Université de Montréal

The Health Experience of Menopause As Described by Native Women

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Mémoire présenté à la Faculté des études supérieures
en vue de l'obtention du grade de
Maître ès sciences (M.Sc.)
en sciences infirmières

Août 1997

Université de Montréal
Faculté des études supérieures

Ce mémoire intitulé

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présenté par

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a été évalué par un jury composé des personnes suivantes:

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Mémoire accepté le 27 août 1997

SUMMARY

Native women will be among the estimated 30 % of the population who will be menopausal by the turn of the century (Roberts, Chambers, Blake and Webber, 1992). Non native primary health care professionals including nurses know very little about the health experience of those native women they serve who are reaching this mid-life transition.

This study sought to answer the following question: What is the health experience of the transition of menopause as described by native women expressed in terms of their underlying beliefs, values and related health practices? Madeleine Leininger's transcultural nursing model served as the conceptual framework of this ethnonursing study.

Seven native women having a close connection with a Mohawk territory in Canada, and into whose conscious experience had crept the notion of menopause, participated in this study as key informants. A total of nine interviews with native women were subjected to a qualitative content analysis using Leininger's four phases. This analysis revealed recurrent patterns, beliefs and values, and five emerging themes describing the experiece of menopause: Native women experience: a) menopause as natural, a part of the life cycle of a woman; b) menopause as a time of vulnerability to negative energy; c) menopause as a time for sharing knowledge, wisdom, and memories; d) the manifestations of menopause with confidence and equanimity; e) different health practices depending on their integration of traditional culture.

It was found that among the dimensions of social and cultural structure influencing a person's health experience (Leininger, 1991), religion and philosophy had the strongest influence on the menopausal health experiences of the native women interviewed. The women's experiences varied according to their degree of acculturation into and identification with mainstream culture, or with their re-appropriation of traditional cultural ways. Regardless of their chosen cultural path,

spirituality was consistently meaningful in the lives of the women interviewed, whether expressed through traditional cultural ways, through western religion, or through a creative blending of the two.

Native women demonstrated considerable diversity in their perceptions and experiences of menopause while sharing commonalities among themselves, as well as with women of other cultures, as reported in the literature.

The present study has revealed some new experiential cultural knowledge about the health experience of menopause of native women. Among the discoveries of this study are knowledge about the vital spiritual life of these women, their perceptions of woman's role, and their connection with nature. Generic health care practices previously unknown to non native, and even to some native women, were shared with us within the context of this study. The acquired knowledge could serve as a base from which nurses can explore with native women their health concerns during this transition and beyond. This study also enriches the body of women's alternative knowledge about the experience of menopause, the type of information for which women have expressed a desire (McKeever, 1988). The sharing of experiential knowledge could help women of all cultures navigate this transition by blending and borrowing ideas and practices in order to come to a new and expanded understanding of themselves and their experience.

Possible venues for further research include an exploration of the significance of sexuality for these menopausal women, the influence of changing social and family patterns on their health, and the impact on their health of the intergenerational transmission of health beliefs about experiences like the menopause.

RÉSUMÉ

La problématique

Le groupe de femmes entre 40 et 60 ans est celui qui croît le plus rapidement dans la société nord-américaine aujourd'hui (Wilton et Noonan, 1991). En l'an 2000, trente pour cent de la population sera composé de femmes ménopausées (Roberts, Chambers, Blake et Webber, 1992). Les femmes autochtones feront partie de celles-ci.

Le système de santé actuel a été établi sans consultation auprès des communautés culturelles et les pratiques professionnelles reflètent les valeurs et croyances de la culture dominante. De plus, ce système repose sur le modèle biomédical. Dans ce contexte, la ménopause est souvent vue comme une maladie ayant besoin de traitement. Cette vision ne reflète pas nécessairement l'expérience vécue des femmes. Buck et Gottlieb (1991) décrivent deux perspectives courantes de la ménopause. L'une voit la ménopause comme étant une phase de croissance et de développement, l'autre comme le début de la dégénérescence. Les professionnels de la santé, incluant les infirmières, ont peu de connaissances sur l'expérience de santé telle que vécue par les femmes, en particulier les femmes autochtones.

Le but de cette étude

Le but de cette étude est d'explorer l'expérience de santé de la ménopause telle que décrite par des femmes autochtones incluant des pratiques de santé ainsi que les valeurs et croyances sous-jacentes.

