A CRITICAL ETHNOGRAPHY OF THE EXPERIENCE OF MENOPAUSE FOR KOREAN WOMEN LIVING IN CANADA

by

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ABSTRACT

The experience of menopause is universally experienced by women during their fourth, fifth, or sixth decade of life. Menopause is not only an experience which is influenced by personal factors, but occurs within a political, social, and cultural context which also influences the way women experience this phase of life. The purpose of this qualitative study was to examine the meaning of menopause for a group of Korean women in Canadian society. Critical ethnography was the theoretical and methodological perspective used to explore the meanings of menopause for the women. Data were collected using a semi-structured interview schedule with Korean women who have experienced or are experiencing menopause.

A purposive sample of seven Korean women, ages 39-52 years, from a mid-sized Southwestern Ontario city participated in this study. The interviews were dialogic in nature and enabled the women to critically review their experiences with menopause. Data analysis was conducted using “negotiated thematic content analysis” whereby meaning is constructed and validated in collaboration with the research participants.

The women identified the theme of control as encompassing the menopause experience. Menopause offered a turning point, the women took control of their lives. Although the women experienced negative symptoms, the women viewed menopause as a natural process. The women used facets of both Chinese and Western medicine to manage menopause. Living between two systems posed difficulties for some of the women.

Critical ethnography is a relatively new approach for nursing research. The knowledge developed from this study will improve the ways nurses care for Korean and
other immigrant women during menopause, and further develop understanding of health and illness for other immigrant women.
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DEDICATION

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CHAPTER I
INTRODUCTION

Many definitions have been put forward to describe the experience of menopause. Menopause has been defined as both a process and an event. The event of menopause has been described as the last menses (Kaufert, 1990; & Zita, 1993) with emphasis on the physical aspects of the experience. As a process (Sheehy. 1992), menopause is defined over a period of time, affected by physical, emotional, cultural, social, environmental, and political factors. Although all women experience final menstruation usually in the fourth, fifth, or sixth decade, this event is not experienced by every woman in the same way. One of the reasons why women experience menopause differently is the way women are perceived by the cultural milieu.

The purpose of this study was to understand the experience of menopause for Korean women living in Canada. The theoretical and methodological approaches used in this study are informed by critical theory and ethnography. Through the use of critical ethnography, the study focussed on the effects of culture on the Korean women’s experience of menopause. The research was guided by three questions: (a) How is menopause experienced by Korean women living in Canada? (b) How are the Korean women’s experiences influenced by cultural values and beliefs? and (c) How are the women’s values and beliefs congruent or incongruent in the context of the Canadian health care system?

The knowledge of menopause is culturally conditioned for it is from the culture that a woman learns beginning in early childhood, consciously or unconsciously, how to
respond to menopause (Flint & Samil, 1990). Framing the study within the critical paradigm (Guba & Lincoln, 1991), I sought to understand the ideology of the dominant discourse about menopause and the effects of culture on the women’s experiences with menopause. Finally, in collaboration with the women who participated in this study, the prevailing values of menopause in Korean and Canadian culture were challenged, questioned, and critiqued. Although there was an emphasis on cultural factors affecting a woman’s experiences, other influences were explored as the women told their stories.

Understanding the women’s views about menopause cannot be understood without exploring their definitions of health and illness. This study is important to nursing in order for nurses to better understand menopause and the perceptions of health and illness for a group of immigrant women. Canada is becoming more multi-cultural. Nurses have an obligation to provide appropriate health care and improve the quality of life to people of many cultures. There must be an understanding of culture and the influences of the culture on individuals’ lives. Attempts need to be made to “even the score” so the values of culture, both Korean and Canadian, do not control and oppress individuals from within and without the culture.

**Paradigmatic Influences on Menopause**

The process of menopause is viewed very differently depending on prevailing societal views and there are several lenses through which to view menopause. Dickson (1993) discussed menopause from the biomedical, sociocultural, and feminist perspectives. Understanding these viewpoints is critical to understanding the views held by society about the experience of menopause. The perspectives as described by Dickson will be
briefly discussed.

According to the tenets of the biomedical perspective, menopause is described as an estrogen deficiency disease. This emphasis on deficiency implies that there is a deviation from true femininity (Zita, 1993). In order for the woman to eliminate the deficiency, there must be replenishing or restoring of the deficiency through hormone replacement therapy. The biomedical perspective seeks to find out the causes of menopause. The body is viewed as an organic entity and any dysfunction of the body requires medical intervention. From this perspective, menopause is viewed as an illness or a negative consequence of aging.

From the sociocultural perspective, menopause is viewed as a natural process which is socially constructed. This viewpoint categorizes women through their responses to society and their environment. A woman learns from early childhood how to respond to menopause from the culture (Flint & Samil, 1990). She is exposed to how other women in society deal with menopause. The expectations of the culture affect the woman's experience. For example, if there is little discussion on menopause between women, a woman will learn that menopause is a private affair to be kept to oneself.

Within the feminist viewpoint, menopause is defined as the natural process of aging that encompasses social, gender and class dimensions (Dickson, 1993). Feminist theory has many qualities (Seibold, Richards, & Simon, 1994): (a) There is an emphasis on gender and women's issues; (b) There is an attempt to balance the power between the researcher and the participants; and (c) There is a critical approach to understanding the experiences of the women. In the past, feminist theory has not demonstrated a track
record of representing women from different cultural groups (Meleis & Rogers, 1987). In this study, components of feminist theory will be used to understand Korean women’s experiences of menopause.

Menopause is an experience encompassing many world views, selecting one paradigm can have negative consequences on the information attended to by the researcher as the women tell their stories. Components of the sociocultural and feminist paradigms will be used in this study. From the sociocultural paradigm, the approach that women learn how to respond to the experiences of menopause from the culture will be emphasized. From the feminist paradigm, empowerment of the women and building from the women’s stories will be aspects of feminist research used in this study.

The biomedical, sociocultural, and feminist paradigms have gained status in the study of menopause. The prevailing paradigms encompassing menopause have gained status because they have been more successful than others in solving problems that a group of experts in menopause have come to recognize as important. However, the success of any paradigm comes with a price. By adhering to one paradigm, there is an insulation from other paradigms (Kuhn, 1970). Questions and problems that do not fit the paradigm may not be seen at all (Kuhn). In order to attain open and reflective discourse, the critical paradigm will be used to focus on all aspects of the women’s stories of menopause and to question the hidden values and ideology of the cultures.

The critical paradigm will be the dominant paradigm used in this study with aspects of the sociocultural and feminist paradigms. The aim of research within the critical paradigm is an attempt to expose hidden power imbalances and to empower those
involved to understand those imbalances and to make changes to the status quo (Ford-Gilboe, Campbell, & Berman, 1995). In this study, the Korean women will be encouraged to examine their everyday lives and their experiences of menopause. Hopefully, through examining their lives, the women and I will uncover the imbalances of culture and the effect of the biomedical perspective of menopause on their experiences. As well, it is hoped that the women who participate will be empowered to take action to alter the effects of culture and the approach to menopause on their experiences. Critical nursing science is appropriate for this study because it provides a framework to ask how social, political, economic, gender, and cultural factors interact to influence health or illness experiences (Ford-Gilboe, et al.).

The Korean Context

Korean women living in Canada are able to offer a unique perspective about menopause. The women are first-generation immigrants who have lived in Canada for several years. They have been strongly influenced by Korean culture, but they have also been greatly influenced by Canadian culture. Their experiences of menopause are, thus, impacted by a combination of two cultures. Their worldview will be based on a unique reality developed through the work and energy expended in making sense of two cultural patterns (Meleis, 1991). Their stories will reflect their experiences of being women and immigrants and the influences of change on their lives.

Historical and Political Overview

Korea is rich in culture and tradition and has a history of over 4000 years (Oliver, 1993). A brief history of the country will be outlined in order for the reader to understand
the influence of history on the experience of these women.

Confucianism took a very strong hold on the culture in Korea, more so than in any other East Asian country. Confucianism had predominant political, cultural, and social influence. In the late 19th century, Korea started to open its doors to the West (Oliver, 1993). The first influences from the West came from religious missionaries. Koreans were introduced to Christianity which remains a dominant religion today in Korea.

Korea was occupied by Japan from 1910-1945. With the defeat of Japan in World War II, Japan quickly surrendered Korea (Oliver, 1993). This period in Korea's history began the division of the country. The Korean War between North and South Korea was fought because of the differences in ideology between the West and the communist regime. The Korean War was fought from 1950-1953. The two Koreas remained split. North Korea with half of the territory and one-third of the Korean population remains under a communist dictatorship that appears to be unaffected by the collapse of the communist empire in Europe. In South Korea after the war, a neo-democracy was faced with the problem of trying to build a modern society with few resources and little experience with societal freedoms.

After the Korean War, South Korea emerged as an industrial giant (Oliver, 1993). Major industrial growth began under the regime of Park Chung Hee. There was growth of the middle classes and increased educational opportunities for men and women. During the 1970s and 1980s, Korea had the most rapid economic development among all developing countries.

The 1980s were characterized by political turmoil in South Korea (Oliver, 1993).
There were demands for democratization, unification with North Korea, and human rights reforms. These demands led to strikes, protests and demonstrations. In 1987, there was a change in the government and a new constitution with more open elections occurred in 1988 and 1993.

The Role of Women in Korean Society

Korea is a patrilineal society. It has been a patriarchal society for generations. Confucianism has had major influences on the role of women in society. There was a hierarchal social structure consisting of a royal monarchy, strong class consciousness, and a patriarchal, large family system which valued maintaining the family line (Gelb & Palley, 1994). According to Confucianism, the woman’s role is to obey, she is to obey her father when she is young, obey her husband when she is married, and obey her son in old age. The father and after his death, the first born male, served as the legal family head and exercised authority and control over joint property and family members. The central role for women in Confucian society was motherhood with the expectation that they would give birth to male children. Before the 20th century, the ideal woman was passive, quiet and chaste; expected to be the obedient daughter-in-law, devoted wife and dedicated mother. This expectation continues to be influential today. There is an emphasis on individual conformity to group norms with little tolerance of any form of deviation. Individuals must conform to family, the hierarchy and the distinct roles and duties of women (Gelb & Palley).

In the late 19th century, when Korea opened its doors to the West, female missionaries had an influence on the women’s position (Gelb & Palley, 1994). In 1886, the
first women’s schools were opened.

During the 1960s, the increase in industrialization marked the start of women working at factory jobs (Gelb & Palley, 1994). They had more access to education, more contact with activists, more media coverage, and with more international travel, exposure to other cultures. Farm and lower-class women had already been working for many years. Women in farm communities worked in rice paddies and vegetable gardens along with their traditional household chores.

Following industrialization, there has been a decrease in the number of children and a movement away from the multi-generational family (Gelb & Palley, 1994). There is still a large gender-based wage gap and few women hold high-status professional, managerial or government positions. A rapid expansion of women’s groups and women’s research centres began in the mid-1980s. In 1988, the Equal Employment Opportunity Act became law, but did not include an enforcement code. In 1991, there were major changes in the Family Law of Korea. Some of the purposes of this law were to maintain a system of patrilineal family headship and to define relationships for a woman’s family differently than for a man’s. The law was changed so that a greater portion of family inheritance was not given to the elder son over other children and the widow. As of 1994, there were 40 women’s organizations that ranged from very conservative to more radical. An area of concern for a number of these organizations is violence against women.

The Role of Immigration

Immigrant women are profoundly affected by the process of relocating to a new country where they must learn a new set of cultural lifestyles. The experience and
transition of immigration takes several years and affects all aspects of life (Meleis, Lipson, & Paul, 1992). Their perceptions and approach to the health care system are keenly influenced by this process.

In this study, the women tell their stories about menopause. Through telling their stories, the women were given an opportunity to express their views and perspectives. Ideally, by telling their stories, the women will further understand their own experiences and may become empowered to make changes to their lives if necessary. Davis has suggested that “the telling of women’s menopausal experiences may generate new ideas that can be incorporated into the cultural domain” (1986, p. 76). The story or narrative includes the context of the women’s stories. Their worldview of life and menopause is expressed more fully through narratives. Through women’s stories, there is an understanding of the folk, popular or lay dimensions of menopause and the political and cultural influences on the women’s lives and their experiences.

**Theory and Methodology**

The theoretical and methodological approaches used in this study are informed by critical theory, ethnography, and critical ethnography. In the following section, key features, with a focus on the relevance of each to this study, will be presented.

**Critical Theory**

Critical theory evolved during the 1920s in Germany by a group of theorists from various backgrounds (McCarthy, 1978). The group of scholars associated with the Institute for Social Research in Frankfurt included Max Horkheimer, Theodor Adorno, Erich Fromm, Herbert Marcuse and Leo Lowenthal. These scholars were greatly
influenced by Hegel and Marx. "Critical theory was developed as a response to technological knowledge being developed by logical positivistic science and its contribution to the oppression of the working classes" (Campbell & Bunting, 1991, p. 4). The goal of critical theory at this time was to nullify ideology, the belief systems that are treated as facts by the ruling class, so that people's perceptions were freed or emancipated to evaluate their true situation (Campbell & Bunting).

Since the 1960s, Jurgen Habermas has been instrumental in developing contemporary critical theory (Bronner, 1994). The earlier critical theorists emphasized socioeconomic oppression, but Habermas broadened this viewpoint to include emancipation of individuals from all forms of domination (Bronner). The emphasis for the critical theorist is to look critically at the way in which reality is framed (Thompson, 1985). Critical theory involves questioning the status quo. For the Korean women experiencing menopause, it is the process of looking at, and reflecting on their experiences and questioning why those experiences are what they are.

Habermas developed a theory of communication to allow people to question their reality (McCarthy, 1978). He believed that true dialogue has been suppressed by the ruling and dominant classes. In order for individuals to be liberated and be able to examine their lives, Habermas proposed that communication must be free from coercion and domination. He called this form of communication the "ideal speech situation." The ideal speech situation involves staying open to all viewpoints. Being open to all viewpoints places the burden on the participants to analyze ways in which they are consciously or unconsciously constrained through the internalization of ideologies (Allen, 1987). In this study, the
researcher and participants work through their own self-reflections. The reflection begins with the self and an examination of how one plays a part in the reality where change is sought (Kendall, 1989). There is a responsibility on the individual to take the results of self-reflection into account when interacting with others. In this study, I analyzed my assumptions and beliefs about menopause, Korean and Canadian culture, and the role as researcher. At the same time, the participants were studying how the written and unwritten rules of culture and knowledge of menopause have affected their perspectives and experiences. Together the participants and I worked together to develop meanings. Ideally, the search for meaning will enable the participants to uncover the influences of unjust social systems and power relations. However, this process is long and awareness or understanding of the influences of social systems and power relations may not occur automatically. The influences of social systems and power relations are embedded in our lives. This study will be a beginning in the journey to look more critically at one’s life.

The process of developing meanings should be as participatory and unconstrained as possible (Allen, 1987). There is a responsibility to ensure that all participants can function autonomously by attending to group dynamics, knowledge imbalances, and power differences (Allen, 1992). The discourse must be open to all and requires mutual respect between researcher and participants. The discourse allows individuals to say what they want under given conditions with the possibility of changing conditions and to say what they ought to want (McCarthy, 1978). Trust is established through dialogue. With trust, relationships become more horizontal and egalitarian (Freire, 1970). As in participatory research, individuals are given a voice in articulating their perceptions of
their problems and solutions (Maguire, 1987).

Through critique, reflection and discourse, there is generation of new knowledge. This new knowledge arises from a collective decision shared by all participants. Maguire (1987) summarized this collective knowledge, observing that researcher and participants know something, none of them knows everything, but working together they will both know more and they will both learn more about how to know. The new knowledge and collective decision leads to further reflection. Following reflection, the participants are involved in the decision making regarding the use and application of the new knowledge in their lives (Maguire). This new knowledge may lead to change requiring action by the participants and the researcher. The objectives for both critical theory and participatory research include the transformation of power structures and relationships.

In an ideal situation, there is emancipation from the hidden rules and structures of the participants' lives. However, in reality, the structure of one's life may be so embedded one is unable to uncover the hidden rules or the structures of society may benefit the individual in some way. Even if there is some uncovering of the hidden rules, hopefully, there is a new understanding. This process of human understanding is a dialogical process of discovering inherited biases or prejudices and recognizing some prejudices as blind and others as enabling (Thompson, 1985). It is a process of expanding horizons and of moving in the hermeneutic circle (Thompson). However, the discovery of the self through the dialogical process is not the end point. Freire defined the next step as “conscientizacao, learning to perceive social, political and economic contradictions and to take action against the opposite elements of reality” (1970, p. 19). Reality is not viewed as
static but as a process. The participants benefit from learning and understanding their reality but also by sharing directly in subsequent policy and program decision making and control (Maguire, 1987). The Korean women in this study provided input on the direction to take with the results of this research and how it will be used to benefit their own lives or other women's lives.

**Ethnography**

Ethnography is a study of culture. Culture is viewed as a system of knowledge used by people to interpret experience and generate behavior (Aamodt, 1991). Cultural knowledge includes understanding of the people, what they do, say, how they relate to each other, what their customs and beliefs are, and how they derive meaning from their experiences (Streubert & Carpenter, 1995). The knowledge gained from the study of culture needs to be viewed as one period of time, one reality. Cultural knowledge is not a predictor of what will occur or what has occurred but as an indicator of what can be anticipated to occur (Streubert & Carpenter). The researcher must be cognizant that what he/she observes, hears, and sees is just one frame of the overall film.

Ethnography attempts to uncover the knowledge people use to interpret experience and mold their behaviors within the context of their cultures (Aamodt, 1991). There are several reasons for choosing ethnography as a methodology. Ethnography provides documentation of alternate realities. These alternate realities can be used to understand other realities. By viewing and seeing other realities, individuals can seek to understand their own. To study another way of life is necessary to seek to extend our own, not simply to bring the other way of life within existing boundaries of our own
(Winch cited by McCarthy, 1978). Ethnography can be used to discover grounded theories, understand complex societies better and to understand human behavior (Streubert & Carpenter, 1995).

