A salivary cotinine concentration was used as the biochemical marker; the sensitivity and specificity of the test was greater than 95%. The sample size was large, including 134 Amish adults, 154 non-Amish within the Amish settlement, and 4,099 non-Hispanic Whites in the United States. Limitations of this study addressed by the researcher include poor response rate among non-Amish in the Amish settlement, and only one Amish community was sampled. The conclusion of the research was "tobacco use is significantly lower among adults in the largest Amish settlement in the world compared to their non-Amish neighbors in Appalachia Ohio and U. S. whites" (Ferketich et al., 2008, p. 84). This study took place in Ohio and cannot be generalized to other Amish communities.

Other literature about the Amish includes a research paper, created through historical research about farm-related injuries by Gilliam et al. (2007). The Amish typically have an agrarian lifestyle and have longstanding presence in farming communities. According to a study by Purdue University, the Old Order Anabaptist communities have a higher-than-expected number of farming injuries (Gilliam et al., 2007). "The children start helping with chores soon after they can walk and frequently

begin driving teams of horses before the age of 10” (Gilliam et al., 2007, p. 12). The researchers came to these conclusions: falls were the most common cause of injury, exposure to animal contact was another common cause, many injuries resulted in broken bones, summer is the most hazardous time in relation to injuries, and injuries were more common among males, with peak ages at 3 and 14 years of age. Strategies to reduce the frequency and severity of farm related injuries were discussed, with an emphasis on safety education.

The methodology of the study was a data analysis from the Purdue University’s Old Order Anabaptist Injury database, with support from the Centers for Disease Control and Prevention National Institute for Occupational Safety and Health. In addition, members from the Young Center for Anabaptist and Pietist Studies at Elizabethtown College partnered with Purdue to assist in analyzing the farm-related injuries. The researchers concluded that the source of information provided accurate data. Another strength of the study was that the data came from areas throughout the United States and Canada, rather than focusing on one Amish population. The researchers addressed the need for safety education among the Amish community and developed possible solutions. This research could be a useful tool for initiating programs related to farming injury prevention.

There is also a great amount of information about the birthing practices of the Amish, such as one article by Kreps and Kreps (1997) regarding the building and use of an Amish birthing center in Ohio. This article described a method used to blend the needs for a medical establishment, meanwhile preserving the important values of simplicity and low cost for the Amish population. The building of this birthing center and

its success may lead healthcare providers to search for their own ways to blend contemporary medicine and accommodate the Amish culture.

Other literature about the health beliefs and practices in an obstetric setting are written by Lemon (2006) and Miller et al. (2007). Lemon's research was a case study about the care of an Amish newborn baby in a neonatal intensive care unit. This case study reiterates the importance of respecting a person's deeply held cultural views. Genetic recessive disorders were discussed, as this is a result of intermarriage among the Amish culture. Lemon highlights other unique practices of the Amish, stating, "therapeutic abortions, amniocentesis, and other invasive prenatal diagnostic testing are also not acceptable" (p. 56). Common herbs used near the end of pregnancy include red raspberry leaves, butcher's broom root, black cohosh root, dong quai root, and squaw vine root.

The research by Miller et al. (2007) was a very large study focusing on women's health, comparing Amish women to non-Amish. The results of the study concluded, in comparison to women of the general population, "Amish women rated their physical health approximately at the same level, but reported less stress, fewer symptoms of depression, and had higher aggregate scores for mental health." In addition, "Amish women reported higher fertility, fewer low birth weight babies, but the same number of preterm births as the general population" (p. 162).

In the search for additional information about the Amish, books were assessed for pertinent literature. The books noted are written about the Amish culture and heritage, providing insight to the lifestyle. One book cited by many researchers is *The Riddle of Amish Culture*, authored by Kraybill (1989). This book refers to a community in Pennsylvania and describes the symbols of the Amish culture that separate them from

“English,” including the plain dress, strict religious discipline, horses and buggies, and resistance to telephones and electricity. Another important difference is the education system. As Amish children attend one-room private schools staffed with Amish teachers, Amish parents control their schools, and the education is stopped after eighth grade. Health beliefs and practices were not discussed in Kraybill’s book.

Two other books were included in the review of literature. Stevick, author of *Beyond the Plain and Simple* (2006), wrote a book about the Amish life in various communities, including a potpourri of stories. *Amish in Wisconsin* (Dawley, 2003) was written as an anecdotal journal about his time spent in Amish communities in Wisconsin. Both of these books were similar to that of Kraybill (1989), but were written from personal experience, in narrative form. For a healthcare provider in search of education about the Amish community, limited research was available in books.

Cultural Competence.

An important part of being a healthcare provider is to treat people with care based on cultural knowledge. This requires an understanding of how to perform a cultural assessment and use the information gained to provide care that accommodates a patient’s cultural system. Three articles were reviewed regarding cultural competence.

The first article, “Assessing Cultural Competence at a Local Hospital System in the United States” (Polacek & Martinez, 2009) presented the findings of one healthcare system’s cultural competency assessment. The hospital researchers examined the perceptions of patients, staff, and employees, relative to its policies and practices on cultural competence, by using a 137 question survey. The results of that research determined the next steps toward maintaining a culturally competent system. The author included tables displaying the results of the research and the accuracy of

statistical tests. To analyze the data received, factor analysis was conducted to determine the most influential variables on cultural competency. The 17 variables were then condensed to five factors by using a factor loading process. The five factors were (a) language skills, (b) communications skills, (c) awareness, (d) knowledge, and (e) relationships. The research determined that “the knowledge of other cultures was markedly low for almost half of the respondents, discrimination was not evident, and the employees were culturally diverse” (Polacek & Martinez, 2009, p. 106). The results also revealed a variation in cultural competency among employees, with some room for improvement. The responses from ethnic minority groups had greater level of awareness about ethnic differences. After analysis of the data, the limitations of the study were addressed. The findings supported the need for cross-cultural education in healthcare systems.