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[1] Les mots *infirmière* et *chercheuse* incluent le féminin et le masculin.

Le cadre conceptuel

Cette étude s'inspire de la théorie de diversité et d'universalité des soins culturels de Madeleine Leininger. Le but de cette théorie est de découvrir des façons de donner des soins infirmiers cohérents aux personnes de différentes cultures; elle permet de découvrir des différences et des similitudes dans les expériences de santé chez divers peuples. Le modèle Sunrise, représentation graphique de la théorie, donne une vision globale des éléments centraux et reliés entre eux. Selon Leininger, la vision du monde est à la base des conceptions qu'un peuple se fait des expériences de la santé et de la maladie (Leininger, 1988). Les composantes de la culture et de la structure sociale, dynamiques et changeantes, sont les facteurs technologiques, religieux et philosophiques, sociaux et familiaux, les valeurs culturelles, les modes de vie, les facteurs politiques, légaux, économiques, et éducationnels. Dans la présente étude, l'expérience de santé de la ménopause des femmes autochtones en termes de valeurs, croyances et pratiques, est explorée à la lumière de cette théorie.

Question de recherche

Quelle est l'expérience de santé de la ménopause, incluant les pratiques de santé, exprimée en termes de valeurs, croyances et pratiques, par des femmes autochtones?

Recension des écrits

Les écrits pertinents à trois thèmes touchant cette étude ont été examinés: le modèle conceptuel de Leininger; les femmes autochtones et leur culture, incluant des données démographiques, l'ethnohistoire, la perspective autochtone du monde, les valeurs et croyances reliées à la santé, et le rôle traditionnel de la femme; la ménopause et les pratiques de santé qui y sont reliées à travers les perspectives biomédicales, socioculturelles, anthropologiques et expérientielles.

Méthode

Pour cette étude qualitative, la méthode ethnonursing de Leininger a été retenue. Sept informatrices clés faisant partie de la nation Mohawk au Canada, ont été recrutées. Les critères de sélection des informatrices étaient:

1. Être femme autochtone ayant un lien étroit à un territoire Mohawk.
2. Se considérer comme vivant la ménopause.
3. Être capable de s'exprimer en français ou en anglais.
4. Être d'accord pour participer à l'étude.

Les femmes ont été interviewées une ou deux fois lors d'entrevues en profondeur. Les entrevues se sont déroulées de façon informelle, avec des questions ouvertes et semi-ouvertes. L'étudiante a utilisé un guide d'entrevue qu'elle a élaboré pour s'assurer de couvrir certains thèmes. Les données enregistrées des entrevues ont été transcrites verbatim.

L'observation participante lors de certaines activités et les données recueillies dans un journal de bord, ont aussi été des sources d'information pour cette étude.

Analyse des données

Les données recueillies lors de neuf entrevues ont été analysées selon les quatre phases d'analyse qualitative de Leininger pour en dégager des patterns et des thèmes permettant de comprendre l'expérience des femmes. Des critères d'évaluation spécifiques à la recherche qualitative ont étés retenus pour cette étude dans le but d'assurer la valeur de l'analyse et de l'interprétation des données: crédibilité, patterns récurrents, transposition, confirmation et "meaning in context."

Limites de l'étude

Les tensions historiques entre les autochtones du Canada et la société canadienne en général, persistent encore aujourd'hui. Le fait que l'étudiante n'appartenait pas à la communauté autochtone a pu être une barrière. Les récents conflits entre les premières nations et le reste de la société canadienne pourraient expliquer en partie une réticence ou une méfiance initiale envers l'étudiante et l'objet de sa recherche. De plus, le délai imposé par le contexte de la maîtrise ne permettait pas une longue immersion préalable à l'étude dans la communauté. Pour une recherche ethnograhique, une telle immersion est souhaitable et aurait probablement contribué à des résultats plus approfondis.

Considérations éthiques

Afin de protéger les droits fondamentaux de toutes les participantes, les principes éthiques ont été respectés. L'étudiante a fourni une explication verbale et écrite sur l'étude. Chacune des participantes a été informée du but ainsi que du déroulement de l'étude. De plus, elles ont été avisées de la confidentialité et de leur droit de se retirer en tout temps. Des noms fictifs ont été utilisés et le matériel de l'étude gardé en lieu sûr. Les cassettes ayant servi aux entrevues seront détruites à la fin de l'étude.