The role of the researcher is vital. The researcher becomes a participant in the study. To understand the culture one is studying, the researcher must understand one’s own. The process of understanding what the researcher brings to the study is called reflexivity (Aamodt, 1991). Reflexivity involves an understanding of the self, a sense of self-consciousness and a desire to know and understand how one’s culture affects what one is capable of observing, hearing and understanding.

**Critical Ethnography**

Critical ethnography is influenced by critical theory and ethnography. Critical ethnography involves reflection and action. Members of the culture not only attempt to analyze their culture but they also make plans to change their situations. In critical ethnography, there is an emphasis on understanding the cultural meanings of ideology and political economy (Denzin, 1991). There is the focus on relationships of power. Culture includes power. Within a culture, different groups have different interests and different access to status and power (Street, 1992). In critical ethnography, the researcher and participants analyze hidden agendas, power centers and assumptions that inhibit, repress and constrain individuals and groups (Thomas, 1993).

The critical ethnographer shares the research process with the participants. Critical ethnographers speak on behalf of their respondents rather than communicating about the participants which is more common in traditional ethnography. By speaking on behalf of
the participants through the participants’ reflection and understanding, the ethnographer assists the participants by giving more authority to their voices (Thomas, 1993). By bringing the participants’ stories forward, the critical ethnographer assists the participants to be empowered and use their new knowledge for social change.

For the researcher and the participants, values and biases are not suppressed. In critical ethnography, the effect of values is unavoidable and the solution is not to avoid them but to identify them and assess their impact (Thomas, 1993).

**Importance of the Research**

Numerous people will benefit from the knowledge developed from this research. This study provides benefits to the Korean women who participated in the study, other Korean women who are presently or will be experiencing menopause, other Canadian women who will or are presently experiencing menopause, and health care professionals who provide care for Korean and other immigrant women.

Through narratives, there is an opportunity for Korean women to express themselves and to tell their stories. The women have the opportunity to be listened to and express themselves as they feel necessary. The women are in control of the content. The study provides the participants an opportunity to analyze their experiences surrounding menopause, their views on culture and menopause, their views on health and illness and the use of the health care system. By communicating and reflecting on their experiences, the women may come to a new understanding, determine discrepancies in their lives and be empowered to change their lives.

Other Korean women who are presently experiencing menopause or will be
experiencing menopause will benefit from the knowledge developed from this study. Through discussions with the participants, some of the women stated that Korean women do not discuss personal matters such as menopause with each other. This study gives the women an acceptable method to pass on their knowledge to other Korean women.

The knowledge developed from this study will benefit other women outside the Korean community. It highlights the shared experiences and provides new information about women’s experiences with menopause. The knowledge shared highlights the women’s beliefs of what has helped them through their experiences with menopause and what has not been helpful.

The research contributes knowledge about the experience of immigrant middle-aged women. Immigrant women have special concerns that are not frequently studied (Anderson, 1985; & Meleis, Arruda, Lane, & Bernal, 1994). The transition of immigration occurs over many years and immigrant women face many obstacles. They are attempting to make sense of two cultural patterns and trying to make their values understood within the two cultures (Meleis, 1991). Immigrant women may be at high risk for physical and mental distress. In Anderson’s study, Indo-Canadian women perceived Canadians as unapproachable and health care professionals did not understand the women’s problems and perspectives (1985). Through the Korean women’s stories, their experiences as immigrant women will be explored and lead to better understanding of their needs.

Another benefit of this study is the use of critical ethnography as the methodology. Critical ethnography is a relatively new methodology in nursing research. Meleis, Arruda, Lane, & Bernal (1994) stated there is a need for innovative methodologies to prompt
individuals to speak and provide venues for women to tell their stories. Critical ethnography provides the opportunity for the women to speak. The women are partners in the research through the telling and sharing of their stories and as a result of telling their stories, there is increased understanding and empowerment. Critical ethnography provides the women with a greater voice in the research process.

This study also provides knowledge to health care professionals about Korean women's experiences with menopause, health and illness and the effects of immigration on these processes. Nurses are in a special position to work with these women and to learn from them.

**Importance of Research to Nursing**

There are many potential benefits to nursing through this research. The research adds to the body of nursing knowledge. There has been limited nursing knowledge development of diverse populations (Meleis et al., 1994). This research will add to the development of nursing knowledge about Korean Canadian women. It will explore the experiences of a group of immigrant women going through menopause. The research will explore how the group of Korean-Canadian women view health and illness through a different cultural lens and it will explore their contacts with the health care system.

The knowledge developed from this research can be used by nurses and the participants to change the approach to health care. Through the telling of the stories, the women offer insights to the improvement of health care for this group of women. Nurses play a major role in health teaching and are often the first contact with the health care system. The experiences of the women can provide suggestions for changes in the
approach to other immigrant women. The stories shared by the women may also lead to consideration of appropriate health teaching needs for Korean women as well as other women experiencing menopause.

Nurses are involved in improving women's health and enhancing the quality of an individual's life. This study offers women the opportunity to reflect on their lives through the experience of menopause and make changes in their lives as necessary. Women telling their stories of menopause benefits the health care professional by providing knowledge of the women's philosophy and understanding of health and illness. Through narratives, the women’s understanding of health, illness and middle age are understood in context. The knowledge shared by the women can be used by other nurses working with immigrant women or women experiencing menopause to improve other women’s quality of life and health.

Culture affects a woman's approach to health and illness. The Korean women in this study have been affected by their culture in their approach to menopause. Understanding the influence of culture on health and illness will benefit other nurses working with Koreans but it also demonstrates and expands the knowledge of culture on health and illness with other groups and mainstream Canadians.

Since every woman reaching middle age experiences menopause, nurses need to be aware of the personal experiences of women through menopause. Nurses are often resources for information and need to be able to share knowledge about menopause from a wide variety of viewpoints. Knowledge of menopause from a group of women from a different culture is especially valuable because of the increased diversity in society.
Culture also affects the use of health care resources. The knowledge developed in this study will explore the use of health care resources by the Korean women. This knowledge is valuable to nurses because in understanding the use of health care resources then there will be better understanding of women's activities which leads to better planning of resources which are friendly to women's needs (Meleis et al., 1994). Nurses need to be involved and influential in health care planning for Korean and other immigrant women.

The knowledge shared by the Korean women in this study reveals valuable information about their lives and how culture influences aspects of their lives, especially menopause and their approach to health and illness. This knowledge is especially useful because nurses are not always exposed to different cultures through their personal lives but come in contact with different cultures through their professional roles. Nurses are one group of health care professionals that are often the primary contact with the health care system for immigrant women (Anderson, 1985). Health care professionals including nurses do not always grasp the circumstances of the women's lives and seem unable to bridge the chasm between themselves and the women (Anderson). Since nurses may not be aware of the circumstances of women's lives from different cultural groups, there is a need to improve education of nurses to take into account sociocultural and political contexts of women's lives (Anderson).
CHAPTER II

LITERATURE REVIEW

Menopause has been studied from several methodological and philosophical perspectives. Each paradigm has a distinct body of research and philosophy. The literature review will include research from several different disciplines including nursing, medicine, anthropology, and sociology. The emphasis of this review will be on the experience of menopause in different cultures. The meaning of menopause and accompanying changes experienced by women from a variety of cultural groups will be reviewed. Also included in this chapter are: a brief history of the meaning of menopause from a North American perspective; a review of the meaning of menopause from several cultures; a synthesis of ideas in the literature regarding how knowledge is obtained among women from diverse cultures; the women’s beliefs about menopause and health; and their approaches to dealing with symptoms of menopause. Finally, the challenges faced by immigrant women dealing with a different culture and health care system will be briefly discussed.

Menopause from a Western Perspective

MacPherson (1981) presented a brief history of menopause as it is understood within North American culture. MacPherson proposed that nineteenth century physicians viewed women as “prisoners of their reproductive systems” (p. 53) and that the reproductive systems controlled the women’s bodies from puberty to menopause. Women had to maintain enough energy in order to feed their reproductive systems. This theory supported the importance of women maintaining their feminine roles to save their energy.
Menopause was seen as a physiological crisis and its resolution determined a woman’s future health.

The next stage in the history of menopause in North America was characterized by a view of menopause as the cause of disease (MacPherson, 1981). Medical science believed that menopause was responsible for many diseases. Menopause was viewed as being particularly bad for women who had too much education, undue sexual indulgence, insufficient devotion to husband or children, or who advocated for women’s suffrage. Menopausal women were advised to maintain a domestic quiet lifestyle, devoted to childrearing and spousal responsibilities.

Gynecological surgery, including clitoridectomies, female circumcisions and oophorectomies began in the 1860s and 1870s (MacPherson, 1981). These practices were used on menopausal women to eliminate their menopause-related diseases, especially depression or disorderliness. Clitoridectomy was the first operation performed to check women’s mental disorders in the United States. Female circumcisions were performed in the U.S. until 1937 and female castration or oophorectomies were most popular between 1880 to 1910 but were still performed until 1946.

Freud’s theory of psychoanalysis in the early 1900s altered the view of menopause from something that caused disease to a loss or wound. This viewpoint represented a major shift in the beliefs about menopause and has remained ingrained in North American ideology today. This conceptualization of menopause was viewed as a period of loss for North American women (MacPherson, 1981).

In the early part of the twentieth century, menopause was seen both positively and
negatively (MacPherson, 1981). Women considered menopause as a natural phenomenon. With the identification of the sex hormones in 1923 by Doisy and Doisy, came the production of synthetic estrogen in 1938. Studies were conducted using synthetic estrogen on menopausal women. Risk of cancer was high and the use of synthetic estrogen subsided. Increasingly, however, physicians identified menopause as a disease that could be treated.

In the 1960s, the drug companies promoted menopause as a physical and emotional disease (MacPherson, 1981). Advertisements showed women that they would remain sexually attractive, young and vital if they took estrogen and other advertisements promoted the doctor’s authority and promotion of estrogen use. The popularity of estrogen use continued to rise until the mid-seventies when studies indicated that estrogen replacement therapy (ERT) increased the risk of endometrial cancer. At this time, Premarin was the fourth or fifth most popular drug in the United States.

Since the 1970s, the use of estrogen replacement therapy has decreased (MacPherson, 1981). At present, 30% of the population of menopausal women take hormone replacement. However, the medical community continue to view menopause as an illness with symptoms requiring treatment. Osteoporosis, heart disease, and Alzheimer's disease have been linked to decreased estrogen and the medical establishment is promoting the use of hormone replacement for prevention of these diseases while relieving menopausal symptoms of hot flashes and other symptoms associated with menopause.

This brief summary of the history of menopause in North America demonstrates
the influence of society and culture on the women’s experiences. MacPherson was critical of the biomedical paradigm and its effect on the experience of menopause for women in North American mainstream culture. In North America, menopause is viewed as an illness or disease whereas in other cultures, menopause holds different meanings. In the following section, the meaning of menopause for women from different cultural groups will be addressed.

**The Meaning of Menopause**

Several scholars and investigators have examined menopause from different cultures. The focus of this section will be: the relationship between menstruation and menopause; menopause as the end of childbearing and fertility; menopause’s effects on role and status and the view of menopause as a symbol of growing older; physical and emotional responses; attaining knowledge about menopause, and reasons for seeking health care for changes during menopause.

**The Meaning of Menstruation**

Meanings surrounding menstrual blood and the changes accompanying this cessation of blood are repeatedly found across cultures. Menstruation has been viewed both positively and negatively in different cultures.

For Chinese (Ahern, 1975) and Thai women (Chirawatkul & Manderson, 1994), menstrual blood was unpleasant and viewed as “bad blood.” In Rice’s (1995) ethnography of Hmong women in Australia, menstruation was seen as “distasteful.” Menstruating women were viewed as unclean and polluted.

In contrast, menstrual blood was also seen as a benefit in women’s lives. Menstrual
blood was seen as a sign of good health and a symbol of reproductive ability (Chirawatkul & Manderson, 1994). For Thai women, menstrual blood was a sign of energy. It was also a sign of cleansing.

The theme of menstruating as cleansing was found by Davis in an ethnographic study of menopause in a Newfoundland fishing village (1986). Davis used a combined approach of surveys, interviews and participant observations to understand meanings of menopause among 38 women.

Davis (1986) suggested the term “blood” had different meanings for both men and women. Women perceived menstrual blood as an indicator of health. “Menopause is seen as the final purge, the final cleaning out” (p. 80). Women stated that at “the change,” it was important to bleed profusely and for a prolonged time because this bleeding was the final cleaning out and it had to last for the rest of the woman’s life. The cessation of menses and the loss of fertility held very little importance to the women. The change was seen as a normal, natural part of the aging process. The experience of menopause was rooted in the symbolic order of life, viewed as a series of gains and losses. Menopause was seen as a life stage to be managed with personal coping skills developed from previous exposure to adversity.

The end of menstruation symbolized both positive and negative feelings for women in different cultures. As well, the onset of menopause brought conflicting feelings for many women.

**Positive and Negative Attitudes Toward Menopause**

There were different opinions on menopause within a culture and across cultures.
The Greek women in Beyene’s (1986) study believed they were no longer in the mainstream of life with the end of menstruation. South Indian women in du Toit’s (1990) study felt they were losing their power as childbearers since children were highly valued. Several Greek women felt their femininity was affected with the beginning of menopause and the end of menstruation (Beyene, 1986).

In contrast, other women viewed menopause positively. For Thai women, menopause brought freedom from menstruation, convenience when travelling and with menopause, women gained respect and power (Chirawatkul & Manderson, 1994). Hmong women saw themselves as no longer polluted but clean “like a man” (Rice, 1995). For Mayan women (Beyene, 1986), there was no longer fear of pregnancy and menopause was viewed as a life stage without taboos and restrictions.

Consistent with these findings, the cessation of menstruation was identified as a benefit to women in two Southern Indian fishing villages (George, 1996). George studied the experience of menopause for 190 women in two villages. All of the women were fish sellers and their ages ranged from 35 to 69. Participant observation, in-depth interviews, and symptom and attitude checklists were used to collect data. A strength of this study was the variety of data collection methods used. The women were happy that menstruation was ending with menopause. Menstruation was seen as a nuisance when women were trying to conduct their business of fish selling. The onset of menopause freed women from worrying about their monthly needs and enabled them to focus on their work as fish sellers. For these women, childbearing and childrearing were transitory roles while selling fish was a role that continued throughout their lives.
In many cultures, with the onset of menopause, there were more freedoms for women in religious aspects of life. The Greek women (Beyene, 1986) welcomed menopause because they were free to go where they wanted, they could go to church and participate in church activities.

In du Toit’s ethnographic study (1990), menopause was described by the Indian South African participants as a time for more freedom for spiritual involvement. Postmenopausal women were viewed as neutral and could participate fully in religious ceremonies. du Toit reported that Hindu temples had rules prohibiting menstruating women to worship. Once menopause was reached, women were free to enter any time and were able to participate in more religious activities. For example, Hindu women could serve as volunteers to help in the temple, participate in prayer meetings and social work, bring offerings to the altar, clean and light the lamps, or open doors. Muslim women were also able to participate in a greater number of spiritual ceremonies once menopause was reached. Muslim women were able to fully participate in the hadj, the spiritual trip to Mecca, pray continuously, touch the Koran and fast for all of Ramadan. Among this population, menopausal women were viewed as neutral and not a threat to ceremonial purity.

As these studies reveal, there are varied perspectives about menopause and the final menstruation. Some cultures viewed menstruating women as disgusting, shameful, and having the power to spoil or pollute certain events, foods, rivers, and so forth. Although the act of menstruation was depicted by some women as “disgusting,” it afforded women the power to affect what was going on around them. Common themes
about menopause and the final menstruation included themes of purging, cleaning out, becoming neutral, and becoming pure. As menopause occurred, there were more opportunities for participation in spiritual life in the community.

The studies reviewed in this section were predominantly ethnographies. This methodological perspective seeks to understand culture and its effect on menopause. Beyene (1986) and Davis (1986) are classical studies. Both researchers spent several months living in the participants’ communities. The Asian studies are less well known but offer unique knowledge about the experience of Asian women. Especially relevant to this study was Rice’s study of Hmong women in Australia. The Hmong women were in transition from one culture to another, not unlike Korean women living in Canada.

**The Experience of Japanese and Chinese Women**

Korean culture has been influenced by both Japanese and Chinese cultures. A review of the experience of menopause for Japanese and Chinese women may provide insight into the experience of menopause for Korean women.

Rosenberger (1986) studied menopause with a group of women in Japan. Data were collected via interviews with 150 women between the ages of 35 and 65 years. Rosenberger hypothesized that menopause was “a symbol of anomaly.” Middle-aged women were caught between two roles. Women were urged to get out of the house, but the part-time work and hobbies which were available to them, did not allow them to be accepted into society equally with men. Since the women were no longer looking after children, they were no longer “classified as ‘inner’, the traditional classification of Japanese women” (p. 21). This experience left women caught between appropriate places.
Rosenberger suggested that this situation leads to problems during the menopausal period and it extends from the time the woman stops caring for children and continues until old age.

Lock, in her study of menopause among Japanese women, analysed the process from a different perspective (1986). Six hundred and seventy-seven women, 65% of the sample, stated that menopause was of little or no importance to them. Lock used a questionnaire with a symptom checklist to elicit information from the participants. Although the questionnaire, developed by Kaufert and McKinlay (cited by Lock) had established content validity and reliability, it may not have been suitable for women from another culture. If women are given a list of symptoms, they may not discriminate the symptoms from aging or they may not have thought about the symptom until they saw it on a list. Although the questionnaire may have had limitations, Lock's study of menopause is classic.

Japanese women use the term konenki, “the change of life,” when discussing menopause rather than the word “heikei” which means end of menstruation (Lock, 1986). Konenki is viewed as a life-cycle transition which is a natural part of the aging process. However, when respondents were asked to state whether menopause changes a woman in any important way, only 56% agreed that it does not change a woman. As well, 79% of the Japanese women surveyed felt that women with many interests hardly noticed menopause. These results are congruent with Rosenberger's (1986) finding that women need to be productive to be able to deal with menopause satisfactorily.

