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Neglecting and Ignoring Menopause Within A Gendered Multiple Transitional Context:

Low Income Korean Immigrant Women

by

Eun-Ok Im

DISSERTATION

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San Francisco

NEGLECTING AND IGNORING MENOPAUSE

WITHIN A GENDERED MULTIPLE TRANSITIONAL CONTEXT:

LOW INCOME KOREAN IMMIGRANT WOMEN

by

Eun-Ok Im

To the Lord

To my parents

To my husband, Wonshik

To my daughter, Eunice

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I thank first the Lord for his grace and providing us the best. My thanks go to the Korean immigrant community in San Francisco Bay Area and to those who helped recruit participants, provided critique, and gave support. The participants' stories have made this study powerful. I hope this research will in turn help empower women to recognize and manage their health care needs.

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Abstract

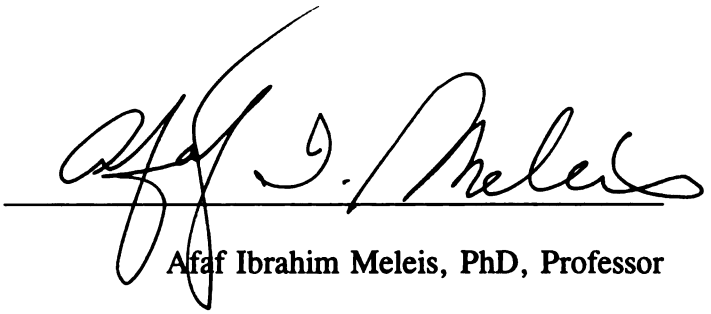
Researchers rarely explore menopausal experience in the context of the totality of women's lives, subsequently making the picture of menopause incomplete, discrete and fragmented. Respecting the totality of women's lives, this study addresses how a vulnerable group of persons— low income Korean immigrant women—experience menopause within a context of multiple transitions.

This is a cross-sectional descriptive study using methodological triangulation. A sample of 119 first-generation Korean immigrant women aged 40 to 60 years, who were in low-income jobs, was recruited from San Francisco Bay Area community using convenience sampling methods. From the total sample, 21 peri- or post-menopausal women were recruited for in-depth interviews following the collection of the survey data. Questionnaires, short interviews, and in-depth interviews were used to collect data. The quantitative data were analyzed using descriptive and inferential statistics. Thematic analysis was used to interpret interview data.

The findings indicate that the women neglected and ignored their menopause. The experience of menopause was reduced to only a biological event, and normalized.

Within a multiple transitional (immigration, work and menopause) and gendered context, menopause was given the lowest priority amidst women's multiple and demanding roles. The lack of language clarity to describe the experience and the symptoms, cultural background, inadequate knowledge, and lack of social supports also made menopause hidden, invisible, and inaudible. The symptom experience of these women had no general patterns. Symptoms were highly individualized, culturally different from those of Western women, and minimized under the influence of Korean culture that stigmatizes psychological symptoms and devalues women's health. There was a difference in total number of physiological ($p < .10$), psychological ($p < .05$), and total symptoms ($p < .05$) by level of work satisfaction.

A theoretical framework is suggested for understanding menopause complicated by multiple transitions (immigration, work and menopause) for women who were marginalized economically and culturally. Conclusions and implications for practice, research and policy are guided by the goal of understanding women's experiences and meanings of menopause and supporting women through reflecting these experiences into their health care, and social and policy changes.



Afaf Ibrahim Meleis, PhD, Professor

Committee Chair

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CHAPTER I

Introduction

Until recently, research on menopause has been sporadic (McKinlay & McKinlay, 1973). Because most of the research has been discipline oriented and hence designed to answer specific, narrowly defined problems, results of the studies have been limited (Lock, 1986a). Lock (1986a) showed that clinicians have focused upon symptomatology of menopause and its treatment. Their research and practice focusing on symptoms draw from clinical samples, including a very high proportion of women who have had hysterectomies. Thus, results are often misconstrued and not representative of the total population. This can lead to false assumptions about a generally high incidence of menopausal symptoms and problems. Moreover, with traditional androcentric bio-medical views, only physiological aspects of menopausal transition have received the attention of researchers (Davis, 1982; Greene & Cooke, 1980; Mikkelsen & Holte, 1982). Consequently, menopause has been defined as a 'disease,' and a normal feature of menopause has increasingly become medicalized, although there are often important differences between lay and medical models of menopause (Dickson, 1990a; 1990b; Helman, 1994; MacPherson, 1981; 1985).

Recently, many researchers have raised questions about psychological, social, and cultural aspects of the menopausal experience. Multiple factors influencing this experience have been explored. Moreover, investigations into the relationship of psychosocial variables with the experience of menopause have been given considerable attention (Davis, 1982; Greene & Cooke, 1980; Mikkelsen, & Holte, 1982). Many

psychosocial variables have been identified as influencing the menopausal experience. Also, cultural differences in menopausal experience have been recently explored and recognized through cross-cultural studies (Boulte, Oddens, Lehert, Vemeer, & Visser, 1994; Chompootweep, Tankeyoon, Yamarat, Poomsuwan, & Dusitsin, 1993; Haines, Chung, & Leung, 1994; Ismael, 1994; Lock, Kaufert, & Gilbert, 1988; McCarthy, 1994; Ramoso-Jalbuena, 1994; Samil, & Wishnuwardhani, 1994; Sukwatana, Meekhangvan, Tamrongterakul, Tanapat, Asavarait, & Boonjitrpimon, 1991; Tang, 1994; Wasti, Robinson, Akhtar, Khan, & Badaruddin, 1993; Wilbush, 1985). Yet, as research on menopause becomes more available, it has become apparent that the picture of this experience is a complicated one (Beyene, 1986; Davis, 1982; Flint, 1974; George, 1988, Lock, 1986a), and virtually nothing is known about the relationships of physiological factors, psychosocial factors, cultural factors, nor about the interrelationship of the variables. Furthermore, research has rarely explored menopausal experience considering the totality of women's lives, subsequently making the picture of menopause incomplete, discrete and fragmented.

A woman's lived experience is anchored within the context of her bio-psycho-socio-cultural world (McBride & McBride, 1981). Neither physiological factors alone nor cultural factors alone fully explain women's daily experiences during the menopausal transition. The menopausal experience, particularly of vulnerable women with low socioeconomic status and family income, low educational level, and limited employment opportunities (Abe & Moritsuka, 1986; Ballinger, 1985; Greene, 1983; Schneider & Brotherton, 1979; Severne, 1979; Uphold & Susman,

1981) cannot be explained and understood without considering the totality of their lives. Their daily lives are complicated by many factors representing hardship and suffering from lack of resources. For example, in the case of low income immigrant women, the menopausal transition takes place among the constraints of economic difficulties, unfavorable labor market conditions (Glenn, 1986; Kim & Hurh, 1988; Kim & Rew, 1994; Lipson & Meleis, 1985; Meleis, 1991), less access to information, language limitations, cultural conflicts (Lipson & Meleis, 1985; Meleis, 1991), lack of resources (Lipson & Meleis, 1985), and marginalization (Anderson, 1990; Meleis, 1991). The experience of menopause is mingled within these multiple factors and together they may create tremendous stress, hardship, suffering, and challenges which consequently influence the menopausal transition. Hence, to understand the menopausal experience of these women, not only their physiological and psychological changes, but also their contextual transitional constraints need to be explored.

There is limited knowledge about menopausal experience of vulnerable women considering the totality of their bio-psycho-socio-cultural world. In this study, menopausal experience of Korean immigrant women who have low income was explored while considering the comprehensive view of their daily life experiences. This study provides a comprehensive understanding of vulnerable women's menopausal experience, and contributes to a more complete understanding of menopause. To ground this study, feminist approaches and transition theory were used: Feminist approaches respect women's own views, subsequently disclosing their own daily experiences; and transition

theory provides a comprehensive theoretical framework emphasizing the context to explain confounding and mediating factors.

Significance of the Study

Despite the continuous efforts to explore women's menopausal experience, very little is clearly known. However, one thing is clear: In the picture of menopausal transition, the context within which women experience menopausal transition has been missing, and the picture is not a comprehensive, integrated one. Rather, the picture is discrete and separated by related factors with fragmented views. As with many elements of modern medical science, women's menopausal experience has certainly been fragmented (MacPherson, 1981), and contributes unnecessarily to a fragmentation of the unity of the person (Martin, 1987).

However, as McBride and McBride posited (1981), women's experiences are embedded in a context that may be constantly in flux, so no single point of view about women's health can ever be expected to emerge. Furthermore, Martin (1987) asserted, taken as a whole, women do not experience menopause as if it was a separate episode in life akin to a stay in the hospital for an illness. Rather, they describe it as a part of all the other events happening in their lives. Therefore, it is important to explore, describe, understand, and explain women's menopausal transition with a comprehensive view considering the context in which they are experiencing their menopausal transition.

Furthermore, studies have rarely explored the menopausal experience of vulnerable groups of women, particularly immigrant women experiencing multiple transitions. Women with low socioeconomic status, low family income, low educational level, or

limited employment opportunities might be particularly vulnerable during their menopausal transition (Abe & Moritsuka, 1986; Ballinger, 1985; Greene, 1983; Schneider & Brotherton, 1979; Severne, 1979; Uphold & Susman, 1981). There is reported variation by occupation in the extent to which women see menopause as an illness (O'Driscoll & Foley, 1983), with professional women having the highest wellness orientation, secretarial-clerical second, homemakers third, and blue-collar workers the lowest.

The lack of knowledge about menopausal transition, especially of vulnerable women, without considering their contexts makes it imperative to take a comprehensive view of the transition of menopause in a group of vulnerable women within the context of their bio-psycho-socio-cultural world. The lack of theory and knowledge base also limits clinical guidance in delivering competent health care to the vulnerable women in menopausal transition. In this study, some essential information on women's menopausal transition is provided while not separating their multiple transitional context and respecting their own daily menopausal experience within the context of their bio-psycho-socio-cultural world. Therefore, this study is a significant effort toward completing the picture of menopausal transition and developing a knowledge base and theories that can support competent health care for women in menopausal transition.

Purpose of the Study

The purpose of this study was to explore the menopausal experience of low income Korean immigrant women within the multiple transitional context of their bio-psycho-socio-cultural world. The study was designed to explore how women who have been

through the immigration transition describe and deal with their transitional menopausal experience.

Organization of the Chapters

Chapter II provides the theoretical background of the study, and related literature is reviewed. Feminist approaches and transition theory, which guided the study design and interpretive approach, are critically reviewed. Also, the literature related to menopause in low income Korean immigrant women is critically reviewed. Finally, the research questions that guided the study are presented. In Chapter III, the research methodology of the study is presented. This includes the study design, settings for the study, recruitment of research participants (inclusion criteria, sample selection process, sample size determination), instruments (Interview Protocol I, Cornell Medical Index, Interview Protocol II, and interview guide), approaches for resolving problems in the research implementation, data analysis methods, and approaches to ensure rigor of the study. The results of this study are presented in Chapter IV and Chapter V. Chapter IV explores participant demographics, description of immigration and work transitions, and meanings and responses toward menopausal transition Chapter V addresses the questions about symptom experience and correlates during menopausal transition. Chapter VI discusses and integrates the findings. In Chapter VII, the findings and discussions are concisely summarized; some theoretical, clinical, research, and policy implications are proposed; limitations of the study and areas of further study are discussed; and concluding remarks are made.

CHAPTER II

Theoretical Background and Review of Literature

This chapter provides the theoretical background for this study and a review of the literature related to menopausal transition of low income Korean immigrant women. Two main theoretical approaches—feminism and transition theory—guided the research design. Feminist approaches respect women's own views and experiences, and transition theory provides a comprehensive theoretical framework emphasizing the ever-evolving context within which women experience their menopause. Literature review explores current understanding about a feminist world view, transition theory by Schumacher and Meleis (1994), transitions, and specifically, menopause in low income Korean immigrant women. Based on this foundational background the research questions will be posed.

Theoretical Framework

Feminist Approaches

Feminism in general. There is no singular and unified framework for feminist research and analysis method. Viewing the world through the lens of gender results in diverse perspectives, commonly labeled as liberal, essentialist, radical, Marxist, socialist, or postmodern feminism. In fact, in the early phases of the women's movement in the United States, feminist researchers could be roughly categorized in terms of their political views as liberal, radical or Marxist (Fee, 1983). Yet, the distinctions have become blurred with the attainment of the maturity of feminism. Political orientations are no longer distinct or are characterized by internal divisions within feminist thought. In the research area, many feminist researchers have mixed qualitative methods or attempted to

create new styles, borrowing freely from other fields including literary criticism, cultural studies, and history. Therefore, the distinctions and the internal divisions within feminist thought have become blurred, and diverse feminist perspectives are blended.

Feminist research is not homogeneous, but highly differentiated and complex, with different potentials for influencing different disciplines. Despite this diversity among the feminisms, all feminist theory posits gender as a significant characteristic that interacts with other factors, such as race and class, to structure relationships between individuals (Rosser, 1994). Except for liberal feminism, most feminist theories reject the neutral objective observer for a social construction of scientific research based on the standpoint of the observer, which is influenced by gender, as well as other factors such as race and class. Additionally, in most feminist theories, dualism is rejected, women's experience is important, the distance between observer and object of study is shortened, and unicausal, hierarchical approaches are rejected. Feminists from all the diverse perspectives share the importance of centering and making problematic women's diverse situations and the institutions and structures that influence those situations. They emphasize the examination of that problematic theoretical, policy, or action framework in the interest of realizing social justices for women (Eichler, 1986).

Feminist research. What is feminist research? Harding (1987) emphasized that women's experience is pluralistic. There is no universal woman's experience because women's lives have never been shaped exclusively by gender. In fact, women's interpretations, values, interests, and actions may differ according to sexual orientation, class, race, ethnicity, education, age, and national origin (Hall & Stevens, 1991).

Therefore, what is feminist research cannot be easily answered. Yet, Hall and Stevens (1991) provide three basic principles of feminist research: (a) a valuing of women and a validation of women's experiences, ideas, and needs; (b) a recognition of the existence of ideologic, structural, and interpersonal conditions that oppress women; and (c) a desire to bring about social change of oppressive constraints through criticisms and political action.

Moreover, feminist research, in general, is distinguished by certain features, even though it may use a variety of methods. Hall and Stevens (1991) posited the features of feminist research as follows: (a) research questions reflect the concern of particular groups of women; (b) feminist research is conducted for the purpose of finding answers for women, rather than for the medical profession, health care administration, welfare establishment, government, or insurance industry; and (c) the researcher's history, assumptions, motives, interests, and interpretations are explicitly scrutinized in the process of study. An objectivistic stance and an anonymous, invisible voice of authority are avoided in favor of a strongly reflexive approach to inquiry.

In this study, within the stance of feminist research, the participants' values, beliefs, and experiences are valued and respected. Their invisible experiences are disclosed and their hidden voices are heard. The study is informed by low income Korean immigrant women's experience as immigrants and women in menopausal transition. Additionally, in the process of the study, my own history, assumptions, motives, interests and interpretations are explored and scrutinized.

Feminist views on menopause. One of the basic debates of social thought has been the 'nature' versus 'culture' controversy. In sum, the nature/culture controversy centers on whether human behavior and the human mind are all due to nature or to culture. 'Nature' is conceptualized as rooted in biology and as something fixed, universal, and immutable, while 'culture' is seen as the influence of the environment and therefore more changeable and more dependent on local contexts (Helman, 1994). This division has many political and social implications. The strict 'nature' line means that one group of people are regarded as 'biologically' inferior to another, and that this could never be altered, no matter what environmental influences are brought to bear upon them (Helman, 1994). In this context, feminists have pointed out that women and their sexuality have frequently been seen as 'less cultural' than men, and equated instead with 'nature' rather than with the 'culture' of the male world (MacCormack & Strathern, 1981). They posited that the conceptual division of 'nature' from 'culture' is in itself artificial, a false dichotomy that represents a specifically Western and culture-bound way of looking at human behavior.

Based on the understanding of gender, feminists assert that women's bodily experiences have been oppressed, neglected, and ignored (Martin, 1987; Young, 1990). According to one feminist philosopher (Young, 1990), oppression typically involves the marking or control of the bodies of the oppressed, and in a patriarchal society, women's oppression is most complexly tied to their bodies, because patriarchal culture gives women's bodies variable meanings and submits them to many controls. From the dawn of the West's distinction between mind and body, women have been identified with the

body and both feared and devalued as a result of that identification. Women's being is largely reduced to their bodies, the media of male pleasure and procreation (Young, 1990). Consequently, women frequently find their ability to live and move freely restricted by that definition.

Also, feminists have posited that science carries a variety of assumptions and methods (Harding, 1986). The assumptions about women are clear; power relations in society structure all areas of life, such as the family, education, and welfare in which women's rights are secondary to those of men (Dickson, 1990a; 1990b). Feminists distrust the purported objectivity and neutrality of science, particularly the scientific ideas about "woman's nature" including menopause (MacPherson, 1985). Feminists believe that there can be no pure biology because people do not live in a vacuum; we are constantly interacting with the environment and being shaped by it (MacPherson, 1985).

Like other women's bodily experiences, feminists view menopause as an oppressed, neglected, and ignored experience. Menopause is envisioned as a tabooed subject, veiled in secrecy and silence, in which women's rights are suppressed in the name of biology. (Delaney, Lupton, & Toth, 1988; Dickson, 1990b; MacPherson, 1981; 1985; Weideger, 1976). Feminists posited that patriarchal misogynous gynecologists and psychiatrists in the U.S. directed and profited from the transformation of menopause into a disease (MacPherson, 1981; Martin, 1987) even though menopause is a natural biological event during the reproductive cycle of women. An explanation of the transformation of menopause into a disease is that modern medicine is increasingly used as an agent of social control, especially over the lives of women, making women dependent on the

medical profession and on its links with the pharmaceutical and other industries (Cooperstock, 1976). Another explanation is that, if some men still see women and their physiology as representative of 'nature'(that which is uncontrolled, unpredictable and dangerously polluting), then medical rituals and medical technology become a way of 'taming' the uncontrolled, especially in the age of feminism and of making it more 'cultural' in the process (Helman, 1994). Clearly, menopause has been regarded as a disease, and the disease model has been socially constructed during the past 150 years by science, medicine, government, and the drug industry to gain power, profits, and social control over women (MacPherson, 1981). Even in Korea, the disease model of menopause has been accepted without any resistance under the strong influences of Western medicine.

The woman's health movement is presenting new insights into menopause and women's menopausal experiences are beginning to be viewed beyond the "medical model" (Boston Women's Book Collective, 1976; 1992; National Women's Health Network, 1980; 1993; Reitz, 1977). A large amount of literature, written by women, discuss menopause positively (Reitz, 1977; Taylor & Sumrall, 1991) and more than 1,000 local women's health groups, projects, health centers and clinics, health professionals, and consumers have emerged to provide education and change health policy legislation to improve the quality of women's health care (MacPherson, 1981; National Women's Health Network, 1980; 1993).

Menopause self-help groups have been developed by several women's health centers in the United States. In these groups, women share their feelings and personal

experiences with menopause, and seek out and share new knowledge (Ruzek, 1978). Alternatives for estrogen replacement therapy are discussed, and each woman shares what she has learned about her body and its needs (MacPherson, 1981; Ruzek, 1978). Based on feminist approaches, the self-help groups respect the woman's voice and encourage participation in her own health. The basic issue of the self-help groups is control of one's own body, and women themselves assume the role of menopausal experts instead of the usual male gynecologists or psychiatrists (MacPherson, 1981).

However, the number of feminist studies of menopause is still minimal, and most of the work is included under the study of the menstrual cycle (Bleier, 1984; Dickson, 1990a; 1990b; Harding, 1986; Posner, 1979). Yet, the feminist literature can be viewed as opposing the powerful image of the scientific discourses about women and menopause even though their effects are weak compared to the effects of the dominant biomedical views of science on women and menopause (Dickson, 1990b).

Transition Theory

Transition theory provides a comprehensive perspective on the transitional experience while emphasizing the context within which people are experiencing their transition. Because of its comprehensiveness, applicability, and affinity with health, transition theory has been applied to many human phenomena of interest and concern to nurses such as illness, recovery, birth, death, and loss as well as immigration (Meleis & Trangenstein, 1994; Murphy, 1990; Schumacher, & Meleis, 1994). This theory is useful in explaining health/illness transitions such as the recovery process, hospital discharge, and diagnosis of chronic illness (Meleis & Trangenstein, 1994). It is useful in explaining

organizational transitions, which refer to transitions in the environment (Schumacher & Meleis, 1994). Organizations can experience transitions that affect the lives of their clients as well as the people who work within them. Organizational transitions may be precipitated by changes in the wider social, political, or economic environment or by intraorganizational changes in structure or dynamics.

Schumacher and Meleis (1994) propose some universal properties of transitions based on an extensive literature review in nursing. One of these universal properties is that transitions are processes that occur over time. Another property is the nature of change that occurs in transitions (Schumacher & Meleis, 1994). Changes brought about by transitions include changes in identities, roles, relationships, abilities, and patterns of behavior. Transitional changes bring a sense of movement or direction to internal processes as well as external processes. Many low income Korean women who have immigrated go through multiple transitions during menopause. Along with a menopausal transition due to aging, they experience a cultural transition due to international immigration and a role transition from housewife to worker. The process of multiple transitions leads to changes in their identity, roles, relationships, abilities, and patterns of behavior. Low income Korean immigrant women certainly experience changes in self identity, cultural conflict, a feeling of loss, marginalization, and role conflicts.

Schumacher and Meleis (1994) identify several "conditions" that influence the way a person moves through a transition. The conditions include meanings, expectations, level of knowledge and skill, the environment, level of planning, and emotional and physical well-being. Transition conditions can be conductive to a smooth transition, or

they may place the person at risk for a difficult transition. Meanings may be one of the most important conditions influencing menopausal experience of low income Korean immigrant women. Meaning refers to the subjective appraisal of an anticipated or experienced transition and the evaluation of its likely effect on one's life (Schumacher & Meleis, 1994). Low income Korean immigrant women may have different meanings attached to menopause, aging, immigration, and women's work from those of women in other cultures. Some may think that the symptoms they experience during their menopausal transition are meaningless and need no attention at all. Yet, others may think that their symptoms are serious and should be managed for their well-being. The different meanings influence their transitional experience and ultimately affect the health outcome of the transition.

Level of knowledge and skill relevant to a transition is suggested as another condition that influences health outcomes and may be insufficient to meet the demands of the new situation. Low income Korean immigrant women may need new knowledge and skill during their menopausal transition within the context of multiple transitions. They may need information on menopause and appropriate self care strategies as well as language skills to access menopause clinic resources.

Environment is also emphasized as a condition that affects the transition process. Many studies investigating transitions of human beings have focused on the environment within which women experience their transitions, and emphasized the importance of resources within the environment (Battles, 1988; Ladden, 1990; Loveys, 1990, Meleis, 1987). The sociocultural environment surrounding Korean immigrant women is an

important factor that shapes their transition experience. Their new environment includes physical, psychological and social situations that certainly affect their menopausal transition. For example, since these women are new in the U.S., they may not know how to get to health care facilities, how to use health care services, or how to describe their health care needs in English. Therefore, even when they have serious symptoms, they may hesitate to seek help from health care providers.

Transitions are accompanied by a wide range of emotions. Stress and emotional distress occurring during transition have been noted by several researchers (Christman, McConnell, Pfeiffer, Webster, Schimitt, & Ries, 1988; Fishbein, 1992; Ladden, 1990; Meleis, 1987). Menopause is frequently regarded as an end of womanhood in current Korean culture (Yu & Chi,1986; Yoon, 1989). Yet, the end of womanhood may have different meanings to Korean women since they have different intrapsychic processes and sociocultural contexts compared to other Western women. The end of womanhood frequently means the end of sexual life to them. After menopause, they are usually viewed as only "mothers" not "wives." Indeed, it was reported that many Korean women in their menopausal period were more concerned about their children and rarely put importance on marital relationships with their spouses (Im, 1994). With this change in their marital relationship, menopause is reported to bring tremendous emotional stress to Korean women in South Korea (Im, 1994; Yoon, 1989; Yu & Chi, 1986).

Physical well-being is also important during a transition. According to Imle (1990), when physical discomfort accompanies transition, it may interfere with the assimilation of new information. As Fishbein (1992) posited, profound bodily changes are inherent

during the menopausal transition as well as other developmental transitions, and the level of comfort with these changes in the body influences well-being during the transition. Menopausal transition brings about profound bodily changes including vasomotor symptoms(Olive & Hammond, 1986); atrophy of sexual organs (Badawy, 1985; Olive & Hammond, 1986); bone loss (Olive & Hammond, 1986); changes in menstruation (Badawy, 1985); and hormonal imbalance (Droegemueller, Herbst, Mishell, & Sterichever, 1987). Low income Korean immigrant women certainly go through these physical changes and discomforts. To some of them, these changes and discomforts can be minimal while they can be tremendously distressful to others. The level of comfort with these changes in the body influences well-being during their transition.

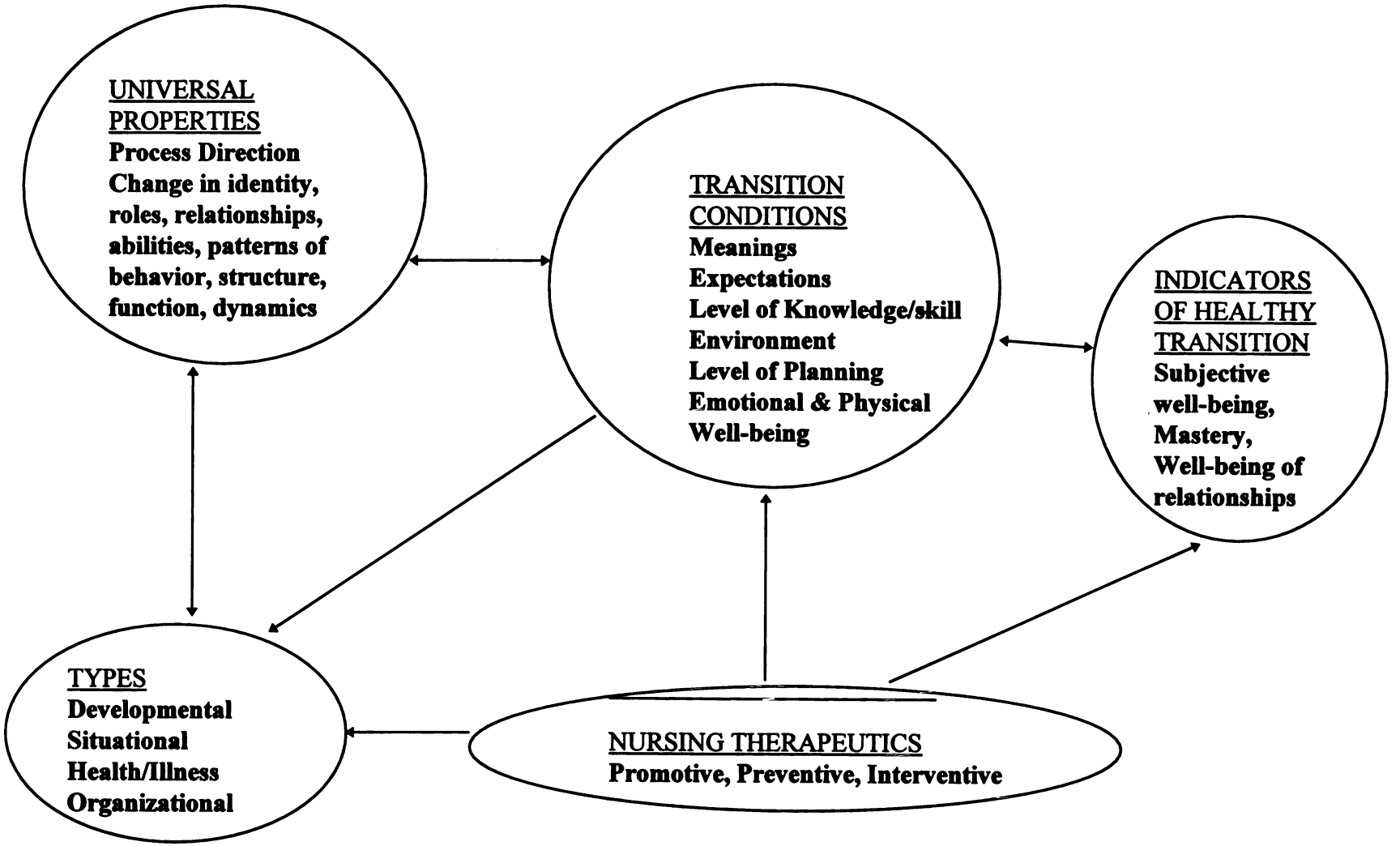
Indicators of healthy transitions include a subjective sense of well-being, mastery of new behaviors, and the well-being of interpersonal relationships (Schumacher & Meleis, 1994). Subjective well-being during transition includes effective coping and managing one's emotions as well as a sense of dignity and quality of life. Work, marital, and other role satisfaction are suggested as other subjective responses indicative of a successful transition. Growth, liberation, self-esteem, and empowerment are also suggested as indicators, but are difficult to measure. Subjective well-being can be one of the important indicators of healthy menopausal transition of low income Korean immigrant women. Since unsuccessful management of menopausal symptoms due to lack of knowledge and skills may increase emotional and physical distress, subjective well-being can provide appropriate validation of their successful menopausal transition. Work satisfaction can also indicate successful transition because the menopausal experience has been reported

to be deeply associated with work role (Birnbaum, 1975; Briggs, Laperriere, & Greden, 1965; Coleman & Antonucci, 1983; Nathanson, 1980; Powell, 1977). Role mastery and well-being of relationships are also suggested as indicators of healthy transitions (Schumacher & Meleis, 1994). Role mastery denotes achievement of skilled role performance and comfort with the behavior required in the new situation. Well-being in one's relationships indicates that a successful transition is occurring.

Schumacher and Meleis (1994) suggest three nursing measures that are widely applicable to therapeutic intervention during transitions. The first is assessment of readiness, which is a multidisciplinary endeavor and requires a comprehensive understanding of the client. Each of the transition conditions is assessed to create an individual profile of client readiness and to enable clinicians and researchers to identify various patterns of the transition experience. The second is the preparation for transition. Education is suggested as the primary modality for creating optimal conditions in preparation for transition. The third nursing therapeutic measure is role supplementation that is initially introduced theoretically and empirically by Meleis (1975) and used by many researchers (Brackley, 1992; Dracup, Meleis, Baker, & Edlefsen, 1984; Gaffney, 1992; Meleis & Swendsen, 1978). Through this study, directions for nursing therapeutics to facilitate low income Korean immigrant women's healthy menopausal transition are suggested based on these nursing therapeutic measures.

Schumacher and Meleis (1994) have provided a framework for showing the relationships of the domain concepts: Types of transitions, universal properties, transition conditions, indicators of healthy transition and nursing therapeutics (Figure 1). This

Figure 1. A nursing model of transitions (Schumacher & Meleis, 1994)



framework was adopted as a theoretical model guiding literature review and investigation of the menopausal experience of low income Korean immigrant women.

Menopausal Transition: A Literature Review

Throughout recorded history, physicians have been aware of the changes in a woman's mental and physical characteristics during menopausal transition and have associated them with loss of menstrual function (Haney, 1986). However, the etiology of menopausal transition has been described in almost mystical terms until relatively recently. In fact, over the last several hundred years, a variety of etiologies have been put forward (Haney, 1986). In particular, physiological etiologies have focused on hormonal imbalance (Koninchx, 1984), the maternal menopausal history (Holte & Mikkelsen, 1982; Torgerson, Avenell, Russell, & Reid, 1994), parity (Ginsburg, 1991; Kaufert, Gilbert & Tate, 1987; Torgerson et al., 1994), and nutritional factors include alcohol and meat consumption (Holte, & Mikkelsen, 1982; London, Willett, Longcope, & McKinlay, 1991).

However, social scientists have cast doubts on the bio-medical views of menopause (Kaufert & Syrotuik, 1981; McKinlay and McKinlay, 1985). Feminist researchers and the Women's Health movement in the United States (Ehrenreich & English, 1973; McCrea, 1983; MacPherson, 1981; Seaman & Seaman, 1977) have strongly critiqued the disease model of menopause, arguing that the menstrual and menopausal myths are a form of social control, through which the health care system in Western cultures legitimatizes sexism and ageism in the disguise of science.

Investigations into the relationships between psychosocial variables and the experience of menopause have been given considerable attention (Davis, 1982; Greene & Cooke, 1980; Mikkelsen & Holte, 1982). Many psychosocial variables are said to influence menopausal experience (Dosey & Dosey, 1980; Green & Cooke, 1980; Uphold & Susman, 1981; Van Keep & Kellerhals, 1975). Moreover, cultural influences in menopausal experience have been considered, and many researchers have recently explored Eastern women's menopausal experience (Boulte et al., 1994; Chompootweep et al., 1993; Haines et al., 1994; Ismael, 1994; Lock et al., 1988; McCarthy, 1994; Ramoso-Jalbuena, 1994; Samil, & Wishnuwardhani, 1994; Sukwatana et al., 1991; Tang, 1994; Wasti et al., 1993; Wilbush, 1985). The major focus of these studies has been to explore whether Eastern women have experiences of menopause similar to Western women.

Indeed, a huge amount of literature on menopause is currently available, but virtually nothing is clearly known about menopausal transition. Furthermore, the studies have some serious limitations. Methodological limitations include: (a) factors related to data collection such as neutrality of interviewers, culturally inappropriate measurement scales, cultural stereotyping, retrospective data, simplicity of oral communication, interview standardization, frequency and intensity of symptoms recorded, age at onset of symptoms and subjectivity of symptoms; (b) factors related to case histories such as group sizes, case history collection techniques, group histories, sociocultural background, economic status, other diseases not related to menopausal transition, and fluctuation of age/post-menopausal age relationship; and (c) factors related to data analysis such as

preparation of data on advanced fertile age and pre-menopausal group, and statistical processing.

Another limitation is that most of the studies on menopausal symptoms have been performed with Western populations (Lock et al., 1988). Information on menopause comes mainly from research in Europe and North America. Researchers customarily created models of the menopausal process based on the concepts of the body and its symptoms that were integral to Western medical thought. The concepts were based on ideas about aging, women, and their place in society that were particular to Western culture. Therefore, the models can be misleading when doing research in societies that do not subscribe to the same view of women and their bodies, or the impact of menopause.

Within the context of menopausal transition for Eastern women, Korean women have been rarely studied and little is known. In this section, the literature on menopausal transition of low income Korean immigrant women is critically reviewed according to types of transitions and their properties, transition conditions, and indicators of healthy transition suggested by transition theory (Schumacher & Meleis, 1994).

Korean Immigrant Women's Menopausal Transition

Limited knowledge exists about the menopausal transition of Korean immigrant women. It can be inferred that their menopausal transition is similar to that of other Korean women, but they may be more likely to suffer due to their complex transitional situation. Exploration of menopausal transition in South Korea is also a relatively new area of research. Until recently, menopause has been invisible in Korean culture because women have never talked about menstruation or menopause in public. Instead, the focus

of discussion was women's positions as daughters, wives, mothers, or grandmothers in their families. Menopause has become public with the introduction of Western culture and Western medicine, industrialization, and increasing longevity.

Research on menopausal transition has been mainly conducted by bio-medically oriented Korean physicians or nurses in South Korea. The researchers have rarely dealt with menopause as a normal bio-psycho-socio-cultural change. Instead, they focused on the physiological aspects of menopausal experience in a fragmented manner. The studies have medicalized menopause and ignored women's own experience. The most frequently explored aspect of menopausal transition of Korean women has been hormonal imbalance (Cheung, Yu, & Wo, 1989; Hwang, Lee, Yu, & Wo, 1989; Min & Ku, 1985; Shin & Chang, 1985) or specific menopausal symptoms or outcomes such as hot flash, sweating, and osteoporosis.

More recently, researchers have moved in the direction of psycho-social aspects of menopausal experience of Korean women (Im, 1994; Lee & Chang, 1992; Lee, 1994; Yoon, 1989). The most frequently explored psycho-social aspects are mid-life changes such as retirement, children leaving home (the empty nest syndrome) or changes in marital relationships. Relatively recently, Korean nursing scholars have been searching for the meanings of menopause and emphasizing women's own experience (Lee & Chang, 1992; Lee, 1994), but the efforts are still minimal.

Findings of recent studies showed that many menopausal Korean women had regarded their children as the purpose and fruition of their lives (Yu & Chi, 1986). Under the strong influence of Confucian norms, Korean women tended to sacrifice themselves

for child rearing and their children became the absolute meaning of their lives. In this context, most Korean women report separation problems when their children become adults, with attendant feelings of loss, depression, anxiety and sadness (Park, 1982). Despite the new wave of menopausal research, these studies about menopausal transition of Korean women are limited by inappropriate study designs, convenience sampling methods, culturally inappropriate instruments, and androcentric views on menopause. However, they do suggest that Korean immigrant middle aged women, especially those who endure tremendous hardship to enhance their family's quality of life and children's opportunities in the new country, may experience loss, depression, anxiety and sadness when their children leave.

Korean Immigrants' Transition Experience

History of Korean immigration. Korean immigration to America began in 1903 (Hurh & Kim, 1984). On January 13, 1903, 101 Korean immigrants (55 men, 21 women, and 25 children) aboard the S.S. Gaelic, a U.S. merchant ship, arrived in Honolulu, Hawaii. By 1905, a total of 7,226 Korean immigrants (6,048 men, 637 women, 541 children) had reached Hawaiian shores by 65 different ships. About 10,000 Koreans entered Hawaii, and 1,000 reached the mainland before 1905 when the Korean government prohibited further immigration (Sawyers & Eaton, 1992). The U.S. Immigration Act of 1924 virtually ended further immigration from Korea. Koreans were not eligible for United States citizenship because of a clause in the immigration act that excluded Asians and non-Whites. Then, in 1965, amendments to the immigration act were made, and the Korean American population began to increase.

The Korean share of the total immigration increased from 0.7 percent to 3.8 percent between the period from 1965 to 1975 (Hurh & Kim, 1984). Koreans are among the most rapidly increasing immigrant groups in the United States. About one in every three immigrant from East Asia is now a Korean. Gardner, Robey and Smith (1985) estimate that Korean population will reach over million within the next decade.

Sociodemographic characteristics of Korean immigrants. The majority of Asian immigrants are young and female. Koreans are more conspicuous in this regard. It is reported that the Koreans in the U.S. have the lowest sex ratio of 67.6 (68 males for 100 females), and 67.8 percent of Koreans are under thirty (Hurh & Kim, 1984; Yu, 1987). The majority (74%) of Koreans under the age of twenty are born in the United States (Hurh & Kim, 1984). In terms of age distribution, the proportion of the Korean population under 18 is 35 percent, about the same as it is for the entire United States population (34%) (Yu, 1987). Only three percent of the entire Korean-American population are elderly, the lowest proportion among all ethnic groups (Yu, 1987). Geographically, a high proportion of Korean immigrants is concentrated in urban areas (67%), but this proportion is lowest among all other immigrant groups (Hurh & Kim, 1984).