Résultats

Cinq thèmes se sont dégagés de l'analyse des données recueillies.

Pour la femme autochtone: a) la ménopause est naturelle, une phase dans le cycle de la vie d'une femme; b) la ménopause est une période de vulnérabilité à l'énergie négative; c) la ménopause est une période pour partager connnaissance, sagesse, et souvenirs; d) confiance et équanimité accompagnent des manifestations de la

ménopause; e) les pratiques de santé varient selon leur degré d'intégration à la culture traditionnelle.

Dans cette étude, parmi les sept dimensions de la culture et de la structure sociale qui influencent les expériences de santé (Leininger, 1991), il apparaît que les facteurs religieux et philosophiques sont les plus liés à l'expérience de la ménopause des femmes autochtones interviewées. Leur degré d'intégration de la culture traditionnelle colore cette expérience. Les femmes qui ont intégré les valeurs, croyances et pratiques traditionnelles vivent cette expérience d'une façon différente de celles qui ont plus intégré la culture de la société occidentale. Les femmes rencontrées ont exprimé une diversité considérable dans leurs perceptions et dans leurs expériences de la ménopause; cependant, elles partagent des éléments communs entre elles, avec les femmes nord-américaines et celles d'autres cultures. En général, pour les femmes autochtones de la présente étude, la ménopause réfère plus à une perspective de croissance et de développement qu'à une perspective de dégénérescence.

Implications

Cette étude apporte de nouvelles connaissances sur l'expérience de santé de la ménopause des femmes autochtones. Ces connaissances peuvent servir de base à partir de laquelle les infirmières pourront explorer, avec les femmes autochtones, leurs préoccupations reliées à la santé, pendant cette transition et après. Tout en tenant compte des valeurs, croyances et pratiques de ces femmes, l'infirmière ayant une approche holiste et une orientation de promotion de la santé, pourra fournir des informations pertinentes et cohérentes en les accompagnant dans cette transition.

Suite à cette étude, l'étudiante énonce quelques recommandations pour des futures chercheuses intéressées à travailler avec des femmes autochtones. Idéalement, une telle recherche prendra la forme d'une vraie ethnographie, ce qui demandera un temps plus long et une véritable immersion dans la communauté. De

plus, il est important pour la chercheuse d'arriver avec une attitude d'apprenante et avec des connaissances ethnographiques du peuple autochtone. Elle prendra soin de respecter le caractère presque sacré de certaines informations reçues, et les transmettra avec le plus grand respect et en toute véracité. La chercheuse respectera le principe d'échange. Idéalement, la recherche chez le peuple autochtone sera faite par les infirmières de cette culture; malheureusement, elles sont trop peu à pouvoir le faire. La profession devrait continuer à promouvoir le recrutement auprès des peuples autochtones.

Des recommandations se sont dégagées suite à cette recherche en ce qui a trait à d'autres thèmes à explorer en sciences infirmières. La signification de la sexualité chez la femme autochtone à la ménopause et l'impact des patterns sociaux et familiaux changeants sur la santé des femmes autochtones sont parmi les pistes de réflexion proposées.

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ACKNOWLEDGMENTS

I would like to thank Jacinthe Pepin, my thesis director, for her expert guidance and continued support . My gratitude also to Suzanne Kérouac without whose caring and inspiration I would have neither undertaken nor completed this voyage. To these two women whom I respect as mentors, wise and faithful advisers, thank you.

Thank you also to Sarah Jane for her belief and support throughout this endeavour, and to my friends for their continual encouragement.

I would also like to acknowledge the contributions of Gynette Aubin, Marie France Bouchard, Monique Coderre and Guy Guenette to the technical preparation of this document.

CHAPTER ONE

RESEARCH FOCUS

As we approach the year 2000, women's health issues concerning a multicultural female population moving towards and beyond middle age must be addressed by health care providers. It is estimated that by the turn of the century, 30 % of the population will be menopausal women (Roberts, Chambers, Blake and Webber, 1992). Women between the ages of forty to sixty are the fastest growing segment of society (Wilton and Noonan, 1991). Native women will be among those reaching the transition of middle age.