Chinese factory workers had a positive attitude toward menopause (Tang, 1994).
Seventy-four percent of the 402 women felt it was a natural process and they were not concerned about it. Eighty percent of the women still menstruating did not anticipate problems with menopause. Tang presented a number of reasons why menopause was not perceived as an area of concern for the women in this research. Since this group of factory workers had low income, little formal education and large families, the economic hardship diverted their attention away from menopausal problems. Sixty to seventy percent of the women believed that they possessed some introspective abilities to cope with menopausal symptoms. Tang suggested that the women’s interpretation of the menopause affects the symptomatology. If menopause is perceived as a natural aging event which every woman must go through, there will be no fear and anxiety. With respect to women who viewed menopause without any fear or anxiety, Tang wrote, “these women were probably not living in their bodies, but rather like men, they live with their bodies and thus, feminine significance would not lie with menstruation” (p. 182). Tang suggested women who view menopause positively did not view their role as women to be affected by menopause.

Collectively, these studies suggest that the meaning of menopause for women across cultures is diverse. Menopause as it relates to menstruation, menopause as it relates to lifting of taboos, menopause and the relation to childbearing and childrearing, menopause and the relation with aging and menopause and the relation to role change and status have been discussed. These different meanings of menopause may affect the women’s experiences of symptoms during menopause.

**Physical and Emotional Responses to Menopause**

Numerous researchers have sought to determine and compare the physical and
emotional experiences of menopausal women. The results of these studies supported the theme that the experiences of women differ across cultures. For the Mayan women, there were no words for hot flashes (Beyene, 1986). They did not link menopause with any emotional or physical symptoms. Instead, the women stated they had headaches and dizziness unrelated to menopause.

For the menopausal and post-menopausal Greek women, hot flashes, cold sweats, headaches, dizziness, insomnia, hemorrhage, irritability and melancholy were commonly reported discomforts (Beyene, 1986). Overall, 68% of the women did not see any change in their health due to menopause, while 30% felt they got sick more often and felt weaker since the onset of menopause. Hot flashes and cold sweats were viewed as normal. The Greek women were able to describe their hot flashes in detail. They said that one gets “exapsi,” or the term for hot flash, because the detained blood boils up in the body. The women believed that if menopause came too early, they would have more problems. Disturbances such as irritability, feelings of melancholy and emotional problems were believed to result when menopause occurred too early.

In Davis’ study of women in Newfoundland, the most frequent symptoms reported by the women, ages 35-60, were nerves and blood (1986). Nerves were viewed as aging faster than other body parts and linked indirectly to the aging process of menopause. Descriptions of blood included hot flashes and flushes. Flashes and flushes were caused by “too much or bad blood” and welcomed by the women as purifiers. There was an abstract component to the women’s experiences of menopause through the description of “nerves and blood.” For these women, the meaning of menopause could not be determined by
symptoms but through the whole fabric of their life in the village.

For Japanese women in Rosenberger’s study, any symptom was considered to be menopausal and society expected women to be able to control their symptoms (1986). If they were unable to do so, they were considered weak. However, some doctors and women recognized that menopausal-like symptoms were not directly related to menopause but to social or familial problems. According to Rosenberger (1986), menopause became a catchall phrase for many problems. In Lock’s study of Japanese women (1986), there was no word in Japanese to describe hot flashes. Thus, only 20% of the women described symptoms similar to hot flashes. The most common complaint was shoulder stiffness and headaches, but whether these complaints were occupation-related or menopausal was questioned by Lock. The psychological complaint identified most frequently was irritability, reported by 11% of the 1082 women.

For the Indian women in George’s study (1996), other than menstrual irregularities, weight gain was the most frequently reported symptom. Only 12% of the 120 premenopausal women and 14% of the 70 postmenopausal women had hot flashes. None of these women complained that the hot flashes were severe or sought treatment for them. Vaginal dryness was reported by 5% of the premenopausal women and 13% of the postmenopausal women. Other symptoms reported that were not directly linked with menopause were fatigue, cold sweats, insomnia, and depression.

In Rice’s study of Hmong women living in Australia (1995), the women could not remember any physical or emotional changes other than menstrual changes after they became menopausal. None of the women reported hot flashes, flushes or night sweating.
Women felt that if traditional restrictions after childbirth were not followed, it would result in problems in old age. Practices to regain body heat lost in childbirth were believed to have an effect on later life. For example, Hmong women were confined to the house for the first month after birth. "For the first three days after delivery, the woman must lie near a fire for most of the day" (Rice, p. 269). This allows the woman to regain the heat in her body, considered to be an important requisite for health as they grow older. If the woman had problems during menopause, it was considered to be the result of failure to adhere to these childbirth practices.

The only study which included Korean women was a multi-country study pertaining to the experience of menopause. This study was carried out in seven Southeast Asian countries including Hong Kong, Indonesia, Korea, Malaysia, the Philippines, Singapore and Taiwan (Boulet, Oddens, Lehert, Vemer, & Visser, 1994). Approximately four hundred women in each country were interviewed about menopausal complaints, consultation of a physician, menopausal status and several background characteristics. The women involved in the study were 40-60 years of age who had experienced natural menopause. The average age at menopause was 51 years.

Findings from this study revealed a range of physical disturbances. Vasomotor complaints were low. The frequency of hot flushes ranged from 10% of Indonesian women to 39% of Korean women (Boulet et al., 1994). The Korean women had the highest frequency for sweating, palpitations and dizziness among the women from the seven countries. Psychological complaints were more frequent than vasomotor complaints. Headache was reported as the highest psychological complaint from 31% of Hong Kong
women to 62% of Filipino women. Urogenital complaints included incontinence and dyspareunia. Korean women reported the highest incidence of incontinence (23%). Vasomotor complaints and incontinence were related to perimenopausal status and psychological symptoms were related to postmenopausal status. Unemployment was related to both vasomotor and psychological complaints and to incontinence. Having no husband or partner and lower educational level were associated with psychological complaints.

While similar menopausal symptoms were reported by women in all of the seven countries, the way these were experienced differed. In addition, the occurrence of symptoms was less than in Western countries when compared to the study by Oldenhave, Jaszmann, Haspels, and Everaerd (1993 cited by Oddens, 1994). Oldenhave et al. reported up to 85% of Western women experience vasomotor symptoms. The researchers suggested that women in Southeast Asian countries may translate physical symptoms of menopause into psychological symptoms. As well, it was suggested that climate, cultural stoicism, diet, improved social status, and lack of time to devote to oneself affected the frequency of symptoms reported.

Flint and Samil (1990) studied the cultural and subcultural meanings of menopause with a group of Indonesian women. Six hundred and three postmenopausal women were involved in this study. The women were categorized as educated, migrant educated, migrant uneducated and rural uneducated. Flint and Samil hypothesized that women who were urbanized and well educated, and whose lives were influenced by Western culture would have similar experiences of menopause as Western women. They hypothesized that
rural and uneducated women would not experience symptoms of menopause. The most prevalent symptom listed by all groups of women was fatigue. Hot flashes were moderate for all groups but were higher for women in urban areas compared to women in rural areas. However, women who were labelled rural and uneducated did have hot flashes. The reporting of hot flashes was less than in Western countries (Flint, 1975 cited by Flint & Samil). Positive symptoms of menopause were reported by the women. Flint and Samil’s hypothesis were not supported and did not take into context the numerous factors that affect a woman’s experience with menopause. They limited their hypothesis to the symptoms of menopause and the level of education of the women. It appeared to place a bias on uneducated women.

**Sexual changes.** There were different views about the changes in sexual relations among women experiencing menopause. Menopause did not represent changes in sexual relations for the Mayan and Greek women (Beyene, 1986) and some of the Indian South African women (du Toit, 1990). The women stated they were more comfortable with sex because there was no longer risk for pregnancy. Other women stated they had less interest in sex. Some of the Hindu women, reported that they would sleep separately from their husbands (du Toit). Younger women more than older women in the study felt their husbands would be supportive during the stage of menopause. Comments from women included “My husband doesn’t like it because I’m not quite a woman anymore and my (sexual) feelings for him die” (du Toit, p. 285). Another women commented, “Many husbands start going out and running around with young girls” (du Toit, p. 285) once their wives reached menopause. In the Japanese studies (Lock, 1986; & Rosenberger, 1986)
and for the South Asian, Afghan and Somali women (Weber, 1994), there was no discussion of sexual relations.

The experience of symptoms with menopause has been reported by some cultural groups and not reported by others. The methods used in a study affects how symptoms are reported. Flint and Samil (1990) suggested that “we structure the reality of our subjects when doing menopause research by giving them a preordained list of symptoms associated with this phenomenon” (p. 142). This list may contain factors related to aging that may not have been automatically connected with menopause by the women. The list does not differentiate what the woman feels as a result of aging or menopause. For example, Flint and Samil questioned the relevance of fatigue to menopause in their study, and wondered whether fatigue was a result of menopause or a result of busy, stressful lives. The point raised by Flint and Samil is a valid one. Using lists of symptoms makes a connection with menopause that may not be connected in the woman’s experience. Open ended questions regarding the experiences of women during menopause may avoid the problem of “providing the reality” to the women.

Gaining Knowledge and Seeking Help with the Experience of Menopause

Women across cultures gained knowledge about menopause through different methods. As well, they sought help in many diverse ways using both traditional and non-traditional medicine. The approaches used by the women to gain knowledge and seek help will be reviewed.

In Flint and Samil’s study (1990), only 4 out of 297 Javanese women and 3 out of 306 Minangkabau women used estrogen replacement therapy. Indonesian women used
different therapies. Women sold jamu, native herbal drinks, produced for all types of women's problems including hot flashes and atrophic vaginitis. Another method to decrease atrophic vaginitis was to eat papaya, an estrogenic fruit.

In Haines, Rong, Chung, and Leung's (1995) study of women in Hong Kong and Southern China, the most common source of knowledge about menopause was friends, followed by reading material and family members. Medical sources contributed to 1% of the sources of knowledge for the Chinese group and 8% of the sources of knowledge for the Hong Kong group. Eighty-nine percent of the women revealed no knowledge of any kind of treatment for menopause.

There was a higher incidence of visiting physicians in the Boulet et al. (1994) multi-national study. Twenty percent of the women visited their physicians for menopausal complaints. Psychological disturbances were the most commonly cited reason for visiting the physician. In the Philippines section of this study, Ramoso-Jalbuena (1994) reported educated women went for consultation to a physician more frequently than less educated women. More than 75% of the Malaysian and Filipino women were prescribed medication for menopause after visiting physicians, but almost half did not follow the prescription. In the Philippine study, tranquilizers were prescribed most frequently (41%), followed by hormones (19%) and in the Malaysian study, herbal medicines were prescribed most frequently. For the Chinese factory workers (Tang, 1994), having time off to see a doctor would mean a reduction of salary so few women visited the physician about complaints. Women most often went to the physician about irregular menstruation.

For Thai women, menopause was regarded as a natural event and changes with
menopause were not seen as illnesses (Chirawatkul & Manderson, 1994). If these changes affected the woman’s daily life so she could not work, then a woman would seek help from either a traditional healer such as “mor tham” (magic healer), “mor yaasamun phraj” (herbalist), or health practitioner. To get help for irregular menses, women sought advice from a village elder who was often a kinswoman or a neighbour or a herbalist for herbal medicine to encourage menstrual flow, consult a health practitioner at the local health centre for prescriptions such as vitamins or present to a private clinic. The psychiatrists interviewed, believed that menopausal women were at a high risk for mental illness, especially for women who had “poor personalities” or were experiencing stress or conflict in their daily lives. The gynecologists interviewed viewed menopause negatively, describing it as an estrogen deficiency disease which required hormone replacement therapy. The media was beginning to play a bigger role in women’s knowledge about menopause. Television programs and media articles were encouraging women to seek medical help.

For the Indian women in du Toit’s (1990) study, there was little discussion about menopause between genders and generations. The majority of women said when menopause happens they wonder about it, ask an acquaintance or kinswoman, or less frequently, consult a physician. More recently, women were learning about menopause through the family planning and antenatal clinics. For older women, menopause remained a taboo subject and information came from sisters, brothers’ wives and husbands’ sisters. Older women were reluctant to talk about menopause with younger women. Women would discuss menopause with a physician, but they would prefer a white female doctor
because whites were outside the Indian community and it was thought that they would keep information confidential.

Women in Japan go to the Western physicians and Chinese practitioners of herbal medicine or acupuncture (Rosenberger, 1986). The physicians did not differentiate social, psychological or physiological problems surrounding midlife and menopause. Therefore, menopause was the label put on many problems that women experience during this phase of life. Some doctors prescribed hormone replacement for hormonal imbalance diagnosis, and for psychological symptoms, tranquilizers for those women diagnosed as neurotic. This latter group were seen as having too much time on their hands and needed to keep themselves busy so that they would not have time to think about themselves (Lock, 1986). Other physicians believed that loneliness was a problem that caused women to have problems with menopause. Japanese gynecologists associated previous reproductive histories with menopausal symptoms, asserting that women who have had many abortions felt guilty and consequently experienced problems with menopause.

Women who went to Chinese practitioners felt that they received a natural treatment for a natural problem. Symptoms were differentiated between physical and psychological. “The problem was defined in terms of the circulation and quality of the blood and ‘ki’ or life energy” (Rosenberger, 1986, p. 23). The woman received a “readjustment of her whole self through a treatment that purifies and balances the blood and the ‘ki’” (p. 23).

For Hmong women, they were surprised when Rice (1995) asked if they had any physical and emotional problems and they were surprised to hear that Australian women
had difficulty with menopause. Rice suggested that this scenario may change with the increased exposure to Western medicine, the longer the Hmong women live in Australia. Rice questioned whether the Hmong women’s menopausal experience will change over time because of the view of menopause held by the Australian medical system.

Beyene (1986) interviewed physicians, midwives and local healers from the Mayan village. The physicians, midwives and healers said that women do not go to them for menopausal complaints. Women experienced irregular menses before menses stopped but there were no other problems associated with menopause. Menopause was not a significant event for Mayan women. For the Greek women, they did nothing to alleviate hot flashes and the village physician stated that women did not come to him for menopausal complaints.

Knowledge of menopause was gained from many sources including friends, family, traditional and non-traditional practitioners, and the media. Other women had very little information regarding menopause. Lack of information about menopause has been identified as a significant problem by Haines, Rong, Chung, and Leung (1995). Haines et al. (1995) were concerned that illnesses related to hormone deficiency would not be prevented because of the lack of knowledge. The researchers of this study reflected the biomedical perspective. They were imposing their views of menopause on a group of women who had little experience with Western medicine. There was little understanding of the participants’ perspectives.

As seen in the multi-country quantitative study of Filipino and Malaysian women (Boulet et al., 1994), many women did not adhere to medication prescriptions. The end
result was that the women were caught between paradigms. They were caught between the cultural paradigm of their experience with menopause and the biomedical paradigm. The apparent incongruencies are felt most often by women who immigrate to Western countries.

The Experience of Immigrant Women

There have been a number of nurse researchers who have studied the experience of immigrant women in Canada and the United States. Although these studies do not address the phenomenon of menopause, their contributions are valuable to understanding the experience of immigrant women.

Anderson (1985) studied Indo-Canadian and Greek immigrant women’s perspectives on health using a phenomenological feminist approach. In-depth interviews were completed with six Indo-Canadian women and eight Greek women. Two themes emerged, the theme of constructing health concerns and women’s experiences surrounding help-seeking. Indo-Canadian women felt alienated from Canadian society and the health care system. They did not think doctors or nurses were approachable. The women felt that they were not understood and that they were looked down upon. Indo-Canadian women had approached health care professionals with social problems related to the family. The health care professional prescribed solutions based from their cultural context which was inappropriate for the woman’s culture. This lack of connectedness or misunderstanding promoted a chasm between the health care professional and Indo-Canadian women. Anderson suggested the education of practitioners must include the sociocultural and political contexts in which health and illness are constructed. There must be increased
understanding and connectedness between health care professionals and immigrant women.

Meleis, Lipson and Paul (1992) studied the relationship among ethnic group, strength of ethnic identity and mental and physical health of 88 women from five Middle Eastern immigrant groups including Egyptian, Yemeni, Iranian, Armenian and Arab immigrants using questionnaires consisting of Likert scales. Results indicated that ethnic identity was significantly related to health variables. As the importance of ethnicity and the relationship with health was identified, Meleis, Lipson and Paul suggested that health care professionals need to learn more than just the ethnic group or country of birth. Health care professionals need to understand the effects of immigration and how it affects health. Knowledge of ethnicity and the immigration experience of individuals assists health care professionals to provide the best care possible for individuals but also helps them to feel welcomed and understood in their new country.

Thompson (1991) used participatory feminist research with a support group for Khmer refugee women to understand ethnicity and immigration. The purpose of the research was to explore psychosocial adjustment among refugee women and to focus on cultural or symbolic traditions that are brought to the United States. Four themes were identified from the dream narratives of the women. This research highlighted the importance of listening to stories and dreams and showed how the stories and dreams reflected the women’s experiences.

The experience of ethnicity and immigration cannot be expressed by the new culture. Understanding must be achieved through the preferred route of communication of
the country of origin, for example as with storytelling or dream analysis. By listening to stories, the experience of immigration will be explained. Understanding immigration will assist health care professionals working with immigrant women to understand their health experiences. Women experiencing menopause have indicated there are more problems with their health when they are in transition between cultures.

In a study of South American and Swedish women's experiences of menopause, South American women living in Sweden had more psychological symptoms (Nedstrand, Ekseth, Lindgren, & Hammar, 1995). Reasons given for increased psychological problems were that the women were isolated in their homes, unemployment was high, and some of the women were involuntarily separated from their families in their home country. In the study of women in midlife from Israeli subcultures including Israel-born Moslem Arabs and immigrant Jews born in North Africa, Persia, Turkey, and Central Europe, Datan (1990) used surveys and questionnaires to understand the experience of change and transition for these women. Datan stated that the women experiencing the most change and transition reported the greatest number of psychological problems. Self-reported psychological well-being was especially low for the Persian women who experienced the greatest diversity between their traditional upbringing and the more modern life they experienced in Tel Aviv.

Immigrant women face many challenges in their new countries. The period of transition from one culture to another can last for several years. Changes experienced by immigrant women affect all aspects of their lives, especially the health of the women and their families.
Strengths and Limitations of the Research

There are numerous studies on the experience of menopause in different cultures. The studies include ethnographic and descriptive, empirical studies examining the experience of menopause.