Unlike pre-World War II Korean immigrants who came from a traditional agrarian society, post-1965 immigrants have come from a rapidly developing capitalist economy (Yu, 1987). They have come from urban areas and are highly educated. In the U.S. in 1980, 52 percent of Korean males and 22 percent of Korean females aged 25 years-and-older were college graduates (Yu, 1987).

According to Hurh and Kim (1984), the majority of Korean males (76%) and slightly less than half of the Korean females (42%) are employed. However, the Korean's income is not significantly higher than that of other groups. A high proportion of Korean immigrants is concentrated in small ethnic business, and the proportion of those who engage in small ethnic business increases as time elapses. Yet, it is reported that the census surveys of business establishments systematically undercount the true Korean business population, two-thirds of which consist of firms too small to notice (Light & Bonacich, 1988). Because of unmeasured part-time, illegal, underground, and barter enterprises, the number of Korean small business cannot be accurately counted.

Immigration transition. Korean immigrants' transitional experiences have been relatively well documented but the research has several limitations. The literature rarely deals with the dynamic process of transition. Most studies only describe or enumerate their difficulties and rarely deal with the dynamic process of transition. Moreover, the studies rarely compare the experiences of Korean women and men even though gender differences have been reported in the immigration experience (Cho, 1987; Hurh & Kim, 1984; Hurh & Kim, 1988; Hurh & Kim, 1990). Rarely do these studies examine the influence of social class on Korean immigrants (Cho, 1987; Light & Bonacich, 1988) but lump the whole population together.

Most studies of the immigration transition of Korean women are descriptive, largely based on interviews using questionnaires. While they provide important information, they show inconsistent findings that are difficult to generalize because the studies are

conducted in specific geographical areas. Such studies need to be systematically replicated with larger samples from multiple geographical sites.

The most frequently reported difficulties among Korean women in the U.S. are language, marginality, difficulties in interpersonal relationships (with spouses, other Koreans and children), alienation and loneliness, and lack of social support (Hurh & Kim, 1984; Nah, 1993; Miller, 1990). The language barrier is reported to be the most serious problem experienced by Korean immigrant women (Hurh & Kim, 1984; Miller, 1990; Nah, 1993), followed by differences in the culture and social systems between Korea and the United States, and transportation problems (Hurh & Kim, 1984; Nah, 1993). Even when they have successfully adapted to this new environment, daily economic struggles and marginality in the new society continue. Job opportunities are restricted by not knowing the language, and their former education and training may not be recognized. Ties with the extended family are sometimes altered or broken.

Strong ethnic attachment has been reported by many researchers. Korean immigrant women's process of adaptation to new culture has been reported to be very slow (Hurh & Kim, 1984). In a study of Miller (1990), it was reported that approximately half of Korean respondents experienced language problems and were not exposed to the American printed media at all. Almost none used English at home. Most of Hurh and Kim's (1984) respondents reported that family duty should be given priority over individual interests; nearly all thought it was necessary for their children to speak Korean language well; the majority preferred the Korean ethnic church over American churches; about half of them desired to return to Korea; and most Korean immigrants

opposed interethnic marriage (Miller, 1990). Social participation and interpersonal relations were largely confined to their own ethnic group. Most of Hurh and Kim's (1984) participants actively participated in Korean voluntary associations, whereas only a very small portion of them were members of American voluntary organizations. Such strong ethnic attachment may help Koreans manage their lives and provide adequate social supports and resources, but it can also inhibit their acculturation and ultimately foster continued marginality.

Transition from housewife to worker. In traditional Korea, women household managers and child-bearers were more highly valued and better rewarded than those who pursued other options (Cho, 1987). Traditional Korean women rarely dreamed about deviating from their wifely status. Most middle-aged Korean immigrant women were raised, socialized and educated in an environment emphasizing traditional gender role and were housewives before immigration (Light & Bonacich, 1988).

However, immigration imposed a transition from traditional Korean housewives to immigrant women workers. A Korean's primary reason for migration is to improve the family's quality of life and further their middle-class aspirations in the new land of opportunity rather than being driven out by hunger or political persecution in Korea (Hurh & Kim, 1990; Light & Bonacich, 1988). Koreans are committed to the middle-class work ethic, and both women and men work hard to fulfill their aspirations.

In addition to the lack of pre-employment experiences, most middle-aged Korean immigrant women work under unfavorable labor market conditions (Kim & Rew, 1994). The lower the income of husbands, the higher the proportion of wives who are employed

(Hurh & Kim, 1984). A typical first-generation Korean immigrant woman routinely works outside of their home ten to fifteen hours a day, seven days a week, going without vacations for many years (Yu, 1987). She starts out as a cleaning woman or seamstress, then works at a hamburger stand or small sandwich shop jointly with her husband.

The transition from housewife to worker engenders physical overload, role conflict and stress among Korean immigrant women. The transition is a gendered transition. Macroscopically, women are employed in the informal-sector female occupations such as paid domestic worker, child care worker, garment worker, or electronic assembly worker (Hurh & Kim, 1990; Light & Bonacich, 1988). Microscopically, women are responsible for most household tasks, similar to married women living in Korea (Kim & Rew, 1994), adding job demands to their usual responsibilities without complaint, doing the second shift (Hochschild, 1989) or double day after working long hours in a dead-end, low-status job. Employed wives shoulder this double burden because of financial needs and persistence of the traditional gender role ideology of woman as homemaker (Hurh & Kim, 1990). Employment outside the home means additional work that brings no intrinsic reward or satisfaction in most cases (Kim & Hurh, 1988).

Most studies of employed Korean immigrant women provide no information about the hardships they endure in the mainstream labor market, and no vivid descriptions of their work experiences or cultural conflicts in attitudes and values about women's paid or unpaid domestic work. Rather, the studies provide quantitative descriptions of socioeconomic status and other related factors, which may not be applicable to other settings where many Koreans live.

Transition Conditions

Cultural norms and values. Norms and values in the Korean culture provide a context for understanding their transition. The Korean family system has been largely based on Confucianism since the Yi dynasty. Confucianism places special importance on the family as both the basic unit of society and the fundamental social structure within which individuals live, and emphasizes tradition and authority as guides to social behavior (Moon & Pearl, 1991). Despite recent changes in family structure, loyalty to the family remains. Thus, Koreans usually have a strong sense of family loyalty. For example, Koreans speak of "our home" and "our father" where Westerners would say "my home" and "my father" (Sawyers & Eaton, 1992).

Based on Confucian philosophy, Korea has traditionally maintained a patrilineal family system that encompasses multi-generations of family members through the male line (Kim & Hurh, 1987). In traditional families, relationships between men and women, one generation and the next generation, the elderly and the young were always vertical and the position of women was very low. In spousal relationships, the husband was metaphorically considered the sky while the wife was considered to be the earth. Women were supposed to obey the orders of men. This traditional family system provided an undemocratic well-defined set of marital roles (Kim & Hurh, 1987). A husband was expected to command his wife while she was expected to obey and serve her husband, her parents-in-law and other members of family lineage. Therefore, married women were confined to a domestic role in their husband's family.

Even though Korean families have changed, patriarchal and Confucian norms are deeply rooted. Traditional family system and attitudes persist in Korean immigrant families (Kim & Hurh, 1987). Most Koreans still prefer sons over daughters and believe in the right and responsibility of sons to support aged parents and to perpetuate the lineage (Kim & Hurh, 1987). Thus, Korean immigrant women continue to be in a relatively lower position than men in their ethnic community and families. Their power imbalance and gender discrimination, which have been rationalized by patriarchal and Confucian norms, are taken for granted. The norms are reinforced by being considered "good tradition" that should be preserved. Korean culture still labels as a "good wife" the woman who silently observes patriarchal and Confucian tradition. These norms make Korean immigrant women's transitional experiences more difficult and force them to sacrifice for their families and take the sacrifice for granted. Yet, the influence of these family norms on their daily experiences has not been studied.

Meanings of menopause. The meanings of menopause undoubtedly mediate the women's menopausal transition because the meanings determine their responses and attitudes toward menopause. Yet, research on the meaning of menopause in Korean women in the United States is nonexistent, and that in Korea is limited. Western researchers often assume that high social status and good self-esteem serve as buffers against potential menopausal symptoms. According to them, women in many non-Western or developing societies do not suffer from menopausal problems because they experience a rise in status at the end of their reproductive life (Lock, 1986b). Negative

cultural attitudes toward aging in general, and menopause in particular, are regarded as responsible for the suffering from menopausal symptoms (Oddens, 1994).

Respect for the elderly is a cultural norm among Koreans (Sawyers & Eaton, 1992). Under the strong influence of Confucianism, Koreans placed special importance on the respect for the elderly and familial bonds. Koreans, along with Chinese and Japanese, have a culture rooted in filial piety wherein care for the elderly from family is accepted as a customary and normative duty (Moon & Pearl, 1991; Parish & Whyte, 1978). In the past, aging was viewed positively and menopause was welcomed as a sign of a woman's increasing power and control in the traditional Korean family.

However, as Korea has rapidly industrialized and urbanized, cultural attitudes toward the elderly have also changed. The increasing population of the old, geographic mobility of the young, expansion of the female labor market, a decrease in multigeneration households, and the movement toward smaller families have influenced attitudes toward the elderly. Recent studies on menopause of Korean women in South Korea demonstrate the changed attitude toward menopause and aging, reporting that many Korean women perceived menopause as a loss of attractiveness as a woman and becoming useless (Im, 1994; Jung, 1988; Yoon, 1989; Yu & Chi, 1986). However, some studies report that attitudes toward menopause are still positive (Lee & Chang, 1992; Lee, 1994).

Most middle aged Korean immigrant women experienced the recent Korean cultural changes before coming to the United States. While no studies have investigated their experience, it can be inferred that these Korean immigrants may have a relatively

negative attitude toward aging and menopause compared to Korean women in the past, but a relatively positive attitude compared to Western women.

In the traditional Korean family, middle aged women had power in managing and controlling their families. However, in modernized Korean society, they have lost this power. Middle-aged Korean immigrant women who grew up in the transitional Korean society face a very different culture in the U.S. Despite mixed cultural attitudes and values, they have served their families throughout their lives. However, their daughters and sons have become acculturated to the modern culture and rarely retain Korean traditional attitudes, values, and ways of thinking. Compared to Korean families in South Korea, women are less likely to have power in managing and controlling their family members. They may be the last generation of women who sacrifice themselves for their families, and the first generation whose later life will not be guaranteed by their children in the new country. Relatively negative attitudes toward aging and menopause and the loss of power and control in their families may make Korean immigrant women more vulnerable to feelings of loss, depression, and lowered self-esteem in their menopausal transition.

Meanings of work. The meanings attached to women's work also mediate the women's menopausal transition within the context of immigration and work transition. This is a relatively new area of study in Korea. Feminist scholars primarily focus on sexism and gender issues in Korean society rather than women's daily experiences (Ewha Womans University, 1990; Korean Women's Development Institute, 1991; Shin, 1988). Little is known about the meaning of women's work and their lives in Korean culture.

Korean language does not have a word that means exactly 'work' in English. Rather, the word, "il," which is usually used in referring to work, means labor, employment, task, job, vocation, business, errand, matter, thing, affair, incident, event, plan, project, scheme, and achievement (Minjungseorim, 1990). Thus, work has been defined as any type of paid or unpaid physical or psychological efforts in a general sense. However, when a woman is asked about "il," the question generally asks if she is employed or not. Usually, housework is not regarded as "il" even though the word means any type of physical or psychological effort. Housework is regarded as a function of gender rather than work. However, housework is really time- and energy-consuming work. Most Korean husbands insist on traditional Korean food, which takes a long time to prepare (Korean food usually consists of steamed rice, one soup or stew, Kimchi, one main dish, and three side dishes). Furthermore, Korean housekeeping standards are very high, and it is the woman's job to attend to housekeeping and children's needs, even if it is the man who is staying at home.

With the limited definition of work, women's work has been devalued and invisible in Korean culture. In particular, low status jobs such as domestic work, waitress, or seamstress are more devalued in Korean culture than in Western culture. Korean immigrants' attitudes and values about women's work may be similar to those of women in South Korea. Since most are employed in low-status jobs, their attitudes may make them more miserable and marginalized within their own ethnic communities.

As many studies on Korean immigrants have shown, women's work has scarcely changed gender relations in families (Hurh & Kim, 1990; Light & Bonacich, 1988; Yu,

1987). In some immigrant groups, such as Mexicans (Hondagneu-Sotelo, 1994), women's economic contribution to their family income is reported to erode men's patriarchal authority in the family and empower women either to directly challenge that authority, or at least to negotiate "patriarchal bargains" (Kandiyoti, 1988) that are more palatable to themselves and their children. However, for Korean immigrant women, the cultural legacy of patriarchy continues intact despite their significant economic contribution to family income, similar to Japanese immigrant women (Glenn, 1986).

Symptom experience. Women's menopause is a transition that influences their symptoms experience. During menopausal transition, women experience changes precipitated by aging processes of the endocrine system. Manifestations include mild to severe physical and emotional symptoms although these are not considered to be pathological. Menopausal symptoms have been well-documented in Caucasian women; however menopausal symptoms themselves are unclear and poorly defined when applied to all women.

Many highly divergent nosological patterns of menopausal symptoms have been suggested for over 30 years (Aloysio, Fabiani, Mauloni & Bottiglioni, 1989). Blatt, Wiesbader, and Kupperman (1953) include 13 symptoms as menopausal symptoms; Jaszmann, van Lith, and Zatt (1969) include 9 symptoms; Neugarten and Kraines (1965) include no less than 41 symptoms; and Greene (1976) include 21 symptoms. Indices for quantifying menopausal symptoms have been developed; however, assigning numerical scores to clinical cases whose nosological profiles are complex and unclear, does not seem to be realistic (Aloysio et al., 1989).

Generally, studies on menopause have divided menopausal symptoms into two categories: Physiological and psychological. The physiological symptoms include those related to vasomotor changes such as hot flashes associated with dizziness, nausea, headache, fatigue, heart palpitations, insomnia, diaphoresis, and night sweats (Olive & Hammond, 1986); atrophy of the ovaries, vagina, urethra, bladder, and breast-supporting tissue with potential symptoms of urethral syndrome, dyspareuria and skin and mucosal changes (Badawy, 1985; Olive & Hammond, 1986); osteoporosis due to bone loss (Olive & Hammond, 1986); irregular vaginal bleeding resulting in nuisance spotting or severe anemia (Badawy, 1985); and hirsutism caused by an increase in the testosterone-estrogen ratio (Droegemueller et al., 1987).

Psychological symptoms include general malaise (Droegemueller et al., 1987), decreased libido (Lichtman, 1991), depression (Droegemueller et al., 1987; Harper, 1990; Hunter, Battersby, & Whitehead, 1986; McKinlay & Jefferys, 1974; Sharma & Saxena, 1981), loss of self-esteem (Droegemueller et al., 1987; Harper, 1990), mood swings (Harper, 1990; Sharma & Saxena, 1981), feeling of unworthiness (Droegemueller et al., 1987; Harper, 1990; Bungay, Vessay, & McPherson, 1980), forgetfulness (Bungay et al., 1980), poor concentration (Bungay et al., 1980), anxiety (Bungay et al., 1980), and psychiatric problems (Ballinger, 1985).

Most researchers tended to investigate a specific menopausal symptom such as hot flash, sweating, and osteoporosis rather than symptoms as a whole (Dennerstein & Burrows, 1978; Feldman, Voda, & Gronsseth, 1985; Lindsay, Hart, Forrest, & Baird,

1980; Prince, Smith, Dick, Price, Webb, Henderson, & Harris, 1991; Radloff, 1980). These studies failed to understand menopausal symptoms with a comprehensive view.

Menopausal symptoms have not been explored in Korean immigrant women. Because of the vulnerability and marginality that may be precipitated by their transitional status, Korean immigrant women may be more likely to suffer adverse outcomes from menopausal symptoms. It can also be inferred that their symptom experience may be quite different from that of women in other cultures. Indeed, researchers have asserted that menopausal experience is culturally different. Arguments related to the universality of menopausal experiences have been one of the critical issues related to menopause. Menopause, as the final menstrual period, has been regarded as a universal phenomenon. However, when menopause is associated with certain symptoms, the universality is questioned. For example, hot flashes, sweating and vaginal dryness have been considered to be typical menopausal symptoms in Western cultures. However, in non-western cultures, it was noted that women did not complain about such symptoms and when explicitly asked about them, only a few reported the experience of 'typical menopausal symptoms' (Oddens, 1994). Considering the findings of previous studies on Eastern populations, symptom experience must be different from that of women in other cultures.

Management strategies. Management of symptoms can mediate the menopausal experience. When symptoms are adequately and appropriately managed, menopausal transition can be successfully facilitated. Generally, six types of management strategies for menopausal symptoms are used: Hormone replacement therapy, alternative medicine therapy, psychological therapy, natural remedies, environmental modification, and

support groups that incorporate educational strategies (Grenier, 1987; Harper, 1990; Lichtman, 1991; Miller, 1992).

Among these strategies, the most frequently researched and used management strategy has been hormone replacement therapy (Miller, 1992). Considering the historical tendency of Western medicine, it is understandable why hormone replacement therapy has been frequently researched and used despite well-known potential risks. During the 1970s, estrogen replacement therapy in postmenopausal women was identified as a prevention measure against osteoporosis, and in the 1980s, it was shown to lower cardiovascular morbidity and mortality (Miller, 1992). Hormonal replacement therapy (HRT) has been known to be generally effective in bringing about relief of vasomotor complaints, frequently accompanied by a feeling of general well-being and the alleviation of psychological complaints (Harper, 1990; Lichtman, 1991; Sheehy, 1991). However, the increasing risks of breast cancer, endometrial cancer, acute liver disease, acute thrombophlebitis or thromboembolic disorders, and undiagnosed vaginal bleeding have been reported in many studies (Harper, 1990; Lichtman, 1991; Sheehy, 1991). Other potential risks of HRT, including risk for gallstones and hypertension, have also been indicated (Cook, 1993). Many studies suggest that women on HRT need to undergo endometrial biopsy several months after starting hormones (Sheehy, 1991), and should have routine mammograms, pelvic exams, stool guaiac and cholesterol and triglyceride levels (Mezrow & Rebar, 1988). Studies also indicate that the expense of physical examinations and screening cannot be dismissed. Many women lack adequate financial or health care resources to manage health-promoting activities (Peden & Newman, 1993).

Miller (1992) posed several alternatives for the treatment of vasomotor symptoms. Those non-estrogen alternatives are classified in four categories: Steroids or steroid analogs; non-steroidal medications; natural remedies such as Ginseng, Vitamin E, Bee pollen, and Cohash; and environmental modifications such as layered clothing and avoidance of caffeine (Miller, 1992). Counseling is also widely used for the women who may require and benefit from more psychologically-based treatments. Yet, very little has been known about the effects of the alternative treatments.

Self-help groups are emerging as useful interventions (Mickelson, 1991; Peden & Newman, 1993). Health care providers are incorporating counseling and support groups into the management strategies for menopausal symptoms (Grenier, 1987; Mitchel, 1989). Studies are beginning to focus on support groups with educational programs for effective management of menopausal symptoms of healthy middle-aged women (Birnbaum, 1975; Granville, 1990; Grenier, 1987; McCracken, 1988; Payling, 1992). These awareness-raising groups have been reported to be effective in transmitting scientific information, sharing experiences, and preventing possible complications due to menopause.

Self-help groups are commonly composed of premenopausal, menopausal, and postmenopausal women who meet with facilitators for four to six sessions to share their feelings and personal experiences with menopause (MacPherson, 1981). Participation in the menopause support group is one way in which women can get the support and encouragement needed as they go through their menopausal transition (Peden & Newman, 1993). The self-help groups are reported to give reassurance about normal

physical changes, but also provide emotional encouragement as well as new direction in women's lives. New knowledge is actively found and shared, and alternatives to HRT (various vitamins, minerals, herbs, calcium, special foods and exercise) are discussed. Support groups provide opportunities for a woman to reflect and examine her values, and discover what she hopes to accomplish during the rest of her life. The main focus of the self-help group is on building and adding to what the person already is. The basic issue is control of one's own body (MacPherson, 1981; Peden & Newman, 1993).

Because of differences in meanings of menopause, the approach to menopausal symptoms must be different for different cultures. In Eastern culture, with its different world view from Western culture, women may manage their menopausal symptoms in their own unique ways, based on their own world view. Yet, it cannot be easily determined which way is better for managing their menopausal symptoms.

Very little is known about how Korean immigrant women manage their menopausal symptoms. Since menopausal symptoms have been regarded as normal age-related phenomena rather than pathological phenomena in Korean culture (Jung, 1988; Lee & Chang, 1992; Lee, 1994; Yoon, 1989), Korean immigrant women may use Hanbang (Korean traditional medicine) or natural foods more frequently than Western medicine approaches. Honey, Ginseng, Royal Jelly, deer horn, Hanyak (Korean traditional herbal medicine), and other herbs may be used to manage vague symptoms; Chi'm (acupuncture) is used to manage muscle or bone related symptoms; and D'um (moxabustion) and Buhwang (cupping) are used to manage symptoms believed to be related to inner organs. When the transition process engenders feelings of stress and

weakness, Korean women may use Hanyak to restore energy, promote health and prevent illness (Hwang, 1992; Jung, 1988).

Traditional herbal medicine, called Hanyak, is the major part of Hanbang. The medicine is used to produce harmony in oneself in relation to a larger harmonious cosmology. Usually, older Korean women prefer Hanyak for promoting health, preventing disease, and treating several diseases. A common type of Hanyak is Boyak, tonic medicine. Usually, Boyak is made from ginseng, deer horn, or bear gallbladder (Pang, 1989). Chi'm is very similar to Chinese acupuncture and frequently used for osteological or neurological problems. D'um is burning mugwort applied to tiny areas of the body. This treatment stimulates circulation and restores energy (Pang, 1989). Buhwang is the treatment in which bad blood is sucked out (Pang, 1989). This treatment also stimulates circulation and restores energy.

Low income Korean immigrant families visit the Western physician's office only in emergency situations (Miller, 1990). They rarely can afford medical insurance or expensive Korean traditional medicine (Miller, 1990). Therefore, many low income Korean immigrant women live with vague menopausal symptoms believed to be just aging related, rather than pathological change requiring Western health care services.

Indicators of Healthy Transition

Few studies on Korean immigrant women's health focus on their transition experiences and little is known about health outcomes of menopausal Korean immigrant women. While studies of mental health provide important information on the influence of the immigration experience (Hurh & Kim, 1990; Kim & Rew, 1994; Kuo, 1984; Shin, 1994), these studies do

not provide a comprehensive understanding of Korean immigrant women's well-being and they rarely convey the women's voices. Using quantitative research methods, the studies attempt to describe relationships between mental health and other variables instead of uncovering the meaning of the immigration experience. In addition, the studies focus on negative outcomes of the transitional experience and rarely mention positive outcomes, such as quality of life, adaptation, functional ability, self actualization, expanding consciousness, or personal transformation. Other indicators of healthy transition have been scarcely explored such as mastery of new behavior and well-being of interpersonal relationships. Consequently, the outcomes of transitional experiences of low income Korean immigrant women in menopausal transition are not fully understood. Also, these studies have been conducted with Korean immigrant populations in specific areas of the U.S., so the generalizability of the findings is limited.

Korean immigrant women have been reported to show relatively high depression rates related to the stress of immigration, minority status, higher educational preparation but lower prestige jobs, poor English skills, the heavy burden of combining full-time employment with traditional performance of household tasks, limited ability to express their difficulties (Kim & Rew, 1994), conflicts in values between the old and new cultures, identity confusion, communication problems, and the experience of prejudice and discrimination (Kim, 1988). Because of cultural attitudes toward depression and other psychological problems, Korean immigrant women report somatic symptoms as an expression of emotional distress or social problems. Gender differences in mental health correlates among Korean immigrants in the United States have been described (Hurh & Kim, 1990). Work-related variables most

strongly correlated with mental health among men. Family life satisfaction and ethnic attachment variables (Korean church affiliation, kinship contact, Korean neighbors, regular reading of Korean newspapers) were significant correlates for women. Even among employed women, the effect of work-related variables (earnings and job satisfaction) on their mental health was more limited than for men. These findings on their health and illness suggest that low income Korean immigrant women's transitional experience is characterized by instability rather than stability.

Research Questions

Based on exploration of feminist and transition theoretical foundation and related literature review, the following research questions emerged to give a bio-psycho-socio-cultural understanding of the menopausal experience of low income Korean immigrant women within a multiple transitional context:

1. What are the meanings of menopause to low income Korean immigrant women (meanings)?
2. What are the symptoms perceived by low income Korean immigrant women during their menopausal transition (physical and psychological well-being)?
    - 2.a. What are the perceived causes of the symptoms (level of knowledge and skill and meanings)?
    - 2.b. What meanings do low income Korean immigrant women assign to the perceived symptoms (meanings)?
    - 2.c. What strategies do they describe to manage their perceived symptoms (level of knowledge and skill)?

3. What is the context in which low income Korean immigrant women experience their menopausal transition (environment)?

3.a. Do data provide evidence against the following null hypotheses?

(a) Hypothesis 1. There is no difference in the population mean total number of the total symptoms by socio-demographic variables (age, education, family income, marital status, work status, perceived health status, and the length of time in the U.S.)

(b) Hypothesis 2. There is no difference in the population mean total number of the physiological symptoms by socio-demographic variables (age, education, family income, marital status, work status, perceived health status, and the length of time in the U.S.)

(c) Hypothesis 3. There is no difference in the population mean total number of the psychological symptoms by socio-demographic variables (age, education, family income, marital status, work status, perceived health status, and the length of time in the U.S.)

(d) Hypothesis 4. There is no difference in the population mean total number of the menopausal symptoms by socio-demographic variables (age, education, family income, marital status, work status, perceived health status, and the length of time in the U.S.)

(e) Hypothesis 5. There is no difference in the population mean total number of the total symptoms between three different ethnic identity groups;

(f) Hypothesis 6. There is no difference in the population mean total number of the physiological symptoms between three different ethnic identity groups;

(g) Hypothesis 7. There is no difference in the population mean total number of the psychological symptoms between three different ethnic identity groups;

(h) Hypothesis 8. There is no difference in the population mean total number of the menopausal symptoms between three different ethnic identity groups;

(i) Hypothesis 9. There is no difference in the population mean total number of the total symptoms between three different work satisfaction groups;

(j) Hypothesis 10. There is no difference in the population mean total number of the physiological symptoms between three different work satisfaction groups;

(k) Hypothesis 11. There is no difference in the population mean total number of the psychological symptoms between three different work satisfaction groups; and

(l) Hypothesis 12. There is no difference in the population mean total number of the menopausal symptoms between three different work satisfaction groups.

3.b. In what ways do the perceived symptoms experienced during menopausal transition affect their daily immigration and work experience (meanings and environment)?

3.c. How do Korean immigrant women during mid-life describe their menopausal transition within the context of immigration and work transition (meanings and environment)?

Definitions of Concepts

Menopause is classified as natural or surgical menopause. Natural menopause is defined as the natural cessation of menses defined after 12 consecutive months of amenorrhea (Treloar, 1974). Surgical menopause is defined as the cessation of menses resulting from removal of the uterus, with or without bilateral oophorectomy (McKinlay, Brambilla, & Posner, 1992). In this study, menopause means both natural and surgical menopause. Yet, when specifically referring to the meanings of menopause, menopause means only natural menopause.

In this study, three natural states of menopause are defined: Pre-menopausal, peri-menopausal, and post-menopausal. The following definitions are based on the perimenopausal menstrual patterns reported by Treloar (1974). Women who have menstruation within the prior 3 months, with no change in regularity of cycle are generally considered premenopausal. Women who report 3-11 months of amenorrhea or increased menstrual irregularity are considered perimenopausal. The postmenopausal state consists of permanent amenorrhea. When a woman reports more than 12

consecutive months of amenorrhea, she is considered postmenopausal. Also, women who were surgically menopaused are regarded as post-menopausal.

Meaning is defined as the subjective appraisal of an anticipated or experienced transition and the evaluation of its likely effect on one's life (Schumacher & Meleis, 1994). In this study, the meaning of menopause means the subjective appraisal of menopausal transition and the evaluation of its likely effect on a Korean woman's life.

Health/illness is indicated by psychological and physiological symptoms. Symptom is defined as subjective experiences reflecting changes in a person's bio-psycho-social function, sensation, or cognition (Blacklow, 1983).

Work is defined as a continuum ranging from formal labor market work to informal work to unpaid household work (Ward & Pyle, 1995). For the purpose of this study, work means formal labor market work as well as informal work including unpaid household work.

Marginalization is defined as being distinguished from the norm in a situation with negative attribution associated with being different (Meleis, Lipson, Muecke, & Smith, 1995). Marginalized people are differentiated by their dress, by their language, and by their lack of power or by possessing power that is not well understood by the majority of people (Meleis et al., 1995).

Finally, as an indicator of immigration transition, ethnic identity is defined as a subjective sense of social boundary or a self-definition (Meleis, Lipson & Paul, 1992). Three ethnic identities are used in this study: Koreans, Korean-Americans, and Americans.

CHAPTER III

Research Methodology

As discussed earlier, a woman's lived experience is anchored within the context of her bio-psycho-socio-cultural world (McBride & McBride, 1981). Exploring just her physiological factors or sociological factors cannot fully explain her lived menopausal experience within that context. Therefore, to understand the lived experience of a menopausal transition, a single research method may not be sufficient. When a single method is inadequate, triangulation is used to insure that the most comprehensive approach is taken to address a research question (Morse, 1991). In this study, qualitative-quantitative methodological triangulation was used to explore the lived menopausal experience of low income Korean immigrant women in transition.

Study Design

This was a cross-sectional descriptive study consisting of two phases. In the first phase, quantitative methods were used to describe sociodemographic characteristics, general health, menstrual history, menopausal status, the meanings of menopause, work satisfaction, ethnic identity, the symptoms perceived during menopausal transition, the severity of the symptoms, the meanings of the symptoms, and management strategies for the symptoms. In the second phase, qualitative methods included in-depth interviews to describe the meanings of menopause and the transitional context in which low income Korean immigrant women were experiencing their menopausal transition.

Settings

The settings of this study included two types: Korean ethnic churches, and Korean ethnic small businesses (Korean grocery stores, Korean restaurants, Korean beauty parlor, and Korean laundries). Korean immigrants have been known as 'churchgoers' compared with Chinese and Japanese immigrants. In Southern California alone, the number of Korean ethnic churches increased from 11 to 215 churches from 1965 to 1979 (11 to 215 churches) (Hankuk Ilbo, May 18, 1979), and the number of Korean churches in California was 1010 in 1997 (The Korea Times San Francisco, Jan. 10, 1997a). Korean churches were good places to meet Korean immigrant women. Korean ethnic small businesses were also good places to meet low income Korean immigrant women who could not be met in Korean ethnic churches. Most Koreans used Korean ethnic small businesses because of their strong ethnic loyalty and language limitations. They frequently used Korean grocery stores and restaurants to shop and enjoy Korean foods. Announcements for low income jobs or ethnic community activities were posted in the Korean ethnic small businesses. For this study, 30 Korean ethnic churches and 20 Korean ethnic businesses were visited to recruit the research participants and observe their lives in indirect ways.

Research Participants

Recruitment of Participants

Inclusion criteria and sample selection process. A convenience sample of 119 women who met the inclusion criteria was recruited from community sites. Self-identified first-generation Korean immigrant women in San Francisco Bay Area, aged 40

to 60 years, who engaged in low-status/low-income wage work outside their own homes (e.g., housecleaning, restaurant work, seamstress) were included. The age range was based on the average age of menopause (approximately 47.2 years old) and its standard deviation (3.2) reported by several studies on menopause of Korean women in Korea (Im, 1994; Jung, 1988, Yoon, 1989). Women who could not speak, read, and write Korean were excluded because Korean language was used exclusively throughout the research process.

Using the Korean Business Directory, 30 Korean ethnic churches in San Francisco Bay Area were identified, contacted, and requested a list of members by mail. Upon obtaining membership lists from the churches, female members aged 40 to 60 years were identified. These women were sent an announcement and information sheet translated into Korean (Appendix A). Because it was anticipated that Korean women would be unlikely to respond to a post card, I contacted the women by phone to verify the inclusion criteria and to invite them to participate in the study.

Twenty other recruitment sites, such as Korean grocery stores, restaurants, beauty parlors, and laundries, were identified through the Korean Business Directory. These sites provided access to potential participants who did not attend Korean churches. I got the permission of the store managers to post announcements and information sheets (Korean version) for customers to see. Women who contacted me were invited to participate in the study. In addition, I employed snowball sampling by asking the participants to introduce other women who were at least closely connected to them providing the referrals in an effort to prevent putting together a sample made up of a

network of close friends (Biernacki & Waldorf, 1981). From the church sites, 95 women (79.8%) were recruited, and from Korean ethnic business sites, 24 women (20.2%) were recruited.

From the total sample of 119 women, a subset of 21 women was drawn and invited to participate in-depth qualitative interviews. The inclusion criteria for the qualitative subset were peri- or post-menopausal women determined by the quantitative data on menstrual regularity and amount. Women who had lived in the U.S. for less than 10 years were preferred because they were more likely to still be experiencing the effects of the immigration experience. Initially, recruitment for the subset was the first 10 participants from the larger sample who met the subset inclusion criteria. Theoretical sampling (Strauss & Corbin, 1990) technique was used to recruit the remaining 11 participants.

Sample size determination. Some assumptions were made in order to estimate a sample size for the quantitative part of this study that would give adequate power for statistical significance. To calculate the sample size for the quantitative part of the study adequately testing the hypotheses that there is no difference in the population mean total number of total, physiological, psychological, and menopausal symptoms by socio-demographic variables, ethnic identity and work satisfaction, a moderate effect size (.30) was assumed. With an alpha level = 0.05 and power of 0.80, it was determined that 84 women would be needed to detect statistical significance (Cohen, 1988). One hundred nineteen low income Korean immigrant women aged 40 to 60 years old were recruited,

so this study has a sufficient number of women to test the hypotheses (refer to page 44 and 45) for statistical significance.

Instruments

To answer the research questions, several instruments were used. A summary of the instruments is presented in Table 1.

Interview Protocol I

An interview protocol was developed to obtain data on sociodemographic profiles, ethnic identity, general health, menstrual history, menopausal status, and work satisfaction (Appendix B). Using the protocol, socio-demographic profiles of the research participants were obtained. Ethnic identity was measured with seven questions: Length of stay in the U.S., preference of foods, music, customs, language, close friends, and self ethnic identity. General health was measured using one 5-point item rating their general health and two items asking diagnosed diseases and medication usage. Menstrual history and menopausal status were determined using seven items asking last menstrual cycle, menstrual regularity, prediction of next menstruation and self identification. Also, the conditions that might make menopausal status uncertain were determined using three items.

Work satisfaction was measured using five items asking research participants to rate their work satisfaction with 5-point scales in terms of overall feeling about work, satisfaction in financial support, satisfaction in the job tasks, satisfaction in self accomplishment related to work, and satisfaction relative to their qualifications.

Table 1. A Summary of Instruments * NA = Not Available

Concepts	Variables	Instruments	Description	Reliability	Validity
Socio-demographic Profiles	Age Education SES Marital status Work	Interview Protocol I (Appendix B)	12 items (multiple choice, dichotomous scale, & open-ended questions)	NA	NA
Ethnic Identity	Length of Stay Preference of foods, music, customs, and languages Close friends Self Identity	Interview Protocol I (Appendix B)	7 items (open-ended question & 5-point rating scale)	NA	NA
General Health	Self perceived general health status Diagnosed diseases Medicine-taking	Interview Protocol I (Appendix B)	3 items (rating scale, dichotomous scale, & open-ended questions)	NA	NA
Menstrual History & Menopausal Status	Last Menstruation Menstrual regularity Conditions making menopausal status uncertain (reproductive health, contraceptive methods, & prescription steroids or hormones)	Interview Protocol I (Appendix B)	12 items (multiple choice, dichotomous, & open-ended questions)	NA	NA
Work Satisfaction	Overall feeling about work Satisfaction in financial support Satisfaction in the job tasks Satisfaction in self accomplishment Satisfaction relative to qualifications	Interview Protocol I (Appendix B)	6 items (rating scale)	NA	NA

Table 1. (Continued)

Concepts	Variables	Instruments	Description	Reliability	Validity
Health/Illness	Physiological health Psychological health	Cornell Medical Index (Appendix C)	153 items (dichotomous scale and divided into 18 section)	r=.98 (test-retest reliability)	good
Menopausal Symptoms	Perceived menopausal symptoms	Appendix C	13 items (dichotomous scale)	NA	NA
Severity of the symptoms	Self-rated severity of the symptoms	Interview Protocol II (Appendix D)	Likert scale per each symptom reported	NA	NA
History of the Symptoms	Symptoms when their mid to late 20's and entire 30's	Interview Protocol II (Appendix D)	Dichotomous scale	NA	NA
Causes of the symptoms	Perceived causes of the symptoms	Interview Protocol II (Appendix D)	Open-ended question per each symptom reported	NA	NA
Meanings of the symptoms	Perceived meanings of the symptoms	Interview Protocol II (Appendix D)	Open-ended question per each symptom reported	NA	NA
Management of the symptoms	Self management strategies for the symptoms	Interview Protocol II (Appendix D)	Open-ended question per each symptom reported	NA	NA

* NA = Not Available

Cornell Medical Index

The Cornell Medical Index (CMI) was designed to be a quick screening method for bodily symptoms, past illnesses, family history of disease, illness behaviors, and habits, and general health (Brodman, Erdman, Lorge, & Wolff, 1949; Brodman, Erdman, & Wolff, 1956). It has been often used as a measure of overall health status or a profile of health patterns.

The CMI is a 195 item dichotomous scale and divided into 18 sections. A-L refer to physiological symptoms (eyes, ears, cardiovascular, digestive, musculoskeletal, skin, respiratory, nervous, skin, genitourinary) and M-R refers to psychological symptoms (feelings of inadequacy, depression, anxiety, sensitivity, anger, tension). Separate forms for men and women differ only in the genitourinary section. This scale can be used in all age groups from 18 to 80. The total score is calculated by adding the total number of "yes" responses. American population norms show scores of 30 and above on A-L sections, and 10 and above on M-R sections are indicative of serious health problems. Similar norms have been reported in Korean Americans, Taiwanese, and Danes (Eyton & Neuwirth, 1984).