The second article, *A Guide to Providing Culturally Appropriate Care* (Black, 2008) on cultural competence is simply a guide to providing culturally competent care. The researcher recognizes the challenge for healthcare providers of awareness and understanding of different cultures. “As the number of people with different sociocultural backgrounds grows, so does the complexity of patient needs that the nurse must address” (Black, 2008, p. 12). Specific psychological issues of the patients are mentioned, such as poor communication, misunderstanding, inability to participate in rituals and prayers, modesty, and social isolation. The importance of good communication with the use of translators is emphasized. Consent and advocacy for the patient is also highlighted. “Cultural insufficiency and lack of knowledge can cause distress to the patient from an ethnic minority and nurses need to recognize their own values and be open minded to cultural differences” (Black, 2008, p.16).

Patrick Knott wrote about impact of a person's culture on their health care. A person's culture influences how they see, think, and feel as well as how they interact with their health care provider (Knott, 2002, p.21). In addition, he addressed the expectations of the clinician to have some understanding of how to perform a proper clinical assessment and use that information as a tool for providing care which supports the culture. "Indeed, clinicians who are aware of such cultural differences as conversational style, language and eye contact, and personal space are most successful at delivering care to a culturally disparate patient population" (Knott, 2002, p.37).

Summary

In this chapter, the theoretical framework of Leininger's Cultural Care Diversity and Universality theory was discussed, as well as its use in studying the health beliefs and practices of the Amish culture. The influence of a person's culture on their healthcare decisions and the importance of appropriately tailored healthcare delivery system is the focus of this study. It is believed that a healthcare provider should be able to perform a good cultural assessment, have a basic understanding of the cultural beliefs, and formulate a culturally supportive plan of care. This knowledge and action will be the backbone of a trusting relationship between a healthcare provider and a patient.

CHAPTER III

METHODOLOGY

The purpose of this qualitative, exploratory study was to obtain an understanding of the health beliefs and practices of the Amish culture. In this chapter the research design, as well as the population, sample and setting, data collection procedures, and data analysis procedures are presented. Additionally, limitations of the study are described.

Research Design

A qualitative, exploratory approach was used for this study. Using a qualitative study design was appropriate to uncover the health beliefs and practices of people in the Amish culture. This design gave the participant the opportunity to openly discuss their beliefs and practices about their health. A quantitative tool may have limited the freedom of the participant to express their true beliefs.

Population, Sample and Setting

The target population for this study consisted of Old Order Amish adults from various church districts in Wisconsin. The sample was chosen from the directories using a purposeful sampling technique. The church directories were available to the public and provided information including names, addresses, employment, church district, and map of each person's location. Inclusion criteria for the sample included Amish adults, age 18 and above, who speak and understand English, and were willing to participate in

the study. The sample size goal was 10 participants. The consent form was mailed to 12 potential participants, of which any of the qualified responses would be accepted.

Data Collections Instruments

With the researcher as an instrument for data collection in the qualitative study, it was planned to have audio recorded interviews conducted with the participants at the location of their choice. Permission for audio recording of the interviews was not granted, and therefore, detailed field notes of the interviews were taken. The open ended question which was asked was as follows: "What are your health beliefs and practices?" Questions seeking clarification were asked as necessary in order to obtain full understanding of the response. Participants were also asked four demographic questions, including age, marital status, number of children, and sector of Amish culture.

In order to increase the validity of the study, trustworthiness of the data collected was ensured. According to the framework by Lincoln and Guba (1985), the four criteria for trustworthiness include (a) credibility, (b) dependability, (c) confirmability, (d) transferability (as cited in Polit & Beck, 2008, p. 539).

Credibility

This aspect of trustworthiness refers to the certainty that the data and interpretation were truthful. One of the assumptions of this study was that the participants would answer the questions with complete honesty. The interview took as much time as necessary, allowing the participant adequate time to express their thoughts. Each interview took approximately an hour. Thorough, accurate field notes reduced the chance of misunderstanding of the participant and ensured credibility. The

participant was offered the opportunity to review the data after it was analyzed to ensure accuracy of the themes.

Dependability and Confirmability

Dependability is the likelihood of receiving the same data if the research was repeated at a later date. This can be assured if the data generated is reliable and the emerging themes are apparent. With the assumption of honest answers from the participants, the information was reliable. Objectivity of data and the interpretation is known as confirmability of the study. The research report included verbatim quotes from the participants, which allows the reader to confirm the researcher's interpretation.

Transferability

The goal of this research study was to gain an in-depth understanding of the health beliefs and practices of the Amish community. A rural area of Wisconsin was chosen as the location for the research. As it turned out, the results show that 100% of the participants were part of the Old Order sector of the Amish group. Transferability in this study refers to the ability to generalize the information obtained from the sample of ten participants toward the larger population of Old Order Amish in Wisconsin. Because the sample of participants did not include other sectors of the Amish culture, the transferability of this study will only be applicable to the Old Order Amish.

Data Collection Procedures

Approval from the University of Wisconsin Oshkosh Institutional Review Board for the Protection of Human Participants was obtained prior to beginning the study. Potential participants were chosen from a church directory, which was available to the public. Initially, letters were sent out to 12 individual Amish people who were chosen

from an Amish directory. The letter explained the purpose of the study, the method of research, the request to audio record the interview, and the contact information of the researcher (Appendix B). The participants were given a choice of scheduling dates and times, with the intent of meeting at the most convenient time for the participant. In addition, a consent form was included, with a self-addressed stamped envelope (Appendix C).