The strengths of the research reviewed was the number of studies that have researched the meaning of menopause across cultures. One limitation of the research was that there have been limited studies completed on the experience of African, Middle Eastern and Latin American and specific groups of Asian women. Weber (1994) studied aging and menopause in women from these cultures however, menopause was not studied in-depth. Therefore, due to the paucity of research on menopause in certain cultures, this study will focus on one of the cultures where research is scarce, the experience of menopause for Korean women.

In the literature review, common themes and the significance of menopause across cultures were found among many of the studies reviewed. However, despite common themes among studies, the experience of menopause for women across cultures is unique. In the literature review, meanings of menopause varied from similar experiences between Tanzanian and North American women (Moore & Kombe, 1991) to very diverse experiences of Mayan women (Beyene, 1986), South Indian women (George, 1996), and Newfoundland women (Davis, 1986). Due to the diversity of experiences, generalization of women's experiences with menopause cannot be made and further research needs to be completed to further understand the experience of menopause for all women across cultures and within cultures.
The experience of menopause is not fully understood by women in North America and Western women are searching for answers and education about menopause. The literature review revealed different strategies for dealing with menopause. Through dissemination of this research and further research on menopause, Western women and all women will benefit from the increased knowledge of menopause.

The quantitative approaches used were a limitation of the research reviewed. Many of the studies reviewed focussed on the identification of symptoms of menopause. Women were asked to identify symptoms from lists of symptoms provided. Flint and Samil (1990) highlighted the problems inherent in providing a list of symptoms and asking women to respond to that list. A woman may not relate symptoms to menopause independently however when symptoms are linked to menopause then women make the connection automatically. As well, the biomedical approach to menopause highlights physiological and psychological symptoms. The biomedical approach to menopause represents the scientific paradigm of the Western world. This paradigm does not fit studies of menopause in different cultures, therefore another paradigm would be more appropriate.

The ethnographic studies of menopause by Beyene (1986), Lock (1986), Davis (1986) and du Toit (1990) provided in-depth understanding of menopause. The ethnographies explored numerous aspects of menopause and communicated information that can be used by other women in understanding the process. Although ethnographies provide information and understanding, they do not answer the question, “what could be?” (Thomas, 1993, p. 3). Critical ethnography as outlined by Thomas attempts to answer this question. Using critical ethnography as the methodological and theoretical
perspective, the purposes of this study are to understand the experience of menopause by
Korean women in Canadian society, the experience of menopause from a cultural
perspective, and the experience of middle-aged Korean women with the health care
system.
CHAPTER III

RESEARCH METHODS

In this chapter, the methods used in this study will be described. The chapter will begin with an orientation to the research method and the purpose of the research, followed by the research design, methods of data collection, analysis, evaluation, and procedures for protection of the rights of the women involved in the study.

The method selected for this study was congruent with the theoretical and methodological perspectives of critical ethnography and the purposes of the study. Critical ethnography was selected in order to study Korean women's experiences of menopause in Canadian society. The women's experiences of menopause were explored through analysis of their stories. The purposes of this research were to understand the experience of menopause by Korean women in Canadian society, the experience of menopause from a cultural perspective, and the experience of middle-aged Korean women with the health care system. Specific questions include: (a) How is menopause experienced by Korean women living in Canada? (b) How are the Korean women's experiences influenced by cultural values and beliefs? (c) How are the women's values and beliefs congruent or incongruent in the context of the Canadian health care system?

Research Design

The research design for this study was descriptive and non-experimental. Critical ethnography was the theoretical and methodological approach used to understand the experience of menopause for Korean women in Canadian society. The study involved analysis of the women's stories of their experiences with menopause.
Ethnography provides researchers and participants an opportunity to develop knowledge of cultures. Critical ethnography is an attempt to identify and illustrate the processes by which cultural repression occurs (Thomas, 1993). Within this framework, the purpose of knowledge is to emancipate and empower the participants. The knowledge obtained is reflected upon to analyse hidden agendas, power centres and assumptions that inhibit, repress and constrain individuals or participants (Thomas). This new knowledge obtained by the participants is viewed as synonymous with having new power. Once the participants have knowledge of social, cultural and power structures, they will have power. With this knowledge, participants and researcher may be empowered to act. The researcher and participants attempt to use this knowledge for social change (Thomas).

"Culture 'speaks itself' through an individual's story" (Riessman, 1993, p. 5). Through narrative analysis, "it is possible to examine gender inequalities, racial oppression and other practices of power that may be taken for granted by individual speakers" (p. 5). Through studying narratives from several Korean women regarding their experiences with menopause, similar experiences of gender, racial or power inequalities may be identified among the narratives. These similar stories will form an aggregate to be reflected upon by the researcher, the participants and the reader. Through the collection of stories, it is possible for the individual, in collaboration with the researcher to understand the inequalities and to become empowered to change these power structures.

In critical ethnography, there is an emphasis on the stories of the individuals. Critical ethnography is more than just the content. It examines how something is said in the context of the shifting roles of speaker and listener (Thomas, 1993).
Sample and Setting

A non-random purposeful sample of seven Korean women living in a mid-sized city in Southwestern Ontario participated in this research. Purposeful sampling involves selecting informants who were best able to meet the informational needs of the study and who were willing to reflect and share with the interviewer (Morse, 1991). The method of sampling must be both appropriate and adequate. "Appropriateness refers to the degree to which the choice of informants and method of selection "fits" the purpose of the study as determined by the research question and the stage of the research" (Morse, p. 134). Adequacy involves the sufficiency and quality of the data. Relevance, completeness and the amount of information obtained are the criteria to ensure adequacy. Final sample size was determined during the course of the study due to availability of participants and when there was no new information identified by the researcher during interviews.

Limitations with purposeful sampling are the ability to generalize and the risk of bias. Purposeful sampling is used as a strategy when one wants to learn and understand something without generalizing to other studies (Patton, 1980). Since generalization is not one of the aims of qualitative research, this sampling technique was appropriate for this study. There was an inherent bias in the selection process. All of the participants had self-selected themselves with the assistance of a contact person. However, since the participant must have knowledge about the phenomenon of interest to ensure appropriateness of the sample, bias in this study is consistent with qualitative approaches and will be used to facilitate the study (Morse, 1991). However, to ensure that all facets of the issue were covered, the women who were invited to participate had very diverse experiences with
menopause.

**Inclusion Criteria**

The criteria for participating in this study were the participants must be (a) Korean women, (b) presently experiencing or had experienced menopause, and (c) the women must speak English.

**Sample Size**

The sample size was determined during the course of the study. Morse (1991) has suggested that a priori sampling may not be appropriate because in such an approach, the researcher does not take the cues from the participants’ stories but makes deductive assumptions about inclusion. Usually these assumptions are based on demographic variables, which may turn out to be insignificant, before hearing the participants’ stories and taking cues from the data. There are no set numerical guidelines for sample size and it is based on the appropriateness and adequacy the data obtained. Practical issues, in particular, availability of potential participants, were also influential in determining sample size.

**Procedures**

**Gaining Access to the Participants**

Gaining access to the participants occurred in stages. The first stage involved recruiting a contact person from the Korean community. The contact person assisted in the identification of Korean women who met the study criteria and made initial contact with several potential participants. The names of those who expressed an interest in participating in the study were shared with me. I then contacted the potential participants
to discuss the study.

Since this initial stage did not result in sufficient data for saturation, the "snowball" strategy of sampling was also used. In accordance with this approach, the women were asked at the end of the interviews, if they knew of any other women who might be interested in participating in the study. This strategy resulted in the recruitment of two additional participants. Two from the initial group of women refused to participate in the study so they were asked if they knew any potential participants. They did not provide any further participants.

Potential participants were contacted by phone. If the potential participants were interested, the letter of information was sent to them (see Appendix A). The investigator followed up the letter with phone calls to discuss an interview time and to answer any questions from the participants. An interview time was arranged and informed consent (see Appendix B) was obtained at the time of the interview. The interviews took place at either the participants’ or the researcher’s homes, whichever the participants preferred.

**Interviews**

Individual interviews were conducted with the women who agreed to participate. All of the interviews were tape-recorded. The interview lasted from one to two and a half hours and an interview guide was used. Probes were used as necessary. "Probes are used to deepen the response to a question, to increase the richness of the data being obtained, and to give cues to the interviewee about the level of response that is desired" (Patton, 1980, p. 238). The use of probes differed with each interview. Occasionally probes were used to give more detail, to encourage participants to elaborate on a topic, or to clarify
what was said by the participant. The interviews were dialogic in nature.

**Follow-up Interviews**

Follow-up interviews or phone calls occurred after all of the initial interviews were complete. These interviews were shorter, lasting several minutes to one hour in length. The purpose of these follow-up interviews was to check the meanings with the participants. This checking of meanings between the participants and the researcher is consistent with the theoretical perspectives of critical theory.

**Instruments**

**Interview guide.** The Interview Guide (see Appendix C), comprised of 4 broad open-ended questions, provided the major source of data. The questions addressed the topics of the effects of culture and menopause, the women’s personal experiences of menopause, finding out about menopause and their contact with the health care system. Less structure in interview instruments gives greater control to the participants (Riessman, 1993). “The purpose of open-ended interviewing is not to put things in someone’s mind but to assess the perspective of the person being interviewed” (Patton, 1980, p. 196).

**Demographic questionnaire.** A structured demographic questionnaire (Appendix D) was used to collect descriptive data about the women. The purpose of this instrument was to obtain additional contextual information. Background information for the women included age, family members, country of origin, year of entry into Canada, languages spoken, religion, occupation and health status.
Data Analysis

Data collection from the individual interviews resulted in the women’s personal stories. The audio-taped interviews were transcribed verbatim by a secretary who had been trained for this purpose. There were language difficulties during transcription; however no data were lost. Field notes were recorded in a journal shortly after each interview and included personal feelings, thoughts, and reflections throughout the process. Lipson (1991) suggested the journal should include ideas, fears, mistakes, confusions, breakthroughs and problems that arise during field work. Data analysis was conducted by identifying meanings from the data using QSR NUDIST 3.0. The participants and researcher collaborated on the identification of the meanings to as great a degree as possible. The analysis was used to understand the experience of menopause by Korean women living in Canada and to empower these women and the researcher to ideally understand the influences and possibly change the influences on the women’s lives.

The content analysis began at the onset of data collection. The tapes were listened to numerous times and the transcriptions read thoroughly and checked with the audiotapes for accuracy. This checking of tape to transcription was important for the interviews when there were language difficulties. The complete transcription was read and “cleaned up.” This latter process involves retranscribing selected portions to determine narrative forms for detailed analysis (Riessman, 1993). “By transcribing at this level, interpretive categories emerge, ambiguities in language are heard on the tape, and the oral record—the way the story is told—provides clues about meaning” (Riessman, p. 58). The researcher determines where the narratives begin and end, thereby establishing boundaries for the
narrative.

Once the transcribed interviews were cleaned up, they were loaded into QSR NUDIST 3.0. The program was used to categorize sections of the stories. These sections were determined by content areas such as diet, herbs, different feelings, physical experiences etc. One hundred and two nodes were formed and they were ultimately condensed into themes after analysis of the nodes. Word searches using words such as control were used as the development of themes emerged.

Evaluation Criteria

Evaluation was completed through validation. Validation is the process by which to make claims for the trustworthiness of an interpretation. Validation is determined through persuasiveness when theoretical claims are supported with evidence from informants' accounts and when alternative interpretations of the data are considered (Riessman, 1993). Correspondence is one aspect of validation. Correspondence refers to checking back with the participants to determine if the interpretations are recognizable to the participants.

Consistency criteria are internal checks that involve comparisons between interpretations of various parts of the text with each other or between parts or all of the text and other texts (Allen, 1995).

Pragmatic use and persuasiveness were used to determine validity of the study. Persuasiveness looks at whether the interpretation is reasonable and convincing (Riessman, 1993) and pragmatic use demonstrates validity of the study through the extent that the knowledge developed is used by other researchers. Further discussion of the
evaluation criteria will occur in Chapter 5.

**The Role of the Researcher**

In critical ethnography, the use of self as researcher focuses on subjectivity rather than objectivity. The role of the researcher in this study was complex. My cultural background is very different from the participants. I needed to be aware of the differences at a conscious and subconscious level. This self-awareness involves knowledge and understanding of my own cultural, social, and political background and the recognition of my situation of relative power from both the researcher role and my background as a white, Canadian woman. My background has influenced my values just as the participants’ background has influenced their values. We need to understand each other’s values, beliefs and practices. Understanding the values of another person is vital to understanding the power differences in that person’s life. Therefore, value clarification must precede value negotiation (Allen, 1992). Since our backgrounds are different, the task of understanding others who have such a different cultural and power position is daunting. Allen suggested that the focus must first be on the participants’ world views; secondarily on the topic at hand, which in this case, was menopause. This process of self-awareness and recognizing world views has been called “situated discourse” which locates the speaker, specifying the personal, social, and cultural perspective of the speaker (Allen). One of the major priorities for the participants and myself, because of the difference in our values and experiences, was to focus on coming to a mutual understanding of our individual perspectives. Along with mutual understanding, there needs to be mutual respect.

In critical ethnography, the contributions of the researcher during the process
are not ignored. This process of the researcher’s participation is called reflexivity.

Reflexivity refers to the moment-to-moment, often subconscious, adjustment of individual behavior (Allen, 1992). Reflexivity refers to the interviewer/researcher as being part of, not separate from, the data and being self-aware of his/her role and internal state (Lipson, 1991). In ethnography, reflexivity focuses on what characterizes the immersion of the ethnographer in the setting, for example, the stress of the observer or the ease of adaption to the socialization process (Aamodt, 1991).

I do not make any statements that I empowered these women to make changes in their lives. I do not see myself as an activist on their behalf. I view myself as someone who has much to learn from these women and possibly through dialogue, we will recognize the influences and the values in the women’s experiences of menopause and together through understanding each other, these influences can be acknowledged, understood and possibly changed.

Protection of Human Rights

Approval for this study was obtained from the Health Sciences Human Subjects Review Board Committee at the University of Western Ontario. Participants were informed of their rights and possible risks or benefits from participating in the study. A letter of explanation with my home telephone number was given to participants. The women were told that they could change their mind and withdraw from the study at any time, without any consequences to them, and that they could refuse to answer any questions.

Confidentiality of the participants responses’ was maintained by using fictitious
names, chosen by the women, to protect their identity during interviews. The fictitious names were used on the transcribed interviews. All data were kept in a locked file.

By telling their stories, the women were exposing very personal information. Where necessary, the researcher supported the women as needed and answered the women’s questions.
CHAPTER IV
ANALYSIS

The research was guided by three questions: (a) How is menopause experienced by Korean women living in Canada? (b) How are the Korean women's experiences influenced by cultural values and beliefs? and (c) How are the women's values and beliefs congruent or incongruent in the context of the Canadian health care system? Each question will be addressed in this chapter and the themes will be presented.

The QSR NUDIST 3.0 program was used to analyze the transcribed interviews. The interviews were coded into nodes and from the nodes, themes were derived using the NUDIST program. The themes were discussed with the women. Two attempts were made to get the women together as a focus group. However, on both occasions, the women were not available or canceled the day or night of the focus group. At the second meeting, one woman arrived hoping to talk with the other Korean women. She was visibly disappointed she would be unable to do so. I was disappointed and frustrated but not surprised. I asked her what she thought were the reasons why the women may not have wanted to come and she thought they were probably too busy. I suggested the women may not have wanted to share with each other about their experiences with menopause and she did not agree or disagree with this possibility. The themes were checked through a discussion with one participant in person and follow-up phone calls with five of the other women. All of the women appeared friendly and happy to talk so I did not feel their refusal to come to a focus group was because of feeling uncomfortable with me. Since the Korean community is fairly small, some of the women knew each other through church or
other organizations. This familiarity may have made them reluctant to share such personal information with each other, a conclusion which was supported through the identified themes.

Because this community of women is relatively small, the need to preserve confidentiality is paramount. Therefore, I will not give specific information, but will provide an overview of the demographic make-up of the group.

Seven women were interviewed. All were from South Korea. They had been in Canada from 12 to 25 years. All spoke English and Korean. Their ages ranged from 39 to 52 years and all were married except one. They all had at least two children ranging in age from 5 to 24 years. Three of the women had an older parent living with them. All of the women were employed outside the home. Five of the women worked in the family-run business. One woman worked as a secretary and one was a computer technician. All of the women had post-secondary education in Korea. Two of the women had trained as nurses but were no longer nursing. Six of the women were Christian, either Catholic or Presbyterian, and one was an agnostic. Reasons given for coming to Canada included: starting a new life; looking for a change; and joining other family members already in the United States or in Canada. Three of the interviews took place in my home and four of the interviews took place in the participants’ homes. The interviews ranged from 1 to 2 ½ hours. I met various family members during interviews. Two husbands sat down and discussed menopause with their spouse and myself. One husband wanted to discuss male menopause and asked if I was studying it. In order to ensure confidentiality, pseudonyms were used in this chapter which were selected by the women.
Three categories of themes were identified from the interviews and after follow-up discussion with the women: experiencing menopause, managing menopause and encounters with the health care system. Experiencing menopause encompassed the women's feelings and physical responses to menopause and their awareness of menopause.

**Experiencing Menopause**

**Physical Responses to Menopause**

The women described uncomfortable symptoms associated with menopause. Hot flashes, headaches, and lack of energy were the symptoms most frequently identified by the women.

"I can't stand it." The women described experiencing hot flashes as well as discomfort with temperature changes. Sookja, a 52-year-old woman, started experiencing hot flashes over one year ago. The hot flashes were occurring irregularly, and at times months would go by between hot flashes. Once the hot flashes recurred, she would have them several times a day.

Well it’s sort of, I don’t know, it just gets hot. Oh, I just can’t stand it, I’m so hot! And then a few minutes later it just goes down and I feel so cold, well usually — I am usually cold, I don’t know. So I go back to the cold state.

Since the interview, Sookja has started on hormone replacement therapy (HRT) to help control the hot flashes. She was reluctant to start the HRT because she did not believe in taking medications. However, at present, she feels better and the hot flashes are more manageable.