When first developed (Brodman et al., 1949), the CMI scores agreed with subsequent physician interviews in 95% of 179 medical outpatient cases. Abramson (1966) reported correlations of 0.52 and 0.57 on male/female versions and physician examinations in Israel. Croog (1961) found the psychological section to be highly correlated (r=0.78) with the Taylor Manifest Anxiety scale. Moreover, content and construct validity have been established with many studies in cross-cultural populations

(Brodman et al., 1956; Brown & Fry 1962; Chu & Rin, 1970; Jackson, Taylor, & Pygnolil, 1991). Rezian and Meleis(1987) reported Spearman r for test-retest on A-L=0.98, M-R=0.94, and Total = 0.98.

In this study, the scale was supplemented by 14 questions on menopausal symptoms reported by the previous studies on menopause of Western and Korean populations (Blatt et al., 1953; Im, 1994; Neugarten, & Kraines, 1965; Yu & Chi, 1986). The supplementary questions were added into the additional section, S (Appendix C). Also, 42 questions, that were found to be inappropriate to this study, were excluded: The excluded questions were related to family history and medical history that were not directly asking about symptoms.

Interview Protocol II

An interview protocol was developed to obtain the following data: The severity of the symptoms using Likert scale 0 to 5 (0= not at all, 5=extremely), the perceived causes for the symptoms, the perceived meanings of the symptoms, and the management strategies of the symptoms (Appendix D). For the each symptom answered 'yes' in the Cornell Medical Index (CMI) and supplementary questions, each woman was interviewed using the interview protocol II to get information on the severity and history of the symptom. Perceived causes, meanings, and management strategies were asked only for the symptoms that were experienced after the age of 40 because the symptoms that had been experienced in their 20s or 30s were less likely to be caused by their menopausal transition.

Interview Guide

In-depth interviews were done to explore the meanings of menopause and the transitional context in which low income Korean immigrant women experienced their menopausal transition. To systematically direct the in-depth interviews, an interview guide (Appendix E) was developed.

During the interviews, areas of questions included: (a) meanings of menopause; (b) names of menopause; (c) their mothers' menopause; (d) perceived causes of menopause; (e) changes in their body, mind, daily life, marital relationships, family relationships, and friend relationships due to menopause; (f) feeling about menopause; (g) meanings of being a woman; (h) meanings of being Korean, American, Korean-American; (i) meanings of aging; (j) difficulties in immigration and work experience; and (k) influences of menopause on their immigration and work experience. The interview questions are presented in detail in the interview guide (Appendix E).

Data Collection Process

Women who agreed to participate were given (in person or by mail) a Korean version of questionnaires to complete (Appendix B: Interview Protocol I; Appendix C: Cornell Medical Index). An interview was scheduled at the convenience of the participant. Each participant was asked to bring the completed questionnaires to the interview.

At the interview, the questionnaires were reviewed to check for completeness, and the incomplete items were asked and filled out. I reviewed the participant's responses

regarding perceived symptoms, and applied the Interview Protocol II (Appendix D) in Korean to each symptom answered with a "yes."

Of the 119 women who participated in the first phase, the 65 who met criteria for the second phase were asked to participate. Among them, the first 10 women were recruited. Then, through theoretical sampling, additional 11 women were recruited. The audio-taped interviews were conducted with the use of the Interview Guide (Appendix E) in the places that the participants decided. The interview places were diverse: Churches, homes, work places, café, restaurants, and so forth. Each interview took an average of 2 hours. In two cases, women rejected the audio-taping, so interviews were done with written memos. Separate field notes were done to supplement the interviews. Following the interviews, the audio-tapes were transcribed in Korean: 19 tapes were recorded, and 21 transcripts were made.

Approaches for Resolving Problems in the Research Implementation

A major challenge in the research implementation was the sample recruitment. Since Koreans are usually unwilling to participate in any type of survey or interview, it was difficult to get an adequate number of research participants. Therefore, before contacting potential study participants, the purpose and other information about the study was announced in church gatherings, and a solicitation was made to church members to participate in the study. Additionally to increase the participation rate, the participants of the 30 minute interview were promised 10 dollars in cash following the interview, and those who participated in the additional in-depth interview were received an additional 20

dollars in cash. Moreover, informal leaders of the church meetings were contacted and their cooperation was asked.

Another challenge in the research implementation was translation. Since Korean language was used exclusively throughout the research process, all materials were translated in Korean. Additionally, the answers to the questionnaires and the codes of the transcripts were translated into English in the data analysis process. Burns and Grove (1993) suggest translating from the original language to the target language and then "back translating" from the target language to the original language using translators not involved in the original translation. Discrepancies are identified and the procedure is repeated until troublesome problems are resolved. To minimize the bias from translation process and guarantee valid and accurate translation, the translated questionnaires in Korean were back translated. Moreover, to ensure the accuracy of English translation, the translated materials were checked by two bilingual translators.

A third challenge was related to how the participants perceived me as a researcher. According to Lipson (1991), similarity and dissimilarity between the researcher and research participants affect the findings of the research in beneficial or detrimental ways. The similarity of being Korean might be beneficial in getting easy entry, and facilitating common understanding and language. However, the similarity resulted in the research participants being less open since gossip was common and feared in Korean immigrant communities. To minimize the effects of the similarity between the research participants and me, it was emphasized before data collection that their names would not be disclosed and anonymity would be ensured. Also, when using snow-ball sampling, the women

were asked to introduce other women who were not close to them, but might be interested in the study.

Data Analysis

Data were collected from two general sources. First, data were obtained from the questionnaires and short interviews. From the data source, information on the sociodemographic profiles, general health, menstrual history, menopausal status, work satisfaction, ethnic identity, perceived symptoms during menopausal transition, severity of the symptoms, history of the symptoms, perceived causes of the symptoms, meanings of the symptoms, and management strategies for the symptoms were obtained. Second, data were also obtained from the in-depth interviews. From this data source, information was obtained on the meanings of menopause, in what ways the perceived symptoms affected their daily immigration and work experience, and how low income Korean immigrant women described their menopausal transition within the context of immigration and work transition. Analysis of the data focused on describing menopausal experience of low income Korean immigrant women and explored the context in which they went through their menopausal transition.

The quantitative data were analyzed with descriptive and inferential statistics using the SPSS statistical package program. Descriptive statistics were used to describe the sociodemographic profiles, general health, menstrual history, menopausal status, work satisfaction, ethnic identity, perceived symptoms during menopausal transition, severity of the symptoms, history of the symptoms, perceived causes of the symptoms, meanings

of the symptoms, and management strategies. Statistics included frequency, percentage, mean ± standard deviation, and range.

To test the hypotheses (refer to page 44 and 45), analysis of variance (ANOVA) was used. To use analysis of variance (ANOVA) tests, the variables were transformed into dichotomous variables: The women were divided into 4 different age groups (40-44, 45-49, 50-54, and 55-60 years old), 3 education groups (low, middle and high education), 3 family income groups (low, middle, and high family income), 4 marital status groups (married, divorced, widowed, and single), 2 work groups (work and not-work), three perceived health status groups (healthy, not-know, and unhealthy), 3 ethnic identity groups (Korean, Korean-American, American), 2 groups according to the length of time in the U.S. (less than 10 years and more than 10 years), 3 menopausal groups (pre-, peri-, and post-menopausal), and 3 work satisfaction groups (low, middle, and high). The ethnic identity groups were divided based on the total scores of the 6 items (preference of foods, music, customs, languages, close friends, and self identity): Korean ethnic group is the women who got the score of 0 to 12; Korean-American group is the women who got the score of 13 to 24; and American group is the women who got the score of 25 to 30. The 3 work satisfaction groups (low, middle and high) were divided based on the total score of the 6 items on work satisfaction (overall feeling, financial support, job tasks, self accomplishment, and qualifications).

The qualitative data obtained from the in-depth interviews were analyzed using thematic analysis including textual examination of interview transcripts, line-by -line coding of the transcripts into categories that emerged from my internal cognitive process

and reflexive thinking, and description of key relationships between the categories. An interactive process that involved reading and re-reading text to produce successively more abstract and refined ideas about domains of interest was used to identify themes common to research participants, and served as an ongoing system of checks and balances. Once codes were developed, data were sorted by codes and associations between themes or domains were examined.

Rigor of the Study

Since this study was philosophically based on feminist approaches, used methodological triangulation, and aimed at culturally competent scholarship (Meleis, 1996), the conventional standards of measuring the reliability and validity to assess the accuracy and consistency of the studies were not adequate to evaluate the rigor of the studies. To ensure the rigor of this study, the evaluation criteria for feminist research by Hall and Stevens (1991) and the evaluation criteria for culturally competent scholarship by Meleis (1996) were used to guide this study. The rigor of the feminist study was established by using criteria of reflexivity, rapport, coherence, consensus, credibility, dependability, adequacy, honesty, mutuality, empowerment, complexity, conscious partiality, naming, insider/outsider issues and ethical concerns for the rights of participants (Hall & Stevens, 1991). The culturally competent scholarship of the study was established by using criteria of contextuality, relevance, appropriateness of communication styles, awareness of identity and power differential, disclosure, reciprocation, empowerment, and time (Meleis, 1996).

Since this study emphasized the uniqueness and the contextualized nature of women's experiences and interpretations, dependability (Hall & Stevens, 1991) was a more appropriate evaluation criterion than reliability because it does not decontextualize the data and does not expect or require that observations be repeatable or constant across observers and time. Dependability is ascertained by examining the methodological and analytic decision trails created by the investigators during the course of the study itself (Hall & Stevens, 1991). Measures to ensure the dependability in this study included systematic documentation of the rationale and outcome, evaluation of all actions related to the research process, prolonged engagement, persistent observation, comparison of individual and group data, and solicitation of spontaneous versus elicited data.

A valid measure is of little use when measurement is inconsistent from context to context, and a reliable instrument that measures an irrelevant construct is likewise inadequate. Thus, feminist research is best evaluated by standards of rigor that reflect the adequacy of the whole process of inquiry, relative to the purposes of the study, rather than by standards that focus only on the accuracy and reliability of measurements within the study (Hall & Stevens, 1991). Adequacy of inquiry implies that research processes and outcomes are well grounded, cogent, justifiable, relevant, and meaningful. Accordingly, feminist researchers must continually question their methods throughout the research process. To assure the adequacy (Hall & Stevens, 1991) of this study, the research methods, goals, research questions, design, scope, analysis, conclusions, and impact of this study within the social and political environment were continuously questioned throughout the research process.

In quantitative research, internal validity measures whether or not manipulation of the independent variable makes a significant difference in the dependent variable. Qualitative research is credible and relevant when it presents such faithful interpretations of participants' experiences that they are able to recognize them as their own (Hall & Stevens, 1991; Meleis, 1996). To ensure the credibility and relevance of this study, cross member validation of the findings was used in the process of data collection and data analysis. It was difficult to arrange an interview only for member validation since many of the women were reluctant to participate in the interviews. Therefore, rather than arranging independent interviews for member validation, cross member validation during each interview was a more appropriate way to check and ensure the credibility and relevance of the study.

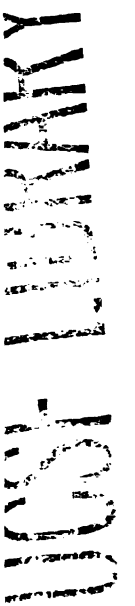
Reflexivity is an important factor in feminist research, which supports an appreciation of integrative thinking, awareness of theory as ideology, and willingness to make values explicit (Hall & Stevens, 1991; Olesen & Whittaker, 1968). Inadequate, invalid representations of participants' reality usually reflect the investigator's preconceptions of participants' experiences (Sandelowski, 1986). In this study, reflexivity was supported by chronological research diary, memos, and field notes. Throughout the research process, the following questions continued to be asked and answered: What biases do I have in performing interviews and analyzing the data? What are the differences between the participants and me? What differences in viewpoints do we hold? and What are the differences between quantitative and qualitative data?

It is explicitly acknowledged that the researcher is an integral part of the research design, procedure, evaluation and findings (Lipson, 1991). Also, it is well known that having accurate knowledge of one's position along an insider/outsider continuum at any given time enhances rigor (Christman et al., 1988). In this study, throughout the research process, the following questions were continuously asked and answered: Who am I? What may enhance or diminish my ability to achieve sensitivity, accuracy and trust in interacting with participants? What advantages or disadvantages does similarity with participants have? and What information is likely to be withheld from me by participants?

Because of its nature, feminist research usually leads to ethical dilemmas related to concern for and involvement with the participating persons (Olesen, 1994). One ethical dilemma concerns the manipulation of the research participant by the researcher, subsequently invading the participant's privacy (Finch, 1984; Stacey, 1988). During the process of completing questionnaires and being interviewed, the possibility existed that participants could experience an invasion of privacy and some emotional discomfort in disclosing and discussing personal health and immigration issues. Throughout the process, the participants' rights to refuse to participate or to withdraw from the study were addressed. To ensure confidentiality, participants' names were not recorded on interview forms and transcripts. Identification numbers and pseudonyms were assigned and used in the data analyses.

To ensure culturally competent scholarship (Meleis, 1996), the historical sociocultural context for the research encounter was contemplated, and context was emphasized throughout the research process. Also, communication styles appropriate to

my research participants were used. For example, when asking about vaginal dryness, the women rarely recognized the meanings of vaginal dryness. Thus, in this study, rather than asking if the women had vagina dryness, they were asked if they needed lubricants when having sexual relationships. Furthermore, throughout the research process, the power differential between the research participants and me was recognized. At best, some effort was made to minimize the distance between them and me by spending time with research participants to establish trust. Several visits to the churches were made, and time was spent chatting about daily lives. Also, to ensure that the research participant's goals as well as my own research goals were met, the research participant's goal was identified in the beginning stage of this study. Then, at each critical point in the research process, their goals and my goals were checked and evaluated to ensure culturally competent scholarship. In addition, to contribute to empowering the women in dealing with their menopausal symptoms and facilitating their transitions, some information on women's health, clinics, and other available resources was delivered to the women. Finally, despite the time constraints, neither time limitations nor an exact number of meetings with the women were predetermined. The consistency of time and number of interviews among and between the women were sacrificed for reciprocity, empowerment, and disclosure for culturally competent scholarship.



CHAPTER IV

Women and Their Transitions

Low income Korean immigrant women usually experience their menopausal transition at the same time they are experiencing immigration and new work transitions. Thus, in this study, to explore their menopausal transition, the participants were asked to describe their immigration and work experience as well as their menopausal transition. Their answers were further probed as they were encouraged to describe the meanings of their experiences and their responses. To capture their experiences, I focused on their daily lives and on those roles and activities that shaped their experience. Several themes emerged from the data using line by line coding and categorization. In this chapter, the data related to the participants' transitional experience are presented according to the emerging themes with two sections: Immigration and work transitions; and menopausal transition. Also, before presenting the themes, the participant's socio-demographic profiles are provided to give some information on who they are.

The Women

Research Participants for the First Phase

For the first phase of this study, 119 low income Korean immigrant women were recruited. Their sociodemographic profile is summarized in Table 2 and Table F1 (Appendix F). The mean age of the 119 women was 47.94 years old (SD = 5.77). Fifty five percent of the participants were highly educated (partial college, college graduates and graduate degrees). Fifty seven percent women were Christians. Only 16 % did not specify a religion. Thirty one percent felt that their income was insufficient, and 48%

Table 2 A Summary of Sociodemographic Profile of Research Participants

Sociodemographic Profiles	1st phase (n=119) N (%)	2nd phase (n=21) N (%)
Age		
40 to 44 years old	50 (42.0)	6 (28.57)
45 to 49 years old	36 (30.3)	6 (28.57)
50 to 54 years old	16 (13.4)	3 (14.29)
55 to 60 years old	16 (13.4)	6 (28.57)
Age (Mean/Standard Deviation)	47.94 (5.77)	49.95 (6.70)
Education		
Low	14 (11.8)	2 (9.52)
Middle	39 (32.8)	9 (42.86)
High	65 (54.6)	10 (47.62)
Family Income		
Insufficient	36 (30.5)	
Sufficient for essentials	57 (47.9)	
More than sufficient	25 (21.0)	
Marital Status		
Married/ Partnered, permanent relationship	107 (89.9)	19 (90.48)
Divorced/separated/no longer partnered	3 (2.5)	1 (4.76)
Widowed	3 (2.5)	1 (4.76)
Single	4 (3.4)	0 (0)

felt that their income was sufficient only for essentials. Ninety percent of the participants were married or permanently partnered. Under the strong influences of Confucian Korean culture, middle-aged Korean women rarely remain single until their mid-life and they are rarely divorced. Eighty two percent of the women reported that they were employed. Even though 22 women (18%) reported that they did not work in the questionnaire, detailed information through short interviews demonstrated that all of the women worked outside of the home. Thirty six percent worked in the informal sector and 59% worked in the formal sector, including small family businesses.

Research Participants for the Second Phase

Socio-demographic profiles of 21 research participants for the second phase are provided in Table 2 and Table F1 (Appendix F). Participants were evenly distributed in four age groups. Ten (48%) were highly educated (partial college, college graduates and graduate degree), and nine (43%) were high school graduates. Most (95%) were religious. Nineteen (90%) women were married, one woman (5%) was widowed and one woman (5%) was divorced. Seventeen (81%) women had more than one child. Fifteen (71%) women had sons. Nine (43%) women were working in family business as unskilled labor workers, cook or cashiers. Four (19%) women were private household workers.

Immigration and Work Transitions

The immigration and work transitions the participants described were situated in their descriptions of their gender. The participants described who they were as women and how being a woman affected the fabric of their daily lives and existence in the U.S.

and how the cultural meanings and values they brought with them, which were constantly reinforced by the Korean immigrant community, continued to dictate how they felt and behaved as women. Also, when focusing on the women's daily lives and on those roles and activities that tended to be shaped or shaped their experience, work within the context of immigration and gender needs to be considered. The participants described how they felt about their work, how their cultural heritage influenced their daily work experience, and how their immigration experience impacted their daily work experience.

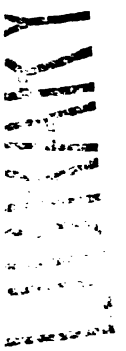
In this section, to ground the exploration of immigration and work transitions, the ethnographic description of the environment within which they were experiencing their daily lives is provided because it is important to gain a perspective on the context of these women's lives. Then, findings on ethnic identity, assumed to represent the participant's immigration transition, are presented. Findings on work satisfaction, assumed to represent work transition, are also presented. Five themes are presented related to the women's immigration and work experience as low income Korean immigrant women: 'Women should be women'; 'women are slaves'; 'Anil (work inside house) is women's work'; 'I cannot trust Kyopo (Korean immigrants)'; and 'I work like ants'.

Their Environment

The women's living environment is characterized by dangerous neighborhoods, easy access to Korean ethnic businesses, a variety of Korean ethnic community activities, and an increasing number of Korean ethnic churches. Like other immigrant women (Meleis, 1987), most of the low income Korean immigrant women were living in dangerous neighborhoods because of financial problems. Since they were employed in

low income jobs, they could not afford to live in safer areas. Even though these areas were not safe, they had a tendency to migrate toward neighborhoods where Koreans or Asians resided. Furthermore, they frequently lived in the same apartment complexes.

Most had easy access to Korean ethnic businesses. In San Francisco Bay Area, a variety of Korean ethnic businesses are available: Jewelry shops, beauty shops, video stores, lawyers' offices, clinics, interior design shops, photo shops, grocery stores, gift shops, laundries, restaurants, and so on. Approximately 1,600 Korean ethnic businesses in this area are listed in the Korean business directory (The Korean Times, San Francisco, 1997b). There is probably a far greater number, considering the number of businesses excluded from this directory.



These ethnic businesses tend to be consolidated in specific sections of the San Francisco Bay Area: Japan Town and Geary Blvd. in San Francisco, downtown Oakland, and El Camino Real in Santa Clara. Participants could easily find and use these businesses through the Korean business directory and other social support networks such as their churches and schoolmate meetings.

Also in the area are a variety of ethnic community activities: Korea Trade Center, Korean Chamber of Commerce of San Francisco, Korean Center, Korean-American Community Center, Korean-American Association of Santa Clara, Korea Academy of Industry Technology, Korean Immigration Service, San Francisco Senior Service, Korean-American Women Artists Writers Association, Korean-American Golden Years Welfare Center, Korean Community Service Center and so on (The Korean Times, San Francisco, 1997b). About one hundred Korean groups are listed in the Korean business

directory. Many of the women were not involved in ethnic community group activities, but help was readily available from these groups. There are also many informal Korean groups for hiking, golf, tennis, art, and alumni, but most of the participants, because of their low socio-economic status, could not afford to participate in these groups.

In the San Francisco Bay Area, there are six Buddhist temples, seven Catholic churches, and approximately 230 Protestant churches. (The Korean Times, San Francisco, 1997b). Most of the women regularly attended churches and participated in their meetings. Only 19 (16%) of the 119 women had no religion (Table F1, Appendix F). Those who reported a religious affiliation frequently received social supports from their church.

Their Ethnic Identity

Table 3 contains the findings of the ethnic identity survey of the research participants. The women had strong preferences for Korean foods: All of them preferred Korean foods to American foods. Ninety five percent preferred Korean music to American music and four percent preferred a variety of music including Korean music, American rock and roll, and classical music. Ninety five percent preferred Korean customs. All of them spoke Korean at home and had Korean friends. Surprisingly, 96 percent identified themselves as Korean. Only four percent identified themselves as Korean-American, and none identified themselves as American. Twelve percent had been in the U.S. for less than 1 year, and 33% have been in the U.S. for more than 1 year and less than 10 years. The proportion of the women who had been in the U.S. for more

Table 3. Participants' responses to single ethnic identity item (%)

	N (%)		N(%)		N(%)
Preferences in foods		Preferences in music		Preferences in customs	
Korean	118 (100)	Korean	113 (95.0)	Korean	113 (95.0)
Mixed	0 (100)	Mixed	5 (4.2)	Mixed	5 (4.2)
American	0 (100)	American	0 (0.0)	American	0 (0.0)
Total	118(100)	Total	119 (100)	Total	119 (100)
Language Preferences		Close Friends		Ethnic Identity	
Korean	113 (95.0)	All Koreans	118 (100)	Korean	113 (95.0)
Mixed	5 (4.2)	Asians	0 (100)	Korean-American	5 (4.2)
English	0 (0.0)	Americans	0 (100)	American	0 (0.0)
Total	119 (100)	Total	118(100)	Total	119 (100)
Length of Time in the U.S.		Length of Time in the area			
Mean (SD)	12.85 (7.31)	Mean (SD)	10.42 (7.31)		
Less than 1 year	14 (11.8)	Less than 1 year	6 (5.0)		
More than 1 year and less than 10 years	39 (32.8)	More than 1 year and less than 10 years	67 (56.3)		
More than 10 years	65 (54.6)	More than 10 years	45 (37.8)		

than 10 years was 55%. Forty five percent had been in San Francisco Bay Area for more than 10 years.

Their Work Satisfaction by Age and Family Income

Table 4 presents the findings on work satisfaction of the participants. Overall, 13% of the women were unsatisfied with their work while 58% were satisfied with their work. The majority (52%) were satisfied with finances, but 21% were unsatisfied. The majority (53%) were satisfied with job tasks, but 17% of the women were not satisfied. Twenty nine percent were unsatisfied with self accomplishment while 46% were satisfied; and 35% were unsatisfied with work qualifications while 40% were satisfied.

When work satisfaction was viewed according to the sociodemographic variables (Table F2, Appendix F) with an alpha level of .05, their work satisfaction was significantly different by education ($p<.05$), and family income ($p<.01$): Middle and high education groups were significantly different in work satisfaction; low and high family income groups were significantly different in work satisfaction; and middle and high family income groups were significantly different in work satisfaction.

"Women Should Be Women"

Most of the participants agreed that women should behave, think, feel, and be like women. They believed that women should try to be beautiful by making themselves up with cosmetics and accessories, be weak and passive, and be protected by men. Also, they thought that women should be passive to their husbands, follow their husbands' opinions and orders, and take care of their children and family chores without complaint. One of the participants felt that she ultimately had a misfortunate life because she did not

Table 4. Work satisfaction

Work Satisfaction	Totally unsatisfied N(%)	A little bit unsatisfied N (%)	I don't know N (%)	A little bit satisfied N (%)	Totally satisfied N (%)	Total N (%)
Overall work satisfaction	3 (2.5)	12 (10.1)	35 (29.4)	59 (49.6)	10 (8.4)	119 (100)
Work satisfaction	6 (5.0)	19 (16.0)	32 (26.9)	50 (42.0)	12 (10.1)	119 (100)
Finance						
Job tasks	3 (2.5)	17 (14.3)	36 (30.3)	50 (42.0)	13 (10.9)	119 (100)
Self accomplishment	12 (10.1)	22 (18.5)	30 (25.2)	44 (37.0)	11 (9.2)	119 (100)
Qualification	10 (8.4)	31 (26.1)	29 (24.4)	34 (28.6)	14 (11.8)	119 (100)

behave like a woman. She believed that women had equal rights to men, so she did not follow her husband's orders and that brought on many arguments. In her workplace, she was never obedient to her male colleagues and bosses; thus, she was frequently fired and had difficulty finding jobs. The results of her resistance have brought only misfortune to her life. In contrast, others who have accepted their role as women evaluated their lives positively. They felt that they were really good as women, and some even called themselves Hyunmo-Yangcho (A wise mother and good wife).

> Women are different from men. In fact, I don't like to acknowledge it. But, society is like that.... Women should be obedient, and women should be women.. Women who are not like women usually have difficult lives. Women should marry, and have children...
>
> In Korean society, women should be patient, and sacrifice themselves for their families.. Then, their families can be managed appropriately. In fact, I used to emphasize that both men and women should be equally responsible for their family matters. However, since being married and having children, I would like my daughter-in-law to sacrifice seventy percent responsibility to the family. I now believe that a women's sacrifice is necessary to have a strong family. Women should be women.
>
> Me? I have tried to do my best to fulfill the responsibilities as a woman, so I don't have anything to be ashamed of. I have taken care of my parents-in-laws since my honeymoon. I am responsible for all the household tasks by myself. I have taken care of my sick father-in-law without complaining once. I did my best as a woman and others acknowledge it.

Additionally, many participants said that they enjoyed being a woman because they like to behave, think, feel, and be like a woman. They like to be protected by their husbands, and they enjoy making themselves up, cleaning the house and cooking meals.

> I wouldn't like to be a man. I like that I am a woman. A woman is better than a man. Women are protected by men. Because... women are weak.....Recently... I had a grandson. My love for my grandson is really really strong..... But, my husband cannot express his love to his grandson

> because he is a man. But... women can express their feelings and love freely... I like that I am a woman.

> Women? Women are beautiful creatures. They teach love to men. When a baby is born, it's the mother who loves it. When a man marries, his wife gives love to him.. I think that women are the people who give love. I try to live with love.

"Women Are Slaves"

The participants described the unfairness and sacrifices they experienced as daughters, wives, and mothers. Many participants described this theme as follows: 'Yeoja (a woman) is the slave of Namja (a man).' Most of the participants felt that being a woman required them to sacrifice for their husband, children, and families even though they considered this unfair. They did choose to accept their sacrifice as their duty toward their children and family. Because they delivered their children into the world, they felt they should take care of their children with unconditional love, in the way animals instinctively do. Even when their children became adults, they still kept their responsibility to their children. All of them provided support for their children's education, and remained a stable throughout their adult lives. The following is their opinions of being a woman.

> Well. Some women who have wonderful husbands say that Yeoja (a woman) is the queen of Namja (a man). But, I have been abused by my husband, so I believe that Yeoja is the slave of Namja. I stay with my husband because Yeoja should care for their children after having them the way that animals even do. I have lived with the belief that my own sacrifice would make my four children grow well. Furthermore, my husband has had Baram (extra-marital love affairs), but I have decided not to pursue a divorce solely because of my children.

> In general, women are... Women deliver their children and help their husbands... Women manage their household and do household tasks. And so on... Women should take care of their household while helping their husbands. Women should take care of their children and manage their household... Men cannot do it by themselves.... Women... As in the Bible, women are the people who assist their husbands.
>
> Women... Women should sacrifice themselves to take care of their children. For their children and husbands... They endure their discomforts.. Yes.. Korean women are... They are responsible for their children because they delivered their children into the world. So...they are the people who worry about their children's education... Those are women.

They spoke about the good traditions of Koreans. One of the good traditions is that a woman is Ansaram (person inside house) and her husband is Bakatyangban (nobleman outside house): Women should be in charge of the household and be responsible for their children, while men are in charge of everything outside the home. Under the influences of Confucian tradition, women were expected to sacrifice themselves for their families inside the home. Even though most of them felt that the required responsibilities were unfair, they believed that these responsibilities were their duties as women who have children and families.

> Ansaram.... Yes. Men are Bakatyangban and women are Ansaram..... However, Korean history.... Culture... Under the influences of Confucianism, I think.... Yeoja is Ansaram and Namja is Bakatyangban. When introducing her husband, a woman says that this is my Bakatyangban. And... When a man introduces his wife, he says that this is my Ansaram. I have been raised like that. Yeoja should take care of their responsibilities as an Ansaram and men should take care of their responsibilities outside of the house. Then, their families will be happy and peaceful.
>
> Korean women are Korean women. It's useless to think that it is unfair for women to do all the household tasks by themselves. Society... and family does not accept it. Do you think that Korean men who have been raised in Korean culture will accept it? Everyone thinks that women who fulfill their responsibilities as women are good women... Everyone thinks like that....

> Women's sin is the fact that they were born as women. Women should do their best to fulfill their responsibilities.
>
> Women should take care of everything in their families. As women, they should have their children, do household tasks, and fulfill their duties. That's a women's job.

"Anil (work inside house) Is Women's Work"

Participants defined work as getting a job, fulfilling self accomplishment, earning income, doing what is expected from them, and a necessity for humans to survive. They divided work into women's work and men's work. Women's work is domestic work, including taking care of the children and household related tasks. Men's work is income earning labor, financial management, and maintaining their cars. As they have divided women into Ansaram and men into Bakatyangban, they also divided work into Anil (work inside the house) and Bakatil (work outside the house). There was a definite boundary between women's work and men's work. Even when the women were working at income earning jobs outside the home, they were expected to come home and do Anil (works inside house) by themselves because it is considered women's work. This placed a heavy burden on them. They complained about the unfairness of having to do Anil even though they were doing work outside of the home.

> Well... We are partners. Partners... Well... We are partners in the sense that we live together.... My husband does not treat me as his partner... Korean men are Korean men... Even though my husband had his graduate education in this country.... He frequently requires me to bring a cup of water for him even though he can do it by himself. For example, when we come back home from our store, my husband goes to the living room to turn on the T.V..... I go to the kitchen to prepare our dinner..... We are not partners. My husband treats me like a maid who prepares his foods and gets some money for him.....

> I do work outside and inside the home. But.. From the beginning it's been that way. There are two il (work). Anil and Bakatil. Anil is women's responsibilities and Bakatil is men's responsibilities. Even though society has changed a lot, but... In fact, there is no definite boundary between Anil and Bakatil, but Korean culture has divided the work like that, and required women to do all the work.

Most of them defined domestic work including cooking, washing dishes, cleaning the house, and doing laundry as work. Yet, they mentioned that domestic work is rarely recognized and is invisible. They called domestic work Pyoannaneunil (invisible work). According to these women, the reason why domestic work is invisible is that the work needs to be done repetitively. For example, several hours after a housewife cooks breakfast and washes the dishes, she needs to cook and wash the dishes again for lunch and dinner. Even though she continues to work, the work she has done is never kept intact, subsequently making her work invisible.

The meanings of work to my participants were diverse: One divorced participant said that she had to work in order to raise her two children; another said that she was working for her self accomplishment and personal pleasure; a third said that she was working because all humans should work. Even though the meanings were diverse, one thing common to the meanings was that they were suffering from the double burden of having to work at home and work for their dreams of success in this new country. Because they immigrated into this country for its infinite opportunities and fortunes, they felt they should contribute to their dreams by working. Their work was indicative of their

dreams for success. These dreams were deeply related to their families, especially their children, and compelled them to tolerate the unfairness of these double burdens.

"I Cannot Trust Kyopo (Korean Immigrants)"

Participants viewed immigrants negatively even though they themselves were immigrants. They said that immigrants were people who could no longer live in Korea for a variety of negative reasons. Some of them even said that immigrants were people who "threw away" their own countries and therefore did not have any roots. They did not trust other immigrants, including Korean immigrants. They did not open themselves to other immigrants because of their negative views on immigrants:

> Koreans in America? Or, Koreans in Korea? Well.... They are totally different. Koreans in Korea are different from Koreans in the U.S. I didn't know how Koreans are.... But, after coming to this country..... Did you see the newspaper? 80 percent of Kyopo (Korean immigrants) are swindlers. I cannot trust Kyopo....

> Kyopo... They are wanderers. They are wandering in search of something.. They don't have their roots. They have two roots. They left their original roots in Korea, and came to America to create new roots here. So, they have new roots and original roots. But, until they finally get their new roots, they are wanderers. American society does not accept them because they are newcomers, and Korean society does not care about them because they left Korea. So.. Immigrants are sad. But, I cannot trust them because they are wanderers.

> Kyopo came to this country for better opportunities.. They are isolated from the mainstream of this new society. Most of them are... They came to this country because of unavoidable situations. For a better life.... Except my own relatives and friends, I cannot trust others because they are people who could not live in Korea due to unavoidable situations such as bankruptcy or other crimes.

Many participants complained about the lack of friends who could understand their suffering and who could support them psychologically. Even though they made many friends through churches and from their ethnic communities, they said that their friends here in the U.S. were not real friends, but they were only church friends or superficial friends. Because of the small size of Korean communities, they worried about gossip if they opened their minds to their church or ethnic community friends. Also, the interviews showed that being an immigrant and subsequent hardships on the lives kept them too occupied to meet their friends. Instead, their busy lives made them closer to their husbands and families, and the importance of family became greater than before.

"I Work Like Ants"

Despite their high level of education, many of them were employed in low status jobs because they were immigrants and had difficulty in communicating in English. Because of their dreams, however, they accepted the jobs without complaint, and worked hard with long hours and no vacations, like ants.

> I came here for my children. I want to provide better opportunities and a good education to them.... So... I work like an ant.... Well.. Some people work for their pleasure. Some people work because others work... But.... I work for money. I work really, only for money. I need to eat and survive. I need to educate my children. I need to support their education... So....
>
> Well. I do work to live... To live, I work.. The thing that I do to live is work. Physically it is difficult.. But, to live, to educate my children. Since I arrived here, I have worked hard. I continuously work hard.
>
> Work... To live and eat... That's work. In fact, I don't want to work if my situation allows me. I want to work at a minimum. I would rather read and study the bible. But, it's impossible. To live and eat, I have to work.

Many of them reported the difficulties in work due to immigration: Lack of social support resources, lack of job opportunities, difficulties in work, financial problems, unsafe environments, language problems, adaptation problems, and physical hardships. The difficulties and hardships in their immigration experience were complicated by their lack of pre-employment experience and their responsibilities as mothers and wives.

Menopausal Transition

The description of the menopausal transition by the participants showed that menopause was situated within the context of their immigration and work transitions. Participants described how they viewed menopausal transition within the context of their multiple transitions. Also, they described it in terms of a transition from menarche to menopause: To explain the menopausal experience, the women began by discussing their menarche experience. Several themes regarding the women's menopausal transition emerged from the process of data coding and categorization. The findings on the menopausal transition of the participants are presented according to these themes.

The Shock of Menarche

Five words were used for menstruation: Wulkyung, Saengri, Mens, Kyungsoo, and Kyungdo. Also, some ambiguous terms such as Geugu (this or that), Sonnym (guest), Wolrehengsa (monthly event) were also used to refer to menstruation. Wulkyung means monthly unchangeable principle; Saengri means physiology; Mens comes from the English word, 'menstruation'; Kyungsoo means water from an unchangeable principle; and Kyungdo means the degree of unchangeable principle. The terms do not directly

refer to menstruation. Rather, they refer to menstruation in vague or indirect ways, and they relate to the physical and biological aspect of menstruation.

The participant's menarche was characterized by the lack of information on menstruation. Many of them described their menarche as an embarrassing or shocking event because they had no prior knowledge of what menstruation would be or look like. Their mothers, sisters, or friends rarely informed them not only about menstruation, but also about pregnancy, sex, and menopause. They described their menarche as follows.

> What a shameful experience! In fact, I was shocked at first. In the restroom, I found darkish blood on my underwear. I was really shocked..... I went to my mother, and said to her. Mom... I have a serious disease..... In those days, there were no sex education classes in Korea. At that time, people were working hard just to survive. They were so busy, they didn't even have time to give their children a regular education, much less, educate them on these matters

> I was shocked... Looking back on it, it's funny. But... At that time, I changed my underwear until there were no more underwear in my dresser. At first, I thought that it was stool, so I changed my underwear. Then, I found it again, so I changed my underwear again. I did it again and again. Then.. It's so funny now. But, it was very serious then. I went to my mom and we talked about it. I thought that I had a serious disease. In fact, a girl in middle school should have known about that. But, I didn't.

Menarche was regarded as a marked point of a women's age: At menarche, a girl becomes a woman. Consequently, menstruation meant fertility and maturity to them. Because they had regular menstrual periods, they felt that they were mature, fertile, and normal, as women should be.

They had ambivalent feelings about menstruation. Menstrual blood was considered a sign of good health and a symbol of reproductive ability, and it was also considered

dirty, messy, disgusting, unsanitary, and uncomfortable. The women believed that long and heavy periods of menstruation meant good health. Also, menstruation brought about feelings of cleanliness and refreshed them. At the same time, many of them complained about the discomforts and psychological or physical difficulties related to menstruation.

Gangnyunki and Pekyungki

In a Korean dictionary, Gangnyunki is defined as the change of one's life (Minjungseorim, 1990), and is equated with menopause in the case of women. In the same dictionary, Pekyungki is defined as the climacteric and menopause. In a English-Korean medical dictionary, menopause is defined as women's Gangnyunki (Soomoonsa, 1985), and the climacteric is defined as Gangnyunki. In short, the terms, Gangnyunki and Pekyungki are defined as menopause or the climacteric.

However, when translating the terms literally, the two terms imply different dimensions of menopause. The term 'ki' of Gangnyunki and Pekyungki means a period of time. The term 'Gang' means 'again,' and 'nyun' means 'years.' Therefore, the term 'Gangnyunki' means a period of time that a woman's life starts again, which emphasizes the social meaning of menopause. The term 'Pe' means 'closed' and 'kyung' means 'unchangeable principles', indirectly referring to menstruation. Thus, the term 'Pekyungki' means a period of time that menstruation is closed, which emphasizes the physiological aspect of menopause.