The initial response from the potential participants was poor. It began with a phone call from a potential participant who had many questions about the intent of the research. During the 25-minute phone conversation, the participant was given an opportunity to ask questions about the research project. He requested some time to think about the conversation and stated he would make a decision regarding participation within a week. He followed through with his statement, and he called the researcher one week later. He stated he felt reassured and comfortable after speaking with the researcher, and he agreed to participate, but he requested for field notes to be taken rather than audio recording. He was informed of the free will to discontinue participation from the study at anytime. He also suggested to the researcher that a poor response from other participants may be a result of the request to audio record, as well as, a misunderstanding of the intent of the researcher.

Another participant wrote a response letter which explained a few of his concerns with participation of the study. In general, he was concerned “in issues that would drift us away from the principals that are left to us by our heritage.” He explained one of the principals of the Amish community was to “shy away from publicity,” and for this reason, he requested the information to be unpublished. He also expressed that he “would be way more comfortable with no use of audio recording.” The researcher wrote a reply

letter to this man to address his concerns. The voluntary participation, as well as, the option of taking field notes instead of audio recording, was reiterated. Upon meeting for the interview, the researcher ensured the participants felt comfortable with participation and answered any additional questions.

The telephone conversation with the first participant, along with the expressed concerns as written in the other participant's letter, gave insight to the researcher on a more appropriate way to enlist participants. The researcher drove to the homes of a few of those who initially received letters. This action allowed the researcher to introduce herself and give them an opportunity to ask questions. With these efforts, three more participants agreed to participate in the study, and two declined. Two letters were received declining participation in the study, and there was no response from the remaining potential participants. Overall, five people agreed to participate in the research. Four of these requested their spouse to be included, and the fifth participant requested the church elder to be present. In total, ten participants were included in the research.

The interviews were not audio recorded as planned, because this conflicted with the beliefs of the participants. Instead, field notes were taken. Consent to participate in the study was acquired from the participants. Those who accepted the invitation to participate were scheduled for an interview at the location of their choice. All of the participants requested to be interviewed in their home.

In order to ensure confidentiality, each participant was identified by a number. One hard copy list was made with the names of the participants correlated with their number. This list, along with the signed consent form, was kept separate from the field notes and demographic forms, thus ensuring anonymity of the participants. This

information was only available to the researcher and was stored in a locked cabinet in the researcher's home. The participant's number was be used on the demographic form, as well as, on the field notes. Per University of Wisconsin IRB, data will be destroyed 3 years after completion of the study.

Ethical considerations were made; although, the risk of physical or psychological harm to the participant was minimal, if any. All participants were informed that they were not required to participate in the study and would not have been penalized for declining participation at any point in the study.

Data Analysis Procedures

Colaizzi's phenomenological analysis approach was used to interpret the field notes from the study. The nine steps for this approach include the following:

1. Describe the phenomenon of interest.
2. Collect participants' descriptions of the phenomenon.
3. Read all participants' descriptions of the phenomenon.
4. Return the original transcripts and extract significant statements.
5. Try to spell out the meaning of each significant statement.
6. Organize the aggregate formalized meanings into clusters of themes.
7. Write and exhaustive description.
8. Return to the participants for validation of the description.
9. If new data are revealed during the validation, incorporate them into an exhaustive description.

The data were reviewed in depth to search for meaningful themes or categories. Subsequently, each interview was compared for similarities and differences between them.

Limitations

Four limitations of the study include:

1. A response bias may have occurred with subjects distorting their responses to present a favorable image.
2. The men and women interviewed in this study were not representative of all Amish, which may have limited the transferability of the study.
3. Although there is a gap in literature on the Amish culture in Wisconsin, this research study on the Old Order Amish may not have brought about new knowledge.
4. Ten participants were interviewed, but this includes four married couples. This small sample size limits the generalizability of the study.

Summary

This qualitative research study was conducted among the Old Order Amish in Wisconsin. Participants were chosen by purposeful sampling of names obtained through church district directories in the area. The sample was 10 participants who met the criteria of the study. After a consent form for participation was signed and questions or concerns from the participants were addressed, face-to-face interviews were conducted. The interviews were not audio recorded, as consent for this part of the study was not obtained, but detailed field notes were taken. Confidentiality was insured by

labeling the demographics form and interview recording with a number rather than a name. All data obtained were stored in a locked cabinet in the researcher's home.

Trustworthiness of the data was gained with honest answers from the participants, use of field notes, member checking, and review from a nurse researcher. Limitations of the study were considered.

CHAPTER IV

RESEARCH FINDINGS AND DISCUSSION

The purpose of this qualitative, exploratory study was to increase knowledge of the health beliefs and practices of the Amish. A sample of 10 Amish adults was interviewed. Detailed field notes were taken during the interview. Letters were written to each of the participants summarizing the knowledge gained from the interview with an opportunity for the participants to provide feedback or make corrections. Data were then examined for themes that described the health beliefs and practices of the participants. This chapter addresses the interview process, demographic data of the sample, results and discussion.

The Interview Process

This study was conducted with a purposeful sample of six men and four women, which included four married couples. One man chose to ask the church elder to be present, who also participated. In total, 10 Old Order Amish participated in the study. Each interview lasted 60 to 70 minutes, and field notes were taken during that time. Following the interview, the notes were reviewed and analyzed to uncover themes in the data which will be discussed later in this chapter.