Other women also experienced temperature changes. Young was very sensitive to
temperature changes and would often sweat heavily while walking and then quickly become cold. At the time, Young did not recognize sensitivity to temperature changes as an early sign of menopause.

Minja talked about her struggles with temperature changes. She had experienced hot flashes since 1987. She described the hot flash as being “constantly hot, and my heart beating so rapid.” Minja used the word, suffer, to describe her experiences with hot flashes.

...how I suffered, like always holding the fan and like that. And I took off the clothes because it is like a fire inside me. I can’t stand it. I can’t stand it and like that.

Minja started hormone replacement therapy on two or three different occasions. However, she was afraid of the risk of cancer with hormone replacement and she stopped. She tried acupuncture but after a while her symptoms got worse. Minja perceived herself as having few options. Although she strongly believed the body could cure itself, and on most occasions did not take medications, she started again on hormone replacement.

I don’t feel any symptoms like hot flashes or night sweat. I don’t have that now. Because I feel okay. But the other side of my mind says no, don’t take it. But I don’t have a choice. I have to. I can’t stand that kind of uncomfortable symptoms.

Thus, although Minja continues to dislike the need for medications, they appear to offer the only means of relief from the discomforts of menopause.

Mia was aware of hot flashes but she had not experienced them. She commented that in Canadian society there is an automatic link between hot flashes and menopause. She believed that Korean women did not experience them because she had never heard Korean women discussing hot flashes and she had never observed a Korean woman
experiencing one. She had observed Canadian women experiencing them because of the skin color. It was more obvious to see pale-skinned people having a hot flash compared to Korean women with olive-colored skin.

Although Mia had not observed Korean women experiencing hot flashes, four of the women in the study did experience them. For the women who experienced hot flashes and temperature changes, they were described as unpleasant and at times, almost unmanageable, reflected in the statement, “I can’t stand it...”

Other symptoms were described in vivid terms. In particular, two women reported headaches as another negative symptom of menopause.

“The headache is unbearable.” Mia is 49 and is just starting menopause. She complained of severe headaches. “I had terrible headaches...I couldn’t move my head it is kind of a migraine.” Mia was afraid of the headaches because she found them “almost unbearable.” The headaches began a couple of days before her period, stopped during the period and resumed after the period. Mia used “all kind of herbs” to get rid of the headache.

Kuyong Sook also experienced headaches. She was angry that she had had a hysterectomy at age 30, and felt the surgically induced menopause had resulted in a lot of her problems, particularly the migraines. The migraines incapacitated her to the point she was unable to think, or do anything with her children. Kuyong Sook blamed the migraines on the surgery and the use of the menopause patch. She expressed frustration that the migraines were induced from an outside source and not a result of natural causes. She continues to question the reason for her surgically induced menopause
at such a young age because she has had to endure so many negative side effects over the past 10 years since the surgery.

For both women, the headaches and migraines were almost unbearable. They questioned why they had to suffer and they felt they had little control over stopping the migraine from occurring. Being unable to stop the migraines from occurring was frustrating for both women.

Lack of energy. Five of the women talked about a lack of energy and not being interested in the activities around them. Kuyong Sook talked about her experiences of fatigue. At one point, she was not interested in anything, she had tried exercise but it didn’t help. Friends would ask her to go shopping and she had no interest in shopping although she had enjoyed it in the past. Kuyong Sook was surprised by the lack of energy because she usually had lots of energy for her children, her husband, her work, and her home. When talking about her lack of energy, she appeared amused about her fatigue. Lack of energy was so different from her usual self, she appeared shocked or surprised by the change.

Soonee had talked to her sister about her fatigue and her sister had suggested she take Royal Jelly peel, a homeopathic medicine available in the United States and Canada. Soonee took the Royal Jelly peel but found it caused weight gain and increased her appetite so she stopped taking it. The benefits did not outweigh the side effects.

Sookja described how her fatigue had changed her priorities, particularly with respect to housework. She viewed her inability to do physical work as one aspect of growing older, as well as the effects of “the change.”
Because I can't handle it, I guess that's why because before physically yes, I could do that. But now I can't. I just can't do it. I think that's the change too. Like I can stand up and work for a couple of hours and then I have to sit down and have a rest. I just can't physically handle that. Like my body is aching, and like my joints are achy and stuff like that so I just can't handle it.

In the past, her priority was to keep a very clean house but now she did not care if her house was messy. Sookja told her husband if he wanted the house clean, he would have to do it himself. She worked full-time outside the home and she recognized she had no longer had the energy to expend on household chores.

Joan, a 48 year-old woman, did not perceive menopause as a particularly noteworthy phase in her life. She experienced both hot flashes and fatigue. However, she did not elaborate on either symptom except to say that the hot flashes were not severe and she did not relate the fatigue to menopause until after it was over. She had gone through it and now did not think about it. Menopause was a closed issue, there was nothing more to say. She said she did not remember her experiences and had gone on with her life.

Although many of the women experienced fatigue and loss of interest in activities, these symptoms were not viewed as severe as the headaches and hot flashes. All of the women experienced one or more negative symptoms associated with menopause. The severity of the symptoms differed and the way the women managed the symptoms also differed. In the following section, the feelings which accompanied the symptoms will be addressed.

**The Feelings of Menopause**

Accompanying the physical symptoms of menopause were a cascade of strong
feelings. Not all of the feelings were negative. The women felt positively about menopause, once they felt they were in control. However, initially, the women shared their negative feelings about menopause. Even though a woman may not have experienced the strong feelings themselves, they shared stories of other women’s experiences.

"I was like death." Depression was one of the strongest emotions expressed by the women. Young’s feelings of depression were severe. Young was married and had three children. Her husband was ill for several years and she managed the family business and cared for her husband and her children. At the start of menopause, Young had prolonged bleeding which resulted in blood transfusions and hospitalization. Young expressed how difficult menopause was for her and how important it was for her roles and responsibilities to change. She needed her husband and her children to take on some of the responsibility for running the business and the household.

...about two months ago, I was so upset. I was depressed, you know and everything can make me upset, mood swings, I was so unhappy. ...For a whole month I was so upset, crying, and I didn’t even go to church. I always—I’m a church goer. I have lots of things to do, too, in church but I didn’t go for four weeks in a row. I was that upset. ...I went through a lot lately and upset and crying all the time, wanted to die. I was rather I died than alive. I was like death.

Young’s depression was evident and very poignant. She was matter-of-fact in relaying this story and at the time of the interview, she stated that the sadness had passed and she was now taking time for herself. Her husband and family were now more supportive, and they were taking on more responsibilities.

Mia described how other Korean women experienced depression and she attempted to explain and give meaning to the experience of depression for older Korean
women.

We just thought it was when we get old there is a time you get depressed and maybe that's...they used to say after, you know, just the Korean women are very devoted to family affairs so they don't work outside of the home but they take care of the children and they take care of the husband and the relationship with family members and they get these all kinds of things, cooking and everything. So they said that because is after children grow up they don't need the mother so much. And they have not much to do and suddenly they have so much time on hand and they don't know what to do. They thought that's why the people got depressed and now I'm thinking that is about the time they are having menopause and they misunderstood it maybe.

Thus, from Mia's perspective, there were life stage changes occurring for the women at the same time as Korean women experience menopause. Mia, speaking on behalf of other women, believed the women became depressed because of the loss of the mother or caregiver role, not unlike an empty nest syndrome.

From Mia's and Young's descriptions, there were a number of factors related to depression: menopause, children leaving home and lack of family support. There was not one single cause. The women's depression was complex.

**Being angry and upset.** The women also expressed feeling angry and upset. Soonee expressed that at one point she thought she was "going crazy" because of her emotional mood swings.

...I'm crying and I forget everything and it doesn't matter if people are thinking about me being crazy or not, I can't think about that at the moment you know, I am just kind of torn like a child or children, you know, I'm just crying and my tears are coming down and it looks mess and it looks ugly...

...I feel like I am getting crazy maybe, that the nerves break down or something like that because a lot of people talk about a nervous breakdown and so I say is that a nervous breakdown or am I getting crazy, that's what I am asking my family doctor, you know, all the time and she say no, no, no.
During my interview with Soonee, it was quickly evident she needed someone to talk to and with whom to share her experiences and feelings. She talked continuously for the first half-hour of the interview answering the first question. There was no need for the use of probes on my part. There was a waterfall of information she wanted to share with me. Soonee was one of the youngest women in the group. She enjoyed talking to other women about her experiences but she had very little opportunity because of her busy life, working and looking after the children. She did not talk to her husband about her feelings. She needed the opportunity to share and talk to someone who would listen.

The range of feelings and the depth of emotion felt by all of the women was evident in their expression of their experiences. Another sensitive issue for the women was their views on the effect of menopause on their sexuality.

**Sex and Menopause**

The topic of sex was not an easy one to broach with the women for many reasons. During my initial contacts with these women, one woman explained to me that she could not participate in the study because Korean women do not talk about personal issues like menopause. Another participant informed me that a Korean woman does not talk about her sex life to anyone. From these two comments, I knew I was on “shaky ground.” Surprisingly, three of the women took the lead on this topic and introduced the topic into the conversation without any probing from me.

Soonee talked about her sexual life openly although she did not name what she was discussing during her lengthy explanation.

So then maybe I’m too dry, you know and I ask my sister-in-law and once we
were talking about that and she is different, you know, she is joyful and she never has a kind of a pain, you know. So I just figure out maybe all people is different. But myself is not interested but I wonder—and before I am already not interested and then like menopause getting more, you know, lose interest.

...my husband say you are 40 and then you already not like it, really. Then I was reading some kind of magazine, you know that’s a problem and maybe you better talk it out and ... so I told my husband and he said don’t worry, you know, you are okay. You’re fine and he’s okay, you know. But I’m kind of sorry because he wants to do something but I say oh no, go away, leave me alone like that, like that and sometimes it’s once or twice I know I hurt his feelings so you know after that I am curious and wondering is he okay, you know like that, and I don’t like that you know?

So some day like I say how come I am always wondering about him and you know, and even if I am really tired and I am really sick and I just say no, no, I say no and then as soon as I say no then I feel not comfortable, maybe he’s going to—what is he thinking about, you know and I hate those feelings, after that.

And then one day I just complained about him, how come I always feel so guilty, you know, what about me? I never have a good feeling, I never have after that feel good about it or whatever, I’m just trying to do something to always make you happy, you know, I complain. How come I always try to make you happy, you never make me happy you know, like that?

There was emotional conflict for Soonee. She felt obligated to please her husband sexually and when she did not fulfill this role, she felt guilty. Yet, once she had the opportunity to think about whether her husband made her feel happy and whether he tried to please her, she felt angry. She perceived the issue as one-sided, she was meeting her husband’s needs or considering his needs while he was not meeting her needs. There was an emotional struggle. Soonee was caught between being a “good wife” and looking after herself and her personal needs. Since Soonee showed less interest in sex during menopause, the issue of sex had brought out other issues in the relationship.

Sookja expressed similar disinterest in sex, however, she felt her husband had
mutual feelings about it. Like Soonee, Sookja did not use the word, sex, during her reply. Sookja described the loss of interest in sex in terms of changes for her husband. She felt men changed psychologically and "he doesn't want to be bothered" about sex. Yet, she did not want to be "bothered by him, either." She was not sleeping with her husband, often going to sleep on the sofa and staying there for the night. At the end of the discussion about sex, Sookja did add, laughing, that maybe there was little interest in sex because "it was too long with the same person."

Kuyong Sook had heard that a woman's sexual life might be different but in her own experience she was happy with her sexual life and felt menopause brought freedom. There was no longer concern about a period. After her hysterectomy, Kuyong Sook was concerned about her sex life because of her grandmother’s experience. Her grandmother, her mother’s mother, had a hysterectomy when she was young. After the hysterectomy, her grandmother was no longer interested in sex and her voice became husky. Kuyong Sook felt that her grandmother was jealous of the relationship between her daughter and her husband because of the good relationship they shared and she tried to make trouble between them. Kuyong Sook’s mother was especially concerned about changes from Kuyong Sook’s hysterectomy because of the negative experiences with her mother.

These women had experienced or had heard stories of changes in a woman’s sexuality or interest in sex during and after menopause. For some it was a loss of interest. In contrast, one woman felt there was new freedom in experiencing sex. For the women who had lost interest or had decreased interest in sex, there were conflicting emotions. There was the conflict between pleasing one’s spouse and pleasing one’s self. The conflict
was greatest for Soonee who always worried about her husband’s needs even though her
own needs were not being met. For Sookja the conflict was not so evident. Sookja had
reached a point in her marriage where she took cues from her husband about his needs,
but she made her own decisions too. Age and length of marriage may have played a factor
in the desire to please one’s partner. Sookja, 52, was the oldest woman in the study and
married longer than Soonee, 40, one of the youngest participants. However, if the older
women are viewed as more traditional, age should have the opposite effect in this case. In
terms of communication, there did appear to be more discussion between Soonee and her
husband about the issue as compared to Sookja and her husband. The experience of
menopause did have an effect, either negative or positive, on the women’s sexual lives and
on the relationships with their husbands.

All of the women expressed negative feelings and symptoms surrounding
menopause. For some women, the experiences of headaches and hot flashes were so
difficult, they had to seek help from the Canadian health care system. Seeking help from
Western medicine went against their belief that menopause was a natural event. Many of
the women were taking hormone replacement therapy. The range of symptoms and
feelings came as a surprise to the women. The women were not prepared for their
experiences.

Awareness of Menopause

The one sign that was familiar to all of the women regarding the onset or
beginning of menopause was the change in menstrual periods. The women were
knowledgeable about menopause being the end of a woman’s period. A change in
menstrual patterns was an indicator to the women that menopause had begun.

Young had severe menstrual changes resulting in hospitalization and blood transfusions. One year ago, Young had five weeks of heavy bleeding. She went to see her doctor, and was given medication. She continued to bleed, her hemoglobin went down to 59 and she was hospitalized. She received blood transfusions and she felt weak for several weeks. Young was unaware of what was normal and abnormal bleeding during menopause. She did not have a reference point to compare her experiences.

Sookja was aware that menopause resulted in the end of a woman’s period. She was looking forward to the end of her period but did not realize what else menopause involved. “Well, menopause, I thought that you stop having periods; that’s it.” She expected the end of her period but did not expect the hot flashes that accompanied the menstrual change.

These two women were surprised at the changes they experienced. They were not aware of the menstrual changes that would occur and one participant was hospitalized. There was knowledge that menopause meant an end to a woman’s period but the women expected the period would end and that would be the extent of menopause.

Experiencing menopause included the feelings and physical symptoms of menopause, changes in sexual relationships and the awareness of the experience. The women told of many negative feelings and symptoms about menopause but the negative consequences did not affect their ability to manage menopause.

**Managing Menopause**

The women shared the methods they used to cope with menopause. The theme
identified was the importance of control: the importance of controlling the menopause experience, the control of emotions, control of knowledge, control of choices, and control of their lives.

**Control of the Menopause Experience**

So now I control by myself. The women felt it was time to take control of menopause. Kuyong Sook expressed anger about her hysterectomy. She felt she had not been part, or did not understand the ramifications, of a decision to have a hysterectomy when she was 30. Because she felt she lost control over that decision, she expressed a need to gain control of her life now. She needed to let her family know what was happening to her. It was important to her for her family to understand her feelings and it was important for her to gain control in her life.

**Control of knowledge.** Several women believed in the power of knowledge. Soonee articulated her belief that knowledge of menopause enhanced her sense of control.

... we didn’t have any information before and so it is kind of a shock you know, but Canadian women maybe they got information so like everything is ready and if something happened they can manage better than us.

I feel like but maybe it’s wrong, but I feel like if I knew then I can control myself a little bit easier... the first time I am kind of really really wondering and then it is a kind of a shock for me because I never heard those things and I never talk with old people and I never heard it before when something happened to me. I feel like I am getting crazy maybe.

And so I feel that if I knew I can control myself and then now I know so it is a little better for myself, you know, I can control and have less anger and less yelling and things like that. Now totally I can control myself. Still sometimes, suddenly I feel sad and tears are coming down but I can be holding that. Before I didn’t know, I was just kind of in shock, you know? I’m scared and I’m afraid because I am getting like crazy, but now I know.
So my opinion is if people knew and were more educated and get more information than we can get through it easier.

For Soonee, having knowledge of menopause meant being prepared and knowing what to expect. At times, Soonee believed she was going crazy because of her mood changes. If she had known of possible mood swings, Soonee would not have been so afraid. Her experience would have been less traumatic.

**Canadian women have more knowledge of menopause.** There was a perception by some of the Korean women that Canadian women have an easier time with menopause. The women perceived Korean women were at a disadvantage because of their lack of knowledge about menopause.

Soonee found menopause came as a shock and believed Canadian women are better prepared and they manage better because they have more information. When Minja sought information about menopause, she did not ask the Korean women. “They are in the same boat as me.” Minja thought there were a number of reasons why Canadian women had more information. Korean women have the disadvantage of communicating in a second language. Since Canadian women discuss menopause more frequently, they would have more information and be able to ask more questions. “But mostly the Korean ladies have a little small business, they are busy with their kids and work at the time so there is not many chance to talk with the Canadians, so they don’t have more information.” There was a perception that Canadian women are able to talk to more people and have access to information, thus, they are better prepared for menopause. For both Soonee and Minja, there appeared to be a desire to talk more about menopause to other women. However,
the women did not have much opportunity to talk with others so they sought knowledge in other ways.

**Self-directed learners.** Since the women did not have an opportunity to talk to other women, they sought information on their own. They sought information from health food stores, medical dictionaries, home medical books and magazines such as Time and women-related magazines like Good Housekeeping. They also borrowed books from the library.

Young wanted to be in total control of the knowledge she attained. She did not trust anything anyone told her, she only trusted what she read. For Young, there was no benefit to talk to others, unlike Soonee and Minja who wanted to discuss menopause with others. Having knowledge was one way to be in control of menopause. Cultural factors also influenced the woman’s control of the experience.

**Being Dependent and Controlled: The Incassance of Culture**

Korean women live in a patriarchal society. A woman’s mission is to be a “good wife and mother.” Some of the women in the study felt frustrated with this arrangement. They felt that Korean culture placed them in a dependent situation. Being controlled made them vulnerable. It appeared menopause brought the frustration of their relationships to the surface.