The participants' definitions of Gangnyunki and Pekyungki were different from the definitions provided in the dictionaries. In short, the differences between Gangnyunki

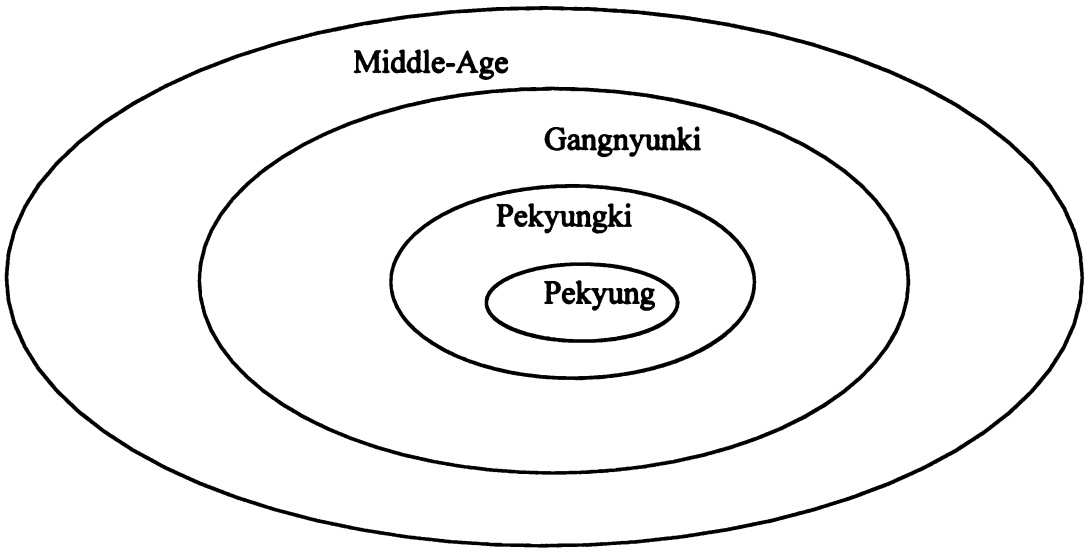
and Pekyungki that the women perceived are visualized in Figure 2. In middle age women reach Gangnyunki; during the Gangnyunki, women have Pekyungki; and women have Pekyung (menopause) during the period of Pekyungki. They thought that Gangnyunki was different from Pekyungki: Both men and women experience Gangnyunki, but only women experience Pekyungki; Pekyungki comes after Gangnyunki; Gangnyunki is the starting point of mid-life, and Pekyungki is the ending point of mid-life; Gangnyunki comes from aging and Pekyungki comes from menstrual changes; Gangnyunki comes from mind, but Pekyungki comes from a marked physical change (the end of menstruation); and Gangnyunki brings psychological or physical symptoms, but Pekyungki brings only menstrual changes, no symptoms. Even though they differentiated Gangnyunki from Pekyungki, they used the terms confusingly when referring to symptoms. The followings are what four post-menopausal women said about the differences between Gangnyunki and Pekyungki:

> Gangnyunki is different from Pekyungki. In Gangnyunki, women experience facial flash and become depressed. Frequently cry... Some women have extramarital affairs. Pekyungki is the end of life and the period of feeling Hurhmoo (nothingness).

> Well. Pekyungki is a process that should be passed during Gangnyunki. There may be several processes in Gangnyunki, and Pekyungki is a process among the processes. Especially, because they are women, they go through Pekyungki.

> I don't know what are the exact differences between Gangnyunki and Pekyungki. Many people say that. To women, Gangnyunki is Pekyungki, and Pekyungki is Gangnyunki. To men, there is no definite line.

Figure 2. Relationships among Pekyung, Pekyungki, Gangnyunki, and Middle-Age



> They are almost the same, but a little bit different. Gangnyunki comes from the aging process, and Pekyung comes because menstruation stops due to their age. Gangnyunki comes earlier than Pekyungki. Gangnyunki only made me , think about my later life. But, Pekyungki made me feel directly that I am going to age.

Pekyung: The End of Womanhood

Pekyung is the only term for menopause in the Korean language. As discussed before, 'Pe' means 'closed', and 'Kyung' means 'unchangeable principle' referring to menstruation. Consequently, Pekyung means closing menstruation. The term 'Pekyung' certainly relates menopause to the physical or biological aspects as do the terms referring to menstruation. Indeed, Pekyung was perceived as a time-limited biological event or experience. Strictly speaking, the women perceived menopause only as the final menstrual period or 'end of menstruation.'

The status of a woman as menopausal is not reflected linguistically in the Korean language. The participants categorized women's status into Chunyu (virgin), Ajumma (mothers), and Halmuni (grandmothers) not connecting them with menopausal status. Grandmother status (Halmuni) was not tied to reproductive status or ability. Rather, the grandmother status implies social age: When a premenopausal woman had a grandchild, she was a grandmother. Also, the grandmother status was not connected to physiological age. Even when a woman perceived herself as middle-aged, she also perceived herself as a grandmother. Additionally, the status of aging—Chungnyun (the young), Jungnyun (the mid-life), and Nonyun (the aged)—was independent of menopausal status. A menopausal woman perceived herself as Jungnyun (the mid-life) because her children were still young; whereas,

a pre-menopausal woman perceived herself as Nonyun (the aged) because she had a grandchild.

In most cases, Pekyung was perceived as a sign of aging and the end of womanhood. Strangely, the end of womanhood also meant the end of sexual activity in many cases. Pekyung meant old age and the end of womanhood. This in turn, meant the inappropriateness of sexual activity. Fertility was associated with sexuality, and sexual desire and activity should end with the cessation of fertility. Also, some of them thought that sexual activity should be minimized for their health. They mentioned the relationship between health and sexual activity as follows.

> To be honest.... Among women's talk..... I usually do it several times per year.... We think that is good for our health.... In the early 40s, we frequently had... We had a lot in the early 40s.... For our health problems... I think that abstinence is better....

> One of my friends said that she had difficulties in sexual relationships with her husband because her water is dry. Because she had diabetes, she had more difficulties. She frequently got hurt from it. Moreover, it usually took a long time to heal. I think that.... In old age, it should be avoided for their health. Indeed.. She also said that she didn't want to do it because of her health.

All of the women were experiencing body changes that they thought were mainly caused by menopause as well as the aging process. They reported recent changes in their physical appearance and mostly associated those changes with the onset of Gangnyunki. Less common were the women who considered their bodily changes in a positive light. Rather, they viewed themselves as Halmuni when it became obvious to them that their physical appearance has changed. Examples range from graying hair, an increase in wrinkles, skin dryness, muscle tone changes, sagging arms, sagging cheeks, and

abdominal fat. Many of the women were taking better care of their bodies than ever before and were experiencing the rewards of that effort, including increased vigor and resilience. The following are remarks from three post-menopausal women about their physical changes.

> Physically... As I thought about that... My skin became dry like leaves falling down from a tree. My skin became really really dry... Hair became dry... Brightness disappeared. I feel 'aging.' So... Recently, I try to take care of myself. I have taken care of other's nails, but now I try to take care of myself.

> Now... I always dye my hair. Without coloring, I am certainly a Halmuni (grandmother).. So, I dye my hair. At first, I pull out my gray hair whenever I saw it. But... My son suggested to me to dye my hair. So, I colored my hair. It looks better.

> I was embarrassed when I realized that I was aging. I was certain that I was old. I thought that I should accept it, but I was embarrassed. I was sad about that fact that I was in the sunset of my life.

Also, the women related menopause with infertility and motherhood. They perceived and understood that they were no longer fertile. While women with more than one son did not express the feelings of sorrow or regret (except one participant), all the women with only daughters did express these feelings of sorrow or regret. Even though they denied preference of sons to daughters, they expressed the feelings of anxiety about having only daughters, because they felt their daughters' lives would be more difficult and unsafe than their sons'. Their children's gender seemed to be related to their feelings toward menopause.

Most of the women were very unclear about the biological process of menopause. Many of them could not speak on menopause with any sense of authority. Most expressed embarrassment over their lack of knowledge of menopause. Some explained it

from insufficient sources of information while others simply mentioned that they had not given menopause much thought until they were personally experiencing it.

While menarche was frequently experienced totally unprepared, they did have knowledge of menopause through several resources. Most of the women reported not hearing about menopause from their mothers. Their main source of information was their friends who had already gone through menopause. Several women heard about menopause from the mass media such as health related programs on television, articles in women's magazines, and radio health counseling emphasizing hormone replacement therapy. In most cases, they heard about menopause not in any formal way, but rather from observing their mother's own experience of menopause or guessing based on their close friends' menopausal experiences.

Most of the participants' knowledge on menopause was uncertain, incorrect, contradictory, and inadequate. Some women thought that their menopause would be delayed because they had menarche earlier than others, while conversely, others thought that their menopause would come earlier because they had menarche earlier. Some women regarded hormone replacement therapy as 'magic medicine' that might regress the aging process, while others did not.

None of the participants connected menopause with any pathological changes. They did not think of menopause as a disease needing medical treatment. Yet, many of them knew about hormone replacement therapy from their close friends who have been to clinics and took hormones. They believed that there must exist some reasonable medical rationale for hormone replacement therapy because medical doctors recommended it.

Even though menopause was not regarded as a disease, they said that they would be willing to use hormones if needed.

Some women reported that they had operations (dilatation and curettage or hysterectomy) around their menopause to prevent more serious problems and cure their heavy menstruation. However, all of the women having these operations were regretful as they considered the operations unnecessary. The followings are what two women who had the operations said about their operations.

> I thought that some changes in body functions due to aging brought that...(heavy menstruation). In fact, I had an operation, Sopa (D&C), before menopause. From the three years before menopause, my menstruation had been on and off. So.. I went to a clinic, and the doctor said that some wastes existed in my womb and recommended the operation. So, I had the operation. Then, my menstrual periods were normal for a while. Then, I had the operation again. The doctor said that some wastes appeared in my womb again. Then, at a point, my menstrual periods stopped. I never thought that I would have the operation around menopause.

> I have many things to say. Around my Pekyung (menopause)... It was the time... 2 years ago... That was a terrible year. My physical condition was very bad. My menstruation became irregular... So. I went to a clinic. The doctor in the clinic said that I had some problems in my womb.. He suggested that I undergo a hysterectomy... Since I've already had three adult children, I went ahead with the operation. Actually, there was no disease at all. But, the doctor said that... If I would not have more children, then I'd better have the operation because my womb would have cancerous cells. So, to prevent cancer, I had the operation. Then... It became horrible. After having the operation, my face became swollen. Moreover, I had fever and my face was flushed... My body became very weak and everything was difficult for me. So.. I went to the clinic again. Then, the doctor gave me a prescription of hormones. I think it was hormones.

Middle Age: Falling Down the Hill

Many participants positively viewed being middle aged as the best time for stability, maturity, energy, composure, settling down, mastery, discretion, success, and perfection. They said that being middle aged meant maturity in every aspect of life. In contrast, others negatively viewed being middle-aged because of its responsibilities, closeness to being elderly, and loneliness. They rarely felt mastery, success, being settled, discretion, and perfection even though they connected middle age with these characteristics. One of the women said that she felt that her middle-age was passing quickly because she was in the U.S. When she was in Korea, she could be active in everything, so she felt that she was young. However, after coming to the U.S., she became passive in everything and could not believe herself. Therefore, she felt depressed and lonely about being middle aged. Her marginality in the new country negatively influenced her mid-life and made her feel like she was becoming older more quickly.

Many women related hope, possibilities, and opportunities to their youth, and their youth was highly valued. To the immigrant women, youth meant energy, health, and an ability to adapt and work. On the contrary, aging was associated with the inability to work and was viewed negatively. Aging meant "falling down the hill", the sunset, immobility, physical and psychological weakness, and impending death. The women thought that they would definitely be old when the time came that they would not be able to work and move anymore.

Many of the women thought that aging was determined by their minds, not by their bodies. They thought that aging would be determined psychologically rather than physically. Except in the case that they could not move at all, they thought that they would still be young as long as they believed they were young, and they were old when they believed that they were old:

> First of all, the mind should be young... Health should be managed. So... Although I am in the late 50s, my mind is not old..... I think that the youth is such as.... Fresh... Healthy.... Active and energetic... Mind should be young, then the body would be fresh, healthy and energetic....
>
> I think so... It depends on the mind... Even though a person is physiologically old.... Except when she cannot move at all... it depends on the mind. So, if a person thinks that she is young and lives young, then she is young. If a person thinks that she is old and lives old, then she is old.
>
> Young? When the mind is young, the person is young. When a person thinks that she is old by herself, she is old... Even though her appearance is young, she is old because her mind is old.

For some women, their roles in the family determined their view of aging. Age was socially determined, rather than physiologically determined, by the women. One participant had a preschool child and felt she was young because she had a preschooler even though she was 45 years old. If a woman had a grandson, she was considered old even though she was only 45 years old. The participants defined the youth, the middle-aged, and the aged according to the life stage of their children. Youth was the period until the first child entered preschool. Middle-age was the period when their lives became stable, their children were independent of them, and their grandchildren were born. The aged was the period when their energy did not allow them to work and their grandchildren were grown up.

Age was also interpreted as a concept of a continuum rather than a specific point of time. One maintained that she was in between the youth and the middle-age. Another asserted that she was in between the middle-aged and the elderly. They did not want to categorize their age into the youth, the middle-aged, or the aged.

> Well... I don't think that I am middle-aged.... Nor am I a youth.... If I am middle-aged, would my children be high school students or college girls? I am between. I am between the youth and the middle-aged. Is there anything like the youth-middle-aged?....
>
> Well... I am not young because I become tired too easily... And I am more than middle-aged... But, I am not old...
>
> I am young and middle aged.. I think so.. I am older than young people, but I am younger than middle-aged people...

To many of the women, aging was associated with physical appearances as well. They perceived their aging process through their physical appearance such as wrinkles, gray hair, skin, and abdominal fat. When they heard that they looked older than their real physiological age, they were upset and depressed. However, when they heard that they looked younger than their real physiological age, they were happy and delighted. Since their appearances were perceived to show their age, they tried to hide their age by using cosmetics and by being more concerned about their outfits and accessories.

An Ambivalent Transition

Most of the participants had ambivalent feelings toward menopause. They admitted the positive sides of menopause. They welcomed what they regarded as freedom from the burdens of menstruation, pregnancy, and childbirth. They described the feeling of

freedom as 'Siwon,' that means feelings of being refreshed (Minjungseorim, 1990). They also had the feeling of 'Subsub,' which means being sorry and regretful (Minjunseorim, 1990). In a word, they described their ambivalent feeling about menopause as "Siwon-Subsub." Koreans usually use the term 'Siwon-Subsub' when referring to an event that has made them suffer and caused them concern for a long time, but when it finally ends, they start to miss it even though they are relieved and refreshed.

> Nothing like that... No... Actually, some. I thought that I became too old when I had menopause. Rather than feeling Seoun (similar meaning to Subsub), I felt Hurhmu, and somewhat Seoun. But, in my last menstruation, I was really tired of having menstruation. So... I felt somewhat Siwon... Siwon-Subsub. That's the right word to express the feeling...
>
> I felt Siwon-Subsub. It was comfortable and good.. But, in a sense, I felt that I became really old... From now on, I could not have any more children.. I really wanted to have a daughter... So.. I planned to have a daughter in the near future... But, it was difficult. So.. When I had Pekyung, I felt that it would be the end...
>
> I tend to be easily sick. Moreover, I had a disease... So... Pekyung passed without any typical changes. Honestly speaking, I felt a little Siwon-Subsub. I have had troublesome menstrual periods, so I felt comfortable and Siwon after menopause. But, after I stopped menstruating, I felt Subsub.
>
> I think that I will feel bad... In a sense, I will feel Siwon.. Many people say that... Siwon-Subsub.. Anyway, Pekyung means the decreasing function as a woman. So.. I think that I will feel Siwon-Subsub.

Many women nearing menopause also had a feeling of 'Hurhmoo', which means nothingness, nihility, nonexistent, null, and vain (Minjunseorim, 1990). The feeling of 'Hurhmoo' is more negative than the feeling of 'Subsub.' When a woman was regretful or sorry about her previous experience, she described her feeling as 'Subsub.' When a woman felt nothingness and nihility of her previous life efforts, she described her feeling

as 'Hurhmoo.' They negatively related menopause to aging and subsequently connected menopause to negative changes in appearance and functions as well. The negative changes due to aging were perceived as losses, and the losses due to aging made them feel 'Hurhmoo':

> I was depressed. I felt I was aged because I felt that not menstruating meant aging to women. I felt that..... I felt Hurhmoo.... Ah... I am going to be aged. Now, I cannot have a baby anymore. In fact, the inability to have a baby doesn't have any meaning, does it? Well.. I was really sad about being aged. But... I felt Siwon also because I would not menstruate anymore.... Siwon... Siwon-Subsub.....
>
> I felt Hurhmoo because I thought that my life would end soon... Aging was sad. In fact, I didn't say anything about my menopause to anyone. I don't know why... But, my self-esteem did not allow me to tell my husband...
>
> Because it turned out that I was not menstruating anymore, I felt Hurhmoo. When I stopped menstruating, I felt I became really old.

Menopause: A Transition Within Transitions

To most of the women their menopausal experience was nothing special within the context of their daily lives. They even said that they did not realize they were in the stage of their lives where they were approaching menopause. Their menopausal transition was very sudden and unexpected to them, because they were too busy in their daily lives. They were so occupied working and trying to survive in a foreign country and in a new workplace that they did not have any time to think about their own bodies. Consequently, they had no time for their menopause either.

They also indicated that there were more important things in their lives than menopause. In fact, around their menopausal stage, they experienced a variety of significant life events such as their husband's retirement, husband's death, children's

independence, health problems and operations, financial problems, and new business ventures. Because of these events they found they could not concern themselves with their menopause. Rather, they needed to resolve the matters and events that were happening in their lives at the time.

> So... I could not be concerned with my menopause at all. My menopause just passed by. When my husband was seriously ill, my menstrual periods ended. Then.... In fact, I could not remember anything about it. I could not guess when it happened... Many events occurred during the time.... I am thinking about.... now..... It is funny... At that time, I was concerned about my husband only... So... I did not care about anything else, even my menopause. However, I had been very depressed for a while after my husband died... I did not have any hope... I was really sick.. I should take care of my children. I should take care of my household...
>
> It's only a process of my life, and it's a period that I should go through. Surely, I will be depressed and I will feel Hurhmoo. I will think that I am a Halmuni (grandmother). But, I think that it's a process. One of the many stages of life... In busy immigration life, it's not something that I should give much attention to. There are more important, more imminent, and more serious things that I should deal with.
>
> In my case, it passed without any problems.. As I said before, many events occurred around the time of my Pekyung (menopause), I could not give any attention to my menopause.. My Pekyung did not mean anything to me because of the other things that I had to deal with....
>
> It was like that. A lot of things happened around my Pekyung. These were important things that were difficult for me to deal with.. So, I didn't know that my Pekyung passed by. In fact, around Pekyung, I frequently had quarrels with my husband.

Many women thought that their relationships with their husbands, family members, and friends were not changed at all around their menopause, but the findings indicated some changes in the relationships. Some women complained about their husband's indifference and bluntness. Others said that their children became adults and had grown

independent of them, while others were glad to have friends to go shopping and on trips with. Certainly their relationships with their husbands, families, and friends were changed during their menopausal transition. Their explanation of the changes in the relationships was diverse. While some persons said that they became much closer to their husbands, others said that they became more distant. Some women said their children became closer because the children began to understand and appreciate them. Others said that their children became distant because of the geographical distance that separated them and their children's desire to be independent of them. While some women said that they began to trust their friends more, others said that they could not trust their friends at all, especially the new friends they met in this country whom they never regarded as true friends.

Many women did not think that the relationships around their menopausal transition would affect their menopausal experience because menopause would be their own experience that they could not share with others. Some of the women said that any influences of the relationships would be positive not negative. Others said that stress from the relationships could negatively influence their menopausal experience. The majority of the 21 peri- or post-menopausal women thought that menopause was an individual experience that could not be shared with others:

> No. I didn't do that. I kept it to myself. I did not talk about it to my family... Even to friends... Maybe I unconsciously talked about it... But, I felt there were no problems due to menopause. It was shameful and embarrassing to talk about with my children... There was nothing like that. Maybe if the relationships were good, then it would be easier to talk about that. But... I did not want to talk about that to others... including my

> husband... It's shameful... and it's not the thing that I could talk about in public.
>
> Well. There will be no influences of Pekyung on my relationships with my husband, children, and friends... At first, my feeling and mood will be... Well. I'll be able to say later, I guess. I may be depressed and I will probably feel old.... So.. I probably won't want to tell my husband and children. I will go through my menopause by myself.
>
> It is shameful to talk about it. In fact... I did not have any problems regarding my daily activities due to Pekyung. Indeed, there were no difficulties due to physical symptoms. Rather, it was a conflict inside myself because I felt that I was not able to do anything. I went through my menopause very lonely because I considered it my own conflict.
>
> There was nothing like that. Well. Pekyung was something that I should go through by myself.. And... It did not make me give attention to it. It simply passed.

When they were willing to share their menopausal experience, they were comfortable telling their husbands or daughters, not their friends or sons. Because their sons were young men to whom they felt it was inappropriate to tell about women's personal matters, they chose not to tell them. Because the Korean community is perceived as so small and full of gossip, they could not talk about their menopausal experience with their friends. Their husbands and daughters were the only ones whom they could confide in without embarrassment.

Difficulties related to immigration as well as those related to work caused the women to ignore or neglect their menopause. As immigrants, their lives were full of difficulties. One of the most trying aspects of their immigrant experience was their language problem: They felt an inappropriateness as adults. Financial problems, difficulties in getting a job, a relatively lower job for their qualifications, and

environmental problems were reported. Because of these difficulties, they felt they could not be hassled by menopause. They said that the stress from immigration and their new work experience made them suffer more during their menopause, consequently allowing them no time for thinking about their lives and menopause. Menopause meant only the stop of menstruation and menstrual changes.

Furthermore, their responsibilities as Korean women forced them to be more concerned about their families, children, and husbands rather than their menopause during menopausal transition. They believed that they should do their best to fulfill their responsibilities as mothers and wives. Their responsibilities as mothers and wives required them to spend much of their time performing household tasks and sacrificing their energy and time for their families. Their busy schedules, difficulties due to immigration and work, and the burdens of their responsibilities forced them not to give any attention to their menopause:

> I am always busy... I don't have time to spare to think about menopause. I have a lot of things to do..... Women should sacrifice themselves for their families..... I know that sounds a little bit unfair. But, Koreans have their own ways of life. Koreans have been raised like that, and taught like that. All women do, don't they? .... I think that Korean women should live in Korean ways.....
>
> Well. There was nothing like that. Because I was really stressed because of so many things to do, I guess that it came and had gone. I think that all Korean woman go through their menopause like that. There are too many things to do as Korean women, so they may not perceive it as a big problem or give attention to it.
>
> I didn't know it at that time.. But, looking back on it... I was really busy in adapting to this new country... and new work... My time passed by like that... My busy schedules and stress from work made me go through Pekyung (menopause) easily. I did not have time to think about

> menopause.. Maybe, I had some symptoms due to Pekyung... But, I cannot remember anything. Compared with other stressful things, it was a very tiny part of my life.
>
> It just passed by. I had many difficult things. At the same time, everything happened. So, I could not give attention to my Pekyung. It just passed by. Looking back on it, it was Pekyung. It's the same experience like being pregnant and having children. After my children became adults, I came to know that it was really difficult to take care of children. Later, I could remember it was difficult. What menopause meant to me, how I deal with the difficulties.... I never thought about....

Looking back upon their menopause, many of postmenopausal women associated their early menopause with the difficulties and troubles in daily lives due to their multiple transitional status. They thought that the difficulties shortened their ki (vital energy) and consumed their energy earlier than others consequently causing them to undergo menopause earlier. However, they emphasized that they were not concerned about their menopause during the transition.

CHAPTER V

The Symptom Experience

Through questionnaires and open-ended questions, the participants were asked about their perception of their health and illness in general, symptoms, the perceived causes of the symptoms, the meanings of the symptoms, and the strategies they used to deal with the symptoms. Also, through in-depth interviews, the influences of the symptom experiences during menopausal transition on their immigration and work experience were explored. In this chapter, descriptions of their symptom experience are presented through nine subsections: (a) perceived symptoms during the past 6 months; (b) perceived symptoms after the age of 40; (c) the perceived causes of the symptoms; (d) the meanings of the symptoms; (e) strategies to deal with the symptoms; (f) comparisons between perceived symptoms by the participants and those listed in the Menopausal Symptom Checklist (MSC) by Neugarten and Kraines (1965) and in the Climacteric Symptom Scale by Chi (1983); (g) a comparison of perceived symptoms among the participants, Americans and Koreans in Korea; (h) the differences in the perceived symptoms by socio-demographic variables, ethnic identity, and work satisfaction; and (i) the influences of symptoms on immigration and work experience. Descriptions of their symptom experience may provide guidance to understanding their responses to symptoms and their symptom management during menopausal transition. Also, they may give important information on the meanings of the perceived symptoms and the level of knowledge and skills dealing with the symptoms, consequently suggesting directions for effective and adequate symptom management.

Perceived Health and Illness in General

The findings on health and illness are summarized in Table 5. Seventy one percent of the women considered themselves either healthy or very healthy. Seventy six percent of the women reported no diseases. Among the 24 % who reported that they had diseases, musculoskeletal diseases such as arthritis and intervertebral herniated disc were the most frequently reported, followed by endocrine diseases including diabetes mellitus and thyroid diseases. Only 25% were currently on medication, of whom 50% used Western prescribed medicine. Except for prescribed medicine, the most frequently (20%) used medicine was estrogen combined with progesterone. Fifty six percent of the women did not use contraceptives. The most frequently used contraceptive method was the condom and the second was tubal ligation. Eleven percent of the women were using steroids or hormones. About 39% of the women reported reproductive health problems such as fibroids or abnormal pap smear results. Only 5% of the women had hysterectomies.

Perceived Symptoms During the Past 6 months

Twenty symptoms were described as most prevalent symptoms experienced during the past 6 months: Sixteen of them were physical and four were psychological (Table F3, Appendix F). The highest among them was declining reading vision ("glasses to read"), the second was "aches in the back of the neck and skull," and the third was "complete exhaustion." When they were asked about the extent of symptom severity, the most severely experienced symptom was "pains in the back", the second was "glasses to read,"

Table 5. Perceived Illness, Health and Medication Use In General (N=119).

	N (%)
Self reported general health	
Very unhealthy	6 (5.0)
Unhealthy	26 (21.8)
I don't know	2 (1.7)
Healthy	73 (61.3)
Very healthy	12 (10.1)
Total	119 (100)
Illness	
Have	29 (24.4)
Endocrine	6(20.7)
Cardiovascular disease	4 (13.7)
Cancer & Benign tumor	3 (10.3)
Respiratory disease	2 (6.9)
Genitourinary disease	2 (6.8)
Musculoskeletal disease	7 (24.1)
Gastrointestinal disease	1 (3.4)
Cholecystitis	1 (3.4)
Multiple problems	1 (3.4)
Have-not	90 (75.6)
Total	119 (100)

	N (%)
Medication	
Take	30 (25.2)
Vitamin and mineral	2 (6.7)
Prescribed	15 (50.0)
Over the counter (i.e. Tylenol)	5 (16.7)
Estrogen + Progesterone	6 (20.0)
Traditional medicine	1 (3.3)
Others	1 (3.3)
Do not take	88 (73.9)
Total	119 (100)
Reproductive Health Problems	
Abnormal pap smear	9 (7.6)
Fibroids of the uterus	15 (12.6)
Ectopic pregnancy	2 (1.7)
Infertility	3 (2.5)
Endometriosis	1 (0.8)
Pelvic inflammatory disease	1 (0.8)
Hysterectomy	6 (5.0)
Removal of ovary	3 (2.5)
Others	6 (5.0)
Vaginal discharge (Naeng)	1 (16.7)
Uteral retroflexion	1 (16.7)
Yeast infection	2 (33.3))
Abortion	1 (16.7)
Multiple problems	1 (16.7))

	N (%)
Contraceptives	
None	66 (55.5)
Oral contraceptives	8 (6.7)
IUD	4 (3.4)
Diaphragm	0 (0.0)
Foam	0 (0.0)
Condoms	11 (9.2)
Rhythm	7 (5.9)
Tubal ligation	9 (7.6)
Vasectomy	7 (5.9)
Natural family planning	2 (1.7)
Abstinence	3 (2.5)
Steroids or Hormones	
Use	13 (10.9)
Estrogen + Progesterone	6 (46.2)
Thyroxin	3 (23.1)
Others	5 (23.1)
Do not use	106 (89.1)
Total	119 (100)

and the third was "tension or jumpy during menstruation." Of the 20 symptoms only one was reported to be caused by menopausal changes (Blatt et al., 1953; Chi, 1983; Flint & Garcia, 1979; Greene, 1976; Jaszmann et al., 1969; Maoz, Antonovsky, Apter, Datan,& Hochberg, 1978; McKinlay & Jefferys, 1974; Neugarten & Kraines, 1965; Thompson, Hart, & Durno, 1973). Many symptoms were perceived to be caused by aging process including physical weakness and functional and structural changes in physical organs. Musculoskeletal symptoms were associated with overwork.

In Table 6, the mean, standard deviation, and range of the total number of the symptoms experienced during the past 6 months are presented according to the type of symptoms-physiological and psychological. The mean (standard deviation) of the total number of symptoms was 23.35 (18.16); that of physiological symptoms was 15.56 (10.96); and that of psychological symptoms was 5.46 (6.62). Twenty percent of the women did not experience any psychological symptoms.

Symptoms Experienced after the Age of 40

The most prevalent 20 symptoms experienced after the age of 40 are summarized in Table F4 (Appendix F). The most prevalent symptom was "glasses to read," the second was "aches in back of the neck and skull," the third was "complete exhaustion," and the fourth was "waking tired and exhausted in the morning." The four symptoms were also the most prevalent symptoms experienced during the past 6 months. However, the fifth ranked symptom was different: "Urinate every night." The symptoms that were not in the list of the 20 symptoms during the past 6 months, but appeared in the list of the 20 symptoms experienced after the age of 40 were as follows: "Eye pains," " recent weight

Table 6. Total number of symptoms experienced during the past 6 months according to the type of symptoms (N=119)

Symptoms	Range	Mean	SD
Physiological symptoms (105 items)	0-53	15.56	10.96
Psychological symptoms (45 items)	0-39	5.46	6.62
Additional Menopausal symptoms (14 items)*	0-11	2.14	2.15
Total symptoms (164 items)	0-103	23.35	18.16

* Since some menopausal symptoms were included in physiological and psychological symptoms, the menopausal symptoms that were not included in either physiological or psychological symptoms were presented in the section of additional menopausal symptoms.

gain," "stiff muscles and joints," " glasses for long distance," " ankle swelling," and "tooth aches." One of the differences between the symptoms experienced during the past 6 months and those experienced after the age of 40 was that symptoms experienced after the age of 40 were related more to physical symptoms that have been commonly believed to be related to aging, physical overwork, and psychological stress by Koreans.

Perceived Causes of the Symptoms

The perceived causes of the symptoms experienced after the age of 40 are presented in Table F5 (Appendix F). Many symptoms were perceived to be caused by aging: "Glasses to read" (70%); "urinate every night" (38%); "overweight"(42%); "eye pains" (19%); "recent weight gain" (50%); "stiff muscles and joints"(22%); "glasses for long distance"(33%); "gum bleeding" (31%); and "frequent urination" (27%). Psychological stress was connected with several symptoms: "Ache in back of the neck and skull" (42%); "sick to stomach"(26%); "upset stomach"(35%); and "headaches" (29%). Also, work-related factors and overwork were connected to the cause of some symptoms: "Complete exhaustion" (27%); "pains in the back" (21 %); "frequent cramps in the legs"(38%); and "ankle swelling" (50%). "Waking up tired and exhausted in the morning" was perceived to be caused by the lack of sleep (21%), and "worry about health" was perceived to be caused by physical weakness and tiredness (25%). Only, "toothache" was perceived to be caused by pathological changes due to some dental diseases (63%). The women rarely connected the symptoms with menopause: Only one symptom, "glasses to read" was perceived to be caused by the climacteric. Interestingly,

some symptoms—"urinate every night," "pains in the back," "gum bleeding," and "frequent urination"—were perceived to be caused by poor postpartum care.

Meanings of the Symptoms

The meanings of the symptoms are summarized in Table F6 (Appendix F). Several symptoms made them feel uncomfortable, but were tolerable: "Glasses to read" (33%); "waking up tired and exhausted in the morning" (18%); "frequent urination" (53%); and "ankle swelling" (22%). Some of the symptoms were experienced without having any special meaning to the women: Among these are "the aches in the back of the neck and skull"(34%); "urination every night"(35%); "overweight" (62%); "frequent cramps in the legs" (33%); "eye pains" (43%); "sick to the stomach" (26%); "upset stomach" (26%); "worry about their health" (50%); "recent weight gain"(61%); "headaches" (35%); "the need of glasses for long distance" (40%); "gum bleeding" (54%); and "tooth aches" (55%). "Complete exhaustion" caused the women to change their mind and mood (32%) to try to be more optimistic. "Pains in the back" (50%) and "stiff muscles and joints" (39%) caused some changes in their work (50%).

Strategies to Deal with the Symptoms

Management strategies are presented in Table F7 (Appendix F). The women used multiple strategies for dealing with their symptoms: Using over-the-counter medicine; seeking medical care; seeking physical therapy; taking vitamins and minerals; taking Korean traditional herbal medicine; using acupuncture; doing exercise; rest; making changes in work; changing their diet; using instruments or tools; and living with the symptoms. They sought medical help only for dental problems. With the exception of

dental problems, they usually managed their symptoms with over-the-counter medicines, exercise, rest, changes in work, or diet changes without any medical consultation.

The meaning and severity of the symptoms determined which strategy to use. Symptoms perceived to be due to aging were accepted and the "living-with-the symptom" strategy was used. Because they believed that the symptoms could not be managed when the symptoms were caused by aging, they just lived with the symptoms. For the following symptoms that were perceived not serious and not effectively managed, the women also used the "living with the symptom" strategy: "Waking up tired and exhausted in the morning"(32%); "urination every night"(55%); "overweight" (46%); "frequent cramps in the legs" (33%), "concern about health" (38%); and "frequent urination" (47%). For the need of "glasses to read" (24%) and "glasses for long distance"(60%), the women used corrective glasses. For "the aches in the back of the neck and skull" (44%) and "headache" (59%), they used over-the-counter medicine such as Tylenol and Advil. "Rest and avoiding overwork" was used to manage the three symptoms: "The complete exhaustion"(32%), "eye pains" (38%), and "stiff muscles and joints" (22%). Gastrointestinal symptoms—"sick to stomach" (42%), "upset stomach" (32%) and "recent weight gain" (50%)—and "ankle swelling" (22%) were managed by diet change. To manage pains in the back, 46% women used combined methods including physical therapy, rest, exercise, traditional medicine, acupuncture and others. For gum bleeding (39%) and toothache (72%), many women visited dental clinics. Even though they did not use hormone therapy for the symptoms experienced after the age of

40, six of the interviewed women (20%) who were currently taking any types of medicine were taking estrogen combined with progesterone (see Table 5).

Comparisons between the Perceived Symptoms by the Participants and the Symptoms Listed in the Menopausal Symptom Checklist (MSC) and the Chi's Climacteric Symptom Scale

Among the symptoms experienced after the age of 40, the symptoms that women related to menopause are summarized in Table F8 (Appendix F). The meanings and management strategies are also presented in the table. Among the most prevalent 20 symptoms experienced after the age of 40, only 5 of the symptoms were related to menopause by the women: "Glasses to read," "aches in back of the neck and skull," "eye pains," "stiff muscles and joints," and "glasses for long distance." However, among the five symptoms, only one symptom, "aches in the back of the neck and skull" has been reported to be caused by menopause (Blatt et al., 1953; Chi, 1983; Flint, & Garcia, 1979; Greene, 1976; Jaszmann et al., 1969; Maoz et al., 1978; McKinlay, & Jefferys, 1974; Neugarten & Kraines, 1965; Thompson et al., 1973). While the participants felt uncomfortable about their declining reading vision, 33% were tolerant of it and 24% used corrective glasses. The symptom, "the aches in back of the neck and skull" did not signify any concern to them so they rarely felt the need to manage them. (34%). Yet, whenever they needed to manage the pain, they used over-the-counter medicine (44%). For the eye pains, the women did nothing special (43%); or they rested and avoided overwork (38%). The symptom, "stiff muscles and joints" brought some changes in or during work by the women (39%): Changes of their occupations, changes of the type of

work, and changes in body postures and positions during work. The need for glasses to see long distances did not alarm them (40%), but they used corrective-glasses (60%) for their declining vision.

In Table 7, the most prevalent (>40%) symptoms experienced during the past 6 months were summarized according to their menopausal status. The most prevalent symptoms by pre-menopausal women were "tension or jumpy during menstruation." Among peri-menopausal women, the symptom, "aches in the back of the neck and skull" was the most prevalent. In the case of post-menopausal women, the symptom "glasses to read" was the most prevalent. There were no general patterns to the symptoms. They appeared to be highly individual; and few women experienced many symptoms.

In Table F9 (Appendix F), the symptoms reported by research participants are presented according to the menopausal symptoms on the menopausal symptom checklist (MSC) by Neugarten and Kraines (1965): The MSC has been widely used in menopausal studies among Western women. Among the 28 symptoms in the MSC, eight symptoms were experienced by more than 20% of pre-menopausal women; nine symptoms were experienced by more than 20% of peri-menopausal women; and ten symptoms were experienced by more than 20% of post-menopausal women. Also, in Table F10 (Appendix F), the symptoms reported by the research participants are presented through the Chi's (1983) climacteric symptom scale: The Chi's climacteric symptom scale was developed by Korean women in South Korea and was widely used in Korean menopausal studies. Among the 21 symptoms in the Chi's scale, four symptoms were experienced by more than 20% of pre-menopausal women; five symptoms were experienced by more

Table 7. The most prevalent (>40%) symptoms experienced during the past 6 months according to menopausal status

Symptoms	Pre-menopausal (n=52) N (%)	Peri-menopausal (n=27) N(%)	Post-menopausal (n=38) N(%)
Tension or jumpy during menstruation	28(53.8)	13(48.1)	
Exhaustion	28(53.8)	14(51.9)	
Glasses to read	22(42.3)	17(63.0)	29(76.3)
Fatigue in the morning	25(48.1)	11(40.7)	
Aches in the back of neck and skull	25(48.1)	20(74.1)	20(54.1)
Touchy person	22(42.3)		
Frequent cramps in legs	21(40.4)	15(55.6)	
Bleeding gums	21(40.4)		
Painful menstrual period	21(40.4)		
Weak or sick in periods	21(40.4)		
Overweight		14(51.9)	
Bloated after eating		12(44.4)	
Urinate every night		12(44.4)	
Pains in eyes		11(40.7)	

than 20% of peri-menopausal women; and six symptoms were experienced by more than 20% of post-menopausal women. Even though the women did not associate their symptoms with menopause, the data showed that they were experiencing the so-called menopausal symptoms that have been found and reported to be related to menopause by previous studies (Blatt et al., 1953; Chi, 1983; Flint, & Garcia, 1979; Greene, 1976; Jaszmann et al., 1969; Maoz et al., 1978; McKinlay, & Jefferys, 1974; Neugarten & Kraines, 1965; Thompson et al., 1973).