Demographic Data

The sample for this study consisted of 10 men and women from a rural Wisconsin community of Old Order Amish. At the beginning of each interview, the participants were asked five demographic questions (Appendix D). Demographic data

can be seen in Table 1. All of the participants were White and were from the Old Order sector of the Amish culture. The age of the participants ranged from 27 years to 64 years, with a mean age of 43.9 years and a median age of 44.5 years. All were married with children. The number of children ranged from four to nine. Participants were asked about their health beliefs and practices.

Table 1

Participant Demographic Data

(n=10)	Range	Mean	Median
Age	27 - 64	43.9	44.9
Number of children	4 - 9	6.5	6.5

Results

Following a thorough analysis of the data, six major themes emerged:

1. Folk remedies first
2. Living a health lifestyle
3. Cost of healthcare
4. Comfort from chiropractors
5. Gift from God
6. Doctors are a last resort

These themes were identified as the major factors regarding the health beliefs and practices of the Amish. Transcripts were reviewed numerous times by the researcher to evaluate the true meanings of the data. The main themes which emerged were the result of recurring data found in the majority of the interview data. The themes

were then considered in the context of the Leininger's Sunrise Model to see how the health beliefs and practices in this specific environmental context interact with the cultural and social structure dimensions. The data discussed here reflects the beliefs and practices of the Amish men and women who participated.

Folk Remedies First

This theme reflects the common practice of treating illness with non-traditional remedies. All 10 participants mentioned the use of herbal remedies as a mode of treatment or prevention of illnesses.

The types of remedies varied between the families in the research. Participant nine said, "My grandmother would collect different parts of plants or roots. She used wild alum root." He continued to say, "I know of a family who used red beets. Heat them up somewhat, then put them around the neck for a sore throat. They used it quite often."

The second participant said, "We use red pepper for the blood stream." Then she handed the researcher a bottle labeled "trigosamine" and said, "We use this stuff for prevention...trigosamine or cod liver oil is good for joint pain." Cod liver oil was mentioned by more than one participant. One participant described it as an "immune system builder... just something healthy. It was practiced by my grandmother." Similarly, cod liver oil was practiced in another family to "build up reserves in winter."

Use of cod liver oil was common, as well as, other oils to treat illnesses. Participant five said, "Essential oils, like peppermint, is for a stomach ache." Peppermint was also used for "tightness in the chest" according to another participant. Tea tree oil was indicated as another essential oil; this one was used in a vaporizer.

A different type of treatment was brought up when participant nine stated, "You can put sulfur on the stove and the fumes would go through the house, as a disinfectant."

My mother did that almost every winter.” Each of the families in the research provided various practices in their family, some of which were more common than others.

According to these participants, in general, the Amish would prefer to use herbal remedies over the use of medications. The second participant said, “So, if we can, we help it with herbal fixes then prescription medicines. You can drug yourself with herbs just as you could with prescriptions.” Participant seven said matter of factly, “My husband hates pill bottles.”

Another woman stated:

We feel drugs are not good for the body. Sometimes we have to use it. I had Lyme's and needed treatment. Then we have to use the herbs to get our system built up again. My mom has been on blood pressure medicine for many years.

The researcher asked one participant, “Where do you learn about these remedies?” The response was, “We have some books, like this one,” and she presented a book entitled, *Prescription for Nutritional Healing. A-Z Reference*. She also mentioned books which are “written by our people.” She said, “What works for one may not work for others. You learn from experience.” One man said, “A lot of home remedies are used, passed on from generation to generation, for different ailments or wounds.”

The participants seemed to agree, overall, that various herbs and natural resources are used for both preventative measures, as well as, treatments for illnesses. In addition, there are times when medications are necessary, but they will try their own remedies first.

Living a Healthy Lifestyle

Another common theme related to health practices was simply to live a healthy lifestyle. Habits, such as eating a healthy diet and taking vitamins, were mentioned by the participants and grouped into the theme of a healthy lifestyle. The ninth participant stated:

We are taught basic health in school. Cleanliness, regularity, routine, balanced diet. Those basics would go a long, long way. If we can stick with it, it would take care of many illnesses. It is based back on the bible again to feed ourselves with proper food. We would be taught to raise our own foods rather than purchasing.

The researcher asked another participant, "What do you do to stay healthy?" His response was, "Aches and pains are something we expect now in our age. We eat a healthy diet and avoid taking risks." He used cigarette smoking as an example of risk-taking behavior and stated it is not allowed in the community.

The first participant said the following in regards to health practices:

We have a practice of fruits and vegetables, eating healthy. We pay a lot of attention, so the children understand their body. We keep a crock of prunes in the kitchen. We pour boiling water over the prunes to use for constipation.

Another common routine was to take vitamins or supplements to help the immune system. A participant affirmed, "We have been taking a daily supplement for 5 or 6 years. The nutrient supplement is to keep healthy. This is more important in the winter, because we don't get fresh fruits and vegetables." Similarly, another participant stated, "We try to take vitamins in winter. If the children have a cold, we like Echinacea."

In addition to a healthy diet and vitamins, participant three suggested that activity and exercise are important practices for good health. He stated his family completes “the usual farm chores,” such as cleaning out the barn, carrying bales of hay, or splitting wood, on a regular basis. He also mentioned the importance of relaxing hobbies, such as fishing. His wife added that she enjoys quilting, sewing, working on puzzles, or feeding the birds. Activities to exercise the body and the mind are thought of as part of good health.

In summary, living a healthy lifestyle was considered an important practice by all the participants who were interviewed. Healthy food choices and the use of vitamins were the most common habits mentioned.