Mia had experienced the effects of control from the culture in her life. She had lived for many years in a controlling relationship.

I can’t say as presenting all Korean women but in my case mostly. And the marriage is more important too, to be together than is for love and joy. And once you get married you are committed all your life. So we try to stay in marriage and
we think that’s not best for the children because in our culture the children from broken family the other people look down on them. So we tried very hard to stay in marriage and we never say anything, you know it is a family problem, we never say outside to other people, you know. And that’s the way we do. Nobody questions your family life. What is happening in your family life is none of (their) business.

So you get bitter or anything so it’s nothing to do with you. And if you beat up your wife, and beat up your children, even if they know they don’t do anything. They are not like here. So we grow up, everything just accept; accept. And we don’t know how to express our anger at things. So maybe we got used to abuse (in) many ways. Even when I was in middle school with a uniform and went to school a teacher hit us with a stick on our neck and leave mark.

From Mia’s perspective, a Korean woman may stay in a marriage, regardless of how difficult and harmful the relationship, because of the importance of staying married for the benefit of the children. Mia added that what happens within the family unit is private and even if neighbors or friends know there may be abuse, they will not interfere. As a result, from Mia’s perspective, women get used to abuse and accept it as a way of life. They do not get an opportunity to demonstrate their anger and the anger remains pent up inside.

Soonee continued with the theme that women remain silent. She expressed a lot of frustration in her relationship with her husband.

Like something you know, like at house, they don’t like us saying much, always, so we don’t have conversations or something like that. Always something decide, father decide you know. All the family members are following father’s decision, you know?

Woman is no control about that, you know? That’s why we are always quiet and so we can’t tell our feelings or our opinion, always bosses decide everything like that. Yes, like the old people. Grandfather, and used to be grandfathers live together. So everything is older people. We obey them, you know. And the father is king.
Soonee felt that her husband never asked politely for anything. He just ordered her like "a maid or a housekeeper." She perceived her life's purpose was to serve. As her children started going to school and became more grown up, Soonee felt she was "nothing."

Mia explained the role of women in Korean culture. Women "have to sacrifice themselves to the family." They are dependent on the men in their lives. Divorce is uncommon because the children stay with the father. The mother becomes a stranger.

Once Korean families become accustomed to Canadian ways, there are sometimes difficulties. In Mia's opinion, women liked to adopt Canadian culture but the men wanted the women to follow Korean customs. The men wanted the wife to serve the husband but also to go out and work outside the home. Mia identified family problems when women "open their eyes" and have stronger opinions and the men feel women are getting "headstrong" and want them to return to Korean ways. The men want the benefits of women working in family-owned businesses but they also want the women to continue with the household expectations.

As is evident in these passages, Mia and Soonee were two of the more open women in the study. The other women did not share their feelings about their roles. They did, however, share stories about the importance of obedience to their father and ancestors.

Mia shared one humorous anecdote about the role of the married woman in Korea.

We used to say at the train station you can tell they are just married or they are
coming from honeymoon because if the man carried the suitcase they are on their way to honeymoon and if woman carried the suitcase they are married now.

Mia and Soonee felt Korean women were restrained in their ability to communicate. According to these two women, there were unwritten cultural rules about talking which served to enforce the women’s silence.

**To Talk or Not to Talk About Menopause**

A recurring theme from the interviews was the issue of communication. For several of the women, there was an implied “no talk” policy regarding menopause. For other women, they identified the need to talk. There was the issue of who is the appropriate person to talk to about menopause. There were definite ideas about who was appropriate and inappropriate to discuss their experiences. One of the women I had invited to participate in this study refused to be interviewed because she said that Korean women do not talk about menopause. There was also little discussion between mothers and daughters about menopause.

The women did not discuss menopause with their mothers and if they did, their mothers did not elaborate on their experiences. The mother’s experiences were very different from their daughters. As well, many of the mothers remained in Korea and discussion of menopause was difficult. Most of the women would talk to their sisters and their close school friends. The women who had no relatives in Canada, felt they were isolated and wished they had older relatives with which to discuss menopause.

One way to communicate to one’s spouse about menopause was through a mediator. Soonee had an older woman talk to her husband about her experiences and she
would intervene on the behalf of other women to help them with their experiences. By having another woman to talk to their husbands, the woman did not have to reveal her feelings directly. It was not easy to open oneself up to others.

Keeping silent. The women felt they had to keep their emotions and their feelings to themselves. Soonee thought women did not share their feelings because they were protecting themselves. She attempted to explain why Korean women and men are not open with their feelings. Korean people are proud and want to take care of themselves. They do not ask for help until it was too late. In Korean culture, "quiet is better." Even if a woman knew something, it was better to stay quiet. The educational system did not support the people who voiced their opinions. Students were not involved in any presentations or speaking to a group. If teachers and professors were wrong, it was forbidden to correct them. The student was to remain silent, just as a wife was to remain silent. Soonee was unable to express her feelings to her husband. She felt she had made progress because instead of holding her feelings in, now she often went to the bathroom to cry or yell when her husband upset her. She had not reached the point when she could express her feelings to her husband. She did admit, it would be better if she could express her feelings to her husband but she had not reached that point in her relationship.

Young had hidden her feelings for a long time. She said she always came across as cheerful and happy. People did not know how much she suffered. She wanted people to know that she suffered just like them. It was time to express herself. It was too difficult hiding her true self.
Yes, now I know. If you don't show yourself your feelings about other people, your true feelings, it catches up to you and stays in there and it hurts back to you later. That's how I felt. Because a few times my husband hurt me and then I was pretending like it's okay, I understand, and that attitude? And now I'm so mad about that. Why I didn't say anything and the person still keeps hurting me without realizing it. Why I didn't stop that. It haunted back to me. I learned that. So you keep—you try to be perfect or you do more than you can handle, it comes back to you.

Young felt it was time to look after herself and let her true emotions show. The women expressed that it was very important to take care of oneself and to be in control of what the woman as a person wanted. The women felt they gave and gave to others which left them little time for themselves.

**The Transition From Caring for Others to Caring for Self**

The experience of menopause appeared to be the turning point for the women understanding how important it was to take care of themselves. Minja was taking care of herself by starting new hobbies and taking courses. Since her children had left home, Minja had time to do what she enjoyed. She started a reflexology course because she wanted to learn about her body and help others.

Soonee voiced a desire to help other women deal with this time in their lives and help other women recognize they have to make time for themselves. She wanted women to know they are not alone in their experiences of menopause and she wanted to try and allay the fear of menopause for other women because she had been afraid during her experiences. Soonee saw this period of time as “a second chance to new life.” She recognized she had spent all of her time caring for her husband and her children and little time caring for herself. It was now her time.

Young’s advice to other women was for women to speak about their emotions, to
“come out of your shell” and not to keep their emotions to themselves. Her advice was not to be selfish but make sure you “make time for yourself.” If a woman looks after herself, then she will be able to look after others, if she does not look after herself, she becomes worn out. She will ‘burn out.’

For the women in the study, menopause was the opportunity to look after themselves and do something for themselves. Although the women had many negative experiences, they were able to view menopause as natural and a time of growth. It was a time when they shifted from looking after others to looking after themselves.

**The Meaning of Menopause**

Menopause was viewed by the women as a natural process. Sookja defined menopause from the Korean equivalent, kang-nyun-ki. Kang means changing, nyun means year, and ki means time period so kang-nyun-ki is a changing period of time or a period of time when change occurs. In Korean culture, kang-nyun-ki is a period of change for both men and women in their fifties.

**Menopause is a natural thing.** Despite the women expressing many strong and often painful emotions about their experiences of menopause, they viewed menopause as a natural process, a stage of growth. Minja accepted menopause. She stated, “there is nothing we can do about it. So just to take it, whatever comes.” Mia viewed menopause as a time to grow older. She felt if she tried to stop menopause from happening, there will be other side effects. She would be tampering with the natural order of events. She had advice for other women experiencing menopause.

"I would say don’t think too much seriously. It’s just happening to everybody. If you are not getting sick or something then just accept naturally and eat more"
balanced and as I said eat lots of tofu if it helps. But I wouldn't suggest taking some kind of medication.

All of the women in the group approached menopause as a natural event. They were strongly influenced by Chinese medicine. Sookja, Soonee, Young, Mia, and Kuyong Sook had or were taking herbs. Minja had tried acupuncture for her hot flashes. They believed in the importance of diet, exercise, and the ability of the body to heal itself through the use of "qi."

**Herbs.** Herbs were used by many of the women for different reasons throughout their lives as well as for menopause. Mia tried to avoid medications because she did not trust them. She turned to herbs for help. Mia made dandelion tea for her headaches with menopause. She found her headaches disappeared shortly after drinking the tea. Mia had a warning about natural medications because of personal bad experiences with herbs in the past. She told women to be careful about seeking advice about herbs. They need to seek out reputable naturalist doctors.

Soonee took Black Cohosh Plus, Passion Flower and Royal Jelly peel. Black Cohosh Plus consists of false unicorn root, black cohosh, cramp bark, bayberry, ginger, squaw vine, uva vise, raspberry leaves, and blessed thistle. This combination is useful in aiding the body to produce natural estrogen and to control hot flashes and mood swings during menopause (Living Naturally with Herbal Formulations). Black Cohosh contracts the uterus and increases menstrual flow when sluggish. Black Cohosh contains calcium, potassium, magnesium, and iron. It also contains Vitamin A, inositol, panthothenic acid, silicon and phosphorus. Passion Flower is a natural sedative. Soonee did decrease her dose of Passion Flower because it made her too sleepy. Royal Jelly Peel is available in the
United States and Canada. It is supposed to increase energy, but Soonee found there was the negative side effect of weight gain with it. Except for the Royal Jelly Peel, Soonee felt more relaxed and better while taking the herbs.

Young took Dong Quai given to her by her husband. She felt there were benefits taking this herb. Dong Quai strengthens the uterus (Elkins, 1995) and contains plant sterols that have estrogen-like effects (Sheehy, 1992).

Sookja was considering Chinese medicine but she had not started it. She knew there was benefits to the herbs.

Well, like for instance if you have, if you are generally weak, then you will feel better after you have it but I heard that you have to do it maybe once a year or a couple times a year. It’s not a healing. That’s just—I don’t know if it’s healing or not, but they feel better. They feel stronger. They feel more energy. But I haven’t tried it. Actually I’m thinking about it. Maybe I should try. But I haven’t.

Sookja had tried herbs in Korea but once back in Canada, she found she could only get the herbs in Toronto and she did not want to go to Toronto for them. She also heard that deer’s antler was good for providing calcium but she had not tried it.

Diet. The women were aware of the importance of diet and felt that a Korean diet was a natural way to deal with menopause. They believed the main reason Korean women had an easier time with menopause was the diet. Mia felt soybean products made menopause easier. She had read an article that Korean women had fewer hot flashes because they ate soy products that have natural estrogen in them.

Young believed soy products were helpful as well as looking after other nutritional aspects of the diet.

So I have been eating it, I love tofu, I love soya, all soya products and soya paste. We, Koreans love it. And misot you heard about misot? Same thing but it’s

...a lot of Koreans eat lots of tofu and we always use soya sauce for marinade beef, beef ribs, beef, we always do. We use lots of soya sauce. We use sesame seed oil all the time. That's our main like oil instead of butter, vegetable oil.

Young felt she was at little risk of osteoporosis because of her diet and exercise.

I don't really hear about that. Even me, no. I don't really have aches. Because in my case I love cheese. I love meat. I eat well. Plus I walk right now. You know osteoporosis but I don't really hear from other people. Me, I'm okay. I don't worry about that because I get enough exercise and eat good things.

The women were aware of the benefits of good nutrition. The women believed their diets affected and benefitted their experiences with menopause.

They managed menopause through natural approaches in conjunction with the use of diet and herbs. However, they did not rely solely on Chinese medicine since they were also in contact with the Western health care system. As will be demonstrated in the next section, these encounters were often difficult and challenging.

Encounters with the Health Care System

As well as using herbs and eating healthy diets, the women turned to Western medicine to deal with menopause. However, Chinese and Western medicine did not always fit together. There were incongruencies between the two systems.

Incongruencies Between Chinese and Western Medicine

The women saw incongruencies between Chinese and Western medicine. Mia had lost faith in Western medicine. When her daughter was young, she had a severe skin ailment. Western medicine was unable to help her. Mia found help with Chinese medicine in Korea. Now, she refused to see a doctor. She read books if she needed information and took "what is natural."
Minja, Sookja, Soonee and Kuyong Sook had or were on hormone replacement therapy. The women had concerns about hormone replacement and cancer. Minja tried acupuncture to avoid hormone replacement therapy but she felt that the hot flashes were unbearable without the hormones. She stopped and restarted hormone replacement therapy numerous times.

One reason why Minja had difficulty taking medications was her belief in the body’s ability to heal itself. She believed a person should not have to take medications because the body could heal itself without medications. She believed in the power of “qi.” Minja had heard about the body’s “qi” as a child growing up. Now she read Korean books about the energy of “qi.”

Mostly in Korean word it is “qi.” That is energy. Like an animal, when they get sick they go to a certain kind of grass to eat to heal it, like that. Nobody teach them. Nobody give them medicine, right? It’s a natural thing. And I read a book about energy. It’s author was Japanese. And I read it and read it and I agree with him about the healing natural power.

Wolfe (1993) described “qi” (pronounced “chee”), as energy, influences or information. “Qi” is responsible for all movement, warmth, protection against the invasion of disease, transformation of raw materials and holding the body organs, tissues, and fluids in place against gravity. “Qi” also controls all movement and flow of blood in the body. “Qi” is difficult to understand in terms of Western medicine. The Chinese view of the human body is very different from Western medicine. Since the two systems are very different, it is not surprising the women had trouble with the incongruencies between them.

Having control over options. The women wanted to have control over their health
care. The women expressed frustration when the control over their health was taken away. Minja was annoyed she was not given options when dealing with menopause. She was frustrated her family doctor did not tell her about the different choices for treatment about menopause. She was never told about taking calcium, Vitamin E or the menopause patch. Minja was started initially on hormones, like a birth control pill, taking a pill for 25 days and stopping for five days. She started having a period and she felt the medication was pushing her body and making it do unnatural things. She went back and told her doctor she did not want to take the medication. Minja was frustrated because she had to always ask for information rather than her physician giving her the information.

Kuyong Sook had a total hysterectomy when she was 30. She is now 39 and feels there should have been other options and feels that today she would not make the same choice as she did when she was 30. She believed communication was a problem when she made her decision but she trusted the doctor. Now, she wishes she had asked more questions and received more information. If she had known she would have had so many negative symptoms, she would have not agreed to the surgery.

The women wanted to have control over their health care. Being given the options and communicating effectively with health care professionals were requirements for the women to maintain control of their health.

Language and cultural differences with the health care professional. There were difficulties with communication because of language. Kuyong Sook had troubles communicating in English. She stated there was a lot of miscommunication between herself and the doctors and nurses. Another issue for Kuyong Sook was the explanations
about health problems. She did not find that nurses and doctors spent enough time explaining procedures, surgeries, and illnesses. She also found the doctors ignored her questions. She was insulted because she had read information and believed she had some intelligent questions. She became frustrated and changed doctors. She believed she needed more details and kindness from doctors and nurses. She would have preferred to go to a Korean doctor because of similar language and also because of the cultural similarities. She knew older Korean people traveled to Toronto to see a Korean doctor because they felt more comfortable with an individual from their own culture and who spoke their language.

Language and cultural differences were impediments to Kuyong Sook receiving supportive health care. She believed doctors and nurses should take more time with patients and explain information to the satisfaction of the patient. Patients should not be ignored because of their difficulties with English and if the patient does not speak English well, the health care professional should take the time to understand her. For Kuyong Sook, health care should be culturally appropriate.

Another communication problem was discussing personal issues with a male doctor. For these women, menopause was too personal to share with a male doctor.

Discomfort with a male doctor. Two of the women did not feel comfortable seeing a male doctor about menopause. Mia did not go to her doctor for check-ups, only when she was sick. She thought visiting an older female doctor who had personal experience with menopause would be best. Mia believed it is easier to trust someone's advice if they have had personal experience. Sookja was embarrassed to go to a young male doctor.
She would have preferred to go to a women’s health center, staffed by women, for women.

Both women preferred older female doctors who had personal experiences with menopause. They put off annual check-ups because of their discomfort and embarrassment when visiting a male doctor.

**The importance of listening.** For Soonee, the most important issue to her was that her family doctor truly listened to her.

And after that every time, I am going to my doctor and she is listen, you know? And she fully understands me, you know, like so I can feel like I talk to my mother or aunt you know, so this time I am getting crazy but I am just crying for something, no reasons, for my doctor, but I am not embarrassed because I feel like very close to her and I ask anything I want and then she never ignore me or anything. She always answer.

Being able to talk to another person about menopause was very important for the women. The women had to find the appropriate person to share their feelings and concerns openly and without discomfort.

There were a number of difficulties with their contact with the health care system:

(a) The women found Western medicine incongruent with Chinese medicine, (b) There were difficulties with language and other cultural differences, (c) The women were not comfortable talking with male doctors, (d) The women needed to have control over their health care, and (e) The women wanted someone to listen.

The women’s stories described the experience of menopause for a small group of Korean women living in Canada. The effects of culture on menopause were also described. However, the women did not directly connect the experience of menopause and culture. When the women were asked directly if culture affected their experience with
menopause, they did not think culture affected it but their stories reflected the subtle
effects of culture and how the differences in the cultures affected their experiences. The
differences in culture were again highlighted in their encounters with the Canadian health
care system. Culture affected their experiences and hopefully, through the interviews and
discussion, the women will begin to recognize the effects of culture on their experiences.
CHAPTER V
DISCUSSION

For the Korean women in this study, the experience of menopause was encompassed by the theme of control. This theme had many faces. Their experiences with menopause were affected by the control felt on their lives from Korean culture. The culture influenced their roles and relationships, and their perceived ability to express themselves. The influence of culture was incessant. It was not always recognized by the women. Yet, menopause brought an understanding of the control in their lives. It was a turning point. The women stated that menopause was a time to take control. It was a phase of life marked by the transition from looking after others, being controlled by others, to looking after oneself. As well, it was time to take control of their health care choices and options. Menopause for the women in this study went beyond the physical event. It involved reflection of the cultural, political, social, gender, physical and psychological factors affecting menopause. For some of the women in the study, it was also time for change.