A Comparison of the Perceived Symptoms Among the Participants, Americans, and Koreans

The prevalence rates of the symptoms experienced during menopausal transition were found to be different from those reported in a study of Western women (Neugarten & Kraines, 1965) and a study of Korean women in Korea (Im, 1994). (Table 8 & Table 9). In Table 8, prevalence rates among the participants are compared with those in Neugarten and Kraine's study (1965), which investigated menopausal experience of 500 American women aged 13 to 65 living in Chicago metropolitan area using the MSC. The pre-menopausal participants in this study had a lower prevalence rate of the symptoms in the MSC than those in Neugarten and Kraine's study, excluding five symptoms: "Aches in the back of the neck and skull", "breast pain," "constipation," "skin crawls," and "feelings of suffocation." The peri-menopausal women also had lower prevalence rates of symptoms with the exception of two symptoms: "Aches in back of the neck and skull" and "concern about the body." The post menopausal women had lower prevalence rates of the symptoms excluding six symptoms: "Aches in back of the neck

Table 8. A comparison between Neugarten & Kraines (1965) study (n=460) and this study (n=119): Percentages of women reporting the symptoms in the MSC

MSC Symptoms	Pre-menopausal		Peri-menopausal		Post-menopausal	
	(a)	(b)	(a)	(b)	(a)	(b)
Somatic						
Hot flashes	28*	9.6	68*	19.2	28*	10.5
Cold sweats	16*	1.9	32*	3.7	16*	13.2
Weight gain	41*	23.1	61*	29.6	41*	26.3
Flooding	24*	11.5	51*	14.8	24*	16.0
Rheumatic pains	46*	7.6	49*	18.5	46*	21.1
Aches in back of neck and skull	34	48.1*	46	74.1*	34	54.1*
Cold hands and feet	31*	9.6	42*	19.2	31*	10.5
Numbness and tingling	37*	9.6	37*	7.4	37*	15.8
Breast pains	10	26.9*	37*	22.2	10	10.7*
Constipation	24	30.8*	37*	25.9	24*	15.8
Diarrhea	20*	0.0	24*	3.7	20*	7.9
Skin crawls	3	15.4*	15*	11.1	3	18.9*
Psychosomatic						
Fatigue	71*	1.9	88*	0.0	71*	7.9
Headaches	47*	36.5	71*	37.0	47*	28.9
Pounding of the heart	36*	17.3	44*	22.2	36*	26.3
Dizzy spells	36*	13.5	40*	3.7	36*	10.5
Blind spots before the eyes	14*	9.6	22*	18.5	14*	7.9
Psychologic						
Irritability and nervousness	71*	21.2	92*	11.1	71*	18.4
Feeling blue and depressed	56*	19.2	78*	3.7	56*	15.8
Forgetfulness	60*	0.0	64*	3.7	60*	5.6
Excitability	47*	42.3	59*	40.7	47*	26.3
Trouble sleeping	40*	21.2	51*	25.9	40*	31.6
Trouble concentrating	46*	19.2	49*	18.5	46*	23.7
Crying spells	38*	17.3	42*	3.7	38*	18.4
Feelings of suffocation	2	5.7*	29*	0.0	2	5.4*
Worries about the body	24*	19.2	24	29.6*	24	37.8*
Feelings of fright or panic	22*	7.7	22*	3.7	22*	13.2
Worry about nervous breakdown	7*	5.7	5*	3.7	7	13.5*

(a) Neugarten & Kraine's study

(b) This study

* Higher prevalence rate of each symptom within each menopausal group

Table 9. A comparison of prevalence rates among 40 to 60 years old women between Im's study (1994) (n=462) and this study (n=119)

Symptoms in Chi's scale	Im's study (1994) Percentage	This study Percentage
Hot flashes	63.6*	19.2
Cold sweats	57.6*	3.7
Skin crawls	45.2*	11.1
Nervousness	84.4*	11.1
Trouble sleeping	56.1*	25.9
Depression	63.9*	3.7
Feelings of fatigue	78.1*	3.4
Headache	72.3*	37.0
Pains in arms and legs	81.2*	22.2
Chest palpitation	67.7*	22.2
Loss of appetite	52.6*	11.1
Constipation	54.5*	25.9
Indigestion	66.9*	11.1
Trouble with concentration	63.9*	18.5
Crying spells	54.5*	3.7
Feelings of suffocation	59.3*	0
Cold hands and feet	62.8*	19.2
Feelings of fright or panic	64.3*	3.7
Knee pains	72.5*	18.5

* Higher prevalence rate of each symptom

and skull," "breast pains," "skin crawls," "feelings of suffocation," "concern about the body," and "concern of a nervous breakdown."

In Table 9, the prevalence rates of menopausal symptoms of the participants are compared with those in Im's study (1994), which investigated menopausal symptoms of Korean women in Korean using the Chi's climacteric symptom scale (1983). It is notable that the participants in this study had lower prevalence rates of all symptoms listed in the Chi's scale compared with Korean women in Im's study (1994).

Differences in the Perceived Symptoms by Other Study Variables:

Socio-demographic Variables, Ethnic Identity and Work Satisfaction

The differences in the population mean total number of the perceived symptoms by sociodemographic variables, ethnic identity, and work satisfaction were explored through analysis of variance (ANOVA) (Table 10, 11, 12, & 13). The population mean total number of total symptoms experienced during the past 6 months was statistically significantly different between the three different self-reported health status groups ($p<.0001$), two groups according to length of time in the U.S. ($p=.02$), and three different work satisfaction groups ($p=.04$) (Table 10).

There was a statistically significant difference in the population mean total number of the physiological symptoms between three different education groups ($p=.07$), three different self-reported health status groups ($p<.01$), two groups according to length of time in the U.S. ($p=.05$) and three different work satisfaction groups ($p=.07$) (Table 11). No two education groups or work satisfaction groups were significantly different; but

Table 10. Differences in the number of total symptoms experienced during the past 6 months according to menopausal status, socio-demographic characteristics, perceived health status, ethnic identity, and work satisfaction: *Statistically significant (α <.05)

Source	d.f.	SS	MS	F-value	P-value	η^2
Menopausal Status						
Between Groups	2	235.30	117.65	0.3490	0.7062	0.0065
Within Groups	106	35735.28	337.13			
Total	108	35970.59				
Socio-demographic Characteristics						
Age	3	291.27	97.09	0.2860	0.8354	0.0080
Between Groups	106	35978.93	339.42			
Within Groups	109	36270.19				
Total						
Education						
Between Groups	2	1443.01	721.51	2.2167	0.1139	0.0398
Within Groups	107	34827.18	325.49			
Total	109	36270.19				
Family Income						
Between Groups	2	1484.02	742.01	2.2824	0.1070	0.0409
Within Groups	107	34786.17	325.10			
Total	109	36270.19				
Marital Status						
Between Groups	3	91.59	30.53	0.0898	0.9655	0.0026
Within Groups	105	35707.36	340.07			
Total	108	35798.95				
Work Status						
Between Groups	1	117.93	117.93	0.3550	0.5520	0.0032
Within Groups	109	36171.37	331.85			
Total	110	36289.30	329.90			
Perceived Health Status						
Between Groups	2	4869.31	2434.65	8.3686	0.0004*	0.1342
Within Groups	108	31419.99	290.93			
Total	110	36289.29				
Ethnic Identity						
Between Groups	1	62.18	62.18	0.1859	0.6672	0.0017
Within Groups	108	36118.99	334.44			
Total	109	36181.17				
Length of Time in the U.S.						
Between Groups	1	1621.26	1621.26	5.1123	0.0258*	0.0452
Within Groups	108	34250.10	317.13			
Total	109	35871.36				
Work Satisfaction						
Between Groups	2	2078.42	1039.21	3.3034	0.0405*	0.0582
Within Groups	107	33660.63	314.59			
Total	109	35739.05				

Total	112	13376.89				
Work Satisfaction						
Between Groups	2	616.14	308.07	2.6679	0.0739	0.0463
Within Groups	110	12702.02	115.47			
Total	112	13318.16				

Table 11. Differences in the number of physiological symptoms experienced during the past 6 months according to menopausal status, socio-demographic characteristics, perceived health status, ethnic identity, and work satisfaction: *Statistically significant (α <.05)

Source	d.f.	SS	MS	F-value	P-value	η^2
Menopausal Status						
Between Groups	2	99.46	49.73	0.4061	0.6673	0.0074
Within Groups	109	13348.97	122.47			
Total	111	13448.43				
Socio-demographic Characteristics						
Age	3	193.55	64.52	0.5265	0.6650	0.0143
Between Groups	109	13355.90	122.53			
Within Groups	112	13549.45				
Total						
Education						
Between Groups	2	622.07	311.03	2.6466	0.0754	0.0459
Within Groups	110	12927.38	117.52			
Total	112	13549.45				
Family Income						
Between Groups	2	445.92	222.96	1.8717	0.1587	0.0329
Within Groups	110	13103.54	119.12			
Total	112	13549.45				
Marital Status						
Between Groups	3	156.03	52.01	0.4270	0.7340	0.0117
Within Groups	108	13153.65	121.79			
Total	111	13309.68				
Work Status				0.8880	0.3480	0.0079
Between Groups	1	106.70	106.70			
Within Groups	112	13455.49	120.14			
Total	113	13562.18	120.02			
Perceived Health Status						
Between Groups	2	2581.59	1290.79	13.0483	< 0.01*	0.1904
Within Groups	111	10980.59	98.92			
Total	113	13562.18				
Ethnic Identity						
Between Groups	1	7.23	7.23	0.0592	0.8082	0.0005
Within Groups	111	13548.39	122.06			
Total	112	13555.61				
Length of Time in the U.S.						
Between Groups	1	445.38	445.38	3.8230	0.0531*	0.0333
Within Groups	111	12931.51	116.50			
Total	112	13376.89				
Work Satisfaction						
Between Groups	2	616.14	308.07	2.6679	0.0739	0.0463
Within Groups	110	12702.02	115.47			
Total	112	13318.16				

Table 12. Differences in the number of psychological symptoms experienced during the past 6 months according to menopausal status, socio-demographic characteristics, perceived health status, ethnic identity, and work satisfaction: *Statistically significant (α <.05)

Source	d.f.	SS	MS	F-value	P-value	η^2
Menopausal Status						
Between Groups	2	23.43	11.71	0.2615	0.7703	0.0046
Within Groups	113	5061.49	44.79			
Total	115	5084.92				
Socio-demographic Characteristics						
Age	3	5.70	1.90	0.0420	0.9885	0.0011
Between Groups	113	5115.37	45.27			
Within Groups	116	5121.08				
Total						
Education						
Between Groups	2	169.02	84.51	1.9454	0.1476	0.0330
Within Groups	114	4952.06	43.44			
Total	116	5121.08				
Family Income						
Between Groups	2	332.79	166.39	3.9615	0.0217*	0.0650
Within Groups	114	4788.29	42.00			
Total	116	5121.08				
Marital Status						
Between Groups	3	21.97	7.32	0.1618	0.9218	0.0043
Within Groups	112	5068.17	45.25			
Total	115	5090.14				
Work Status						
Between Groups	1	0.209	0.209	0.005	0.9450	0.00004
Within Groups	116	5121.08	44.1470			
Total	117	5121.29	43.7720			
Perceived Health Status						
Between Groups	2	231.10	115.55	2.7174	0.0703	0.0451
Within Groups	115	4890.19	42.52			
Total	117	5121.29				
Ethnic Identity						
Between Groups	1	18.94	18.94	0.4294	0.5136	0.0037
Within Groups	115	5072.31	44.11			
Total	116	5091.25				
Length of Time in the U.S.						
Between Groups	1	203.79	203.79	4.7952	0.0306*	0.0400
Within Groups	115	4887.45	42.50			
Total	116	5091.25				
Work Satisfaction						
Between Groups	2	353.04	176.52	4.2471	0.0166*	0.0693
Within Groups	114	4738.20	41.56			
Total	116	5091.25				

Table 13. Differences in the number of menopausal symptoms experienced during the past 6 months according to menopausal status, socio-demographic characteristics, ethnic identity, and work satisfaction: *Statistically significant (α <.05)

Source	d.f.	SS	MS	F-value	P-value	η^2
Menopausal Status						
Between Groups	2	8.26	4.13	0.8803	0.4175	0.0156
Within Groups	111	520.90	4.69			
Total	113	529.16				
Socio-demographic Characteristics						
Age	3	8.11	2.70	0.5706	0.6355	0.0152
Between Groups	111	525.67	4.74			
Within Groups	114	533.77				
Total						
Education						
Between Groups	2	7.00	3.50	0.7439	0.4776	0.0131
Within Groups	112	526.78	4.70			
Total	114	533.77				
Family Income						
Between Groups	2	5.63	2.81	0.5969	0.5522	0.0105
Within Groups	112	528.14	4.72			
Total	114	533.77				
Marital Status						
Between Groups	3	6.30	2.10	0.4384	0.7260	0.0118
Within Groups	110	526.73	4.79			
Total	113	533.03				
Work Status						
Between Groups	1	0.91	0.91	0.195	0.659	0.0017
Within Groups	114	532.88	4.67			
Total	115	533.79	4.64			
Perceived Health Status						
Between Groups	2	67.85	33.93	8.2280	0.0005*	0.1271
Within Groups	113	465.94	4.12			
Total	115	533.79				
Ethnic Identity						
Between Groups	1	0.13	0.13	0.0274	0.8689	0.0002
Within Groups	113	529.05	4.68			
Total	114	529.18				
Length of Time in the U.S.						
Between Groups	1	28.00	28.00	6.2721	0.0137*	0.0526
Within Groups	113	504.49	4.46			
Total	114	532.49				
Work Satisfaction						
Between Groups	2	10.83	5.41	1.1695	0.3143	0.0205
Within Groups	112	518.36	4.63			
Total	114	529.18				

unhealthy and healthy groups were significantly different ($p<.05$) in the population mean total number of physiological symptoms.

The population mean total number of psychological symptoms experienced during the past 6 months was significantly different between three different family income groups ($p=.02$), three different self-reported health status groups ($p<.10$), two groups according to length of time in the U.S. ($p<.05$), and three different work satisfaction groups ($p<.05$) (Table 12). Middle and high family income groups, and middle and high work satisfaction groups were significantly different; but no two health groups were significantly different in the population mean total number of psychological symptoms at $\alpha = 0.05$.

The population mean total number of menopausal symptoms was significantly different only between three different self-reported health status groups ($p<.01$) and two groups according to length of time in the U.S. ($p=.01$) (Table 13): Unhealthy and healthy groups were significantly different in the population mean total number of menopausal symptoms at $\alpha = 0.05$.

Influences of the Perceived Symptoms on Immigration and Work Experience

Most of the participants believed that their symptoms rarely influenced their immigration experience. Even though they reported some uncomfortable feelings, the feelings were not perceived to influence their immigration and work experience. Some of them had no ideas about the influences of the symptoms on immigration experience, and others had not thought about it. In answer to the question, why they had not thought about the influences of the symptoms on their immigration and work experience, they

answered that they did not have time to think about it. One woman said that it is a woman of leisure who could worry about her symptoms. Their busy schedules due to their immigration and new work transitions did not allow them to think about their symptoms or have the time to worry about the symptoms experienced during menopausal transition:

> I was indifferent to it. I didn't care.... Life as an immigrant is very difficult and busy... Maybe. Women who are not busy.... Women who are not busy would care.. So. They may care about that... I didn't. So... I think that my menopause passed by without any notice.
>
> There were no influences of the symptoms to my immigration life. There was nothing difficult... Honestly speaking, because I immigrated into this country, I think that my menopause passed by very simply. The symptoms. menstrual irregularity, physical difficulties... Actually, I had them. But, I didn't care about that because I didn't have the time, and the symptoms never really bothered me.
>
> As I said before, to me, menopause was really simple. It passed by naturally. Surely, as others said, I had several symptoms, but they did not cause any problems in my life. Moreover, my child was so young and it's not like my life would be ending soon. There were many things to do...

Interestingly, some women said that their immigration experience became easier and more comfortable after having menopause. Because they had serious menstrual difficulties and pains before menopause, their immigration experience had been burdened by their premenstrual tension (PMS) and menstrual difficulties and pains. Furthermore, even preparing pads for their menstrual periods were sometimes burdensome because of the lack of time and money. To the women who just recently came to this country, even going to market and getting pads were embarrassing experiences.

> I cannot figure anything good about menstruation. My menstrual period is 20 days. I have heavy periods... So, I always wanted not to have menstruation. It's too difficult. I cannot work at all... Especially, in this

> new country, menstruation makes me more stressful. Actually, even going to the supermarket and buying pads is stressful to me. I need to spend some time in figuring out where they are... I need to talk about it to my husband.... Well... As I became older, the amount of menstruation seems to have reduced. But, I still want my menopause to come sooner.
>
> Because of menstrual irregularity and pains, I have suffered. It's physically difficult for me to work during my period. Especially, in this new country.... I was usually depressed during my periods... And, I had heavy menstruation. So, whenever I had my period, my mood was really bad. So, when menopause came, I was really glad that I would not have the difficulties anymore. Indeed, my condition became better than before, and I could concentrate on my work.

Some women reported that their symptoms during menopausal transition were so severe that they could not work well. Because they were so depressed, they did not want to work at all; menstrual changes and irregularities made them easily tired and made it physically difficult to work; and they did not even want to wake up in the morning. However, they did not think that their work influenced their symptoms. Rather, they thought that their work made them more healthy, consequently reducing their symptoms, especially psychological symptoms.

It was found that work mediated the management strategies for symptoms. There were differences in their attitude toward serious physiological symptoms and serious psychological symptoms. When physical symptoms experienced during menopausal transition inhibited their work in their daily lives, they sought help for the symptoms. Some women visited clinics and began to take hormones. Other women quit their jobs, or changed their jobs because their previous employment was too difficult for them. However, when they had psychological symptoms, they showed different behaviors: They worked harder than before. Not wanting to be concerned about these psychological

symptoms, such as depression, they concentrated more on their work. They felt that working harder would keep them from thinking or worrying about these symptoms, consequently, expecting to cure their psychological symptoms:

> Well... That was better. Anyway, work causes people not to spend time worrying. So.... Depression and other symptoms became better than before.... Well... At that time, I was really depressed, so I did not even want to do household works. I did not to want to work at that time... Well... When a person is depressed, she does not want to do anything, even the things that she liked to do. I didn't care about our household tasks. It was like that.... So... I tried to work harder than before. I did not want to waste time worrying about my depression.... Actually, people usually say that work makes people stronger and healthier. I did not want my depression to get worse, so I tried to work harder and harder.
>
> Menopause made me work harder than before. Even though I became depressed. Whenever I thought about my life and became depressed, I tried to look for more meaningful things. And, started concentrating more on my work. So, I worked harder and harder.
>
> Maybe I will work harder than before to get rid of the symptoms. Everything is like that. When people concentrate on other things, people tend to forget their worries. So, they try to work harder and harder.

CHAPTER VI

Neglecting and Ignoring Menopause

Within A Gendered Multiple Transitional Context

From the findings, a common theme concerning menopausal experience of low income Korean immigrant women was constructed: The women were neglecting and ignoring their menopausal transition within a gendered multiple transitional context. In this chapter, the constructed theme is discussed in four subsections. In the first subsection, the women's daily experience in dealing with multiple transitions is discussed focusing on their gendered experience, strong influences of cultural factors on their daily lives, and work experience. Since the women's daily experience as immigrant middle-aged women is situated in gendered contexts, their transitions are called gendered transitions here. This discussion provides answers to the research question on the context within which the women were experiencing their menopause. In the second subsection, the participants' menopausal experiences are discussed, trying to grasp the meanings of menopause and responses to changes due to menopausal transition. This answers the research question on the meanings of menopause. In the third subsection, the participants' symptom experience during menopausal transition is discussed, considering other correlates influencing their symptoms. The discussion on symptom experience provides the answers corresponding to the research question on symptom experience of menopause. In the final section, the entire discussion is integrated, and the women's menopausal experience is discussed considering themes emerging from the findings.

Gender, Family, Social Supports and Their Transitions

Gendered Immigration Transition

As Hondagnue-Sotelo asserted (1994), immigration is a gendered transition and gender is a fundamental category of analysis for developing theories of immigration and settlement. In fact, the multiple transitions that the women experienced were gendered experiences. Macroscopically, most of the women were employed in informal-sector female occupations such as paid domestic worker, child care, garment and electronic factory assembly. Interestingly, many of the participants were involved in their small family business as unpaid family workers, and most of the women in small business were the wives of shopkeepers. However, the life of an unpaid family worker in an immigrant small business was not easy: The hours were long while the work was often boring and tedious. There was an ambiguity in the wife's position as co-operator of a small business. She was both co-owner and unpaid family labor worker, an employee of her husband without the benefit of a paycheck. Indeed, her unpaid labor enabled the business to stay open for as much as fourteen hours a day, and on weekends, without having to hire additional labor.

Microscopically, the women were responsible for most household tasks, doing their second shift (Hochschild, 1989): There is growing awareness among feminists that women's paid employment does not automatically trigger any notable shift in the division of labor at home. Spitze (1988), Tompson and Walker (1989), and Hochschild (1989) term it, wives' "second shift" of unpaid work. Most of the women regarded their second shift as their duty.

As discussed in the literature review, compared with a modern family in western society, the Korean traditional family was characterized by patriarchal order and an undemocratic relationship between wife and husband. A clause in the Confucian law requires that the head of any Korean family be a male (Sawyers & Eaton, 1992). Family leadership is passed from father to the eldest son even when he is only an infant. The eldest son is responsible for any family affairs including caring for the widowed mother and for any unmarried siblings. Even though there have been many changes in the traditions, the women who participated in this study still had patriarchal traditions. They continued to hold relatively lower positions than men in their ethnic community and families while their husbands still occupied the center stage of their families, reluctant to give up their patriarchal status and authority. Taking the traditions and lower positions in their families for granted, women worked inside and outside the house. Indeed, it was the wife who actually bore the heavy burden of performing household tasks such as grocery shopping, housekeeping, laundry, cooking, and dish washing. Husbands rarely performed the household tasks and were not expected to do so. The burden of performing household tasks was shared with their children or other family members, but not with their husbands. Daughters, not sons mainly helped the women in household tasks.

As other studies on immigrant women have shown (Glenn, 1986; Hondagneu-Sotelo, 1994), traditional social relations and cultural resources neither disintegrate nor continue intact, but are reshaped through processes of migration and resettlement. The cultural legacies of patriarchy are selectively reproduced and rearranged through migration and resettlement in the new society. In fact, the women showed more

democratic relationships with their husbands in comparison with typical Korean family in Korea. Since the women crucially contribute to their family's economic position in the new country, their husbands shared some household tasks even though they did so only to the extent that they felt obliged. In their generation, men were taught never to enter the kitchen, and men who helped their wives were regarded as stupid men. Getting help from their husbands certainly signified a relatively higher position in the family and reshaped gender relations within the family.

The Centrality of the Family in Their Lives

In Korean history, the Confucian-dominated Yi dynasty maintained a strict authoritarian system based on a rigid hierarchical order. Every human relationship was governed by the order, which was determined by social class, sex, generation, and age (Yu, 1987). Based on the order, Korean culture placed special importance on the family as both the basic unit of society and the fundamental social structure within which individuals live (Moon & Pearl, 1991). Even though modernization and industrialization have brought tremendous changes, the traditions are still alive. Indeed, the women who participated in this study had put their family as their priority. Family was frequently the ultimate goal and dream of their lives. A woman said that her final goal of life was to see that her son would marry. It may mean that she wanted to see her children and grandchildren live happily ever after owing to her current sufferings and hardships.

In fact, all the women came to the United States for high quality of life and good opportunities for their families. Their decision to immigrate to the United States was frequently made because of their families. To accomplish their dreams, which were

frequently associated with their families, they have gone through the hardships and sufferings in this new country. Their families are very important and central in their daily lives.

Lack of Social Supports

As many studies on immigrants have shown, (Lipson & Miller, 1994; Meleis, 1991; Meleis et al., 1995; Nelson, 1995), immigrant women have inadequate social support resources. Their extended families, relatives, and "real" friends here in the U.S. are scarce; they rarely have adequate financial security; and they lack governmental support. Indeed, even though the participants of this study had strong and intimate social networks among extended family members and close relatives, they rarely had adequate social supports from other resources.

Participants in this study also differentiated their social support resources. When they needed to use a grocery store, they chose to shop at the grocery store owned by one of their church friends. However, when they had a quarrel with their husbands and wanted someone to listen and provide advice, they rarely sought help from their church friends. In other words, their social support resources rarely provided psychological support. One of the reasons for the differentiation was the mistrust among Korean immigrants. Since the women could not trust other Korean immigrants, they were unwilling to disclose private aspects of life to their friends, subsequently lacking psychological support from the friends. They might also have been worried about gossip because of the small size of Korean ethnic churches and communities.

Aging, Gendered Culture and Menopause

Holistic, but Negative Views on Aging

The findings showed that the women had holistic views on aging. They did not emphasize the physiological, psychological, nor social aspects of aging. Rather they viewed aging with mind, body, and social roles. They believed that aging came from the mind: When a woman has a young mind, she is still young despite her physiological age. Also, the women perceived their age based on their children's developmental stage and other social changes. When their children were still young, they perceived themselves as still young. Indeed, their age was perceived based on their physiological, psychological, and social ages. Also, their age was not perceived as a point of time, but rather along a continuum. They did not divide their age into the young, the middle-aged nor the aged. The women in the early and middle 40s perceived that they were between the young and the middle-aged while the women in the middle and later 50s perceived that they were between the middle-aged and the aged.

Aging was perceived to be associated with their daily lives. They believed that their physical appearances and physical and psychological functions and structures became old at an earlier age than their relatives and friends the same age living in Korea. One of the reasons was that they had been busy taking care of their appearances and bodies. They worked hard in labor, extensively using their body and energy, and consequently lacked vital energy. A third reason was that their mind became depressed and sad because they could not be capable and active in daily lives in this new country, consequently making

them easily old. In short, the hardships and sufferings from daily lives were perceived to make them become old at an earlier physiological age.

In the past, becoming a mother-in-law and grandmother signified a change of status from reproductive adulthood with a low position in their family structure to another stage in the life cycle with higher position and power and control over family members. Women at that age were regarded as less ego-centered, more concerned with others, and more wise. They were respected and served by their children, and aging was more positively viewed than nowadays.

Today, with modernization and industrialization in Korea, the perception of aging and attitudes toward the aged have been negatively changed with tremendous cultural changes. The wisdom that the aged gave to children has become useless, and materialist values have become norms in Korean culture. Korean immigrants in the U.S. may have even more materialistic views and altered perceptions of aging and attitudes toward the aged. A woman whom I met in a church meeting said:

> No... It is time for rich people. The aged should have money... And... The aged should not give all of their money to their children before dying. Today, only the aged who has money has a Hyoja (a good and filial son). If one wants to have a Hyoja, she should have money and never give all the money to their children. Really.... The aged who has money is the one who is respected. I will continue to work until I will not move my fingers, and I will save money for my later life.

These women associated the aging process with negative physiological, psychological and social changes. They believed that aging would bring ugly physical appearances, degeneration in functions and structures of their body and mind, and rare opportunities and possibilities. Many associated aging with decreasing work capability

and greater physical and financial dependency, consequently connected with hopelessness, which was detrimentally influencing their lives as immigrants. With the materialistic and Westernized views, aging meant tremendous loss and the women approached their later life with fear and sadness.

Gender Equated with Sex

Based on the study of discourse (Macdonell, 1986), Kim (1993) posited that, in Korean society, there have been social and cultural discourses that treated sex and gender as one and the same, creating an exclusive axiomatic truth, that is, a woman's body is not a man's body and they occupy different spheres. Subsequently, Kim (1993) maintained that the historical and cultural experience of women's lives tended to be reduced to women's biological condition in which a woman would have a reproductive capacity; in this capacity, women's "factual" and "real" gender has been inscribed. Indeed, the findings of this study showed that the women themselves emphasized that 'women should be women,' treating sex and gender as one and the same. Because they were biologically women, they believed that they should be, behave, and feel like women while satisfying social and cultural expectations.

As explored through literature review, feminist anthropologists have pointed out that, particularly in Western thought, women and their sexuality have often been seen as 'less cultural' than men, and equated instead with 'nature' rather than with the 'culture' of the male world (Helman, 1994). 'Nature' represents biological aspects of human lives and is characterized as something fixed, universal, and immutable. 'Culture' represents the influence of both social and cultural environments, and is characterized as more

changeable and more dependent on local contexts. In Korean culture, women's gender has been reduced to and equated with biological sex as Western culture has regarded women's gender as 'nature.'

The results of this study verified the exclusive axiomatic truth that a woman's body is not a man's body, so they should occupy different spheres: Women should do Anil (work inside house) and men should do Bakatil (work outside house). The strict division of labor in households required middle-aged Korean immigrant women in low income jobs to sacrifice themselves. However, under the strict division of the spheres by sex, which was equated with gender, the women rarely challenged this unfairness.

Kim (1993) posited the 'sameness' of women's lives in Korean culture. According to her, the ultimate boundary of female gender is confined by their physicality, namely their reproductive capacity. Thus, women's reproductive capacity explains the essential and natural difference between men and women, consequently making women's experience the 'same.' This experiential 'sameness' of women's lives is understood as the almost instinctual practices of the sex based on women's biological unity. Thus, women's diversities in their experiences are continuously denied, reducing all women's life experiences to these practices. The findings presented in this dissertation also show the 'sameness' of women's experiences. The participants believed that women should behave, think, feel and be like women, which ultimately make all women's experiences 'sameness.' When the 'sameness' was negated by the women, they experienced frustration, conflict, and uncertainties in their lives.

Menopause Equated with the Stop of Menstruation

As gender was equated with sex by the participants, the findings indicate that the women's menopausal experiences have been simply reduced to women's biological condition, 'the stop of menstruation.' The women seemed to unconsciously simplify the meanings of menopause into infertility and the changes in menstruation. To them, menopause meant the end of maternal lives, signifying that the biological practices of reproduction would be the essence of female gender.

The Korean terms referring to menstruation might have constructed power in their linguistic meanings. The word 'Kyung' is frequently used when referring to menstruation and means 'unchangeable principles' that emphasize biological aspects of women as the principles of being a woman. The word 'Kyung' is used when referring to the sutras and the Buddhist scriptures (Minjungseorim, 1990). In considering this word, it can be inferred that Koreans emphasize the significance of woman's fertility as a woman's being.

However, women's lives, in a general sense, cannot be simplified into a biological aspect. Women's menopausal experiences cannot be simplified only as the cessation of menstruation, just as gender cannot be simplified as sex. Rather, the biological aspects are complicated and intertwined with other factors, including socioeconomic status, cultural influences, and so on. Indeed, the findings on the meanings of menopause showed the complexity and contextuality of menopausal transition. The meanings of woman, middle-age, immigration, and work were quite different from those of women in other cultures. Meanings were deeply linked to the cultural, socio-economic, and

immigration factors, influencing and complicating the meanings of menopause within the context of their daily lives.

Invisible Menopausal Experiences

Issues on menopause were not brought to the attention of researchers until the 20th century (McCreas, 1983; Neugarten, 1968; Voda & Eliasson, 1983). One of the reasons has been that society has had a taboo against openly discussing menopause. In Korean society, it has been regarded as a taboo to talk openly about menstruation, pregnancy, sexual relationships, and menopause. In fact, the participants were reluctant to answer some questions related to menstrual changes and menopausal experiences. They rarely knew about menstruation at menarche, and their mothers, sisters, and friends scarcely informed them about menstruation. Some had not known about sexual relationships until their marriage. One woman said that she had thought that merely sleeping beside a man would cause pregnancy. They rarely knew about their mother's menopause because their mothers never talked about that. The silence of women's health experiences has made the menopausal transition invisible in Korean culture.

As discussed before, the verbal and non-verbal language is the condition of the discourse (Macdonell, 1986). In fact, language has the constructed power in it. Feminists have long been aware that naming is political. Labels attached to activities establish and justify their social worth. Women's activities have often been labeled in ways of controlling and subordinating women (Frye, 1983). Considering the constructed power in the language labeling women's experience, it can be easily inferred that Koreans have

made women's experiences invisible. Korean languages referring to women's experiences are frequently vague and unclear in their meanings.

In menstrual and menopausal experiences, languages used were especially vague and unclear as the findings have shown. Indeed, when referring to menstrual experiences or menopausal experiences, the women rarely used the direct and powerful terms. Rather, they used vague terms such as 'Geugu (that), 'Wulrehangsa (monthly event), and Sonnym (guest). Additionally, when they were referring to sexual organs, they did not say directly the name of sexual organs. Rather, they used vague terms such as 'Gugi (there).' They never said that they had vaginal dryness. They said that their water was dry. Also, when they referred to sexual intercourse, they never directly pointed that out. Rather, they said their sleeping place with husbands, or just the relationships to their husbands were rare or frequent. The indirect and vague terms referring to women's health certainly made Korean women's health experiences invisible.

Menopause Without Adequate Information

The women expressed embarrassment over the lack of information and knowledge on menopause. While most women experienced their menarche in totally unknown states, some information was given by their close friends, television, and articles in Korean women's magazines. The most important initial source of information about menopause was old wives tales transmitted through a variety of means including conversations with friends, books, magazines, movies, and family stories. However, the information was scarce, and the women rarely tried to seek information. Considering the

tendency in Korean culture to not openly speak about women's health needs, it is understandable that information is rarely available to the women.

One of the important issues related to knowledge on menopause is the adequacy and correctness of the information that is provided. Because most of the information was given through unclear and non-professional sources, the given knowledge on menopause could be detrimental to women's health in some cases. For example, many women regarded heavy menstruation as a sign of good health or menopausal transition, and did not seek medical help. However, in some cases, unusual heavy menstruation can mean serious disease such as cervical cancer, ovarian tumors, fibroids, genital infections, and pelvic inflammatory disease (Gorrie, McKinney, & Murray, 1994).

Even when the information was given by physicians, it is questionable how adequately the information was provided because the women usually understood the information in their own ways. For example, a woman said that the reason for her operation during her menopausal transition was to remove wastes in her womb. The vague word 'wastes' might mean something different to the women than what the physician intended. Moreover, when she transferred the information to other women, the word 'wastes' could have different meaning for these women.

Menopause Medicalized by Doctors

The concept of medicalization has been put forward by many medical sociologists. Medicalization is defined as 'the way in which the jurisdiction of modern medicine has expanded in recent years and now encompasses many problems that formerly were not defined as medical entities'(Gabe & Calnan, 1989). As Helman (1994)

asserted, this now includes a wide variety of phenomena, such as many of the normal phases of the female life-cycle-menstruation, pregnancy, childbirth and menopause-as well as old age, unhappiness, loneliness, social isolation, and the results of wider social problems, such as poverty or unemployment.

Conrad and Schneider (1980) assert that medicalization occurs on three levels: Conceptual, institutional and interactional. On the conceptual level, it occurs when a medical vocabulary or model is used to define a problem. On the institutional level, medicalization comes about when professionals legitimate an organization's work, serving as 'gatekeepers' or 'formal supervisors'. On the level of doctor-patient interaction, medicalization occurs when physicians define and/or treat a patient's complaints as medical problems.

The findings showed that the women's menopause was medicalized by physicians on all three levels. On the conceptual level, the physicians with whom the women met used medical vocabulary when referring to the problems that the women reported. For example, when the women talked about their heavy periods, their physicians referred to the menstrual changes with medical term, 'menorrhagia.' On the institutional level, scientific discourses and practices of the Western biomedical perspectives on menopause have contributed to the evolution of a stereotypic picture of menopause as hormone-deficiency syndrome. Menopausal women are described as irritable, frequently depressed, asexual, and besieged by hot flashes (Dickson, 1990a; 1990b). Also, the extant knowledge of menopause transmits and perpetuates, through the sanctity of science and the authority of the medical "expert," the knowledge and power relations that help

structure and reinforce society's expectations and stereotypes of menopausal women. Therefore, on the institutional level, menopause is medicalized by medical experts under the name of science. On the level of doctor-patient interaction, medicalization of menopause was done as well. The findings indicated that the women did not perceive menopause as a disease, and did not think that menopause would need medical treatments. However, when they visited clinics, their doctors frequently suggested hormone replacement therapy, dilatation and curettage (D&C), and hysterectomy. At the doctor's office, they got 'a disease' that needed to be medically managed.

Koreans usually believe their doctors. They have respect for, and do not challenge the authority of the doctors. Even when they have different opinions on their health problems, they respect doctors' opinions and follow doctors' prescriptions and orders. Considering the doctor-patient relationship in Korean culture, medicalization of menopause by doctors can be frequently accepted silently by women themselves. Indeed, some participants had surgery or took hormones without questioning its use because their doctors recommended it.

Recently, although rates have declined slightly, hysterectomy remains the second most frequently performed surgery in the United States, and it is estimated that 33 percent of U.S. women will undergo this procedure by the time they reach the age of 60 (Scully, 1994). Even though the American College of Obstetrics and Gynecology has acknowledged that the hysterectomy and dilatation and curettage (D&C) have been overused and have issued a set of guidelines regarding appropriate indications for the

procedures, (Scully, 1994) it is questionable if doctors acknowledge and appropriately use the procedures.

Menopause Complicated by Multiple Roles

The findings showed that the women's menopausal experience was complicated by their multiple roles (maternal, marital, and worker). Indeed, researchers have reported that one of the prominent psychosocial factors affecting menopausal experience was roles (Dosey & Dosey, 1980; Polit & LaRocco, 1980; Uphold & Susman, 1985). Recent studies indicate that the psychological processes related to roles were undoubtedly related to the menopausal experience in complex ways. Yet, as Uphold and Susman (1985) asserted, the influences of roles on menopause need to be examined while considering the interrelationships among the multiple roles.

Until recently, only the loss of the maternal or feminine role in menopausal women has been stressed. As Uphold and Susman (1985) asserted, a decline in the maternal role may result in lowered self-esteem, diminished life satisfaction, and increased psychosomatic symptoms in some mid-life women. Indeed, the menopausal period has been regarded as an 'empty nest' period because of its numerous role losses, and the loss of roles has been regarded as contributing to menopausal symptom experience. Consequently, the 'empty nest' concept of menopausal transition has led to an almost singular emphasis on the effects of the child-rearing role on menopausal transition.

However, the findings showed that their multiple roles made women less concerned about the loss of their maternal role. Rather, they felt freedom when their children were independent of them. They said that their responsibilities and obligations as mothers

were finally reduced and they now have more time for themselves. Considering Korean culture, it is understandable how their maternal role had been burdensome, and how their children's independence had brought freedom from responsibilities and obligations.