Cost of Healthcare

The majority of the participants volunteered that the cost of healthcare is a factor that influences their health practices. Many of the research articles about the Amish healthcare discussed the fact that the Amish do not have health insurance. This research supported the findings in those articles, as many participants eluded to cost as an impacting factor in the healthcare decisions.

The first participant brought up the issue of payment in the beginning of the interview. He said, “We are not insured outside our group. If there is a medical bill more than I can handle, the group will help pay for it.” He continued to talk about the process of addressing hospital bills and explained that one particular member of the group will often meet with a person from the hospital regarding payment. The discussion between the Amish member and the responsible hospital personnel will result in a lowering of the bill, because the hospital takes into consideration that the Amish patient will be paying in cash and does not have insurance. The participant said, “We try to pay what an

insurance group would pay.” He described the difficulty of paying hospital bills by stating, “It’s like a dragon coming after us with hospital bills. It becomes quite a burden real quick.”

This burden of cost was strongly expressed by the third participant. She said the following:

We have heard some people say ‘We know they pay.’ That’s part of the reason we avoid. They know they will get it so they sock on a little more. One person in the community works at getting a good price. They say they can give a big percent of discount but it seems they just charge more so it’s not much cheaper. We have had bills in the mail that we don’t understand. When we question it sometimes the bill is cut in half. It’s hard for us. Is it actually that much? Be fair and be honest and we will pay.

Although cost is clearly an influencing factor, participants seemed to agree in general that they will go to the hospital in emergencies. “Somehow, some way, that bill will be paid. Sometimes it gets sent out statewide,” one participant said. If it is not an emergency, the location of treatment may be determined by cost. One participant described a time when her son needed a hernia repair. She explained that the family went to Toledo, Ohio because the expenses were about half in comparison to local hospitals. She also added they needed to pay for the surgery ahead of time.

Surgical procedures were discussed during the conversation about the cost of healthcare. In the second interview, one participant said, “I’ve had two hernia surgeries, two cesarean sections, and one carpal tunnel. If at all possible, we avoid it. Partly because of cost.” Her husband added, “I could get some teeth, but I can eat so I am not suffering.” The first participant also discussed surgery and stated, “Knee replacements

and hip replacements are not uncommon. You have some time to think about it and negotiate.”

Paying for expenses not only is displayed with paper bills, but also by the impact on the family. The fourth participant said the following:

They always try to keep them there [at the hospital] longer. We have to pay our own bills. We try ever so hard to do what the doctor says. You have to be very persistent about bringing them home sooner. Sometimes it's the father of the family and then they can't work.

The cost of healthcare was mentioned by eight of the ten participants as an impacting factor to healthcare. In general, the participants agreed that the location of the treatment and the types of treatments were dependent on cost.

Comfort from Chiropractors

Chiropractors are commonly known to be trained to diagnose and treat patients with problems of the musculoskeletal system and the symptoms related to those problems. From the results of this research, it was apparent that chiropractors were used in this manner, but also for general health problems. The practice of seeking treatment or advice from a chiropractor was a common theme among the participants' responses.

When asked the initial question regarding health beliefs and practices, the fifth participant mentioned the benefits of a chiropractor almost immediately. She said, “We have a couple of our people who do the work, but they do not have a license, so they do not charge.” This quote elicited three points: first, the participant used the words, “our people,” which implied a separation between the Amish and “English,” and possibly, an increased comfort with treatment from an Amish person. Second, she mentioned the

lack of licensure, which was acceptable to her. The training or education of the chiropractor was unclear, but this may not have any implication for the Amish people, as they themselves typically have an education at the eighth grade level, according to research. Third, here again, the impact of cost was brought into play.

She talked at great length about one of her children who battled repeated ear infections. She said, "The chiropractor really helped because the top of the vertebrae was out of place. When it is misaligned, it makes pressure on the ears." She described the ability of the chiropractor by stating, "The chiropractor can feel with their hands whether it is a problem with the ears, stomach, or head. The more they do it, the better they are. After many years they understand the body ... especially with experience from butchering." Eventually, despite home remedies, chiropractor treatments, and antibiotics, her son was treated with ventilation tube placement.

The fourth participant said, "I get chiropractor treatments, one treatment every other month to help me sleep...for tight shoulders. It keeps my knees and other things in better shape. I'd rather go to a chiropractor than a doctor." During a different interview, participant nine said, "My son was growing quickly. He was not feeling well...I thought maybe growing pains. We gave him minerals and we went to the chiropractor. He was not able to sleep well. Well children do sleep and rest." In response, the researcher asked, "When do you turn to the chiropractor?" The participant's response was, "We may just see them for an opinion".

Although each family depended on the chiropractor for various concerns, it was apparent that work and knowledge of the chiropractors were appreciated. Whether seeking advice or treatment for illnesses, the chiropractor has been a great resource for this Amish community.

Gift from God

The Amish are known for their Anabaptist religious beliefs, and this was confirmed through this research. A few of the participants discussed religion as an influencing factor of their health beliefs and practices.

In the first interview, the topic of religion was briefly mentioned. He stated, "Religion is a part of our beliefs ... like my dad does not want any major life support. I personally go the same way. If it's my time to go, just let me go." This led to questions from the participant about power of attorney papers and end of life care. He proceeded to a file cabinet to pull out his paperwork and requested clarification. After the researcher answered his questions, he admitted he did not have a good understanding of the form at the time he signed it, and he was very grateful for the explanation. This clueed the researcher about some lack of knowledge about important healthcare related issues. Although this was not the intent of the researcher, it provided insight on ways to improve healthcare practices not only for the Amish, but for any patient encountered.