Although Canadians have traditionally prided themselves on tolerance toward different cultures within our country, tolerance alone is no longer sufficient to assure health care deemed satisfactory by diverse members of our society (Grimpa, 1993). Our health care system, and the ways of delivering care, were established without input from cultural groups who now use them, including native women. The values and beliefs that the system reflects, and the health practices promoted, are those of the dominant culture. Menopause treated as a disease state, as it is in many health care contexts, does not necessarily correspond to women's life experiences of this natural transition to middle age. Buck and Gottlieb (1991) present two current views of midlife: the biomedical model offers a decremental view of midlife in which menopause is considered a health problem indicating treatment, while the developmental perspective considers menopause as part of the life cycle, and as a time for continued growth and development. It is possible that the developmental perspective corresponds more closely to native women's perspective.

As a primary health care practitioner working with native women in northern communities, the student researcher noticed that menopause is largely ignored by health care workers, let alone considered in it's cultural context, or as a part of the native holistic concept of health. This, in spite of regular "well woman clinics" to

which all women are invited by non native health workers. For middle aged women as for the young, the focus of these clinics is on screening for cancer and sexually transmitted disease, contraception if appropriate, and on issues of violence or abuse. The experience of menopause, including health care practices used by native women to move towards and maintain wellness, remains largely unaddressed by health practitioners. As non native health care practitioners, we have in fact minimal knowledge about the health experiences of the native women we serve, and virtually none concerning their menopause experience. In order to accompany native women through this life transition in a way that is appropriate and meaningful to them, practitioners need to acquire culturally specific and direct knowledge from these women.

Existing studies concerned with women's experience of menopause have been conducted either with non native women, or did not consider the menopause specifically as a health experience.

McKeever (1988) stated that little is known about what it is like to be a middle-aged woman in menopause within a white (Anglo-Saxon) culture. Since then, she and other nurse researchers have provided a glimpse of what it is like through several phenomenological studies. (Dickson, 1989, 1990a,b, 1994; McKeever, 1988; Quinn, 1988). Using an interpretive approach, McKeever (1988) attempted to identify what she termed the available menopausal passages from the North American woman's point of view. This descriptive naturalistic study also explored the self-care practices and/or health interventions used by healthy, Caucasian women during menopause. Four informal explanatory models of menopause emerged from this study as well as significant information concerning the kind of knowledge or information women desire. To decrease the uncertainty associated with menopause, these women expressed the desire for experiential knowledge from other women, rather than theoretical, physiological knowledge.

The experience of menopause for North American perimenopausal women was studied using grounded theory by Quinn (1988). A substantive theory, of

"Integrating a Changing Me", as well as a conceptual model, were developed from this study. Self-care practices were also identified. Menopause was seen as natural by the women in this study, countering the biomedical point of view.

Dickson (1990b) challenged the prevailing discourse on menopause, by exploring the interrelation between knowledge in the scientific/medical discourses, and knowledge in the everyday discourses of a sample of ten midlife women. This phenomenological study takes issue with the way scientific discourses have been accepted as truth, and identifies links among values, assumptions, research and knowledge. These women's stories yielded themes common to their experiences, and both reflected and countered the dominant medical and scientific discourses on menopause (Dickson, 1994). The results of this study confirmed the continuing effects of discourses that reinforce the medicalisation of women's bodies. Dickson (1990b) concluded that free and open discussion with other women could lead women to question the assumptions behind scientific and medical discourses and the resulting expectations associated with menopause (1990).

Knowledge about what native women's health experience is like during menopause is rare. Kearns (1982) studied Papago native women in order to elicit knowledge, attitudes and perceived behavioral patterns concerning menopause. Kearns concluded that there was a significant amount of incorrect knowledge, or lack of knowledge concerning menopause among Papago women, and that attitudes and knowledge appeared to be governed largely by traditional values and practices, particularly among older women. Menopause was difficult to accept because it means no more children.

Wright (1982) studied native women using sociological variables to explain variability in symptom experience. Interviews were conducted with forty "traditional" women, and an equal number of "acculturated" women, between the ages of 40 and 60. Wright concluded that sociological variables alone did not explain variability in symptom experience, and that the issue is more complex than originally hypothesized. Neither of these early studies examined the health

experience of native women from their own perspective.

One of the few studies of native women's experience of menopause is that of Buck & Gottlieb (1991). This study explored the experience of menopause of eight Mohawk women within the context of their other important life experiences, using a grounded theory approach. The four major issues experienced at midlife as described by these native women related to the concept of time : it is time for me, being where I should be, time for myself, and my time is spent meaningfully. Buck & Gottlieb describe the women as falling into one of two groups - those "in synchrony," who viewed their lives as following expected time pathways - and those "out of synchrony," who identified certain aspects of their lives as problematic. The idea of menopause specifically as a health experience including health care practices, is not addressed in this study.