Another important role, that has been emphasized with respect to menopausal transition, is the marital role, even though studies have critiqued that emphasis on marital role is based on the male-dominant view that the identity of women is linked exclusively to their relationship with men (Fuchs, 1977). In this study, all of the women indicated changes in their marital role during their menopausal transition. Some became more distant while others became closer to their husbands. Even though most participants negated the influences of marital role on their menopausal experience, it was clear that they depended on their husbands during menopausal transition more than ever before. Their menopausal experience was clearly influenced by their marital role.

Work role also complicated the women's menopausal transition. Previous studies have shown the influences of work role on women's menopausal transition. Some studies suggested that employment provided protection against poor health by providing social and environmental support (Birnbaum, 1975; Briggs et al., 1965; Coleman & Antonucci, 1983; Nathanson, 1980; Powell, 1977). Others reported women's health status did not improve after joining the work force particularly in those with traditional role values. Work might create excessive physical demands on women (Livson, 1976). This study supports these findings. New work experience brought physical overloads. The participants who were raised under the strong influences of Confucian culture

silently fulfilled the double burdened tasks and responsibilities while silently accepting the double duty responsibilities.

In short, the women's menopausal experience was complicated by their roles as a mother, wife, and worker. Changes in maternal and marital role were especially salient while their work role was rarely changed during menopausal transition. Work role was more important than maternal and spousal role, and needed to be continued because of their financial insecurity in a multiple transitional status. George (1996) found that South Indian village women who identified themselves as not just wives or mothers but as fish sellers easily experienced their menopause. Considering the importance and continuity of work role during menopausal transition, it can be easily understood why the women were rarely concerned about changes in maternal and marital role and they scarcely perceived the loss of the roles.

Lonely Menopause

Loss of social supports during immigration transition has been relatively well known (Anderson, 1991; Lipson, 1992; Meleis, 1987; Schumacher & Meleis, 1994). Extended families, relatives and friends were left behind in their home country. As immigrants, they lacked friends. Mistrust among Korean immigrants puts them on guard against their friends. When they needed help, there were no friends to be concerned about them or give them a helping hand. Without friends and other social support resources, they experienced their menopause alone.

Korean culture making menopause invisible, also influenced the loneliness of women's menopause. As mentioned before, in Korean culture, it has been regarded as

taboo to talk about menstruation, sex, pregnancy, and menopause in public (Kim, 1993). In Kim's study (1993, p.71), she reported that her Korean research participants refused even to look at pictures showing women's sexual and reproductive organs and child birth in public. Under the influence of Korean culture, the participants in this study rarely share their menopausal experience with others, even their family members, consequently making their menopausal experience lonely.

Neglecting and Ignoring Menopause

As women's health has been generally neglected and ignored, menopausal experiences have been neglected and ignored by women themselves, other family members, and even health care providers. Indeed, the participants viewed their menopausal transition only as an aging process and rarely gave their attention to it. They seemed to minimize the importance of menopause in their lives by emphasizing that menopause came from the normal aging process. Also, their husbands and children rarely considered their menopausal transition as a main critical point of their lives.

One of the factors influencing them to neglect and ignore menopause may be Koreans' attitude toward women's health problems. As discussed in the literature review, Koreans have emphasized the importance of family. In the hierarchical structure of the Korean family system, women have always occupied a lower position. Their lower position in their family system has made their own needs secondary to the needs of other family members. Therefore, women's health problems tend to be regarded as trivial. Indeed, it can be easily heard from Korean grandmothers how they have neglected and ignored their health problems or needs. The following story about a grandmother's

postpartum care was frequently given as a good example of neglecting and ignoring women's health care needs in older generations:

> Well... You may not know how older generation women have suffered.... In the past, women were supposed to work hard even when they were pregnant. Thus, they sometimes delivered their babies in their workplaces such as a rice paddy and kitchen. I heard that... after delivering their babies and cutting the umbilical cord, many women continued to work in the workplace. Before darkness came, they never left their workplaces.... No woman in poor households had good postpartum care. But, they never complained. Rather, they were proud of sacrificing themselves for their families."

Another important contributing factor may be their marginalized status due to their immigration. Because of the marginalization, immigrant women are treated with disrespect—at best as somewhat lesser human beings, at worst with virulent prejudice. They tend to be minimally compensated and lack financial security and governmental support. They suffer from unfriendly neighbors and outright hostility from their immediate communities; and they are frustrated and saddened by constant reminders that they do not belong, which makes their integration into the mainstream even more difficult. They feel stereotyped, misunderstood and set apart, and they lack appropriate and adequate access to health care. Like other immigrant women, their marginalized status might not allow them to concern themselves with their menopause.

Busy schedules and other difficulties related to their immigration and work experiences did not allow them to have their own time. There were many tasks and responsibilities to fulfill. They should adapt to the new environments; they should learn the skills needed for their new jobs; and they should arrange and take care of their children. Their immediate and extended families expected them to maintain the culture

of origin identity and help family members integrate into the educational and social systems of society. They lived with small amounts of income. At the same time, they were faced with a new society, with new values, new norms, and new sets of expectations. Their multiple transitional status certainly put the tasks and responsibilities in priority, and their menopause was put behind.

Health, Symptoms of Menopause, and Their Correlates

Holistic Views on Health

According to Park and Peterson (1991), Koreans perceive health as positive, necessary, and pertinent to both body and mind. This contrasts with a biological orientation and indicates that Koreans hold a holistic view of individuals. Health is attributed to physical, psychological, and spiritual factors. The women perceived their symptoms to be caused by multiple factors: The aging process, poor postpartum care, work-related factors and overwork, nutrition and diet, psychological stress, depression, worry, and pathological changes due to a disease. They especially associated musculoskeletal symptoms and exhaustion with overwork. Gastrointestinal symptoms and headaches were linked to depression, stress, and worry. The women frequently connected their physical symptoms to their mind, and believed that their symptoms came from the mind. For example, 42% of the women who experienced "aches in the back of neck and skull" believed that their symptoms came from psychological stress. Twenty six percent of the women who were experiencing "sick to stomach" believed that their symptoms came from psychological stress as well.

Their holistic views on health and illness came from Korean traditional medicine, which views health as a state of balance. In Korean traditional medicine, the etiology of illness is often based on a state of imbalanced social conduct, and health is related to the effort to keep oneself in harmony, internally and externally (Pang, 1989). The understanding of human physiology and anatomy is holistic and emphasizes the functional interrelationships among major organs of the body. All parts of the body influence one another in the environmental, social, and physiological domains. The signs of illness and the symptoms of disease are interpreted and treated on the basis of the metaphysical and cosmological philosophy that is centered on the concepts of um and yang and the five elements—fire, earth, metal, water, and wood. The immutable course of nature is believed to act through two opposing and unifying forces, um and yang (Pang, 1989). The um force represents the female aspect of nature and is characterized as the negative pole that encompasses darkness, cold, and emptiness (Chin, 1992; Miller, 1990; Pang, 1989). The yang, or male force, is characterized by fullness, light, and warmth and represents the positive pole (Chin, 1992; Miller, 1990; Pang, 1989). The various parts of the human body correspond to the principles of um and yang: The inside of the body is um while the surface is yang; the front part is um, and the back is yang; the five jang—liver, heart, spleen, lungs, and kidney—are um, and the six bo—gallbladder, stomach, large intestine, small intestine, bladder, and lymph system are yang (Chin, 1992; Miller, 1990; Pang, 1989). Diseases of winter and spring are um and those of summer and fall are yang. When um and yang are balanced, the person is living in peaceful

interaction with mind and body and an imbalance of forces creates illness (Chin, 1992; Miller, 1990; Pang, 1989).

Individualized, Culturally Different and Minimized Symptoms

The women's symptom experience can be characterized by its individualization, cultural difference, and minimization. The symptoms experienced by the participants were highly individualized. One woman experienced 103 symptoms and another experienced no symptom. Some women experienced only physiologic symptoms. Other women experienced only psychologic symptoms. Many women experienced only menstrual changes. There were no general patterns in their symptom experience. Rather, their symptom experience can be characterized by individualization.

The women's symptom experiences were different from those reported by Western women and Korean women in Korea (Neugarten & Kraines, 1965; Im, 1994). The women in this study were less likely to experience so-called menopausal symptoms. For example, the most frequently experienced symptom among Western women (50%) is hot flash (McKinlay et al., 1992). Yet, studies have shown that Eastern women are less likely to experience 'hot flash' than Western women. In a study by Chang and Chang (1996), 12% of the Chinese women participants experienced hot flashes and sweats. In a study by Chirawatkul and Manderson (1994), 23% of Thai women participants experienced hot flashes and sweats. In this study, only 12% of the 119 participants experienced hot flashes and sweats.

The types of symptoms that the women in this study experienced were different from those of Western women. Generally, the menopausal symptoms included those that

could be regarded as vasomotor, somatic/physiologic, and psychological in a clinical context (McKinlay et al., 1992). Recent research among Western women has shown that the most prevalent menopausal symptoms included only vasomotor symptoms such as hot flash and cold sweats (Berkun, 1986; Bungay et al., 1980; McKinlay & Jefferys, 1974). Yet, in this study, the three most prevalent symptoms were 'glasses to read (58%),' 'aches in the back of neck and skull (55%),' and 'complete exhaustion (48%)' (Table F3, Appendix F). Indeed, participants rarely experienced vasomotor symptoms such as hot flashes and sweats (12%), dizziness (10%), and night sweating (8%) compared with Western women (Table F3, Appendix F).

The symptoms that the women experienced were minimized in several ways. First, in Korean language there is no exact term referring to 'hot flash' as in Japanese language (Lock, 1986b). Therefore, when referring to a 'hot flash', many terms have been used in the studies of menopause in Korean women: 'Yulgam,' 'Ulguli-Hwakeun,' 'Gaseumeurobuta-Yuli-Olaonda,' and so on. When using these terms, the symptom 'hot flash' could not be reliably or accurately measured. Indeed, it was found that some women answered 'no' to the question of 'hot flash' because they thought that it was facial flushing.

Second, the terms 'Gangnyunki' and 'Pekyungki' minimized the symptoms experienced during their menopausal transition. As mentioned earlier, Gangnyunki is perceived to be related to the aging process while Pekyungki is perceived to be only related to menstrual changes. Therefore, Gangnyunki symptoms are perceived to be a variety of physiological or psychological symptoms that are commonly connected with

aging while Pekyungki symptoms are perceived to be only menstrual changes and the related minor symptoms such as menstrual pain and irritability. By limiting the Pekyungki symptoms, the symptom experience during menopausal transition was minimized.

Third, the symptoms were minimized under the strong influences of Korean culture stigmatizing psychological symptoms. Many did not report any psychological symptoms at all. Since Korean culture stigmatizes psychological problems, participants might be hesitant to answer the questions on psychological symptoms. It was also possible that they converted their psychological problems into some vague physiological symptoms such as headaches, stomach ache, diarrhea, constipation, or exhaustion. The somatization could conceal psychological symptoms under the veil of a physical symptom.

Interestingly, the most prevalent diseases were musculoskeletal, which were perceived to be caused by their work or work-related factors, not by menopause. Considering their multiple transitional status as immigrant women workers, it is understandable that they frequently experienced musculoskeletal symptoms, and associated the symptoms with work-related factors and overwork. Because many of the women were employed in unskilled labor (e.g., private household workers, baby-sitters, factory workers) and worked overtime with two or three shifts, overwork and other work-related factors were certainly threatening their health. Furthermore, their workplace conditions were likely detrimental to their health (Boyd, 1984).

Neglecting and Ignoring Symptoms

The women neglected, ignored, and endured their symptoms for a long time and put their health care needs behind other imminent family needs for plausible reasons. First, most women did not view the symptoms as serious because they usually connected their symptoms with life events (retirement, children leaving home, financial problems, spouse's death, children's independence, family matters, and interpersonal conflicts) or degenerative changes from aging rather than with pathological etiologies. Consequently, they usually believed that their symptoms would disappear after they resolved the current conflicts and troubles. Or, they thought that they should live with the symptoms until their death because aging brought the symptoms. They believed that the symptoms could not be effectively managed if the symptoms came from the aging process, and the symptoms would continue regardless of any management efforts.

Another reason for ignoring symptoms was the belief that the symptoms were temporary. This influenced the meanings of the symptoms with an expectation that the symptoms would end soon. For example, when one of the woman experienced 'aches in the back of neck and skull,' she did not manage the symptom because her friends informed her that the symptom would be temporary and go away after menopause.

A third reason for neglecting or ignoring symptoms was that they regarded the symptoms as normal and appropriate changes for women's lives. Since menopause was regarded as a natural event in a woman's life, changes associated with the natural event were not regarded as serious health problems. Only when the changes affected a woman's daily life so that she could not work as usual, did she seek help from either a

traditional or Western doctor. For example, since sexual inactivity was regarded as appropriate in older people, and loss of libido with aging was regarded as both natural and appropriate, no perimenopausal or postmenopausal women sought help for this.

Strategies for the Symptom Management

The participants used multiple strategies to manage their symptoms. Sometimes they just lived with the symptoms, and they frequently combined different types of management strategies for one symptom. The severity, perceived causes, and meanings of the symptoms tended to determine the management strategies for the symptoms.

When the symptoms were so severe that the women were not able to work, they visited clinics to get medical help. When the symptoms were tolerable, they did not seek medical help. When asked why they did not manage the symptoms, many answered "because the symptoms were not severe." Because their symptoms were tolerable, they meant nothing special to them even though the symptoms could indicate potentially serious health problems.

When they associated their symptoms with work-related factors and overwork, rather than seek medical help, they managed the symptoms with rest, avoiding overwork, changes in the type of job, and changes in body postures and positions. Because they thought that their symptoms would continue as long as they worked, they believed that the most effective way to manage the symptoms might be to quit their job. However, in reality, it was impossible for them to quit the job, so they changed the types of job tasks, body postures and positions during work, and allowed more time for rest. In a sense,

their health care needs were met by the changes. However, in the sense that their symptoms would be potentially serious, their health care needs were only partially met.

When the women viewed symptoms as relating to the aging process, they used Korean traditional medicine rather than other medical help. As discussed in the part of literature review, Korean traditional medicine emphasizes the harmony and balance of um and yang, and helps women to preserve their vital energy, ki. Aging is believed to deplete the vital energy, ki. To restore the vital energy, Korean traditional medicine was usually chosen to manage the symptoms.

Self help measures were used to manage symptoms that they perceived to be caused by aging process. These measures included: Diet control; exercise; keeping cool; layered clothing; avoiding large meals, caffeine, alcohol and strong emotions; and taking Vitamin E, ginseng, Vitamin B complex, and nutritional supplements. Self help measures were frequently reported to be used in managing menopausal symptoms in other studies (Adams, 1986; Greenwood, 1984; Scharbo-DeHaan & Brucker, 1991). According to Greenwood (1984), keeping cool, wearing layered clothing, avoiding large meals, caffeine, alcohol, and strong emotions, and drinking cool beverages can assist women in coping with hot flashes. According to Adams (1986), the use of Vitamin E has also been reported to relieve hot flashes. The herb ginseng was reported to increase feelings of well-being and contains small amounts of estrogen (Greenwood, 1984). However, prolonged use of ginseng has been known to cause hypertension (Greenwood, 1984). According to Scharbo-DeHann and Brucker (1991), Vitamin B complex is useful in controlling hot flashes through acting to detoxify and eliminate FSH. FSH increases as

estrogen decreases, causing a shortening of the menstrual cycle. Diet and exercise are most commonly recommended to decrease skeletal system changes (Peden & Newman, 1993). A diet of vegetables, whole grains, fruit and foods high in calcium provides necessary nutrients and can result in an increase in energy, weight stabilization, healthy hair, skin and gums (Greenwood, 1984; Peden & Newman, 1993). Exercise with adequate dietary calcium can build bone and slow bone loss (Adams, 1986; Peden & Newman, 1993).

For emotional symptoms perceived to be related to psychological stress and tense, the women tried to change their mind and think in optimistic ways, calming themselves through praying or diverting their attention to other activities such as exercises, taking a walk, or other group activities. For physical weakness such as "complete exhaustion," they took vitamins and minerals, exercised, took walks, and ate nutritious foods.

Influences of Ethnic Identity on Symptom Experience

The participants had very strong ethnic identity as Koreans—96% of the participants defined themselves as Koreans. This is understandable since the participants were first-generation Korean immigrant women most of whom came to this country after they had been raised in Korea. Considering the high number of Korean ethnic businesses, ethnic community activities, and ethnic churches, they might have little contact with other than Korean-Americans in their daily lives. Consequently they are isolated from the main stream of their new country. If an immigration transition begins with preparing to move to another country and ends with being an integrated member of a new community, then this group of participants is still in a transition process. They

geographically moved, but they continue to maintain strong ties to the Korean community.

The findings indicate that there was no difference in the population mean total number of physiological, psychological, menopausal and total symptoms between three different ethnic identity groups (see Table 10, 11, 12, & 13). One of the reasons why the population mean total number of the symptoms did not differ by ethnic identity may be the small sample size within groups identified as Americans and Korean-Americans. Due to their strong ethnic identity as Koreans, the participants could not be differentiated into several groups according to their ethnic identity. To explore the differences in the total number of symptoms by ethnic identity, more participants who define themselves as Korean-Americans or Americans and speak English need to be included.

Another reason may be that ethnic identity could not effectively measure their immigration transition at all. Most of the women who participated in this study (96%) identified themselves as Koreans, and only 4% identified themselves as Korean-Americans. However, some of the women who defined themselves as Koreans might have already gone through their immigration transition while still identifying themselves as Koreans. Others who are more recent immigrants could identify themselves as Korean-Americans with the expectation of an easy adaptation. Moreover, preferences in foods, music, customs, close friends, and language were not useful measures of immigration transition. In fact, Korean women who have spent more than 20 years in the U.S. still preferred Korean foods, music, and customs. However, they could hardly be considered to be still in the process of immigration transition.

As the findings showed, yet, the population mean total number of physiological ($p=.05$), psychological ($p<.05$), menopausal ($p=.01$), and total symptoms ($p=.02$) was statistically significantly different between the women who have lived less than 10 years and those who have lived more than 10 years (refer to Table 10, 11, 12, & 13). The length of stay in the U.S. might measure the women's immigration transition more adequately than the questions on self ethnic identity, preferences in foods, customs, friends, and language. However, it should be also considered that some women who had lived in the U.S. more than 10 years also did not feel comfortable in living in the U.S. They still had problems in their daily lives due to language problems and cultural conflicts, and wanted to go back to Korea before they would become too old.

A third reason can be that, really, there is no difference in symptom experience of menopause by immigration transition. However, the possibility of the third reason is not likely. Immigration transition brings tremendous changes in women's lives: Changes in language, occupation, socioeconomic status, social support systems, roles, and so on (Meleis, 1987; Lipson & Miller, 1994; Nelson, 1995). With the tremendous changes due to immigration, the women's symptom experiences could not help being influenced by immigration transition.

Influences of Work Satisfaction on Symptom Experience

Approximately one third of the participants were unsatisfied with their work in terms of financial aspects, job tasks, self accomplishment, and job tasks. Considering the negative attitude of Koreans toward low income jobs, it could be easily understood why many participants were unsatisfied with their work. Koreans stigmatize low income labor

jobs because of their strong Confucian background ignoring and devaluing physical work. It seems that the negative attitude toward low income jobs strongly influences their work satisfaction in negative ways.

Their work satisfaction was different only according to age ($F=2.29$, $p<.10$), education level ($F=4.27$, $p<.05$) and family income ($F=6.64$, $p<.01$). Older women tended to be less educated or ambitious about their future than younger women, and they were more likely to be satisfied with their work. Perhaps older women were more easily satisfied with their current status because of their age. Moreover, the fact that they could work and contribute to their family income might influence them to be psychologically satisfied with their work. Higher family income could compensate for the negative attitude toward low status jobs and subsequently influence work satisfaction in a positive way. Usually, dreams of immigration are connected to financial success, so higher family income easily motivates them to work and be satisfied with the work.

There was a significant difference in the population mean total number of the symptoms by level of work satisfaction (see Table 10, 11, 12 & 13). The significant difference showed that the symptom experience of the women during their menopausal transition was influenced by their work experience. In negative or positive ways, their work satisfaction influenced their symptom experience—psychological or physiological.

Relationships with Other Correlates

The total number of physiological, psychological, and total symptoms differed by self reported health status. Women who had more symptoms perceived their health status as negative, and the women who perceived themselves unhealthy complained more of

symptoms ($F=8.37$, $p<.01$). This agrees with the findings of Abe and Moritsuka (1986), in which women who reported a higher number of menopausal symptoms tended to view themselves as being in poorer health than women with fewer or no symptoms.

The finding that the total number of psychological symptoms differed by family income ($F=3.96$, $p<.05$) agrees with the findings of previous studies (Dosey & Dosey, 1980; Greene & Cooke, 1980; Severne, 1979; Van Keep & Kellerhals, 1975). Low socioeconomic status women are more likely to complain menopausal symptoms. Considering that an immigrant's psychological stress commonly comes from financial problems and their dreams of immigration commonly mean financial success (Lipson & Miller, 1994; Nelson, 1995), it can be easily understood that family income is significantly related to psychological symptoms.

The significant difference in physiological symptoms by education level can be understood when considering that higher educational level is commonly associated with socioeconomic status before immigration. Higher socioeconomic status frequently means better health, better nutrition, more money, and more opportunities. Additionally, even though their education was rarely acknowledged in this new country, higher pre-immigration socioeconomic status leads better opportunities and possibilities in this new country. The women who had higher education might understand English better than others with lower education, and a better understanding of English might provide more opportunities and less stress.

Immigration, Work, and Menopausal Transition of Korean Immigrant Women

As shown in the previous discussion, the women neglected and ignored their menopausal transition within a gendered multiple transitional context. Menopause rarely meant something important to these women, and their menopausal experience was only a very small part of their daily experience. This agrees with the findings of Martin (1987).

Their neglecting and ignoring menopause can be explained in several ways. First, as the findings and discussion on the meanings of menopause showed, menopause was equated only with the stop of menstruation and simplified as a biological event among the women. When gender is equated with biological sex, the women should behave, think, feel and be like women because they are biologically women (Kim, 1993). The women perceived menopause as a natural event that should be gone through by women because they were women. Consequently, the women put little importance on their menopausal experience because they regarded it as a natural women's experience.

Second, as shown in the discussion on women's transitional experiences, the context of multiple transitions required them to fulfill a variety of roles, and the responsibilities from the roles made them sacrifice their energy, money, and time. Many studies describe the hazards of multiple roles and suggest that stress from multiple roles and lack of support have a negative influence on women's health (Greenhaus & Beutell, 1985; Voydanoff & Donnelly, 1989). Indeed, the women rarely had time and energy for themselves or leisure activities, and the lack of time and energy made them neglect and ignore their menopause within their daily lives. Their busy schedules, lack of resources, other imminent life events, and cultural heritage rarely allowed them to concern

themselves with menopause. As one research participant said, only the women who have time can afford to think and give attention to their menopause.

Third, the findings indicate that the three transitions that the women were concurrently experiencing were highly differentiated by the women. The women put more importance on immigration transition and work transition than menopausal transition. Even when they had symptoms during their menopausal transition, their menopausal transition hardly meant anything to them. Rather, their difficulties due to the symptoms in work transition made them seek help. Indeed, stress from immigration and work was more imminent and visible to them, so menopause could not be a big part of their lives. Consequently, the differentiation of menopause from other multiple transitions contributed to making menopausal experience neglected and ignored by the women.

Fourth, menopausal experience was embedded in a gendered context that devalues women's experiences, including menopause. The findings agree with the feminists' opinion on menopause: Menopause is an oppressed, neglected, and ignored body experience, and is envisioned as a taboo subject, veiled in secrecy and silence, in which women's rights are suppressed in the name of biology. (Delaney et al., 1988; Dickson, 1990b; MacPherson, 1981; 1985; Martin, 1987; Weideger, 1976). Indeed, the women lived in macroscopic and microscopic gendered contexts. Within this context, menopause could not be given much attention, and the women frequently neglected and ignored their menopause.

Fifth, the women put their own health care needs behind their family members' needs, especially male members' needs such as son's tuition and husband's financial crisis. Even though they unconsciously did so, their symptom experience during menopausal transition was found to be certainly a gender-discriminated, neglected, and ignored experience. Because they were women, their Confucian patriarchal heritage made them behave, think, feel, and be like women and frequently required them to sacrifice themselves for their families (Cho, 1987; Kim & Hurh, 1987). Consequently, they put their families ahead and their own health care needs behind while neglecting and ignoring menopausal experience.

Finally, it was clear that the woman's menopausal experience was a hidden, inaudible, and invisible experience in her daily life because of her cultural background. The women rarely talked about body experience such as menstruation, sex, pregnancy, and menopause directly in front of others. Even among family members, it was taboo to talk about the bodily experience directly. Their stoic attitudes toward symptoms and stigmatization of psychological symptoms made their menopausal experience invisible, neglected and ignored.

CHAPTER VII

Summary and Conclusion

Summary

This study explored the menopausal experience of low income Korean immigrant women emphasizing the multiple transitional context with a comprehensive view based on transition theory and feminist perspectives. The data analysis focused on the following research questions: What are the meanings of menopause to low income Korean immigrant women? How is their symptom experience? and What is the context within which they were experiencing their menopausal transition?

To ground the exploration, women's immigration and work transitions were explored. Their living environments were characterized by dangerous neighborhoods, easy access to Korean ethnic businesses, a variety of Korean ethnic community activities, and an increasing number of Korean ethnic churches. Study participants had a very strong Korean ethnic identity. Their immigration experience was characterized by three themes: Women should be women; women are slaves; and they cannot trust Kyopo (Korean immigrants). Their work transition was shaped by their daily experiences. About half of them were satisfied with their work, and their work satisfaction was significantly different according to age and family income. Two themes about their work transition were found: Anil (works inside house) is women's work; and they work like ants.

The findings on the women's menopausal transition indicated six themes: Shocked menarche; Gangnyunki and Pekyungki, Pekyung, the end of womanhood; middle-age or

falling down the hill; an ambivalent transition; and menopause, a transition within transitions. All of these themes suggested that the women's menopausal experience was characterized by neglecting and ignoring it within a gendered multiple transitional context. Because of their busy schedules, difficulties, and hardships in daily lives, they rarely gave attention to their menopause. They did not have any room for menopause, consequently neglected and ignored their menopausal transition. Also, their menopausal experience was complicated by multiple roles. Their menopause was a lonely experience that they felt they should go through by themselves.

Their symptom experience during menopausal transition was examined in relation to other variables. There were several findings in these areas. The women had holistic views on health and illness. They did not separate body and mind. They perceived that their symptoms came from multiple etiologies. Their symptom experience was different from other cultural groups of women. They were less likely to experience Western established menopausal symptoms documented for Western Caucacian. The types of symptoms that they experienced were different from other cultural groups of women. They individualized and minimized their symptoms. They did not medicalize menopause, but neglected and ignored their symptoms. They used multiple strategies for their symptoms. The severity, perceived causes, and meanings of the symptoms determined the type of management strategies.

A common theme from the findings was that they neglected and ignored menopause within the context of their gendered role and multiple transitions. Menopause was differentiated from other transitions, and embedded within the gendered multiple

transitional context. Given the lowest priority, menopause was hidden, inaudible, and invisible due to their cultural background.

Implications

Theoretical Implications

In this study, the theoretical framework suggested by Schumacher and Meleis (1994) was adopted and used in reviewing literature and explaining the women's menopausal transition throughout data collection and analysis. Yet, it could not adequately explain the women's menopausal experience characterized by neglecting and ignoring their menopausal transition among low income Korean immigrant women within a gendered multiple transitional context. This theory could not explain why the women's menopausal transition was regarded only as a biological event while importance was given to other transitions. It does not account for how the women experienced their menopause concurrently with multiple roles as women, middle-aged Koreans, immigrants, and workers. It does not explain how their low socioeconomic status influenced them to have no time for themselves; how their gendered context influenced their menopausal experience; why they put their health care needs behind other family members' needs; why they insisted that menopause meant nothing to them; why these women did not manage their symptoms at all; and how their menopausal experience was hidden, inaudible and invisible in their daily lives.

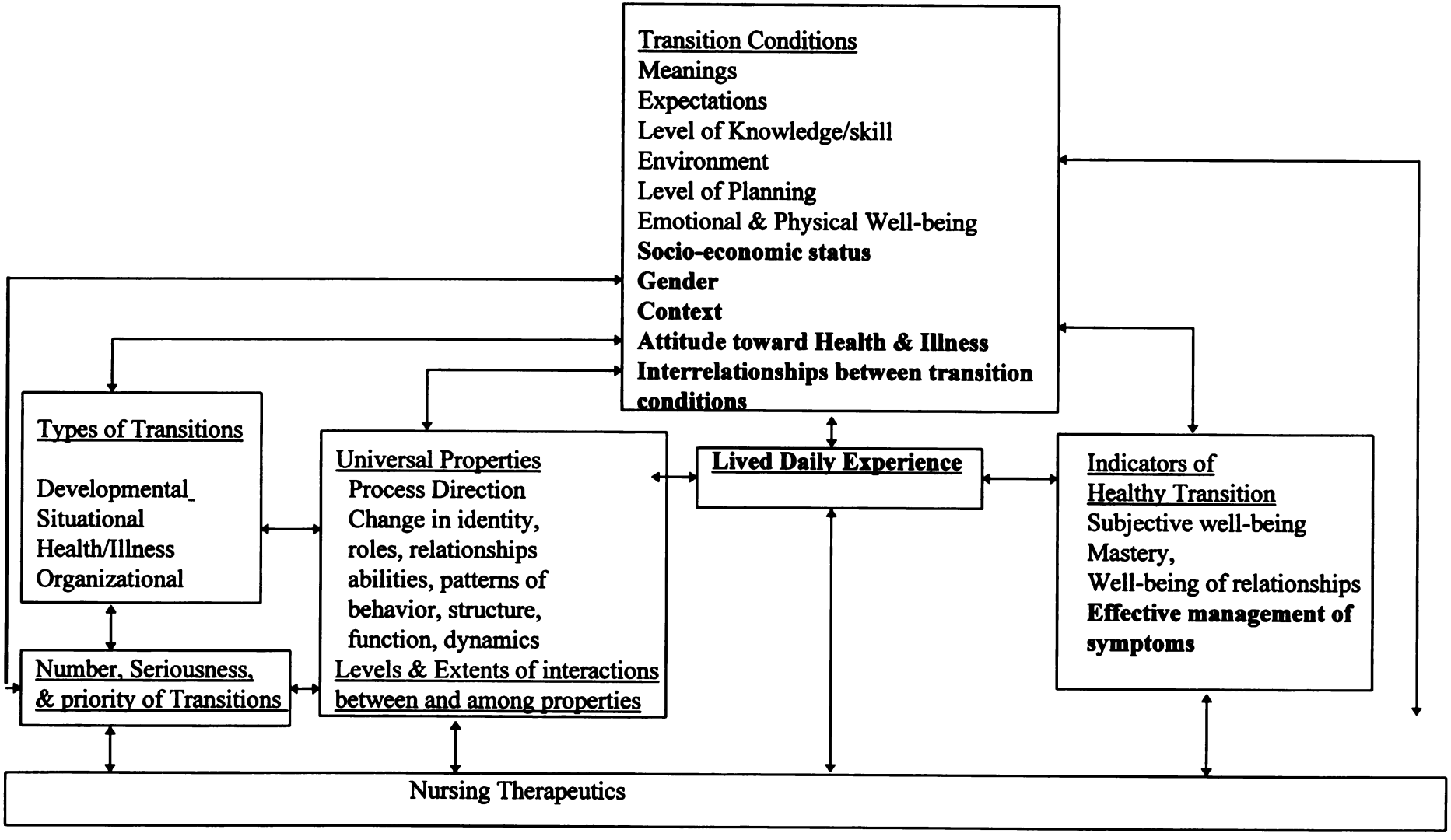
Considering the inadequacy of the theory for this phenomenon, some additions and changes in the theoretical framework by Schumacher and Meleis (1994) are made, and a

modified theoretical framework is suggested for better explanation of menopausal transition of vulnerable women in the context of multiple transitions (Figure 3).

Number, seriousness, and priority of transitions. In investigating multiple transitions, it is noticeable that the number, seriousness, and perceived priority of each transition are more important than the type of transition. In the transition theory model by Schumacher and Meleis (1994), transitions are only characterized by the type of transitions: Developmental, situational, health/illness, and organizational. However, as the findings of this study showed, for explaining multiple transitional experience of women, the number, seriousness, and priority of transitions as well as the type of transitions need to be incorporated in the model. Indeed, the research participants did not place much importance on their menopausal transition because of other two imminent and important transitions that they were concurrently experiencing in addition to menopause. Because the difficulties and troubles in their daily lives as immigrants and workers were more serious and significant to them, menopause rarely meant much to them. For studying menopausal transition within a multiple transitional context, the number, the seriousness, and the importance of each transition need to be considered.

Levels and extents of interactions between universal properties of transitions. Women's menopausal transition certainly brought changes in their identities, roles, relationships, abilities, patterns of behavior, structure, function, and dynamics. Also, their menopausal transition was a dynamic process rather than a static experience, and had a direction toward later life. Yet, there was one thing missing regarding the universal properties of transition in the theoretical framework: Transitions bring changes in the

Figure 3. A Nursing Model of Multiple Transitions



interactions between multiple identities, roles, relationships, abilities, patterns of behavior, structure, function and dynamics. Considering the changes as isolated entities, menopausal transition could not be fully explained. The levels and extent of the interactions between and among the universal properties need to be incorporated into the model.

Indeed, the results and discussion showed that the women's menopausal transition brought changes in the levels and extent of the interactions between and among their multiple identities. For example, the women's menopausal transition brought changes in their identities as mothers and spouses, but not in their identity as workers. Since their immigration and work transitions made them place more importance on their identity as workers (financial problems were usually more imminent than other problems), the changes in their identities as mothers and spouses rarely influenced their menopausal experience. Also, because they did not place much importance on spousal role, their infrequent sexual relationships with their husbands did not mean much to them. As George (1996) showed in her study, the levels and extent of the interactions between the changes in the identities have more influence on women's menopausal transition than the identity changes themselves.

Additional transition conditions. Transition conditions (Schumacher & Meleis, 1994) include meanings, expectations, level of knowledge and skill, environment, level of planning, and emotional and physical well-being. Yet, the women's menopausal experience was complicated by other transition conditions that are excluded from the

model: Socio-economic status, gender, context, attitude toward health and illness, and interrelationships between transition conditions.

The findings showed that the women's experience of psychological symptoms was significantly affected by their socio-economic status rather than menopausal states (see Table 12). As other studies have shown (Abe & Moritsuka, 1986; Ballinger, 1985; Greene, 1983; Schneider & Brotherton, 1979; Severne, 1979; Uphold & Susman, 1981), the participants who were in low socio-economic status were more likely to experience psychological symptoms. To understand women's menopausal experience in context, their socio-economic status needs to be considered.

Another transition condition that is missing in the framework is gender. The women experienced their menopausal transition influenced by their gendered transitional context. As mentioned previously, their daily lives were characterized as microscopic and macroscopic gendered experience (Cho, 1987; Kim & Hurh, 1987; Kim & Hurh, 1988; Light & Bonacich, 1988). Therefore, viewing menopausal transition without considering gender issues embedded in their daily experience cannot be adequate. For example, in patriarchal Korean culture, women's lower position in their family structure is relatively well known (Cho, 1987). When not considering the women's lower position, it could not be adequately understood why they put their own health care needs behind other family members' needs and why the women sacrifice them for their family members consequently having no time for themselves. Therefore, as a transition condition, gender is suggested.

A third transition condition that needs to be incorporated in the model is context. Even though the model includes environment as a transition condition, the concept of environment does not adequately address the concept of the context in which the women experience their menopausal transition. In fact, the mixture of cultural, social, political, historical, and psychological contexts cannot be simply included in the concept of environment. Context is more than the sum of the environments. Understanding the independent and interactive effects of the social, cultural, psychological, and biological changes within context is crucial for understanding women's unique menopausal experiences. As McBride and McBride (1981) posited, women's health cannot be fully understood without intertwining physical and psychological well-being determined by the context in which the individual operates. The results of this study emphasize context by showing that the women neglected and ignored their menopausal transition under the strong influences of cultural attitude toward women's health and the importance of family in priority. Viewing their menopausal transition without considering context draws a conclusion that their menopausal transition meant nothing special and no important changes occurred during their menopausal transition. However, in considering the context within which they were experiencing their menopause with a comprehensive view, one cannot draw that simple conclusion. There were salient reasons for their neglecting and ignoring their health care needs. Context is proposed to be an important transition condition.

A fourth transition condition is the attitude toward health and illness. In the model (Schumacher & Meleis, 1994), emotional and physical well-being is included as a

transition condition, but the attitude toward emotional and physical well-being is not included in the transition conditions. However, as the results showed, the women's menopausal transition was influenced by their attitude toward women's health problems and psychological symptoms. Since women in Korean culture tended to regard it as a shameful behavior to talk about women's health problems in public (Im, 1994), they silently went through their menopause by themselves and their menopausal experience became a lonely experience. Also, the stigmatization of psychological problems was indicated. They rarely reported psychological symptoms. Rather, they somatized their psychological conflicts into physical symptoms such as headache as other Asians frequently do (Spector, 1985). Therefore, in explaining women's menopausal transition, attitude toward health and illness needs to be incorporated.

Finally, the interrelationships between the transition conditions need to be incorporated in the model as a transition condition. Transition conditions were mingled and weighted according to their importance. In some cases, socio-economic factors were more important than other transition conditions in their menopausal transition. In other cases, the meanings of menopause were more important than others. Sometimes, the socio-economic factors and the meanings of menopause were equally important in their menopausal transition.

Effective management of symptoms as an indicator of successful transitions. Within the transition framework (Schumacher & Meleis, 1994), subjective well-being, mastery, and well-being of relationships are included as indicators of successful transition. Yet, effective management of symptoms can be an indicator of successful

menopausal transition. As the results and discussion of symptoms showed, the women neglected and ignored their symptoms because of several reasons. However, as discussed before, some symptoms that they experienced could be serious potential health problems (Gorrie et al., 1994). To have successful menopausal transition, it is essential to prevent health problems and promote their health through effective management of the perceived symptoms. In other words, successful menopausal transition can be indicated by effective management of potential and actual health problems. However, it does not mean that neglecting and ignoring symptoms are always negative management strategies. Except the serious potential health problems, most of the symptoms experienced during the menopausal transition are normal and do not need to be medically managed. Therefore, neglecting and ignoring symptoms can be an effective management of some symptoms in a way.

Clinical Implications

Based on the three nursing measures suggested by Shumacher and Meleis (1994)—assessment of readiness, the preparation for transition, and role supplementation—the findings of this study suggest the following clinical implications for appropriate management of menopausal symptoms and facilitation of healthy menopausal transition.

Women-centered assessment. As the findings of this study show, women's explanation of their symptoms is different from that of nurses or other health care providers. Without considering women's own explanation of menopause and symptoms, their health care needs cannot be adequately assessed. For example, in this study, many women did not associate their symptoms with menopause but rather with aging.