Lack of knowledge also tied into religious beliefs in another interview. The participant said, "Some people do take shots...a small percentage. We haven't educated ourselves on shots. There is a little bit of our faith involved in that. It is a manmade intervention rather than letting the Lord care for us." Like another participant, he also discussed life support. "Life support is a common question. In general, it would not be chosen. If we follow the Lord's teachings, he will protect us from plagues and diseases." This participant continued the discussion of religion and stated, "Faith is a very important element in health. Mental health influences physical health. Mental health comes from faith. If we believe in our faith, then we help ourselves. Counseling would come from faith. The bible would be what we need." In regards to mental health,

the researcher asked, “Is the bible enough?” The participant’s response was clear, “Yes, the bible is enough.”

This religious influence is imperative to keep in mind when caring for Amish patients, as it clearly influences the health beliefs and practices. One participant summed it up by stating, “Good health is a gift from God.”

Doctors as a Last Resort

With the use of home remedies, the impact of cost, and the healing powers of the Lord, the Amish typically see a physician as a last resort for their healthcare needs. This was mentioned in four of the five interview sessions.

Routine visits to a healthcare provider for preventative health was not practiced among these Amish participants. One participant said, “We don’t come in for regular visits. We will come in when symptoms last too long, so we may have a different doctor each time.” Her husband later confirmed this by adding, “We don’t make regular visits to the doctor. We stick to dental pretty good. A toothache would not be ignored.” After discussing the cost factor, he added, “We use home remedies...maybe too much.” This statement was supported by another participant’s comments. She laughed as she said, “I’ve been told we wait until we are half dead before going.”

Waiting too long to see a doctor was mentioned by during another interview. The participant said the following:

There are times we wait too long. My brothers were throwing down silage. It accidentally poked into his knee. The doctor told him if he would not have come to the hospital, he would have died. The infection was in his system. Forty or fifty years ago he would have died.

Another participant also had a story to describe their healthcare practices, which illustrated the practice of avoiding doctors. He used the following example:

When my son was 2 years old, he poured boiling water down his back from the stove. Putting him in the hospital would make him scared. A neighbor gave some us advice and we treated him at home. It left scars on his back, but it doesn't bother him today. We didn't go to the hospital because of the trauma he would go through. He would be more relaxed at home.

That story described the concern for the emotional impact of a hospital treatment. Participant seven had a different concern. She said, "There's a time when you definitely need a doctor, but it's just the idea that we don't need a quack doctor. Some doctors don't know what they are talking about."

It was clear that these participants had various reasons for choosing other means of treating illness or injury rather than going to a doctor or hospital for assistance. The stories provided by the participants gave insight to the thought processes of the participants.

Discussion

After the analysis of the interviews, the researcher found six themes. The results of this study compare to the field work observation performed by Blair and Hurst (1997). Both studies revealed the concern for cost, the lack of preventative care, the tendency to "wait too long," and the use of folk remedies. Similar to this study was a secondary analysis performed by Gerdner et al. (2002). This study had a slightly different method, but the results were equivalent on the topics of prayer, folk remedies, and the use of health care providers.

Armer and Radina (2006) had similar results regarding the importance of physical activity and nutrition. The study differed in the discovery of “the ability to work hard,” “family responsibility,” and “sense of freedom to enjoy life” as definitions of health. These themes did not appear in the current research.

The focus of this research revealed some of the cultural and social structure dimensions which influence the healthcare beliefs and practices for the Amish culture. These results correlate with Leininger’s Culture Care Diversity and Universality Theory. Each of Leininger’s seven dimensions in the Sunrise Model is tied into the responses from the participants.

Leininger states these dimensions “may be interrelated and function to influence human behavior” (Reynolds & Leininger, 1993, p. 21). This statement is clearly supported with the analysis of each of the themes. For example, the common use of folk remedies could be considered a cultural lifeway, an educational factor, and also part of the kinship factors. The next theme of living a healthy lifestyle could fall into these same dimensions. The third theme, cost of healthcare, is an economic factor, as well as, a political factor. The philosophical and technological dimensions are apparent with the comfort of chiropractors. The religious influences are obviously part of the religious dimension but also fit into the cultural lifeways. Finally, visiting the doctor only as a last resort would be part of any of the seven dimensions. Being aware of the dimensions of the culture is important, because it can enlighten the healthcare provider to the core of the beliefs and practices.

Once this foundation is appreciated, the healthcare provider will have a grasp on the generic care practices of the culture. The next step is to link the generic care to the professional nursing care in order to develop creative and appropriate nursing care

practices. Connecting these two aspects leads to the ultimate goal of providing culturally congruent care.

Summary

In this chapter, the results of the study were presented. The results revealed six prominent themes regarding the health beliefs and practices of the Amish. These themes are similar to those found in previous studies about the health beliefs and practices of the Amish culture. The qualitative method facilitated a flow of information, including feelings, conflicts, and successes in regards to their health. This information gave insight to the strong influences of culture in regards to health decisions. The results of this study support Leininger's Theory of Culture Care Diversity and Universality. Chapter V follows with the summary, conclusions, and recommendations of the study.

CHAPTER V

SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

The purpose of this study was to explore the health beliefs and practices of the Amish in Wisconsin and increase cultural competence among healthcare workers. The summary, conclusions, and implications for practice and research are presented. Recommendations for future research are also discussed.

Summary

The population of Amish is growing rapidly, and Wisconsin is fourth among the states with the highest population of Amish. Being cognizant of their health beliefs and practices is important, because the culture is unique and the likelihood of providing care for an Amish patient is to be anticipated. With knowledge of the dimensions of the culture, a healthcare provider can create ways to care for the patient which connect the generic care with the professional nursing care.