To the author's best knowledge, no study examining the life transition of menopause as a health experience, including health care practices and in relation to underlying cultural beliefs and values, has been done with a population of native women.

With the kaleidoscope of cultures in our increasingly pluralistic society, health care providers are challenged to consider the cultural and individual diversity of women going through the universal health experience of menopause, as well as the shared commonalities of the experience. By gaining direct knowledge from these women, health care providers like nurses may come to understand the differences and similarities of women's experiences of the transition of menopause. As Dickson (1994) points out, nurses may have general knowledge to share with a woman regarding physiological changes taking place in this transition. But, as McCain (1991, in Dickson, 1994, p.19) underlines, "menopause is so much more than machinations of hormones, it is longer and wider and much deeper than the happenings in my physical self." The meaning of the experience for each individual woman, (Dickson, 1994) and her health perceptions, beliefs, values and practices, are what nurses may learn to understand and help women grow with. Shared

knowledge and understanding of experience between women, care givers and care receivers, could lead to more truly appropriate and helpful supportive modes of action by nurses accompanying women through this transition.

Leininger (1991), founder of the field of transcultural nursing, states that culturally congruent care can only be given by providers having specific cultural knowledge. Health experiences, including generic health care practices, are embedded in social context and culture. Values, beliefs and knowledge, acquired in the cultural context, are handed down through generations and form the foundation of health experiences. By seeking out information about the health experience of native women going through the universal midlife transition of menopause, we hope to gain understanding about the differences and similarities of their experience as native women. Through the framework of Leininger's transcultural nursing theory (1991), we hope to understand the cultural influences on their experience and health practices.

Exploration of native women's perception of the experience of menopause, including their health practices and underlying beliefs and values, could enrich the body of women's alternative knowledge about this universal health experience. It could provide nurses with experiential transcultural knowledge from which to explore with native women their health concerns and needs during menopause. According to transcultural nursing scholars, enhancement of a client's health practices is contingent on the nurse's ability to use the individual's culturally based beliefs and values as an integral component in the collaborative planning and implementation of care (Boyle & Andrews, 1989; Giger, 1991; Henkle & Kennerly, 1990; Leininger, 1991).

The goal of this study is to describe the health experience, including health care practices, as expressed by native women going through the transition of menopause, as well as their underlying beliefs and values.

The women targeted for this study are those native women in the transition to middle age, into whose consciousness has crept the notion of menopause...the idea that it might actually apply to themselves.

Research Question

What is the health experience of menopause as described by native women expressed in terms of their related values, beliefs and practices?

CHAPTER TWO

LITERATURE REVIEW

This chapter devoted to the review of literature is divided into three sections. The first of these explains Madeleine Leininger's Theory of Culture Care Diversity and Universality, chosen as the frame of reference for this study. In the second section, an overview of native women and various aspects of their culture is presented. A brief ethnohistory covering the time period from contact until present day will situate them within the sociopolitical context. A presentation of native world view helps the reader to better understand various contextual cultural elements of the study. Health beliefs and values underlying traditional and western medicine will be examined for comparison. A discussion of native woman's traditional role will follow. The final section of this chapter consists of a review of the various perspectives from which menopause has been studied, including those studies identifying health care practices during menopause. Pertinent literature from the biomedical, sociocultural, anthropological and experiential perspectives will be reviewed.

Frame of Reference

It is appropriate to study health experience in cultural context within the framework of Madeleine Leininger's Theory of Culture Care Diversity and Universality. This theory was developed over three decades to discover ways of providing care to people having cultural values and beliefs, health perceptions and practices, different from those of the health care provider and to increase client's degree of satisfaction with care (Leininger, 1985a). The ultimate goal is that nurses provide culturally congruent care to all people. According to Leininger, founder of the field of transcultural nursing, culturally sensitive health care can only be provided by care givers having specific cultural knowledge about the people's health perspective, and the values and beliefs underlying their health care practices

(Leininger, 1991).

It was through a judicious blend of anthropological and nursing knowledge that Leininger (1978) conceived her theory, whose uniqueness lies in the comprehension of the influence of culture on health experiences of individuals and cultural groups (Kuster, 1997).