Therefore, when assessing the symptom experience during menopausal transition, health care providers cannot adequately assess their symptom experience with the questions on 'menopausal symptoms.' Rather, the question, 'What symptoms have you experienced during the past 6 months?' may be more appropriate to assess their symptom experience during menopausal transition. Hence, when assessing health care needs of women in menopausal transition, women's own explanation should be placed in the center of the assessment process.

Adequate information and participatory decision making. In general, Korean health care providers often fail to provide their clients with enough information regarding management of health problems including menopausal symptoms. Especially regarding menopausal symptoms, the health care providers, especially male physicians, rarely provide adequate information to their clients. Explanations in medical terms without considering comprehension by women are the typical miscommunication pattern (Lack & Holloway, 1992; Rosenberg, 1993). Indeed, the findings showed that the women rarely had adequate information on menopause and were hardly informed about medical treatments with which their symptoms would be managed.

As a nurse providing nursing care to women in menopausal transition, the information needs of their clients should be assessed, and it should be ensured that enough information is delivered to their clients. The more women know about menopause, hormone therapy, and alternatives, the better they will be able to make informed decisions regarding management of their symptoms. Therefore, nurses must educate women that menopause is a positive experience for most women, and provide

specific information to women clients regarding menopause, menstrual changes, management strategies and advantages and side effects of the management strategies. Also, public education campaigns are needed to inform women of the significance of symptoms that could seriously impact their health and the benefits of early detection and treatment of problems. Efforts should also be directed toward minimizing the barriers to accessing health care.

With adequate information, women need to be involved in the process of decision making on management strategies as well. Successful management of their symptoms requires partnerships between women and health care providers. More involvement of women in the planning of their management of health problems, including symptoms related to menopause, is desirable because participatory planning allows for the clear identification of demands and needs that must be met.

Also, their neglecting and ignoring symptoms should not be viewed as a negative management strategy. Rather, medical treatment of the symptoms experienced during menopausal transition should be carefully decided with the women because some of the symptoms can be normal and possibly medicalized by health care providers.

Using family as resources. This study showed that family members were the only people in this new country that the women trusted and depended on during their menopausal transition. Family was the most valuable source of social support for the women. Therefore, as other studies have suggested (Ballinger, 1985; Crawford & Hooper, 1973; Dosey & Dosey, 1980; Greene, 1983; Schneider & Brotherton, 1979; Severne, 1979; Uphold & Susman, 1981), efforts need to be made to involve their family

in the process of the management of menopausal symptoms and explore how to use family members for the effective management of menopausal symptoms. Also, assessing the women's kinship relations and identifying authoritative family members are essential for nurses to effectively use influential family members and achieve therapeutic goals (Sawyers & Eaton, 1992). Yet, it should be considered that Korean women would be unwilling to talk about their reproductive health problems in front of their sons and husbands.

Developing menopause self-help groups. With the woman's health movement, self help groups for menopausal women have been developed by several women's health centers in the United States (Ruzek, 1978). Participation in a menopause support group is one way in which women can garner the support and encouragement needed as they make this life transition (Peden & Newman, 1993). As in other women's self-help groups, the basic issue is control of one's own body and women themselves, instead of the usual male gynecologists or psychiatrists, assume the role of menopausal experts.

Among the immigrant women, self-help groups have rarely been developed and they scarcely get information on menopause from other women, health care providers, or other resources. As the findings and discussions showed, lack of information on menopause was an important issue of their menopausal transition. Through developing menopause self-help groups, experiences can be shared, and they can get control of their own body, ultimately making their menopausal experiences positive life experiences.

Research Implications

Searching for the missing parts. So far, virtually nothing is clearly known about menopausal experiences, especially of marginalized groups of women. In future research, missing parts in the picture need to be investigated to develop an integrated picture of menopause as a whole. Menopausal experience of marginalized groups of women is quite different from others at the margins of their society. The differences in menopausal experiences according to their marginality, which is frequently represented by social class need to be further studied to explore the relationships between socio-psychological factors and menopausal experiences within the context of mid-life.

Second, gender issues embedded in menopausal experiences need to be further explored. This study showed that low income Korean immigrant women were experiencing their menopause within a gendered multiple transitional context, and gender issues were deeply associated with their menopausal experiences. As Martin (1990) asserted, men's and women's social roles themselves are grounded in nature, by virtue of the dictates of their bodies in current society, and women are intrinsically closely involved with the family where so many 'natural,' 'bodily' (and therefore lower) functions occur. Therefore, to understand women's body experience including menopause, gender issues embedded in their familial and societal environments need to be considered to ground the exploration.

Third, the impacts of interpersonal relationships on menopause have been rarely known. Yet, this study revealed that the interpersonal relationships in the lives of participants were important in their menopausal transition. Lack of social support during

their menopausal transition was noted, and high participation in the ethnic community and churches was found. Even though the women frequently negated their ethnic community and church friends' impacts on their daily experiences, influences of the ethnic community and church friends on their menopausal transition certainly existed. In future research, the meanings of ethnic community and churches as social supports and resources in immigrant women's menopausal transition need to be investigated further.

Searching for meanings in lived experience. This study presented the meanings of menopause, immigration, and women's work. Meanings were deeply associated with the women's menopausal experience and critical in understanding their menopausal experience. Yet, most previous studies on menopause have focused on only the description of their experience or enumeration of the related factors without searching for the meanings of their experience. Considering the lack of knowledge on meanings, future research needs to further explore the meanings in the lived experience of diverse groups of women.

To search for meanings, emic perspectives may provide more appropriate approaches. Most of the previous studies on Korean immigrant women have been conducted with the etic approach. Studies have focused on gathering concrete data on sociocultural variables for the purpose of describing immigration experience or health/illness experience in a way that can be generalized for health policy planning. However, health policy must be informed by meanings as well as numbers. As this study showed, concrete data on sociocultural variables rarely explained the meanings of menopause, immigration and women's work while qualitative data based on in-depth

interviews provided rich explanations regarding meanings. As many feminist scholars posit, analysis of a lived experience and other qualitative research methods are appropriate approaches for uncovering the meanings of particular experiences (McBride & McBride, 1981; Woods, 1988).

Policy Implications

Challenging traditional attitudes toward women and their bodies. Until very recently, women's health issues have not been part of the public policy agenda. With the women's health movement, the sensitivity to this reality has been growing (Jones, 1994). However, a relatively small investment is allotted by the National Institute of Health (NIH) for basic research on women's health care needs (Sheehy, 1991; Solomon, 1991). The discriminatory politics of women's health are being challenged not only by women's health activists but by female health professionals and lawmakers through grassroots and consumer-driven political activism (Neus, 1993; Jones, 1994). These efforts have played an important role in raising public consciousness of the health needs of women fueling social change and challenging traditional attitudes about women and their bodies.

Yet, the efforts have been limited toward mainstream women while isolating women in the margins (i.e., immigrant women and women of color). As the findings of this study showed, under the strong influences of patriarchal culture, immigrant women from the Eastern culture tend to ignore and neglect their health problems. They rarely seek help for their symptoms. Rather, they take it for granted to leave their own health care needs behind and put their family matters in priority. For social and policy change, consciousness raising efforts must focus on changing traditional attitudes about women

and their bodies, especially as they relate to the transition of menopause. Furthermore, the discriminatory politics of women's health among immigrant women and women of color should be challenged through women's group activities, health professionals and lawmakers.

Changing health care services to women. This study showed that the women were the active agents who chose to visit clinics, or to monitor their menstrual changes or other symptoms. However, when they visited clinics, they became passive patients who followed their physicians' orders and prescriptions. They were often treated with hysterectomy, dilatation and curettage (D&C), or hormone replacement therapy without involving themselves as active participants in their health care and the treatments were frequently perceived as unnecessary.

To decrease unnecessary costly and invasive therapies and to increase informed choice in the selection of medical treatments, providers must change their approach to the delivery of medical services to women. Women must be involved in their own health care and broader utilization of nonphysician women health workers in primary care needs to be made. Involving women in their own health care would assure effective management of health care needs without unnecessary medicalization of the menopausal experience.

Delivering adequate knowledge on menopause. An inadequate awareness of women's health needs is salient among this group of women. One of the reasons for inadequate knowledge was biased information. Even though the magnitude of health problems related to menopause in Korean women has not yet been investigated,

television programs, Korean newspapers, and articles in Korean women's magazines imported from Korea are widely read by Korean immigrant women and have described menopause as a 'crisis' stage of middle-age for which women should seek medical advice. Hormone replacement therapy has been frequently recommended as a 'Bulnocho' (a herb bringing eternal youth) (Minjungseorim, 1990) to maintain health and youth, and to prevent a loss of bone mass and heart disease. Since women are exposed only to biased androcentric bio-medical information on menopause, their knowledge on menopause cannot help but be biased and inadequate. Unlike women in mainstream U.S., immigrant women who have been marginalized in their new society and its health care systems have rarely been provided adequate knowledge on their health care needs.

By providing education on women's health needs through mass media, ethnic community, ethnic churches, and health care providers (including physicians, counselors, nurses and health educators), adequate knowledge on women's health care needs should be delivered. Changes in health policies need to be made in the direction of supporting these efforts. If education is not adequate through these resources, the women themselves should push for their own needs through a women's health movement, such as in mainstream U.S. (Boston Women's Health Collective, 1976; 1992; Fishbein, 1992; Greenwood, 1984; National Women's Health Network, 1993; Rothert, Rovner, Holmes, Schmitt, Talarczyk, Kroll, & Gogate, 1990).

Limitations of the Study

This study has several theoretical and methodological limitations: (a) the scope of the study sites was limited to San Francisco Bay Area; (b) this study involved one-time

interviews covering rather sensitive personal information consequently increasing the possibility that some relevant material was not obtained; (c) the accounts were frequently retrospective, so the efficiency and accuracy of memory were questionable; (d) participants in this study were voluntary and self-selected. Their accounts might not be representative of the entire range of menopausal experience of low income Korean immigrant women; and (e) there were continuously emerging questions on appropriateness and adequacy of the translation process.

Further Study

In relating the findings to extant literature, attention needs to be directed to several areas on menopause for further study and consideration: (a) socio-economic-cultural-political contextual constraints to menopausal experiences; (b) gender-related issues involved in women's daily experience; (c) the role of interpersonal relationships in the menopausal experience; (d) experiential differences and validation needs of diverse socio-economic groups of women in menopausal transition; (e) cultural influences of menopause and women's health; (f) relationships between symptoms and its correlates; (g) empowerment and political consciousness in marginalized women's health; and (h) the needs for developing and using self-help groups throughout the menopausal transition.

Conclusion

The experience of menopause in vulnerable groups of women, including immigrants who are marginalized by society, has been rarely explored. Furthermore, virtually nothing is clearly known about menopausal transition and descriptions are discrete and

fragmented. Research has rarely explored the context within which women live and experience menopause. This study contributes to a comprehensive view of menopause through emphasizing the bio-psycho-socio-cultural multiple transitional context while respecting women's own views.

In this study, the menopausal experience of a marginalized group of women—middle-aged low income Korean immigrant women—was explored. It was found that the women neglected and ignored menopause within their gendered multiple transitional context. Menopausal experiences were complicated by gender issues in Korean culture. Gender was equated with sex and menopause was reduced to "the stop of menstruation." Their socio-cultural context emphasized women's subordinate, passive, and low positions in their family and community structure. They sacrificed themselves for their family and community, consequently lacking time, energy, and money for their own health care needs including menopausal symptom experience. Furthermore, menopausal experience was situated within the context of their immigration and work transitions. Within the context, women's symptom experiences were minimized and individualized due to their cultural background and busy daily schedules.

In conclusion, the gendered multiple transitional context of these marginalized women was an overriding theme capturing the minimization and individualization of symptoms, and their neglecting and ignoring menopause. We should view and understand women's menopausal experience, respecting the totality of women's lives and considering the context in which women are experiencing menopause. We should also continue to examine how the nursing profession deals with the health care needs of

vulnerable women experiencing multiple transitions who are frequently thrust out from mainstream society toward the margins.

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APPENDICES

APPENDIX A

Information Sheet, Announcement Sheet, & Sample Letter

UNIVERSITY OF CALIFORNIA, SAN FRANCISCO

INFORMATION SHEET FOR PROSPECTIVE PARTICIPANTS

MENOPAUSE OF LOW INCOME KOREAN IMMIGRANT WOMEN IN TRANSITION

A. PURPOSE AND BACKGROUND

Afaf Meleis, Ph.D., Dr.P.S. (hon). and Eun-Ok Im, M.S., M.P.H., Ph.D. Candidate in the department of Community Health Systems in School of Nursing are conducting a research study to help understand how Korean immigrant women experience menopause. You are being asked to participate in this study because you are a healthy Korean immigrant woman.

B. PROCEDURES

If you agree to participate, the followings will occur:

1. Within a few days, you will receive a questionnaire written in Korean that needs to be filled out before coming to the appointment.
2. During the appointment, you will be asked to give the questionnaire back, and be interviewed in Korean. It will take 20 to 30 minutes.
3. Some participants will be asked to participate in a second, more in-depth interview. If you agree to participate in this, another appointment will be made. It will take about 2 hours and will be held in a place that you choose. In this interview, questions about your menopause and life will be asked, and the interviews will be audiotaped.

C. RISKS/DISCOMFORTS

1. Participation in this study may be an inconvenience and some of the questions may make you uncomfortable or upset. Yet, you are free to decline to answer any questions you do not wish to answer or to stop the interview at any time.
2. Confidentiality: Participation in the research will involve a loss of privacy, but your records will be handled as confidentially as possible. Only Dr. Meleis and Ms. Im will have access to your study records (questionnaire and interview contents). In case you participate in the in-depth interview, the tapes will be

destroyed after the interview has been transcribed. No individual identities will be used in any reports or publications that will result from this study.

D. BENEFITS

There will be no direct benefits to you. Yet, you may get some satisfaction from knowing that the information you give provides basic information on menopause of Korean immigrant women and gives a direction for promoting their well-being.

E. COSTS

There will be no costs to you as a result of taking part in this study.

F. PAYMENT

You will be paid $10 for your time for the 30-minute interview. If you decide to withdraw prior to 30-minute interview completion, you will receive $5. If you are asked to participate in the second in-depth interview, you will be paid an additional $20. If you decide to withdraw prior to the in-depth interview completion, $10 dollars will be paid. You will be paid in cash immediately after you complete your participation in the study.

G. QUESTIONS

If you have further questions, you may call Ms. Im at (415) 661-7739.

If you have any comments or concerns about participation in this study, you should first talk with Dr. Meleis or Ms. Im. If for some reason you do not wish to do this, you may contact the Committee on Human Research, which is concerned with the protection of volunteers in research projects. You may reach the committee between 8 A.M. and 5 P.M., Monday through Friday, by calling 415-476-1814 or by writing: Committee on Human Research, Box 0962, University of California, San Francisco, San Francisco, CA 94143.

* You should keep this information sheet for yourself and may share it with your family, relatives or friends. Thank you for taking the time to read this!

UNIVERSITY OF CALIFORNIA, SAN FRANCISCO

WRITTEN ANNOUNCEMENT

Are you a Korean immigrant woman aged 40 to 60 years?

If yes, please read the following announcement.

Afaf Meleis, Ph.D. is a professor and Eun-Ok Im, MPH, MS is a doctoral candidate at the University of California, San Francisco studying menopause of Korean immigrant women. We hope that this study will help Korean women and their health care providers better understand the experience of menopause for Korean women. Participants will fill out a questionnaire and participate in a short interview.

For the study, **volunteers are needed, who are Korean immigrant women aged 40 to 60 years, and able to read, write, and speak Korean.** If you think you meet the criteria, and you are interested in this study, **please contact Ms. Im at 415-661-7739.** Thank you for taking the time to read this.

**** 10 dollars for the completion of questionnaire and 30 minute interview will be paid in cash immediately after the interview.***

UNIVERSITY OF CALIFORNIA, SAN FRANCISCO
A SAMPLE LETTER OF REQUEST

Date:_____

Dear Pastor

I would like to introduce myself and solicit your help and cooperation in our research efforts. I am a doctoral student at the University of California, San Francisco (UCSF), School of Nursing, and my dissertation research is a study of the menopausal experience of Korean immigrant women. The study is being conducted in association with Dr. Afaf Meleis, Ph.D., Dr.P.S.(hon), a professor of the U.C.S.F., School of Nursing. So far, few researchers have explored the menopausal experience of immigrant women, especially Korean immigrant women. Thus, health care providers have very little information available to help them understand and care for Korean immigrant women who are experiencing the menopause.

The study will involve Korean immigrant women aged 40 to 60 years. If you could provide me with a list of the names and telephone numbers of the immigrant women who are attending your church, this would greatly enhance the recruitment process. The list and telephone numbers will be used only for recruiting research participants. Immediately after finishing this study, their list and telephone numbers will be destroyed. Throughout the research process, confidentiality will be ensured and their names will not be recorded on interview forms and transcripts. We really appreciate your kind assistance.

If you have any comments or concerns about this study, please feel free to call me at 415-661-7739 (e-mail address: eoicws1@itsa.ucsf.edu; address: 56 Behr Ave. San Francisco, CA 94131). Thank you very much.

God be with you.

Regards.

Eun-Ok Im, MS. MPH.

Appendix B

Interview Protocol I

ID#_____

* We want to know your background as a group. Please answer the following questions.

1. When is your birth date?

_____ So, I am _____years old.
day/month/year

2. What is the highest grade or type of education you reached in school?

- ☐ No school
- ☐ Elementary school/graduated
- ☐ Middle school/graduated
- ☐ High school/graduated
- ☐ Partial college
- ☐ College (graduated)
- ☐ Graduate degree

3. Our family income is....

- ☐ Totally insufficient for our family
- ☐ Somewhat insufficient for our family
- ☐ Sufficient for essential needs
- ☐ More than sufficient

4. My religion is....

- ☐ Christianity
- ☐ Catholicism
- ☐ Buddhism
- ☐ No Religion

5. Which one of the following best describes your marital status now?

	For how long?
☐ Married	_____ years
☐ Partnered, permanent relationship	_____ years
☐ Divorced/separated/no longer partnered	_____years
☐ Widowed	_____ years
☐ Single, never partnered	_____ years

6. Are you currently working?

☐ No
☐ Yes

If yes, what sort of work do you do?

_____

What are your main duties

_____?

How long have your worked at this job?

_____(month) or _____ (year)

If less than 6 months working at this job, please describe the type of work you did before.

_____

How long did you work at that job?

_____(month)_____(year)

7. How long have you been in the United States?

_____ months or _____ years

8. How long have you been in this area?

_____ months or _____ years

9. What Is your food preference?

☐ Exclusively Korean food
☐ Mostly Korean food, some American
☐ About equally Korean and American
☐ Mostly American food
☐ Exclusively American food

10. What is your music preference?

☐ Only Korean music
☐ Mostly Korean
☐ Equally Korean and American
☐ Mostly American
☐ American only

11. What do you prefer?

☐ Only Korean customs
☐ Mostly Korean customs
☐ Equally Korean and American customs
☐ Mostly American customs
☐ American customs only

12. What language do you prefer?

- ☐ Korean only
- ☐ Mostly Korean , some English
- ☐ Korean and English about equally well (bilingual)
- ☐ Mostly English, some Korean
- ☐ Only English

13. What is the ethnic origin of your close friends?

- ☐ All Koreans
- ☐ Mostly Koreans
- ☐ Korean-Americans
- ☐ Mostly Americans
- ☐ All Americans

14. There are many different ways in which people think of themselves. Which one of the following most closely describes how you view yourself?

- ☐ I consider myself basically a Korean person. Even though I live and work in America, I still view myself basically as a Korean person.
- ☐ I consider myself as a Korean-American, although deep down I always know I am a Korean.
- ☐ I consider myself as a Korean-American. I have both Korean and American characteristics, and I view myself as a blend of both.
- ☐ I consider myself as a Korean-American, although deep down, I view myself as an American first.
- ☐ I consider myself basically as an American. Even though I have a Korean background and characteristics, I still view myself basically as an American

15. Please check one box indicating how you feel about <u>your health</u>.

- ☐ I am very unhealthy
- ☐ I tend to be unhealthy
- ☐ I don't know
- ☐ I tend to be healthy
- ☐ I am very healthy

16. a. Do you have any diagnosed diseases?

- ☐ No
- ☐ Yes

b. If yes, please specify_____

_____

17. Are you taking any medicine?

☐ No
☐ Yes
If yes, please specify_____
_____

* We want to know your menstrual experience. Please answer the following questions.

18. Please estimate how many days ago your last menstrual period started.

_____days ago or
_____months ago or
_____years ago

* If you have not had menstruation for more than 1 year, please go to #16!

19. Considering the past 3 months, would you say your menstrual periods were:

☐ Very regular
☐ Mostly regular
☐ Somewhat irregular
☐ Very irregular
☐ No more menstruation

20. Considering the past 12 months, would you say your menstrual periods were:

☐ Very regular
☐ Mostly regular
☐ Somewhat irregular
☐ Very irregular
☐ No menstruation at all

21. Did anything happen to you in the past 12 months that you think affected your period? For example, pregnancy, stress, medications?

☐ No ☐ Yes
If yes, please describe what happened to you:
_____
_____
_____

22. Which of the following best describes the regularity of your menstrual cycles (the average number of days between menstrual periods) when your mid to late 20's and your entire 30's (years of age).

☐ Very irregular (Almost no regular cycles)
☐ Somewhat irregular (Some regular cycles)
☐ Somewhat regular (Some irregular cycles)
☐ Very regular (Almost no irregular cycles)

23. Considering the past 6 months, which one best applies to you?

☐ I can predict my period within a day of when it will start
☐ I can predict my period within 3 to 5 days of when it will start
☐ I can predict my period within a week or when it will start
☐ I never know if or when I'll have another period
☐ No more menstruation

24. How far away from menopause (no more periods) do you think you are? We need your opinion.

☐ Already in Menopause (No period for one or more years)
☐ Within 1 year of menopause
☐ Within 1-2 years of menopause
☐ Within 2-3 years of menopause
☐ More than 3 years from menopause
☐ I have not begun the transition into menopause

25. Have you experienced the following problems?

a. Abnormal pap smear	____	No	____	Yes
b. fibroids of the uterus	____	No	____	Yes
c. Ectopic pregnancy	____	No	____	Yes
d. Infertility	____	No	____	Yes
e. Endometriosis	____	No	____	Yes
f. Pelvic inflammatory disease	____	No	____	Yes
g. Hysterectomy	____	No	____	Yes
h. Removal of ovary	____	No	____	Yes
i. Other major gynecological problem	____	No	____	Yes

If yes, Please describe _____

26. What is your current contraceptive method?

a. None ____
b. Oral contraceptive (the Pill) ____
c. IUD ____
d. Diaphragm ____
e. Foam ____
f. Condoms ____
g. Rhythm ____
h. Tubal ligation ____
i. Vasectomy ____
j. Natural Family Planning _____
k. Abstinence ____

27. Are you currently taking prescription steroids or hormones?

☐ No
☐ Yes

If yes, please specify_____

* We also want to know your work experience. Please answer the following questions.

28. Please check one box indicating how you feel about your work overall.

- ☐ I am totally unsatisfied
- ☐ I am a little bit unsatisfied
- ☐ I don't know
- ☐ I am a little bit satisfied
- ☐ I am totally satisfied

29. Please check one box indicating how your work is satisfactory in terms of financial support.

- ☐ I am totally unsatisfied
- ☐ I am a little bit unsatisfied
- ☐ I don't know
- ☐ I am a little bit satisfied
- ☐ I am totally satisfied

30. Please check one box indicating how your work is satisfactory in terms of the job tasks.

- ☐ I am totally unsatisfied
- ☐ I am a little bit unsatisfied
- ☐ I don't know
- ☐ I am a little bit satisfied
- ☐ I am totally satisfied

31. Please check on box indicating how your work is satisfactory in terms of self accomplishment.

- ☐ I am totally unsatisfied
- ☐ I am a little bit unsatisfied
- ☐ I don't know
- ☐ I am a little bit satisfied
- ☐ I am totally satisfied

32. Please check one box indicating how your work is satisfactory considering your qualifications.

- ☐ I am totally unsatisfied
- ☐ I am a little bit unsatisfied
- ☐ I don't know
- ☐ I am a little bit satisfied
- ☐ I am totally satisfied

APPENDIX C

Modified Cornell Medical Index (CMI)

The followings are the questions about symptoms that you have experienced during the past 6 months. Please, answer all questions. If you are not sure, guess.

A.

1. Do you need glasses to read?	_____Yes	_____No
2. Do you need glasses to see things at a distance?	_____Yes	_____No
3. Has your eyesight often blacked out completely?	_____Yes	_____No
4. Do your eyes continually blink or water?	_____Yes	_____No
5. Do you often have bad pains in your eyes?	_____Yes	_____No
6. Are your eyes often red or inflamed?	_____Yes	_____No
7. Are you hard of hearing?	_____Yes	_____No
8. Have you ever had a bad runny ear?	_____Yes	_____No
9. Do you have constant noises in your cars?	_____Yes	_____No

B.

10. Do you have to clear your throat frequently?	_____Yes	_____No
11. Do you often feel a choking lump in your throat?	_____Yes	_____No
12. Are you often troubled with bad spells of sneezing?	_____Yes	_____No
13. Is your nose continually stuffed up?	_____Yes	_____No
14. Do you suffer from a constantly running nose?	_____Yes	_____No
15. Have you at times had bad nose bleeds?	_____Yes	_____No
16. Do you often catch severe colds?	_____Yes	_____No
17. Do you frequently suffer from heavy chest colds?	_____Yes	_____No
18. When you catch a cold, do you always have to go to bed?	_____Yes	_____No
19. Do frequent colds keep you miserable all winter?	_____Yes	_____No
20. Are you troubled by constant coughing?	_____Yes	_____No
21. Have you ever coughed up blood?	_____Yes	_____No
22. Do you sometimes have severe soaking sweats at night?	_____Yes	_____No

C.

23. Do you have pains in the heart or chest?	_____Yes	_____No
24. Are you often bothered by thumping of the heart?	_____Yes	_____No
25. Does your heart often race like mad?	_____Yes	_____No
26. Do you often have difficulty in breathing?	_____Yes	_____No
27. Do you get out of breath long before anyone else?	_____Yes	_____No
28. Do you sometimes get out of breath just sitting still?	_____Yes	_____No
29. Are your ankles often badly swollen?	_____Yes	_____No
30. Do cold hands or feet troubles you even in hot weather?	_____Yes	_____No
31. Do you suffer from frequent cramps in your legs?	_____Yes	_____No

D.

32. Have you lost more than half your teeth?	_____Yes	_____No
33. Are you troubled by bleeding gums?	_____Yes	_____No
34. Have you often had severe toothaches?	_____Yes	_____No
35. Is your tongue usually badly coated?	_____Yes	_____No
36. Is your appetite always poor?	_____Yes	_____No

37. Do you usually eat sweets or other food between meals?	_____Yes	_____No
38. Do you always gulp your food in a hungry?	_____Yes	_____No
39. Do you often suffer from an upset stomach?	_____Yes	_____No
40. Do you usually feel bloated after eating?	_____Yes	_____No
41. Do you usually belch a lot after eating?	_____Yes	_____No
42. Are you often sick to your stomach?	_____Yes	_____No
43. Do you suffer from indigestion?	_____Yes	_____No
44. Do sever pains in the stomach often double you up?	_____Yes	_____No
45. Do you suffer from constant stomach trouble?	_____Yes	_____No
46. Do you suffer from frequent loose bowel movements?	_____Yes	_____No
47. Have you ever had severe bloody diarrhea?	_____Yes	_____No
48. Do you constantly suffer from bad constipation?	_____Yes	_____No
49. Have you ever had piles (rectal hemorrhoids)?	_____Yes	_____No
50. Have you ever had jaundice (yellow eyes and skin)?	_____Yes	_____No
E.		
51. Are your joints often painfully swollen?	_____Yes	_____No
52. Do your muscles and joints constantly feel stiff?	_____Yes	_____No
53. Do you usually have severe pains in the arms or legs?	_____Yes	_____No
54. Do weak or painful feet make your life miserable?	_____Yes	_____No
55. Do pains in the back make it hard for you to keep up with work?	_____Yes	_____No
56. Are you troubled with a serious bodily disability or deformity?	_____Yes	_____No
F.		
57. Is your skin very sensitive or tender?	_____Yes	_____No
58. Do cuts in your skin usually stay open a long time?	_____Yes	_____No
59. Does your face often get badly flushed?	_____Yes	_____No
60. Do you sweat a great deal even in cold weather?	_____Yes	_____No
61. Are you often bothered by severe itching?	_____Yes	_____No
62. Does your skin often break out in a rash?	_____Yes	_____No
63. Are you often troubled with boils?	_____Yes	_____No
G.		
64. Do you suffer badly from frequent severe headaches?	_____Yes	_____No
65. Does pressure or pain in the head often make life miserable?	_____Yes	_____No
66. Do you have hot or cold spells?	_____Yes	_____No
67. Do you often have spells of severe dizziness?	_____Yes	_____No
68. Have you fainted?	_____Yes	_____No
69. Do you have constant numbness or tingling in any part of your body?	_____Yes	_____No
70. Was any part of your body ever paralyzed?	_____Yes	_____No
71. Were you ever knocked unconscious?	_____Yes	_____No
72. Have you at times had a twitching of the face, head or	_____Yes	_____No

shoulders?

73. Did you ever have a fit or convulsion (epilepsy)?	_____Yes	_____No
74. Do you bit your nails badly?	_____Yes	_____No
75. Do you troubled by stuttering or stammering?	_____Yes	_____No
76. Are you a sleep walker?	_____Yes	_____No
77. Are you a bed wetter?	_____Yes	_____No

H.

(If you do not have menstruation anymore, please skip the question 78 to 81, and go to the question 82.)

78. Have your menstrual periods usually been painful?	_____Yes	_____No
79. Have you often felt weak or sick with your periods?	_____Yes	_____No
80. Have you often had to lie down when your periods came on?	_____Yes	_____No
81. Have you usually been tense or jumpy with your periods?	_____Yes	_____No
82. Have you ever had severe hot flashes and sweats?	_____Yes	_____No
83. Have you often been troubled with a vaginal discharge?	_____Yes	_____No
84. Do you have to get up every night and urinate?	_____Yes	_____No
85. During the day, do you usually have to urinate frequently?	_____Yes	_____No
86. Do you often have sever burning pain when you urinate?	_____Yes	_____No
87. Do you sometimes lose control of your bladder?	_____Yes	_____No

I.

88. Do you often get spells of complete exhaustion or fatigue?	_____Yes	_____No
89. Does working tire you out completely?	_____Yes	_____No
90. Do you usually get up tired and exhausted in the morning?	_____Yes	_____No
91. Does every little effort wear you out?	_____Yes	_____No
92. Are you constantly too tired and exhausted even to eat?	_____Yes	_____No
93. Do you suffer from sever nervous exhaustion?	_____Yes	_____No

J

94. Are you frequently ill?	_____Yes	_____No
95. Are you frequently confined to bed by illness?	_____Yes	_____No
96. Are you always in poor health?	_____Yes	_____No
97. Are you considered a sickly person?	_____Yes	_____No
98. Do severe pains and aches make it impossible for you to do your work?	_____Yes	_____No
99. Do you wear yourself out worrying about your health?	_____Yes	_____No
100. Are you always ill and unhappy?	_____Yes	_____No
101. Are you constantly made miserable by poor health?	_____Yes	_____No

K.

102. Are you definitely under weight?	_____Yes	_____No

103. Are you definitely over weight? _____Yes _____No
104. Do you often have small accidents or injuries? _____Yes _____No

L.

105. Do you usually have great difficulty in falling asleep or staying asleep? _____Yes _____No
106. Do you sweat or tremble a lot during examination or questioning? _____Yes _____No
107. Do you get nervous and shaky when approached by a superior? _____Yes _____No
108. Does your work fall to pieces when the boss or a superior is watching you? _____Yes _____No
109. Does your thinking get completely mixed up when you have to do things quickly? _____Yes _____No
110. Must you do things very slowly in order to do them without mistakes? _____Yes _____No
111. Do you always get directions and orders wrong? _____Yes _____No
112. Do strange people or places make you afraid? _____Yes _____No
113. Are you scared to be alone when there are no friends near you? _____Yes _____No
114. Is it always hard for you to make up your mind? _____Yes _____No
115. Do you wish you always had someone at your side to advise you? _____Yes _____No
116. Are you considered a clumsy person? _____Yes _____No
117. Does it bother you to eat anywhere except in your own home? _____Yes _____No

N.

118. Do you feel alone and sad at a party? _____Yes _____No
119. Do you usually feel unhappy and depressed? _____Yes _____No
120. Do you often cry? _____Yes _____No
121. Are you always miserable and blue? _____Yes _____No
122. Does life look entirely hopeless? _____Yes _____No
123. Do you often wish you were dead and away from it all? _____Yes _____No

O.

124. Does worrying continually get you down? _____Yes _____No
125. Does every little thing get on your nerves and wear you out? _____Yes _____No
126. Are you considered a nervous person? _____Yes _____No
127. Did you ever have a nervous breakdown? _____Yes _____No

P.

128. Are you extremely shy or sensitive? _____Yes _____No
129. Are your feelings easily hurt? _____Yes _____No
130. Does criticism always upset you? _____Yes _____No
131. Are you considered a touchy person? _____Yes _____No

132. Do people usually misunderstand you? _____Yes _____No

Q.

133. Do you have to be on your guard even with friends? _____Yes _____No

134. Do you always do things on sudden impulse? _____Yes _____No

135. Are you easily upset or irritated? _____Yes _____No

136. Do you go to pieces if you don't constantly control yourself? _____Yes _____No

137. Do little annoyances get on your nerves and make you angry? _____Yes _____No

138. Does it make you angry to have anyone tell you what to do? _____Yes _____No

139. Do people often annoy and irritate you? _____Yes _____No

140. Do you flare up in anger if you can't have what you want right away? _____Yes _____No

141. Do you often get into a violent rage? _____Yes _____No

R.

142. Do you often shake or tremble? _____Yes _____No

143. Are you constantly keyed up and jittery? _____Yes _____No

144. Do sudden noises make you jump or shake badly? _____Yes _____No

145. Do you tremble or feel weak whenever someone shouts at you? _____Yes _____No

146. Do you become scared at sudden movements or noises at night? _____Yes _____No

147. Do you often awakened out of your sleep by frightening dreams? _____Yes _____No

148. Do frightening thoughts keep coming back in your mind? _____Yes _____No

149. Do you often become suddenly scared for no good reason? _____Yes _____No

150. Do you often break out in a cold sweat? _____Yes _____No

S

151. Do you recently have weight gain? _____Yes _____No

152. Does your menstruation become heavy recently? (In case you don't have menstruation any more, do not answer this question.) _____Yes _____No

153. Do you sometimes have aches in back of neck and skull? _____Yes _____No

154. Do you sometimes have breast pains? _____Yes _____No

155. Do you have skin crawls? _____Yes _____No

156. Do you have feeling of suffocation? _____Yes _____No

157. Do you worry about your body? _____Yes _____No

158. Do you worry about nervous breakdown? _____Yes _____No

159. Do you recently have weight loss? _____Yes _____No

160. Do you recently lose your sexual interest? _____Yes _____No

161. Do you have shortness of breath? _____Yes _____No
162. Do your have vaginal dryness? _____Yes _____No
163. Do you recently lose your interest in things? _____Yes _____No
164. Do you have any other symptoms? _____Yes _____No
If yes, please specify_____

_____

APPENDIX D

Interview Protocol II

ID#_____

* Thank you for answering the questionnaire. Now, I am going to ask you some questions about the symptoms you checked 'yes' in the questionnaire.

Severity of discomfort
0 Not at all
1 A little bit
2 Moderately
3 Quite a bit
4 Extremely

How do you describe the severity of the symptom by ------

Question # ( ) ☐ (severity of the symptom)

a. Did you had the symptom when your mid to late 20's and your entire 30's?

☐ Yes ☐ No ☐ I don't know

a1. If you answer 'Yes', stop here and go to another symptom.
a2. If you answer 'No' or 'I don't know', from when have you had the symptom?

b. What do you think causes the symptom?

c. How is the symptom affecting your life (meanings of the symptom)?

d. d1. How do you manage the symptom?

d2. If you do not manage the symptom, why?

APPENDIX E

Interview Guide

INTERVIEW GUIDE

1. Introduction
   Introducing the researcher and the research
   Answering the questions

2. Getting Verbal Consent

3. Getting Started: Questions

Interview Questions

* We want to know your opinion on **menopause**. Please answer the following questions in your words.

(1) Do you have name for 'menopause' in your own words?
(2) a. How was your mother's menopause?
   b. What did the menopause mean to your mom?
(3) What does the menopause mean to you?
(4) What do you think causes your menopause?
(5) What changes does menopause make in your body and mind(in your opinion)?
(6) Overall, how do you feel about menopause?

* We want to know your opinion on the **meanings of several words.**

(1) What does 'woman' mean (in your opinion)?
(2) How would you like to describe yourself as a woman?
(3) What does 'Korean' mean (in your opinion)?
(4) What does 'American' mean (in your opinion)?
(5) What does 'Korean-American' mean (in your opinion)?
(6) How would you like to describe yourself as a Korean?
(7) How would you like to describe yourself as an American?
(8) How would you like to describe yourself as Korean-American?
(9) What does 'mid-aged' mean (in your opinion)?
(10) What does 'young' mean (in your opinion)?
(11) How do you describe yourself as young, mid-aged, old?
(12) What do 'immigrants' mean (in your opinion)?
(13) How would you like to describe yourself as an immigrant?

* We want to know your **menopausal experience within your daily immigration and work experience**

(1) In what ways, menopause influences/will influence your life (marital, family and friend relationships)?
(2) How are your daily immigration experiences?
(3) What are the difficulties due to immigration in your daily lives?
(4) How is your daily schedule?
(5) How is your work?
(6) How is your work situation?
(7) How is/was your menopause?
(8) How do you think immigration influences your menopause?
(9) How do you think your work influences your menopause?
(10) How do your symptoms influence your daily immigration experience?
(11) In what ways, do the symptoms affect your daily immigration experiences?
(12) What are the interruptions and disturbances brought by menopause in your daily immigration experience?
(13) How do your symptoms influence your work?
(14) In what ways, do the symptoms affect your work and work situation?
(15) What are the interruptions or disturbances brought by menopause in your work and work situation?