The purposes of this research were to study: (a) the experience of menopause for Korean women living in Canada, (b) the influence of culture on menopause, and (c) the influences of Canadian culture and the health care system on the women's experiences. In this chapter, the results presented in chapter 4 will be discussed. The chapter will include: a discussion of the findings from each of the research questions; an analysis of the relevance of this research to nursing practice, research and education; and the strengths and limitations of the research.
This study of Korean women’s experiences of menopause using critical ethnography has highlighted the influence of culture on many aspects of the women’s lives. These cultural influences can have both positive and negative effects on the women’s experiences. When the women were asked if culture affected menopause, they typically answered that culture did not affect it and asserted that menopause was affected more by individual characteristics. However, the women told many stories whereby culture did influence their experiences with menopause. The effects of culture on the experience of menopause was embedded in their personal experiences. Yet, the women did not always recognize the influence of culture on their experiences.

The incessance of culture was evident in: (a) how the women expressed their feelings about menopause; (b) how they sought and gained knowledge; (c) who the women talked to about menopause; (d) how the women perceived and managed menopause, and (e) how they were perceived by health care professionals. The impact of culture was reflected in every aspect of the women’s experiences with menopause, beginning with the women’s roles and relationships.

**Women’s Roles and Relationships**

Korea is a patriarchal and patrilineal society. In traditional society, the role of the woman was to be a good wife, mother, daughter and, after marriage, a good daughter-in-law. She was to obey her father as a young girl, her husband as a wife, and when she became old, she was expected to obey her son. The woman had very few rights as an equal partner. According to one of the participants, in the past, if a Korean woman and man divorced, the woman would not be allowed to remain with the children and the
husband would automatically get custody. Another participant signed an agreement stating she would stop working at the bank where she was employed when she got married. The woman's primary role was to look after others. Consequently, this obligation left little time for attending to her own needs.

At the onset of menopause, the women began to realize they had psychological and physical needs that were not being met. They therefore began to examine the relationships with their spouses and their children. The women repeatedly stated that they gave and gave to others but received little in return. Some of the women resented this arrangement. One woman did not have any energy to continue to look after her family and their business so she approached her husband and her family to take over some of the work. Another woman kept her feelings to herself, continued to resent the relationship but she did not feel comfortable expressing her concerns. However, this woman welcomed the opportunity to share her feelings with me and she poured out her feelings with very little encouragement or questioning.

Silent Voices

The women recognized the need to talk but they did not always feel they could open themselves up to their husbands or others. A similar finding was reported by Dickson (1994). In her phenomenological study on menopause with a group of American women, Dickson reported that the women did not feel able or willing to share their experiences with their husbands. Dickson defined the reluctance to talk about menopause as the "silence of the last taboo." Like the American women in Dickson's study, the Korean women in this study were reluctant to talk about menopause with their spouses. However,
the reasons for the reluctance to talk with their spouses were not clear. One of the participants attributed this to the perception that women’s voices were not respected by their husbands. The subservient role of women in Korean society contributed to a devaluing of women’s feelings, thoughts, and concerns resulting in the women being reluctant to express themselves.

The women in this study did not express their feelings about menopause to their spouses. The metaphor “a woman’s fate is a gourd’s fate” (Kim, 1995) was used by one participant to explain why Korean women did not express their feelings. She stated if the woman talked, her voice was compared to the scratching of a cobash. A cobash is a hollowed-out gourd usually used for preparing food and carrying water. The scratching of the cobash has an irritating sound not unlike fingernails scratching a chalkboard. When a woman talked the men would say that her voice was like the sound of scratching on the inside of the cobash. If a woman talked, it was considered displeasing and what she had to say was considered nagging. This metaphor does not fully explain why women do not talk about their emotions, but it does give a glimpse into how their feelings and expressions may be received. If their feelings are not respected, perhaps the women do not believe there is any point in expressing them.

Another reason why women may not express their feelings during menopause is the sensitivity of the subject. One potential participant refused to talk about menopause. The refusal to talk about menopause was influenced by the past and how other family members dealt with menopause. Many of the participants stated that their mothers did not talk about menopause and so there was a tradition of silence.
Maintaining the "private self" was another reason why the women may have been reluctant to share their feelings. One woman did not want to expose herself to her husband. Another participant discussed the concept of privacy in relation to the Korean family. One family would never let another family know or become involved in their affairs. Even if an individual or family were aware of problems, they would not interfere. This participant also suggested that Koreans would not ask for help until it was too late. For the woman experiencing menopause, like a family needing help, there may be embarrassment or "loss of face" if they admitted having problems or weaknesses. So a woman may want to suffer on her own rather than feel embarrassment or shame in front of others. By maintaining the private self, there may be positive consequences. By staying in control of the experience, a woman feels a sense of accomplishment because she has overcome the negative aspects of menopause.

The women's experiences with menopause were affected by their relationships and roles within the family and the culture. The traditional culture of Korea did not encourage women to voice their concerns and needs. Women were to keep their problems to themselves. Even if women did speak, their voices may not have received the appropriate attention because of the lack of respect for their needs.

Keeping silent about menopause was not restricted to Korean culture. Dickson (1994) and Sheehy (1992) suggested that American women were reluctant to talk with their spouses about menopause. Some of the difficulties communicating with men may not be culture-specific. Women may not want to expose themselves and feel vulnerable. Sheehy suggested men do not want to hear about their spouses' experiences with
menopause because it is a reflection of their own aging. Perhaps the woman, in part, feels she will no longer be attractive to her husband if she is experiencing menopause. Pleasing one’s husband and maintaining one’s youth may be universal and travel across cultures (Weber, 1994).

Rediscovering the Self

The women told of difficult times during menopause but they felt the negative times were over and they were moving on. The end of menopause seemed to bring a new-found sense of strength, and assertion of the “self.” They recognized the importance of looking after themselves and they were tired of always looking after others. From their perspective, there needed to be a shift in family responsibilities and roles. It was important for the family to understand what the woman had experienced. One woman said she was not as strong physically as she was in the past and it was time for her husband and her children to recognize it. Another woman had given up on trying to maintain the ultimate clean house. She told her husband that if he wanted it clean then he would have to do it. Housecleaning had lost its importance in her priorities. One participant was planning for the future and taking courses to understand her own body. She was taking reflexology and other general interest courses to assist herself and others in the future. Flint and Samil (1990) suggested in their study of Indonesian women’s experiences of menopause, that the discomforts of menopause lead many women to examine their daily habits, their roles and relationships. This reflection led to positive changes such as giving up smoking, taking up regular exercise, adjusting diet, spending more time with female friends or changing jobs. Three of the women in this study had recently become involved in regular exercise.
and two of the women highly recommended talking with female friends about personal issues.

The concept of time for the self was also identified as an important theme in a grounded theory nursing study on Mohawk women at midlife (Buck & Gottlieb, 1991). The themes surrounding the concept of time were, “It is time for me,” “being where I should be,” “time for myself,” and “my time is spent meaningfully.” The “It is time for me” theme signified a time for redirecting or shifting priorities from meeting the needs of others to satisfying their own needs. Like the Mohawk women, the Korean women in this study described this shift to their own needs when children left home. The event of children leaving home occurred about the same time as the beginning of menopause for the older women in the study. Once the women did not have to worry about their children, they had time to look after themselves. However, for the younger women in the study who still had young children at home, there was less time to focus on the self. Like the women in Buck and Gottlieb’s study, there was conflict between looking after the self and looking after the children. According to Buck and Gottlieb’s study, the women who felt that they had time for themselves were in synchrony with the dimensions of time and appraised their situations as positive. For those women who were out of synchrony with time, there were more negative feelings toward their situation.

In this study, the younger women were the group most likely out of synchrony because events had not occurred when they were “expected” to occur. One woman had a surgical hysterectomy when she was 30 and had struggled with the results of that experience for years. Now that she was 39, she finally came to terms with it and was
becoming action-oriented and taking control. For another woman, she had little support from her husband, she felt stuck. More recently on follow-up conversations, she too was taking action and taking control of her life. She was not going to dwell on the negative aspects of menopause but intended to focus on what she could do to improve her life. She was praying and seeking spiritual help to deal with her experiences.

The experience of time is an important variable to consider at midlife (Neugarten, 1996). Neugarten suggested that life transitions occur along temporal pathways like a social clock and it is the appropriate timing of events that determines whether the transition is stressful. This view does help explain why the younger women, who experienced menopause earlier than expected, may have had more difficulty during this life phase.

The Strengths of the Women

Regardless of negative aspects of life including the less pleasant aspects of menopause, the women possessed courage and strength. The women were successful in their adopted country. They had left a culture that was familiar and moved to another country that was unfamiliar and very foreign to the one in which they had been raised. The women were successful in their businesses and careers. Their children were doing well and the women were very proud of them. The women were conscious of the importance of health and took action to maintain the health of the family. They were self-confident and were willing to share their experiences. The women worked very hard and they were fairly satisfied overall with the life they led. They had made decisions in life and were content with those decisions. Sheehy (1992) wrote that menopause is a time for meditation and
spiritual exploration and a wise woman will take time to review her life and appreciate the life she has. The women in this study were in the process of contemplating life and appreciating it. One participant was attempting to understand menopause from a spiritual standpoint. She believed that God gave women the hardships of menopause to make them stronger.

Despite the negative experiences the women had, they passed through menopause with relatively little difficulty and were ready to move on with their lives. They wanted to look to the future and not dwell on the past. Experiencing menopause did represent a turning point in their lives. It was time to take control of their lives and to change their roles of caring for others to caring for oneself. The women were satisfied with their lives and they viewed menopause as a natural process.

**Menopause is Natural**

The women suffered from many physical and psychological symptoms during menopause, yet they viewed menopause as a natural process. One woman had passed through menopause and she had little to say about her experience. Menopause was in the past, she felt no reason to dwell on it or think about it. It was a natural event and it was over. This attitude was passed on from older relatives and mothers. A woman experienced menopause without discussion or fuss. Like the Korean women, Japanese women viewed menopause, or “konenki” as a life-cycle transition, as natural and part of the aging process (Lock, 1986). In Japanese culture, it was not marked by any importance, ritually or socially (Lock).

Since menopause was viewed as a natural process, the women who participated in
this research used natural methods to cope with it. All of the women had used herbal medicine at some stage in their lives. Five of the women had used herbs during menopause and one woman tried acupuncture for the relief of hot flashes. She also explained the basis of "qi," the natural healing power of the body. The women were well aware of the role of nutrition in dealing with menopause. There was strong support for herbal medicine, diet, acupuncture and the influence of "qi," all components of Chinese medicine.

From the Chinese medical point of view, menopause is an intelligent homeostatic mechanism (Wolfe, 1993). Menopause brings an end to the unnecessary loss of blood each month via the menses and holding on to this blood is part of the body's way of slowing the aging process (Wolfe). Like Korean women, many Japanese women turned to Chinese medicine for help with menopause. Rosenberger (1986) interviewed 150 Japanese women about their experiences with menopause. Many women went to Chinese practitioners because they felt they received a "natural" treatment for a "natural" malady (Rosenberger). In Chinese medicine, symptom causation is not differentiated between the physical and the psychological (Rosenberger). The problem is defined in terms of the circulation and quality of the blood and "qi."

"Qi is the information or energy that is sent between and among the organs and tissue of the body. Qi cannot easily be translated but it is sometimes called energy, influences, or information. This information or qi is responsible for all movement, warmth, protection against the invasion of disease, transformation of raw materials such as food and air into blood, fluids, tissues, and energy, and finally for holding the body organs, tissues, and fluids in place against gravity. Qi also controls all movement and flow of blood in the body. It is the interrelationship of the energy or qi in the channels and the movement of the blood in its vessels which controls and describes the process of menstruation in Chinese medicine. It is this internal, energetic relationship which must change at the time of menopause. The qi in some of the meridians must change its timing and direction of flow in order that the uterus does not fill with blood any longer and in order that the blood not be
allowed to flow out of the body (Wolfe, 1993, p. 1).

For a woman to have a trouble free menopause, the reorganization of the blood flow and meridians must occur quickly and smoothly (Wolfe, 1993). If there is some reason why the reorganization cannot occur smoothly such as physical, cultural or emotional problems then the process gets dragged out or stuck before completion (Wolfe). In Chinese medicine, the organs and their functions are linked to emotions. The heart and liver play important roles in the menopausal process. The heart and liver rule the circulation and storage of the blood and each one is directly connected to the uterus (Wolfe). If these organs are not in balance, unpleasant symptoms such as anxiety, insomnia, nervousness, unusual sweating, frustration, irritability or depression, may result. Through the use of diet, herbs, or acupuncture, a woman is promised a readjustment of her whole self through a treatment that purifies and balances the blood and “qi” (Rosenberger, 1986). Balancing “qi” guarantees the patient stability without the use of hormones or tranquillizers (Rosenberger). Benefits of Chinese medicine include its long and proven track record of success as well as being individualized for each person. For example, three women with hot flashes would be treated differently depending upon whether they had any other accompanying symptoms. There would not be the same treatment for the three women. Other benefits of Chinese medicine include few or no side effects. Chinese medicine is empowering to the woman because it looks at all aspects of a woman’s lifestyle and how each aspect impacts upon her health (Wolfe).

Chinese medicine is very different from Western medicine and the women in this study were part of both systems. There were obvious incongruencies between their beliefs
in Chinese medicine and their use of Western medicine. These incongruencies will be discussed in the following section.

**Contact with the Health Care System**

Contact with the Canadian health care system occurred through family physicians and specialists. There was no contact with nurses regarding menopause. Numerous problems relating to incongruencies between Western and Chinese medicine, communication difficulties, power and knowledge issues and the discomfort of visiting male physicians were encountered.

**Incongruencies Between Western and Chinese Medicine**

In Korean culture, women view menopause as a natural event with little notice or concern as evidenced by the lack of discussion about menopause between the women in this study and their friends and mothers. In Chinese medicine, menopause is a natural event requiring natural remedies such as herbs, diet and exercise (Wolfe, 1993). In Western culture, menopause is viewed as an illness, and deficiency of hormones. Hormone replacement therapy is recommended as treatment of choice by Western medicine (MacPherson, 1981). The two cultures represent divergent approaches to menopause.

The women in this study experienced many physical and psychological symptoms associated with menopause. Six of the seven women had taken or were presently on hormone replacement therapy. However, there was incongruency between their beliefs in their approach to menopause and their acceptance of Western medicine, including hormone replacement therapy. The women reluctantly took hormone replacement therapy, but did not stop taking herbal medications. Five of the women who took hormone
replacement therapy were also taking herbal medicines. Three of the women had started and stopped the hormone replacement therapy because they did not think they required it any longer and were reluctant to keep taking it. The hormone replacement therapy did not alleviate all of their symptoms. Thus, they chose herbal medicines because hormone replacement therapy was not completely effective and they believed menopause was a natural process. Through the use of herbs and “qi,” the body had the ability to heal itself.

Diet and exercise were other natural processes important in the experiences of menopause. Tofu and other soya products were believed by the women to provide an easier menopause experience. The women combined the influences of Korean culture, including their belief that menopause is natural, with the influences of Canadian culture and Western medicine whereby menopause is viewed as a disease or illness. Although the women went to family doctors and were prescribed hormone replacement therapy, there was strong influence from the Korean approach to menopause. The effects of Canadian culture had not taken precedent over the women’s beliefs that menopause is a natural process.

The women did not perceive any attempt, on the part of the doctors, to understand the women’s health concerns or their health belief system. The women did not feel comfortable telling the doctors that they were taking herbs. They did not view the doctors as good listeners and they did not feel the doctors explained information effectively or gave them choices about care. The two cultures of health care remained separate and, at times, incongruous. Immigrant women must make sense of two cultural patterns (Meleis, 1991) and two separate approaches to health. For the women, there are discrepancies
between the two cultures and philosophies which the women have to learn how to negotiate their way around.

**Family physicians and specialists.** The contact with the Canadian health care system was limited to visiting family physicians and specialists. None of the women had been in contact with nurses regarding menopause. However, they did have contact with nurses for other health-related reasons.

The family physicians and gynecologists had prescribed hormone replacement therapy for six of the seven women. MacPherson (1981) and Dickson (1993) criticized the widespread practice of prescribing hormone replacement therapy for indefinite periods of time. According to MacPherson, the physician is basing his/her judgment on information provided by the pharmaceutical companies manufacturing the hormone replacement drugs. One participant was started on one hormone replacement drug which was causing monthly periods. She felt the medication was forcing her body to behave in an unnatural way. She returned to her doctor and discussed her concerns and a new hormone replacement drug was prescribed. Another participant who had a hysterectomy when she was 30 and who was now 39 had been taking hormone replacement therapy since she was 30. After several years, she began to have severe headaches and was switched to the menopause patch. The Estraderm patch is a small adhesive bandage that releases the hormone through the skin (Sheehy). The patch maintains a continuous, consistent level of estrogen in the system, like a time-release capsule. The Food and Drug Administration approved the patch as effective treatment for menopause and osteoporosis but not heart disease.

These women were switched from one form of hormone replacement therapy
(HRT) to another form. For one woman, the negative side effects of HRT were becoming worse. The headaches were becoming unmanageable and were possibly worse than the effects of menopause. Perhaps the hormone replacement should have been stopped and the women’s body given a chance to respond naturally.

Obtaining Knowledge about Menopause

The women were self-directed in obtaining knowledge about menopause. They obtained knowledge from books and women’s magazines, and like the American women in Dickson’s study (1994), Korean women stated that friends were good sources of knowledge. Physicians were not regarded as sources of knowledge by the women in this study or by the American women in Dickson’s study. Kaufert and Gilbert (1986) completed a study on menopause with 2500 women in Manitoba. One third of the women replied through a mail survey that none of their information came from the physician. Based on these findings, it would appear that women do not always turn to their doctors for information!