This study included 10 participants, all of whom were Old Order Amish from a rural area of Wisconsin. The sample consisted of six males and four females between the ages of 27 years of age to 64 years of age. The mean age of the participants was 43.9 years. Each participant completed a demographic data form, followed by an open-ended discussion. The research question for this study was: What are the health beliefs and practices of the Amish? Each interview lasted approximately an hour. Detailed notes were taken during the interview. Results were analyzed, and six themes were identified as the health beliefs and practices of the participants in the study: (a) Folk

Remedies First, (b) Living a Healthy Lifestyle, (c) Cost of Healthcare, (d) Comfort from Chiropractors, (e) Gift from God, and (f) Doctors as a Last Resort.

The first theme, Folk Remedies First, was based on the descriptions of home treatments used. The Amish believed in many generic care practices used to prevent and treat illnesses before seeking assistance from a medical professional. The second theme, Living a Healthy Lifestyle, was identified because many of the participants discussed the importance of following a healthy diet and remaining physically active on a daily basis. The Cost of Healthcare was the third theme. This theme was very apparent and had a strong influence on the practices of their health. Without health insurance, the Amish face large hospital bills that can be difficult to manage. The next theme, Comfort from Chiropractors, is supported by the frequent visits to a local chiropractor in request of advice or treatment for a variety of ailments. The Anabaptist beliefs of the Amish led to the next theme, A Gift from God. Finally, the Amish participants expressed their desire to try generic care practices, and seek help from friends or a chiropractor before visiting a doctor, hence the theme, Doctors as a Last Resort.

Conclusions

1. The Amish have a long heritage of which they maintain with a simple lifestyle.
2. In general, the Amish try to make good choices in life, including a healthy diet, physical activity, and avoidance of poor behaviors.
3. The kinship of the community is very important for friendship, advice, and financial stability.
4. Religion has a strong influence on the health beliefs and practices of the Amish.

5. Among the Amish, there is a sense of misunderstanding and lack of communication between the Amish and the hospitals.

Implications for Nursing Practice

As a result of this study, the importance of cultural competence is reinforced. As a healthcare provider it is advantageous to know of the various cultures in the surrounding areas of where one provides care. In one rural area of Wisconsin, the Amish incorporate a large population. Although various sectors of Amish exist, the Old Order Amish is the largest group. The health beliefs and practices of the Amish are unique to those of the English. With the power of cultural competence, the provider is benefited in three ways: the knowledge provides clues to the diagnosis, the patient appreciates the culturally supportive care, and a trusting relationship is established between the provider and the patient.

Knowledge of the Amish culture will assist the provider in diagnosing the presenting issue. From the interviews, it is learned the Amish often try home remedies before presenting to a healthcare provider. These remedies may change the appearance of the concerning issue. In addition, the differential diagnoses may be atypical due to the unique practices. For example, the Amish often do not receive immunizations, and therefore, diseases which are uncommon to the English, may be more common to the Amish. Additional information about the diagnosis may come from asking other questions in the initial review of systems that are pertinent to the Amish practices.

The patient will appreciate the provider's cultural knowledge, especially if the provider has the opportunity to treat the presenting issue with culturally supportive care.

The patient may prefer treatments that are considered “alternative” or “natural” rather than prescriptions. The responses from the research also emphasized the importance of cost considerations. The patient would appreciate treatment that is less expensive, as they do not have health insurance. The follow up care would also be affected by cultural aspects, as transportation by horse and buggy does have some limitations. Keeping these issues in mind when developing the plan of care will assist in building a trusting relationship.

A positive experience from a health professional, including culturally congruent care, may provide opportunities to educate the Amish on health related topics. Information about health prevention strategies, safety concerns, or potential dangers of herbal products may promote the health of the Amish, yet still being supportive of their generic practices.

Culturally congruent care is the central theme of Leininger’s Culture Care and Universality Theory. Leininger (as cited in Leininger, 1988) was quoted to say “care and culture were inextricably linked together” (p. 3). This research has supported her claim. Each of the seven cultural and social structure dimensions in the Sunrise Model, which depicts Leininger’s theory, is mentioned in the responses of the participants. Being able to provide nursing care which blends the generic cares and the professional nursing care is the key to culturally congruent nursing care.

Implications for Research

1. A replication study of Old Order Amish in Wisconsin with a larger sample size would provide a better understanding of the health beliefs and practices. The

larger the sample size, the greater the credibility and generalizability to target populations (Polit & Beck, 2008).

2. Studies comparing the various sectors of the Amish may help distinguish differences and add to the knowledge of the Amish culture.
3. Studies focusing on other cultures in Wisconsin would assist healthcare providers in delivering culturally congruent care.