APPENDIX F

Tables: Table F1-F10

Table F1 Additional socio-demographic profile

Additional Socio-economic Profile	Quantitative Part N (%)	Qualitative Part
Religion		
Christianity	68 (57.1)	11 (52.38)
Catholicism	27 (22.7)	6 (28.57)
Buddhism	5 (4.2)	3 (14.29)
No religion	19 (16.0)	1 (4.76)
Number of Children		
1 Child		4 (19.05)
2 Children		9 (42.96)
Above 3 children		8 (38.10)
Son		
Have son		15 (71.43)
Do not have son		6 (28.57)
Work Status		
work	97 (81.5)	
not work	22 (18.5)	
private household workers	1 (4.5)	
housewife	1 (4.5)	
volunteer work	1 (4.5)	
unskilled labor work	1 (4.5)	
baby-sitter	18 (81.8)	
Type of work		
Informal sector work	43 (36.1)	
Private household worker	8 (6.7)	4(19.05)
Cleaning women	2 (1.7)	
Unskilled labor work	6 (5.0)	
Baby-sitter	21 (17.6)	
Volunteer work	4 (3.4)	
Combined	2 (1.7)	
Formal sector work	31 (26.1)	
Waitress	1 (0.8)	
Factory worker	3 (2.5)	2(9.52)
Seamstress	2 (1.7)	
Cashier	4 (3.4)	
Medical assistant and nursing aid	8 (6.7)	1(4.76)
Preschool teacher	3 (2.5)	
Postman	2 (1.7)	
Clerical worker	3 (2.5)	
Hair dresser & nail shop	1 (0.8)	1(4.76)
Cook	2 (1.7)	1(4.76)
Sales	2 (1.7)	2(9.52)
Small family business	39 (32.8)	9(42.86)
Others	5 (4.2)	1(4.76)

Table F2. Differences in work satisfaction by sociodemographic variables

Sociodemographic Characteristics and Work Status	d.f.	SS	MS	F-value	P-value
Age					
Between groups	3	124.14	41.38	2.2892	0.0822*
Within groups	113	2042.63	18.07		
Total	116	2166.77			
Education					
Between groups	2	150.98	75.49	4.2692	0.0163*
Within groups	114	2015.79	17.68		
Total	116	2166.77			
Family Income					
Between groups	2	225.99	112.99	6.6373	0.0019*
Within groups	114	1940.78	17.02		
Total	116	2166.77			
Marital Status					
Between groups	3	78.10	26.03	1.3963	0.2477
Within groups	112	2088.34	18.65		
Total	115	2166.45			
Type of work					
Between groups	3	92.96	30.99	1.6902	0.1731
Within groups	113	2071.67	18.33		
Total	116	2164.63			
Length of stay in the U.S.					
Between groups	2	29.04	14.52	0.7788	0.4614
Within groups	114	2125.27	18.64		
Total	116	2154.31			
Length of stay in the area					
Between groups	2	3.66	1.83	0.0970	0.9077
Within groups	114	2150.65	18.87		
Total	116	2154.31			
Ethnic Identity					
Between groups	1	22.01	22.01	1.1814	0.2793
Within groups	115	2142.98	18.63		
Total	116	2164.99			

Table F3. The most prevalent 20 symptoms experienced during the past 6 months

Rank	Symptoms	No N(%)	Yes N(%)	Total N(%)	Not at all N(%)	A little bit N(%)	Moderately N(%)	Quite a bit N(%)	Extremely N(%)	Total N(%)
1	1. Glasses to read	50(42)	69(58)	119(100)	7(10.1)	35(50.7)	11(15.9)	12(17.4)	4(5.8)	69(100)
2	153. Aches in back of neck and skull	52(44.1)	65(55.1)	119(100)	8(12.3)	45(69.2)	9(13.8)	2(3.1)	1(1.5)	65(100)
3	88. Complete exhaustion	62(52.1)	57(47.9)	119(100)	9(15.8)	32(56.1)	12(21.1)	3(5.3)	1(1.8)	57(100)
4	90. Waking up tired and exhausted in the morning	68(57.1)	51(42.9)	119(100)	8(15.7)	28(54.9)	11(21.6)	2(3.9)	2(3..9)	51(100)
5	31. Frequent cramps in legs	71(59.7)	48(40.3)	119(100)	5(10.4)	33(68.8)	9(18.8)	1(2.1)	0(0.0)	48(100)
6	103. Over weight	73(61.3)	46(38.7)	119(100)	20(43.5)	20(43.5)	4(8.7)	0(0.0)	2(4.3)	46(100)
7	81. Tense or jumpy in periods	35(43.8)	45(56.3)	119(100)	5(10.2)	28(57.1)	5(10.2)	6(12.2)	5(10.2)	49(100)
8	84. Urinate every night	75(63.0)	44(37.0)	119(100)	11(25.0)	27(61.4)	6(13.6)	0(0.0)	0(0.0)	44(100)
9	131. Considered as a touchy person	77(64.7)	42(35.3)	119(100)	20(47.6)	18(42.9)	4(9.5)	0(0.0)	0(0.0)	42(100)
10	64. Headaches	79(66.4)	40(33.6)	119(100)	4(10.0)	23(57.5)	8(20.0)	3(7.5)	2(5.0)	40(100)
11	99. Worry about your health	79(66.4)	40(33.6)	119(100)	9(22.5)	26(65.0)	5(12.5)	0(0.0)	0(0.0)	40(100)
12	33. Gum bleeding	80(67.2)	39(32.8)	119(100)	20(51.3)	14(35.9)	4(10.3)	1(2.6)	0(0.0)	39(100)
13	85. Frequent urination	81(68.1)	38(31.9)	119(100)	11(28.9)	21(55.3)	6(15.8)	0(0.0)	0(0.0)	38(100)
14	40. Feel bloated after eating	80(67.2)	38(31.9)	119(100)	20(52.6)	14(36.8)	3(7.9)	1(2.6)	0(0.0)	38(100)
15	39. Upset stomach	82(68.9)	37(31.1)	119(100)	5(13.5)	19(51.4)	7(18.9)	5(13.5)	1(2.7)	37(100)
16	57. Sensitive skin	83(69.7)	36(30.3)	119(100)	9(25.0)	21(58.3)	4(11.1)	2(5.6)	0(0.0)	36(100)
17	138. Angry to have anyone tell you what to do	84(70.6)	34(28.6)	119(100)	9(26.5)	19(55.9)	5(14.7)	1(2.9)	0(0.0)	34(100)
18	42. Sick to stomach	85(71.4)	33(27.7)	119(100)	4(12.1)	22(66.7)	4(12.1)	3(9.1)	0(0.0)	33(100)
19	55. Pains in the back	86(72.3)	33(27.7)	119(100)	0(0.0)	15(45.5)	7(21.2)	9(27.3)	2(6.1)	33(100)
20	109. Get mixed up when you have to do things quickly	86(72.3)	33(27.7)	119(100)	14(42.4)	15(42.5)	4(12.1)	0(0.0)	0(0.0)	33(100)

Table F4. The most prevalent 20 symptoms experienced after 40 years old

Rank	The most frequently reported 20 symptoms
1	1. Glasses to read
2	153. Aches in back of neck and skull
3	88. Complete exhaustion
4	90. Waking up tired and exhausted in the morning
5	84. Urinate every night
6	103. Over weight
7	31. Frequent cramps in legs
8	5. Eye Pains
9	42. Sick to stomach
10	39. Upset stomach
11	55. Pains in the back
12	99. Worry about your health
13	151. Recent weight gain
14	64. Headaches
15	52. Stiff muscles and joints
16	2. Glasses for long distance
17	33. Gum bleeding
18	85. Frequent urination
19	29. Ankle swelling
20	34. Tooth ache

Table F5. Perceived causes of the symptoms experienced after 40 years old

Rank	The most frequently reported 20 symptoms	Perceived Causes	N(%)
1	1. Glasses to read	Aging	32(69.6)
		Work-related factors and overwork	3(6.5)
		Environment	
		Genetic factors	2(4.3)
		The Climacteric	2(4.3)
		Combined	2(4.3)
		Others	2(4.3)
		Total	3(6.6)
			46(100)
2	153. Aches in back of neck and skull	Psychological stress	17(41.5)
		Aging	4(9.8)
		Pathological changes due to disease	4(9.8)
		Work-related factors and overwork	4(9.8)
		Others	12(29.4)
		Total	41(100)
3	88. Complete exhaustion	Work-related factors and overwork	10(27.0)
		Aging	8(21.6)
		Psychological stress	6(16.2)
		Physical weakness and tiredness	3(8.1)
		Others	10(27.0)
		Total	37(100)
4	90. Waking up tired and exhausted in the morning	Lack of sleep	6(21.4)
		Work-related factors and overwork	7(25.0)
		Aging	3(10.7)
		I don't know	3(10.7)
		Heavy physical overload	2(7.1)
		Physical weakness and tiredness	2(7.1)
		Others	5(18.0
		Total	28(100)
5	84. Urinate every night	Aging	11(37.9)
		I don't know	4(13.8)
		Nutrition and diet	3(10.3)
		Genetic factors	3(10.3)
		Poor postpartum care	2(6.9)
		Pathological changes due to diseases	2(6.9)
		Others	4(13.8)
		Total	29(100)
6	103. Over weight	Aging	11(42.3)
		Nutrition and diet	5(19.2)
		I don't know	2(7.7)
		Others	8(30.4)
		Total	26(100)
7	31. Frequent cramps in legs	Long standing	8(38.1)
		I don't know	4(19.0)
		Work-related factors and overwork	3(14.3)
		Pathological changes due to diseases	2(9.5)
		Others	4(19.0)
		Total	21(100)

Table F5. (Continued)

Rank	The 20 symptoms	Perceived Causes	N(%)
8	5. Eye Pains	Aging	6(28.6)
		Pathological changes due to diseases	4(19.0)
		Work-related factors and overwork	2(9.5)
		Psychological stress	2(9.5)
		Genetic factors	2(9.5)
		Others	5(24.0)
		Total	21(100)
9	42. Sick to stomach	Psychological stress	5(26.3)
		Aging	3(15.8)
		Pathological changes due to diseases	3(15.8)
		Nutrition and diet	2(10.5)
		Physical weakness and tiredness	2(10.5)
		I don't know	2(10.5)
		Others	2(10.5)
		Total	19(100)
10	39. Upset stomach	Psychological stress	7(35.0)
		Nutrition and diet	4(20.0)
		Pathological changes due to diseases	3(15.0)
		Others	6(30.0)
		Total	20(100)
11	55. Pains in the back	Work-related factors and overwork	5(20.8)
		Accidents and injuries	4(16.7)
		Poor postpartum care	3(12.5)
		Pathological changes due to diseases	3(12.5)
		Others	9(37.5)
		Total	24(100)
12	99. Worry about your health	Physical weakness and tiredness	2(25.0)
		Aging	3(18.8)
		Personality	2(12.5)
		Pathological changes due to diseases	2(12.5)
		Operation and medical treatments	2(12.5)
		Others	3(18.8)
		Total	16(100)
13	151. Recent weight gain	Aging	9(50.0)
		Lack of exercise	2(11.1)
		Hormone therapy	2(11.1)
		Psychological stress	2(11.1)
		Others	16.8)
		Total	18(100)
14	64. Headaches	Psychological stress	5(29.4)
		Aging	2(11.8)
		Physical weakness and tiredness	2(11.8)
		Pathological changes due to diseases	2(11.8)
		Others	6(35.4)
		Total	17(100)

Table F5. (Continued)

Rank	The 20 symptoms	Perceived Causes	N(%)
15	52. Stiff muscles and joints	Aging	4(22.2)
		Work-related factors and overwork	4(22.2)
		Combined	3(16.7)
		Operation and medical treatments	2(11.1)
		The climacteric	2(11.1)
		Others	3(16.7)
		Total	18(100)
16	2. Glasses for long distance	Aging	5(33.3)
		Environment	2(13.3)
		Work-related factors and overwork	2(13.3)
		I don't know	2(13.3)
		Others	4(26.6)
		Total	15(100)
17	33. Gum bleeding	Aging	4(30.8)
		Poor postpartum care	2(15.4)
		Nutrition and diet	2(15.4)
		Physical weakness and tiredness	2(15.4)
		Others	3(23.1)
		Total	13(100)
18	85. Frequent urination	Aging	4(26.7)
		Psychological stress	2(13.3)
		Poor postpartum care	2(13.3)
		I don't know	2(13.3)
		Others	5(33.5)
		Total	15(100)
19	29. Ankle swelling	Long standing	5(50.0)
		Pathological changes due to diseases	2(20.0)
		Others	3(30.0)
		Total	10(100)
20	34. Tooth ache	Pathological changes due to diseases	7(63.3)
		Combined	2(18.2)
		Others	2(18.2)
		Total	11(100)

Table F6. Meanings of the symptoms experienced after 40 years old

Rank	The most frequently reported 20 symptoms	Meanings	N(%)
1	1. Glasses to read	Uncomfortable, but tolerable	15(32.6)
		Nothing special	13(28.3)
		Feeling aged	6(13.0)
		Changes in life style	4(8.7)
		Others	8(17.4)
		Total	46(100)
2	153. Aches in back of neck and skull	Nothing special	14(34.1)
		Changes of mind and mood	7(17.1)
		Uncomfortable, but tolerable	6(14.6)
		Uncomfortable, bothered and painful	5(12.2)
		Depressive life with fatigue	3(7.3)
		Worry about health	2(4.9)
		Others	4(9.8)
		Total	41(100)
3	88. Complete exhaustion	Change of mind and mood	12(32.4)
		Changes in work	7(18.9)
		Uncomfortable, but tolerable	5(13.5)
		Uncomfortable, bothered and painful	5(13.5)
		Others	8(21.6)
		Total	37(100)
4	90. Waking up tired and exhausted in the morning	Uncomfortable, but tolerable	5(17.9)
		Nothing special	3(10.7)
		Feeling aged	3(10.7)
		Uncomfortable, bothered and painful	3(10.7)
		Depressive life with tiredness	3(10.7)
		Change of mind and mood	3(10.7)
		Others	8(28.4)
		Total	28(100)
5	84. Urinate every night	Nothing special	10(34.5)
		Uncomfortable, but tolerable	8(27.6)
		Changes in life style	3(10.3)
		Depressive life with tiredness	3(10.3)
		Change of mind and mood	3(10.3)
		Others	2(6.8)
		Total	29(100)
6	103. Over weight	Nothing special	16(61.5)
		Change of mind and mood	3(11.5)
		Uncomfortable, but tolerable	2(7.7)
		Uncomfortable, bothered and painful	2(7.7)
		Others	3(11.5)
		Total	26(100)
7	31. Frequent cramps in legs	Nothing special	7(33.3)
		Uncomfortable, but tolerable	7(33.3)
		Uncomfortable, bothered and painful	4(19.0)
		Others	3(14.4)
		Total	21(100)

Table F6. (Continued)

Rank	The 20 symptoms	Meanings	N(%)
8	5. Eye Pains	Nothing special	9(42.9)
		Uncomfortable, bothered and painful	5(23.8)
		Uncomfortable, but tolerable	4(19.0)
		Others	3(14.4)
		Total	21(100)
9	42. Sick to stomach	Nothing special	5(26.3)
		Uncomfortable, but tolerable	4(21.1)
		Uncomfortable, bothered and painful	2(10.5)
		Change of mind and mood	3(15.8)
		Others	5(26.3)
		Total	19(100)
10	39. Upset stomach	Nothing special	5(26.3)
		Uncomfortable, but tolerable	5(26.3)
		Changes in diet	3(15.8)
		Changes in life style	2(10.5)
		Other	4(21.2)
		Total	19(100)
11	55. Pains in the back	Changes in work	12(50.0)
		Uncomfortable, bothered and painful	4(16.7)
		Uncomfortable, but tolerable	3(12.5)
		Others	5(21.0)
		Total	24(100)
12	99. Worry about your health	Nothing special	8(50.0)
		Change of mind and mood	3(18.8)
		Depressive life with tiredness	2(12.5)
		Others	3(18.8)
		Total	16(100)
13	151. Recent weight gain	Nothing special	11(61.1)
		Depressive life with tiredness	3(16.7)
		Change of mind and mood	2(11.1)
		Others	2(11.1)
		Total	18(100)
14	64. Headaches	Nothing special	6(35.3)
		Uncomfortable, bothered, and painful	5(29.4)
		Uncomfortable, but tolerable	2(11.8)
		Depressive life with tiredness	2(11.8)
		Others	2(11.8)
		Total	17(100)
15	52. Stiff muscles and joints	Changes in work	7(38.9)
		Uncomfortable, bothered, and painful	3(16.7)
		Changes in life style	2(11.1)
		Depressive life with tiredness	2(11.1)
		Others	4(22.2)
		Total	18(100)
16	2. Glasses for long distance	Nothing special	6(40.0)
		Uncomfortable, but tolerable	4(26.7)
		Change of mind and mood	4(26.7)
		Others	1(6.7)
		Total	15(100)

Table F6. (Continued)

Rank	The 20 symptoms	Meanings	N(%)
17	33. Gum bleeding	Nothing special	7(53.8)
		Uncomfortable, bothered and painful	2(15.4)
		Uncomfortable, but tolerable	2(15.4)
		Change of mind and mood	2(15.4)
		Total	13(100)
18	85. Frequent urination	Uncomfortable, but tolerable	8(53.3)
		Nothing special	5(33.3)
		Feeling aged	2(13.3)
		Total	15(100)
19	29. Ankle swelling	Uncomfortable, bothered, and painful	2(22.2)
		Uncomfortable, but tolerable	2(22.2)
		Others	5(55.5)
		Total	9(100)
20	34. Tooth ache	Nothing special	6(54.5)
		Uncomfortable, bothered, and painful	3(27.3)
		Depressive life with tiredness	1(9.1)
		I have no idea	1(9.1)
		Total	11(100)

Table F7. Management strategies for the symptoms experienced after 40 years old

Rank	The most frequently reported 20 symptoms	Management Strategies	N(%)
1	1. Glasses to read	Using devices (eye-glasses)	29(24.4)
		Nothing special	11(23.9)
		Why not manage?	
		Not serious	3(23.1)
		No specific reasons	3(23.1)
		It's normal, not illness	3(23.1)
		Others	2(30.8)
		Eye exercise	2(4.3)
		Rest and avoid overwork	2(4.3)
		Others	2(4.3)
		Total	46(100)
2	153. Aches in back of neck and skull	Using over-the-count medicine	18(43.9)
		Combined	7(17.1)
		Nothing special	6(14.6)
		Why not manage?	
		No specific reasons	2(33.3)
		It's normal, not illness	2(33.3)
		Others	2(33.3)
		Others	10(24.0)
		Total	41(100)
3	88. Complete exhaustion	Rest and avoid overwork	12(32.4)
		Combined	8(21.6)
		Nothing special	6(16.2)
		Why not manage?	
		No specific reasons	2(25.0)
		Management is useless	2(25.0)
		Others	2(25.0)
		Traditional medicine	3(8.1)
		Others	8(21.6))
		Total	37(100)
4	90. Waking up tired and exhausted in the morning	Nothing special	9(32.1)
		Why not manage?	
		No specific reasons	6(66.7)
		Others	3(33.3)
		Combined	6(21.4)
		Changes in life style	5(17.9)
		Rest and avoid overwork	3(10.7)
		Others	5(17.9)
		Total	28(100)
5	84. Urinate every night	Nothing special	16(55.2)
		Why not manage?	
		No specific reasons	7(38.9)
		It's not serious	4(22.2)
		Others	5(27.8)
		Diet change	9(31.0)
		Visiting clinics and medical management	2(6.9)
		Others	
		Total	2(6.9)
			29(100)

Table F7. (Continued)

Rank	The 20 Symptoms	Management Strategies	N(%)
6	103. Over weight	Nothing special	12(46.2)
		Why not manage?	
		It's not serious	4(33.3)
		I don't care	3(25.0)
		No specific reasons	2(16.7)
		Management is useless	2(16.7)
		Others	1(3.8)
		Diet change	8(30.8)
		Exercise	6(23.1)
		Total	26(100)
7	31. Frequent cramps in legs	Nothing special	7(33.3)
		Why not manage?	
		No specific reasons	2(33.3)
		Management is useless	2(33.3)
		Others	2(33.3)
		Symptomatic treatment	4(19.0)
		Combined	
		Rest and avoid overwork	
		Changes in body position and postures	
		Others	
		Total	
8	5. Eye Pains	Rest and avoid overwork	8(38.1)
		Nothing Special	5(23.8)
		Why not manage?	
		No specific reasons	3(60.0)
		It's not serious	1(20.0)
		It's from aging	1(20.0)
		Using over-the-count medicines	3(14..3)
		Using devices	2(9.5)
		Others	3(14.4)
		Total	21(100)
9	42. Sick to stomach	Diet change	8(42.1)
		Nothing special	5(26.3)
		Why not manage?	
		It's not serious	1(20.0)
		It's from aging	1(20.0)
		It's from menopause	1(20.0)
		Others	2(30.0)
		Using over-the-count medicines	2(10.5)
		Others	4(42.0)
		Total	19(100)
10	39. Upset stomach	Diet change	6(31.6)
		Nothing special	3(15.8)
		Why not manage?	
		It's not serious	2(66.7)
		It was useless to visit doctors	1(33.3)
		Using over-the-count medicines	3(15.8)
		Visiting clinics and medical treatments	3(15.8)
		Others	4(21.0)
		Total	19(100)

Table F7. (Continued)

Rank	The 20 symptoms	Management Strategies	N(%)
11	55. Pains in the back	Combined	11(45.8)
		Rest and avoid overwork	6(25.0)
		Others	7(29.4)
		Total	24(100)
12	99. Worry about your health	Nothing special	6(37.5)
		Why not manage?	
		No specific reasons	2(28.6)
		Management is useless	2(28.6)
		Others	3(42.9)
		Combined	3(18.8)
		More pray and religious life	2(12.5)
		Others	5(31.3)
		Total	16(100)
13	151. Recent weight gain	Diet Change	9(50.0)
		Nothing special	8(44.4)
		Why not manage?	
		Management is useless	3(37.5)
		It's normal, not illness	2(25.0)
		Others	3(37.5)
		Changes in life style	1(5.6)
		Total	18(100)
14	64. Headaches	Using over-the-count medicines	10(58.8)
		Nothing special	1(5.9)
		Why not manage?	
		Management is useless	1(100)
		Seeking friendship	1(5.9)
		Diversion	1(5.9)
		Combined	1(5.9)
		Others	3(17.7)
		Total	17(100)
15	52. Stiff muscles and joints	Rest and avoid overwork	4(22.2)
		Combined	4(22.2)
		Symptomatic treatments	3(16.7)
		Others	7(38.9)
		Total	18(100)
16	2. Glasses for long distance	Using devices	9(60.0)
		Nothing special	2(13.3)
		Why not manage?	
		It's not serious	2(100)
		Others	4(26.6)
		Total	15(100)
17	33. Gum bleeding	Visiting Clinics and medical management	5(38.5)
		Hygiene	4(30.8)
		Nothing special	2(15.4)
		Why not manage?	
		No specific reasons	1(50.0)
		I don't know how to manage it	1(50.0)
		Others	2(15.4)
		Total	13(100)

Table F7. (Continued)

Rank	The 20 symptoms	Management Strategies	N(%)
18	85. Frequent urination	Nothing special	7(46.7)
		Why not manage?	
		It's not serious	5(71.4)
		No specific reasons	2(28.6)
		Water restriction	3(20.0)
		Visiting clinics and medical management	2(13.3)
		Others	3(20.0)
		Total	15(100)
19	29. Ankle swelling	Diet change	2(22.2)
		Symptomatic treatment (i.g. massage)	2(22.2)
		Changes in positions and postures	2(22.2)
		Others	3(33.3)
		Total	9(100)
20	34. Tooth ache	Visiting clinics and dental care	8(72.7)
		Nothing special	3(27.3)
		Why not manage?	
		No specific reasons	2(66.7)
		It's not serious	1(33.3)
		Total	11(100)

Table F8. Symptoms perceived to be caused by menopause, and their meanings and management

Symptoms perceived to be caused by menopause	Meanings	n(%)	Management Strategies	n(%)
1. Glasses to read	Uncomfortable, but tolerable	15(32.6)	Using devices (eye-glasses)	29(24.4)
	Nothing special	13(28.3)	Nothing special	11(23.9)
	Feeling aged	6(13.0)	Why not manage?	
	Changes in life style	4(8.7)	Not serious	3(23.1)
	Others	8(17.4)	No specific reasons	3(23.1)
	Total	46(100)	It's normal, not illness	3(23.1)
			Others	2(30.8)
			Eye exercise	2(4.3)
			Rest and avoid overwork	2(4.3)
			Others	2(4.3)
			Total	46(100)
153. Aches in back of neck and skull	Nothing special	14(34.1)	Using over-the-count medicine	18(43.9)
	Changes of mind and mood	7(17.1)	Combined	7(17.1)
	Uncomfortable, but tolerable	6(14.6)	Nothing special	6(14.6)
	Uncomfortable, bothered and painful	5(12.2)	Why not manage?	
	Depressive life with fatigue	3(7.3)	No specific reasons	2(33.3)
	Worry about health	2(4.9)	It's normal, not illness	2(33.3)
	Others	4(9.8)	Others	2(33.3)
	Total	41(100)	Others	10(24.0)
			Total	41(100)

Table F8. (Continued)

Symptoms perceived to be caused by menopause	Meanings	n(%)	Management Strategies	n(%)
5. Eye Pains	Nothing special	9(42.9)	Rest and avoid overwork	8(38.1)
	Uncomfortable, bothered and painful	5(23.8)	Nothing Special	5(23.8)
	Uncomfortable, but tolerable	4(19.0)	Why not manage?	
	Others	3(14.4)	No specific reasons	3(60.0)
	Total	21(100)	It's not serious	1(20.0)
			It's from aging	1(20.0)
			Using over-the-count medicines	3(14..3)
			Using devices	2(9.5)
			Others	3(14.4)
			Total	21(100)
52. Stiff muscles and joints	Changes in work	7(38.9)	Rest and avoid overwork	4(22.2)
	Uncomfortable, bothered, and painful	3(16.7)	Combined	4(22.2)
	Changes in life style	2(11.1)	Symptomatic treatments	3(16.7)
	Depressive life with tiredness	2(11.1)	Others	7(38.9)
	Others	4(22.2)	Total	18(100)
	Total	18(100)		
2. Glasses for long distance	Nothing special	6(40.0)	Using devices	9(60.0)
	Uncomfortable, but tolerable	4(26.7)	Nothing special	2(13.3)
	Change of mind and mood	4(26.7)	Why not manage?	
	Others	1(6.7)	It's not serious	2(100)
	Total	15(100)	Others	4(26.6)
			Total	15(100)

Table F9. Symptoms reported by research participants according to the menopausal symptoms on menopausal symptom checklist (MSC) by Neugarten and Kraines (1965)

MSC Symptoms	Pre-menopausal (n=52) N (%)	Peri-menopausal (n=27) N(%)	Post-menopausal (n=38) N(%)	Total (n= 117) N(%)
Somatic				
Hot flashes	5(9.6)	5(19.2)	5(10.5)	14(11.8)
Cold sweats	9(1.9)	1(3.7)	5(13.2)	7(5.9)
Weight gain	12(23.1)*	8(29.6)*	10(26.3)*	30(25.4)*
Flooding	6(11.5)	4(14.8)	16(43.2)*	14(13.7)
Rheumatic pains	4(7.6)	5(18.5)	8(21.1)*	17(14.3)
Aches in back of neck and skull	25(48.1)*	20(74.1)*	20(54.1)*	65(55.1)*
Cold hands and feet	5(9.6)	5(19.2)	4(10.5)	14(11.8)
Numbness and tingling	5(9.6)	2(7.4)	6(15.8)	13(10.9)
Breast pains	14(26.9)*	6(22.2)*	4(10.8)	25(21.0)*
Constipation	16(30.8)*	7(25.9)*	6(15.7)	29(24.4)*
Diarrhea	0(0)	1(3.7)	3(7.9)	4(3.4)
Skin crawls	8(15.4)*	3(11.1)	7(18.9)	18(15.1)
Psychosomatic				
Feeling of fatigue	1(1.9)	0(0)	3(7.9)	4(3.4)
Headaches	19(36.5)*	10(37.0)*	11(28.9)*	40(33.6)*
Pounding of the heart	9(17.3)	6(22.2)*	10(46.3)*	25(21.0)*
Dizzy spells	7(13.4)	1(3.7)	4(10.5)	12(10.1)
Blind spots before the eyes	5(9.6)	5(18.5)	3(7.9)	13(10.9)

* Symptoms that more than 20% of each menopausal group experienced.

Table F9 (Continued)

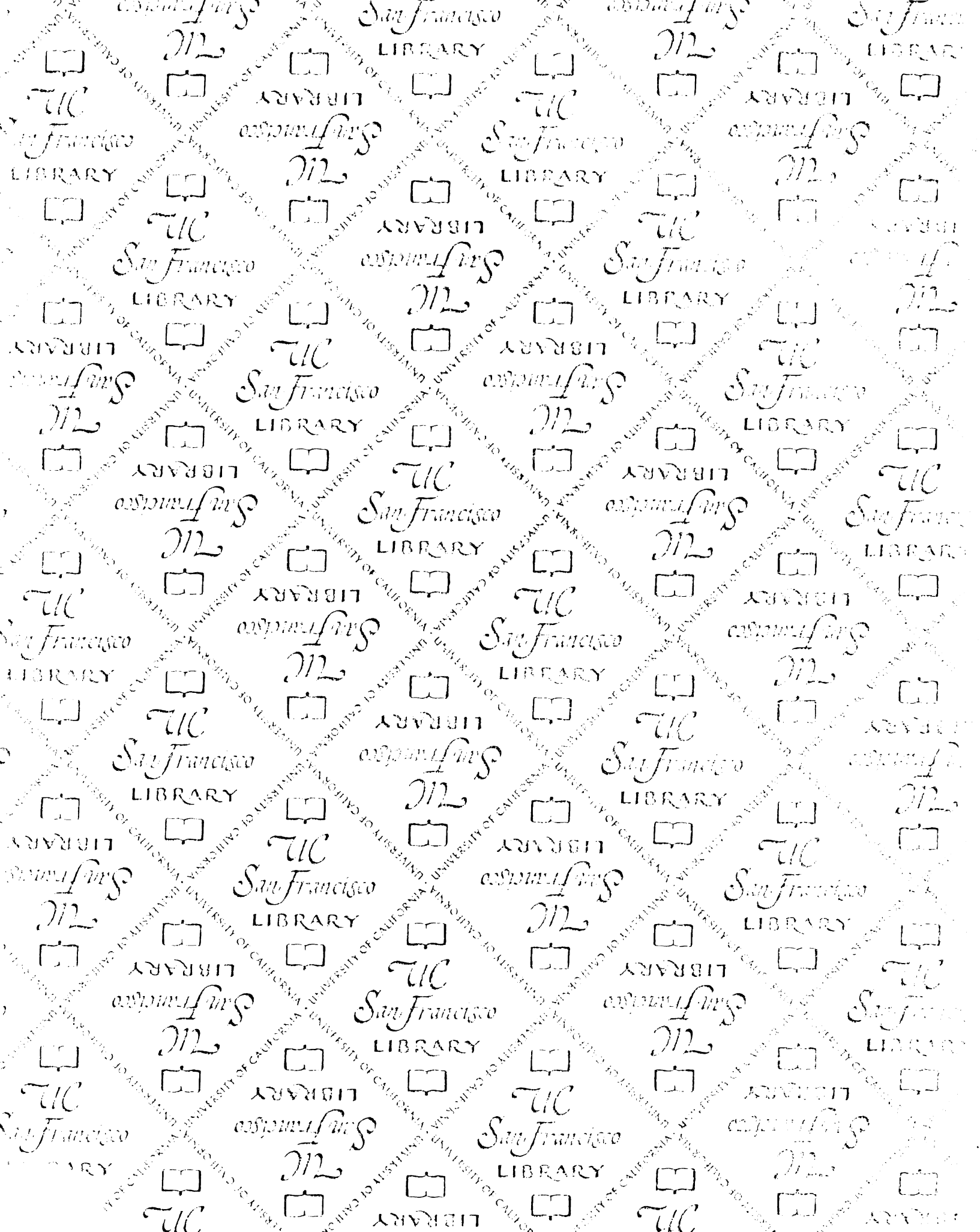
MSC Symptoms	Pre-menopausal women (n=52) N (%)	Peri-menopausal women (n=27) N(%)	Post-menopausal women (n=38) N(%)	Total (n=117) N(%)
Psychologic				
Irritable and nervous	11(21.1)*	3(11.1)	7(18.4)	21(17.6)
Feel blue and depressed	10(19.2)	1(3.7)	6(15.8)	17(14.3)
Forgetfulness	0(0)	1(3.7)	2(5.2)	3(2.5)
Excitable	22(42.3)*	10(40.7)*	10(26.3)*	42(35.3)*
Trouble sleeping	11(21.1)*	7(25.9)*	12(31.6)*	30(25.2)*
Can't concentrate	10(19.2)	5(18.5)	9(23.7)*	24(20.2)*
Crying spells	9(16.7)	1(3.7)	7(18.4)	17(14.3)
Feeling of suffocation	3(5.7)	0(0)	2(5.4)	5(4.2)
Worry about body	10(19.2)	8(29.6)*	14(37.8)*	33(27.7)*
Feeling of fright or panic	4(7.7)	1(3.7)	5(13.1)	10(8.4)
Worry about nervous breakdown	3(5.7)	1(3.7)	5(13.5)	9(7.6)

* Symptoms that more than 20% of each menopausal group experienced.

Table F10. Symptoms reported by research participants according to the menopausal symptoms in the climacteric symptoms scale by Chi (1983)

Symptoms in Chi's scale	Pre-menopausal women (n= 52) N (%)	Peri-menopausal women (n= 27) N(%)	Post-menopausal women (n=38) N(%)	Total (n= 117) N(%)
Hot flashes	5(9.6)	5(19.2)	5(10.5)	14(11.8)
Cold sweats	9(1.9)	1(3.7)	5(13.2)	7(5.9)
Skin crawls	8(15.4)	3(11.1)	7(18.9)	18(15.1)
Nervousness	11(21.1)*	3(11.1)	7(18.4)	21(17.6)
Trouble sleeping	11(21.1)*	7(25.9)*	12(31.6)*	30(25.2)*
Depressed	10(19.2)	1(3.7)	6(15.8)	17(14.3)
Feeling of fatigue	1(1.9)	0(0)	3(7.9)	4(3.4)
Headache	19(36.5)*	10(37.0)*	11(28.9)*	40(33.6)*
Pains in arms and legs	9(17.3)	6(22.2)*	8(21.1)	23(19.3)
Chest palpitation	9(17.3)	6(22.2)*	10(46.3)*	25(21.0)*
Loss of appetite	2(3.8)	3(11.1)	5(13.2)	10(8.4)
Constipation	16(30.8)*	7(25.9)*	6(15.7)	29(24.4)*
Indigestion	8(15.4)	3(11.1)	5(13.1)	16(13.4)
Can't concentrate	10(19.2)	5(18.5)	9(23.7)*	24(20.2)*
Cry spells	9(16.7)	1(3.7)	7(18.4)	17(14.3)
Feeling of suffocation	3(5.7)	0(0)	2(5.4)	5(4.2)
Cold hands and feet	5(9.6)	5(19.2)	4(10.5)	14(11.8)
Feeling of fright or panic	4(7.7)	1(3.7)	5(13.1)	10(8.4)
Knee pains	4(7.6)	5(18.5)	8(21.1)*	17(14.3)

* Symptoms that more than 20% of each menopausal group experienced.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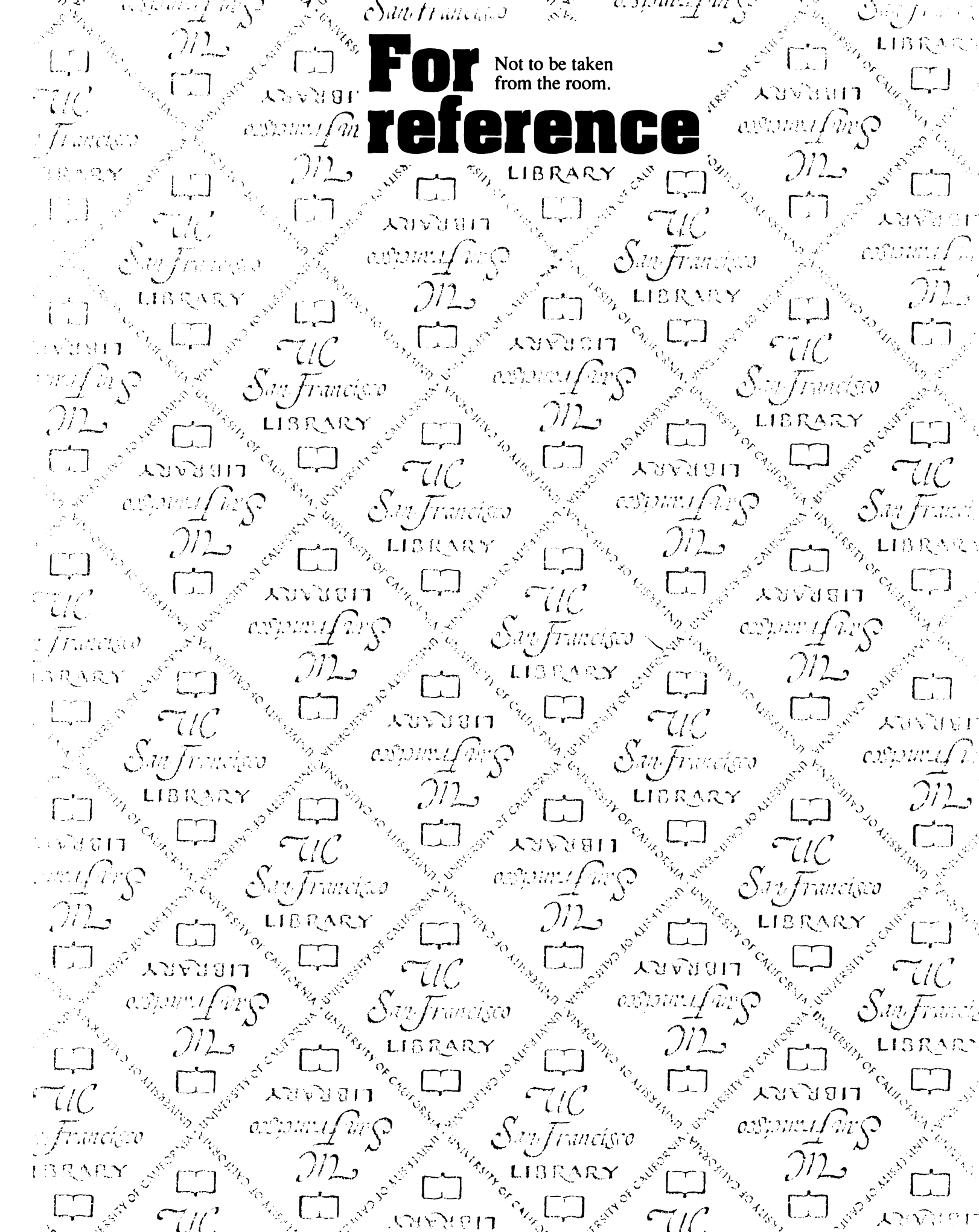
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