Women get information from other sources. One woman stated that she did not trust anything that she was told but only what she read. Cobb (1990) suggested women distrust most of what they hear because of the contradictory nature of all the information. Articles in magazines are typically written by premenopausal journalists whose objective it is to provide reassurance or by doctors who take information from a clinical population or from studies published in medical journals (Cobb). The doctors who write for the women’s magazines or medical journals are not the doctors the women consult. The family doctors have their own beliefs and values. Cobb noted that another source of
information is the lore of other women and their stories of misery and suffering. For the women, it is not only a lack of information that makes education about menopause difficult, but the sorting out of what is authentic and what is not (Cobb). Add to that the influence of another culture and the women have even more difficulty figuring out what is authentic or reliable. The women are at risk for being misinformed and confused. In this study, the women were confused about the use of hormone replacement therapy and its unnatural effect on their body when compared to Chinese medicine.

**Barriers to Communication**

There were communication problems between physicians and the women, especially when the women were new immigrants to Canada. One woman felt totally misunderstood and she felt the physician treated her as if she was not knowledgeable because she was unable to communicate well in English. This experience of being portrayed as ignorant was very distressing to her. In Anderson’s (1985) study on health of Indo and Greek Canadian immigrant women, Indo-Canadian women found language a barrier to health care and the doctors and nurses were viewed as not approachable. Immigrant women are at risk for physical and mental distress because of the differences in language (Meleis, 1991). Most of the women in this study experienced the mental and physical distress caused by language differences. The women felt they were not listened to or respected for their knowledge because they were not fluent in English.

Talking with male doctors was uncomfortable and embarrassing for the women. They would prefer talking with female doctors or other female professionals. One woman kept putting off visiting her family physician because he was younger and male.
Embarrassment in talking with male doctors about menopause is not unique to Korean women. Many Western women have similar reservations discussing menopause with male doctors.

The women had informed themselves and had done their research before visiting their physicians but they did not feel they were listened to by the physicians. AbouZahr, Vlassoff and Kumar (1996) suggested women from other cultures are usually the main health providers in their own families. They are not familiar with a “top-down” situation where they are told what to do and dialogue is discouraged (AbouZahr et al., 1996). All of the women were intelligent and well-educated. When the women were not listened to, power was taken out of their hands and they had less autonomy in the choices of their health care and in their lives.

From the experiences of the women in this study, there were several areas requiring improvement in health care regarding menopause. There are many opportunities for nursing practice, education, and research.

**Implications for Nursing**

There are numerous opportunities for nurses to be involved in the experience of menopause and to provide unique nursing knowledge and care. The women did not mention nurses in their stories of menopause. This void in nursing care needs to be filled. Nurses have a responsibility to apply their knowledge to women’s health.

**Nursing Practice**

Education about menopause has been identified by the women of this study as a priority. Individual and/or group information sessions should be offered to women from
different cultural groups. The information sessions and education materials should be available in traditional languages. Contact should be made with a key person in the community. The Korean women told me that nurses are well respected in the Korean community and they should be involved in health related issues. Another key contact person would be the leader of a women's group. The key contact should be instrumental in organizing and supporting information nights. Translators should be available because older women of the group may not speak English. The location and the time of the information session is important. The women suggested the churches are good locations for sessions. The session could be combined with another group's meeting especially if there are other Korean women's groups. Information provided should include information about diet, exercise and relaxation techniques along with components of Western and Chinese medicine, if appropriate. During information or education sessions, an opportunity should be provided for the women to discuss their feelings.

The use of language is a very powerful tool. Allen (1995) stated health care professionals assume that Western medicine is objective science applied for the patient's benefit rather than it being viewed as a value system. Nurses should avoid imposing their values and the values of Western medicine on women and instead support immigrants to maintain their values (Meleis, 1991). It is essential that nurses be cognizant of the social and political conditions in which language is produced and reproduced (Allen). The use of words is even more important when a woman is seeking help in a second language. Nurses need to be patient and effective listeners.

Women should be respected for their knowledge and a dialogue should occur
between the woman and the nurse rather than the more traditional scenario whereby the nurse gives information and the woman receives the information passively. The women in this study were offended when their knowledge of menopause was not recognized.

Translators should be available during one-on-one counselling. Translators should be female and of similar age if available. Spouses should not act as translators. One problem that may arise is the familiarity between the translator and the woman. As I found in this study, women who know each other as acquaintances may not be willing to share their experiences in front of another woman from the community especially if the community is small.

Female nurses, preferably with their own experiences of menopause, have been identified as the most suitable person with whom a woman will discuss her menopause. One woman identified health centres exclusively for women's health as her preferred choice of health care.

By encouraging women to tell their stories, the women were empowered because they were listened to and their input was perceived as valuable. The women in this study did not always get the opportunity to share their views. One woman said she had felt so much better after she talked to me about her experience. The opportunity to share her feelings had made her able to move on with her life and to have a whole new perspective. If nurses truly listen to individuals and provide them an opportunity to speak, nurses will assist people to understand the influence of culture and politics on their lives.

The knowledge nurses gain from listening to others will help them to understand the culture and the lives of the individuals affected by the culture. Accurate information
gained from first-hand experience will reduce prejudice and stereotyping.

As well as understanding other cultures, it is important for nurses to be aware of the effects of immigration on women's lives. Meleis, Lipson and Paul (1992) suggested the transition of immigration occurs for many years. Immigration has a profound effect on the women's lives, and especially on the health and illness status of the woman and her family (Meleis et al., 1992). The immigrant woman is at risk for physical and mental distress because she is trying to make sense of two cultural patterns, different values, different social networks, different languages and the disappointments when events happen that do not fit with her own values (Meleis, Arruda, Lane, & Bernal, 1994). Recognizing and anticipating the varied tensions on the lives of immigrant women affords nurses an opportunity to provide culturally relevant nursing care.

Nursing Education

Canada is multicultural. Nurses need to be knowledgeable about many cultures when caring for patients. Undergraduate and graduate courses in multicultural nursing should be mandatory. Meleis et al. (1992) stated that nurses need to know more than the ethnicity of a patient, they need to understand the culture. Guest speakers from different cultural backgrounds should be invited to share their cultural values with students. Perhaps representatives from different cultures could be invited to review the syllabus or participate in developing a course. As I found in this study, the women were very happy to share their experiences and culture. Many of the interviews went far beyond the issue of menopause. Students should go to different agencies in the community working with multicultural groups to visit families in their home and learn about their culture.
Nurses have a responsibility to learn about menopause. They should educate themselves in the different points of view about menopause. Cobb (1990) suggested women need information before they see their doctors because it is unrealistic for doctors to spend 30 minutes discussing menopause to each woman. Nurse practitioners, nurses working in the community, and nurses working in doctors’ offices could be the initial educators. Cobb suggested that in order to develop a viable education program to be developed for both the community and health care providers, there must be a consensus of what menopause means. Coalitions on menopause should be developed to include physicians, nurses, dietitians, physiotherapists, women’s health centre workers, and members of women’s groups. Coalitions could develop a coherent perspective on menopause (Cobb). The information given to women would be somewhat standardized, however, it should maintain room to be individualized. The challenge would be to communicate the information from the coalition to all individuals working with or representing women experiencing menopause.

**Nursing Research**

There are many opportunities for nursing research with middle-aged women from different cultures. The needs of women at mid-life have not been the focus of many nursing studies and there is limited nursing knowledge development of diverse populations (Meleis, Arruda, Lane, & Bernal, 1994). Research completed on immigrant women has often focussed on the cultural practices of childbearing. There are few studies on menopause and the mid-life experience of immigrant women. There is the need for more nursing knowledge in this area because of nurses’ ability to change health care.
Nursing research must become more sensitive to the emerging focus on diversity and internationalization (Meleis, et al. 1994). In order to understand this diversity, there is a need for innovative methodologies that allow and encourage women to tell their stories. Narratives bring out women’s views from their perspectives and by sharing their stories from different cultures, the stories highlight the differences as well as the similarities. Telling stories capture the context of the women’s situations. In critical, action-oriented research, the stories provide an opportunity for the women to reflect upon and critique their experiences. Through critique, there may be greater understanding of the cultural and political influences in their lives. Hopefully, the women then have a chance to change the effects of these influences.

Questions arising from the issue of control in this research that could be explored in follow-up studies are: (a) Do the women feel that taking control has improved their lives? (b) If yes, then do they wish they had tried to take control earlier? and (c) “Do they think that other women could be helped to take control?”

Another area for research is to determine the women’s needs for care during menopause. Research into the resources that are friendly to women’s needs and that are useful to women is another priority for nursing. Specifically for Korean and other Asian women, there needs to be greater understanding of the role Chinese medicine plays in their lives.

There are numerous opportunities for nurses in research, education and practice to make a difference when working with women from different cultures. Being open and receptive to truly listening to these women will make a difference in the lives of the
women as well as the nurses who work with them.

**Theoretical Significance**

Critical ethnography was the methodological and theoretical perspective used to guide this research. Through the use of this perspective, there was an opportunity to use an approach relatively new to nursing research. Critical ethnography provided a unique lens through which to view the experience of menopause for Korean women. In critical science, there is a focus on understanding and change (Berman, 1996). Understanding and change are not separate identities but occur simultaneously through dialogue, reflection, and critique (Berman). In this study, any evidence of change was difficult to see because of the small group of women involved in the study. The cultural influences did have a major impact on the women's experiences. This influence was particularly evident when I tried to organize focus groups on two separate occasions. Four of the women agreed to attend a focus group to discuss their experiences with each other. However, the women cancelled the day of the focus group. Possibly, the women did not feel comfortable sharing with each other. At the beginning of the study, the women had stated that they did not feel comfortable sharing their experiences with other Korean women. Their discomfort of sharing with each other continued. Change had not occurred. The effects of culture remained embedded.

Even though the women did not feel comfortable sharing with each other, they did share with me. They did explore experiences and told stories that were seen as taboo topics. They reflected on their relationships and roles with their husbands and children. They voiced their concerns about having to remain silent. In this sense, it would seem that
they had gained new insights and awareness regarding their experiences with menopause.

The focus of critical theory and critical ethnography is to understand the impact of cultural, political, and social factors on individuals’ and groups’ lives and to further understand the ideology behind these effects. In critical theory, there is a recognition that ideological beliefs keep certain groups more privileged than others (Berman, 1996). Thus, effort must be made to understand how and why one group is more privileged than others and ways to avoid maintaining the ideological framework that perpetuates the system. The women did tell their stories about the effects of culture on their experiences with menopause. However, complete critique of the cultural effects on their experiences with menopause did not occur. The women’s critique of their experiences varied. Two of the women were open about evaluating the cultural influences while the other women did not view culture as impacting their experiences.

Critical theory influenced the format of the study. The interviews were dialogic in nature. The women were encouraged to tell their stories in their own words. The themes were derived from the women’s stories and checked with the participants. The women assisted with the development of themes to some extent, but the bulk of the theme development was completed by me.

Nursing has the opportunity to work with groups of individuals such as immigrant women to understand the influences in their lives that may prevent them from experiencing health. For the Korean women, there were the effects of sexism, racism and oppression on their lives. Critical theory and critical ethnography were used to attempt to assist the women to understand their experiences better with an attempt to change the status quo.
Change is not easy to measure and probably will not be recognized easily. Like culture, change is incessant.

**Evaluation Criteria**

Validation of qualitative research is achieved by applying the criteria to evaluate the study. Validation is the trustworthiness of the interpretations. Techniques to evaluate the trustworthiness used in this study included: persuasiveness, correspondence, pragmatic use and content consistency.

Persuasiveness looks at whether the interpretation is reasonable and convincing (Riessman, 1993). In this study, the themes were supported with evidence from the participants’ accounts.

Correspondence refers to the validity of the researcher’s interpretations through member checks that is the themes of the study were checked with the participants.

Pragmatic use demonstrates validity of the study through the extent that the knowledge developed is used by other researchers. Pragmatic use is future oriented. Since there are limited studies on Korean women’s experiences of menopause as well as the experience of immigrant women and health, hopefully, this knowledge will be used by other researchers.

Consistency criteria are internal checks that involve comparison between interpretations of various parts of the text with each other or between parts or all of the text and other texts (Allen, 1995). The use of the NUDIST program was useful in determining consistency across the interviews.
Strengths and Limitations

The experience of menopause for immigrant women has been the focus of a number of studies. However, the focus on the experience of Korean women in Canada has not been studied from a critical ethnographic approach. Critical ethnography is a new and unique approach for nursing research, with much potential for the development of nursing knowledge.

One strength of the study was that the women were given an opportunity to tell their stories. Although menopause and women's issues are not readily discussed in Korean culture, rapport, dialogue and respect were developed to provide the women an opportunity to share their experiences. For one woman in the study, the opportunity to talk about her experiences had made a difference in her life. Whether or not the woman felt emancipated is too much to expect, but for me, having one participant say it helped made the research worthwhile.

The women were involved in the finalization of the themes. Their perspectives were sought and further clarification about the themes was obtained.

There were many limitations to the study. The women were approached through two personal contacts. The contacts used their circle of friends and acquaintances to approach women who would be willing to discuss menopause. This sampling technique did not allow for a true representation of the community. However, because generalization is not an aim of this research, this limitation is relatively minor.

Some of the women in the study knew each other and they knew that I was interviewing one of their friends. They had been speaking about the study to each other.
From speaking to each other, there may have been an influence on what they shared in their interviews.

The issue of language may have biassed the sampling. One criteria that I placed on the sampling was the women needed to speak English to avoid the use of translators. By not including non-English speakers, the older women in the Korean community who spoke Korean were not included in the study. These women may not have wanted to participate but the opportunity would have been given to them if translators were used.

Participatory research is one goal for critical nursing science. However, the study limited the participation of the women. I made most of the decisions for the study. For the study to be more participatory, the women should be involved at the beginning, at the ground level.

**Conclusions**

My decision to study menopause in another culture was based on my praxis experience in working with women experiencing menopause at a health unit during the master’s program. Contacting health units across the country indicated there were few education programs geared toward immigrant women and menopause. The lack of education programs piqued my interest and led to this research.

As an outsider from the Korean culture, I struggled with how being an outsider would disadvantage the research and the willingness of the women to speak about their experiences. It was difficult to get participants. However, the reluctance of Korean women to discuss menopause went beyond the fact that I was an outsider as I learned over the process of the study. By being an outsider, I believe the women who did participate were
more willing to discuss their personal experiences. I was perceived as a safe outlet.

The research did give insights to the experience of menopause for Korean women including the effects of roles and relationships, the incessance of culture, the meaning of menopause, the contact with two separate health care philosophies and through their experiences, many opportunities for the role of nursing emerged. As follow-up to the research and consistent with critical nursing science theory, I hope to organize with the women from the Korean community an information night about menopause. The suggestions given by the women will be used to plan this meeting.

The women in this study revealed courage and remarkable flexibility and adaptability. Despite difficult times in their lives, they were able to make the most out of life and successfully pass through the hard times with renewed energy and understanding. I admire them for their perseverance. I don’t think one can fully understand what life is like for an immigrant woman without sharing the “immigrant experience.” However, this research into the experience of menopause for Korean women has just been a small attempt to understand one aspect of their lives better. There is much more research needed to understand the lives of Korean women and help the women understand their own lives. Nurses have an incredible opportunity to learn and share with these women and to learn and share with women from other cultures. Through learning and sharing with others, we will learn and understand and be able to make changes in our own culture. As nurses we have an obligation to improve health for others and ourselves.
APPENDICES
APPENDIX A

Letter of Explanation

A Critical Ethnography of the Experience of Menopause for Korean Women Living in Canada

I am a graduate nursing student at the University of Western Ontario and I am conducting a study to understand the experience of menopause for Korean women living in Canada. I am interested in understanding women’s personal experiences with menopause and how Korean and Canadian culture influence women’s experience of menopause. Understanding menopause will have benefits for Korean and Canadian women and health care professionals to provide better health care and to understand women’s issues from a cultural perspective.

If you choose to participate, I will meet with you on two occasions. The first time will involve an interview lasting 1 to 2 hours. The second meeting will be shorter and will involve the discussion of themes identified from the initial interviews. This meeting should take less than 1 hour. The interviews can take place in your home or at another convenient location if you prefer. I will be audio taping the interviews and making a transcript of the interviews. No names will be used in the transcript and any identifying information changed so that the information will not be traceable to you. The tapes and/or transcripts will be kept in a locked cupboard in a locked office. The audiotapes will be erased after the study is complete or given to the participants as the participants’ wish. Only I and my thesis advisor will view the transcript. No names will be used in the final report.

There are no known risks to taking part in this research although some of the questions may be uncomfortable. Participation in this study is voluntary. You may refuse to participate, refuse to answer any questions or withdraw from the study at any time.

At the end of the interviews, you will receive $10 in appreciation for your time and inconvenience. If you have any questions regarding this study, please contact myself, 474-2968 or my thesis advisor, Dr. Helene Berman, 661-2111 ext. 6578. Thank you.

Sincerely,

Janice Elliott
APPENDIX B

Consent Form

I. (print) __________________________ agree to participate in the nursing research project “A Critical Ethnography of the Experience of Menopause for Korean Women Living in Canada” conducted by Janice Elliott, a graduate nursing student at the University of Western Ontario. I have read and understand the letter of information concerning this study and have had all the questions answered to my satisfaction.

__________________________  __________________________
(Participant’s Signature)    (Date)

__________________________  __________________________
(Researcher’s Signature)     (Date)
APPENDIX C

Interview Guidelines

The interviews will be dialogic in nature so that the women will be able to share their stories about menopause. For the interviews to be dialogic, a few broad questions have been developed to begin the interviews and probing questions will be used as needed.

Tell me about your experiences with menopause.

What are your feelings about menopause?

In your opinion, how does culture affect the experience of menopause?
   Probe: What is menopause like for a Korean woman?

What have you heard from other people about their experiences with menopause?

What experiences have you had with the health care system during menopause?
APPENDIX D

Demographic Data

Name:
Phone Number:
Age:
Family members:
Country of Origin:
Year of entry into Canada:
Languages spoken:
Dominant language:
Religion:
Occupation:
Health Status:
Age at beginning of menopause:
Age at end of menopause:
Events surrounding menopause:
Contact with health care system during menopause:
The UNIVERSITY of WESTERN ONTARIO

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TITLE:

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