Recommendations

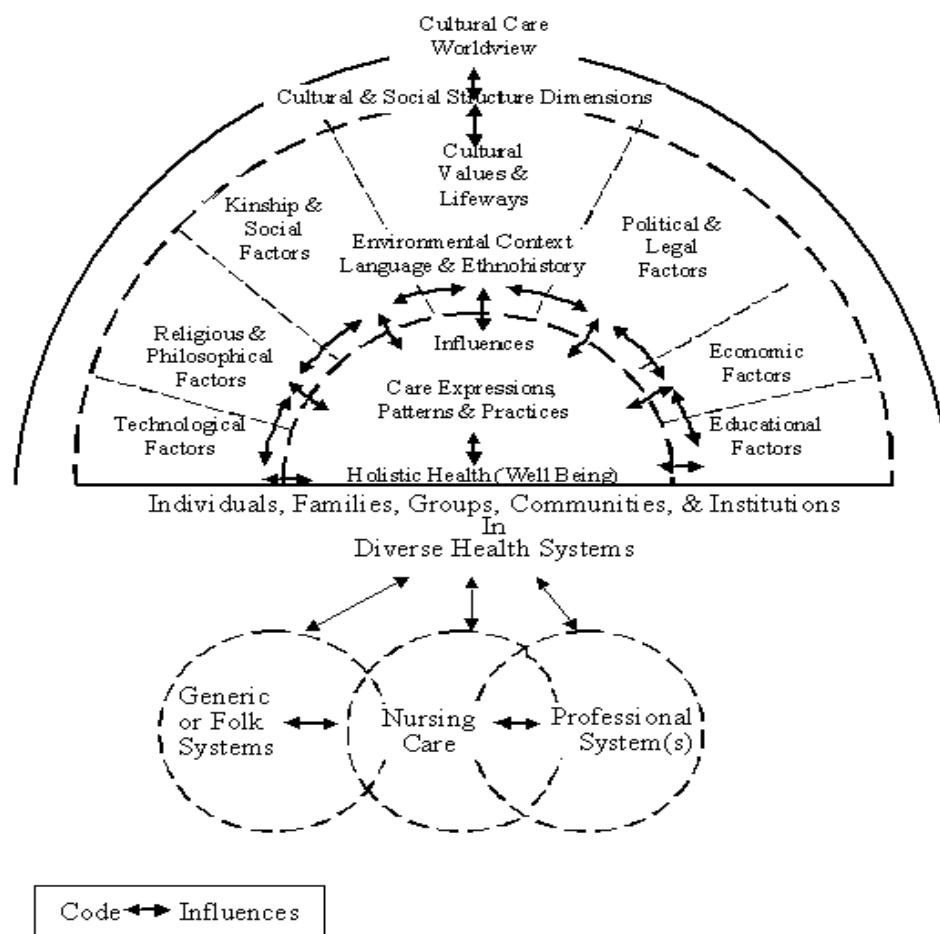
1. Develop programs within health systems which provide education and resources on the topic of culturally congruent care.
2. Encourage healthcare providers to apply their knowledge when creating a plan of care for a patient.

Summary

In this chapter a summary of the study and its findings were presented. The results of the qualitative study reveal six key themes in regards to the health beliefs and practices of the Amish. The results supported Leininger's Culture Care and Universality Theory.

Conclusions were drawn based on these results. Implications for future practice based on these results were also presented. Practitioners need to be aware of the cultural impact of the health beliefs and practices of their patients. Care for the patients should be supportive of the culture in order to increase patient compliance and build a trusting relationship. In addition, recommendations for future research were offered, including the need for additional research with a larger sample.

APPENDIX A
The Sunrise Model



APPENDIX B
Letter to Participants

Hello, my name is Amy Schroeder; I am a registered nurse and a student in the Master of Science in nursing program at the University of Wisconsin Oshkosh. Under the guidance of Professor Leona Dempsey of the Department of Nursing, I am conducting a study about the health beliefs and practices of Amish adults. I would appreciate your participation in this study, because it will assist healthcare providers in making recommendations for improving the education of health professionals as well as improving health care for Amish people.

As part of this study, I am asking that you participate in an interview, which can take place at the location of your choice. I will be asking you to share with me your beliefs and practices related to your health. I ask for your permission to audio record our session. The audio recordings will be transcribed, and I will analyze the information for themes and attempt to describe the general beliefs and practices of Amish in a rural area of Wisconsin regarding health. The total amount of time required for your participation will be about an hour. All of the personal, identifying information I collect will not be used in any way that could identify you with this study. Therefore, the data collected from you and other participants will remain confidential. This consent document does have your name on it, but it will be kept separate from all other information.

Although I could study this question by passing out surveys or interviewing medical providers, I feel that speaking with you in person is the best way to obtain accurate information about your beliefs and practices.

I do not anticipate that the study will present any medical or social risk to you, other than the inconvenience of you taking your time to speak with me. In the case of a need for a healthcare provider, a name of a local physician will be provided to you.

If you choose to withdraw from the study at any time, you may do so without penalty. The information collected from you up to that point would be destroyed if you so desire.

Once the study is completed, I would more than happy to share the results with you. In the meantime, if you have any questions, please contact me at:

Amy Schroeder
N8786 County Road F
Berlin, WI 54923
(920) 369-6936

If you have any complaints about your treatment as a participant in this study, please call or write:

Chair, Institutional Review Board
For Protection of Human Participants
C/O Grants office- UW Oshkosh
800 Algoma Boulevard
Oshkosh, WI 54901
(920) 424-1415

Although the chairperson may ask for your name, all complaints are kept in confidence.

APPENDIX C
Informed Consent Document

University of Wisconsin Oshkosh

Informed Consent Document

I have received an explanation of the study regarding health beliefs and practices, and I agree to participate. I understand that my participation in the study is strictly voluntary.

NAME

DATE

I agree to audio taping of the interview in which I participate.

NAME

DATE

APPENDIX D
Demographic Questionnaire

Demographic Questionnaire

Are you Amish?

Yes _____

Of what sector of the Amish religion do you belong? _____

No _____

Age: _____

Gender:

Male _____

Female _____

Marital status:

Married _____

Widowed _____

Single _____

Separated _____

Divorced _____

Do you have children?

Yes _____

Number of children _____

No _____

APPENDIX E
Research Question

What are the health beliefs and practice of the Amish Community?

Any further questions will be based on the participant's answers.

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