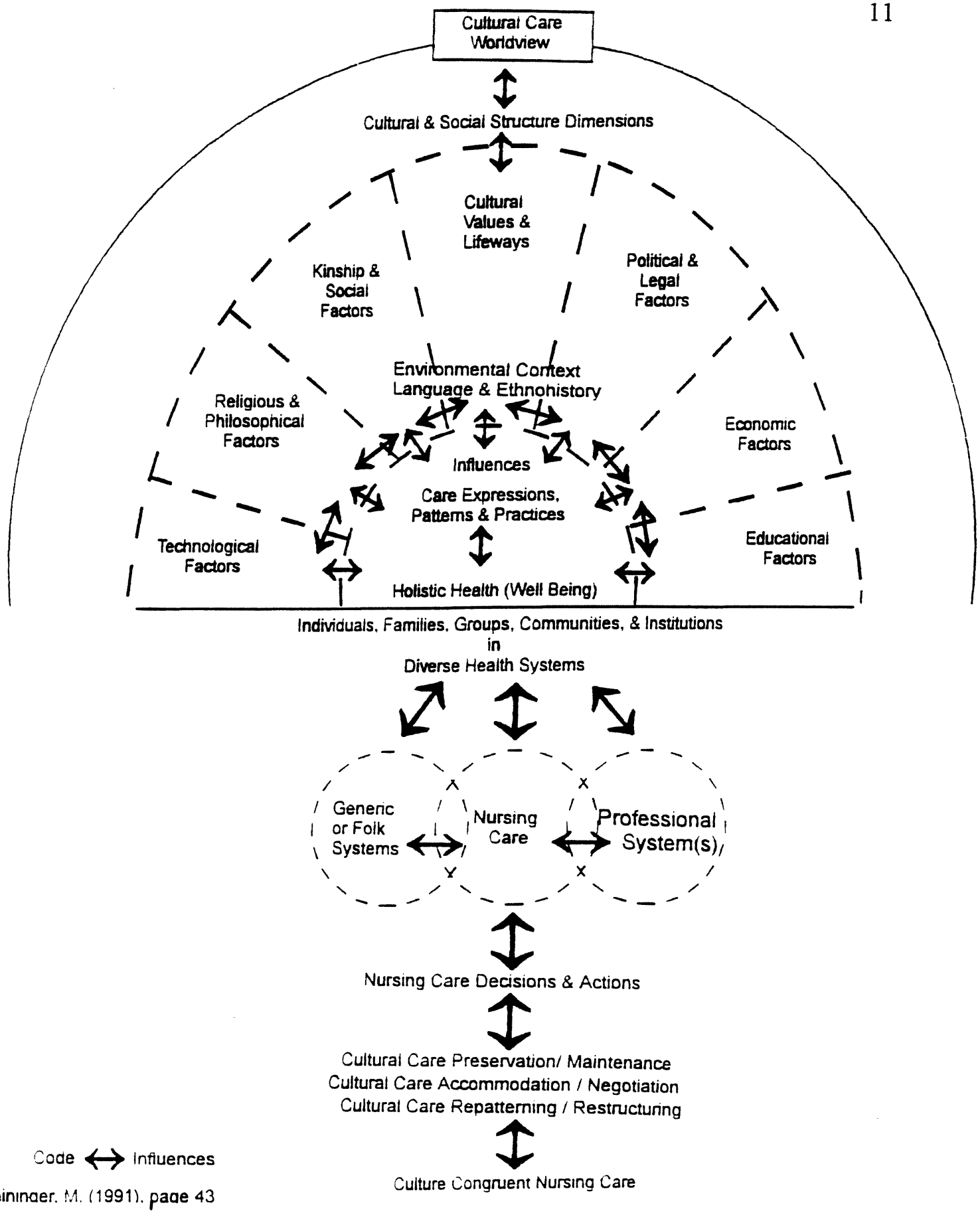
The Sunrise Model, graphic representation of Leininger's theory of Culture Care Diversity and Universality, provides a gestaltic view depicting different but closely inter-related dimensions of the theory (Figure 1). These dimensions, all influencing well being and health experiences, are held to be inextricably related to each other. The model thus helps the student researcher envision a cultural world where these various dimensions may influence the health experience of menopause as lived and described by native women.

The upper part of the semi-circular model represents the world view, including cultural and social dimensions affecting well being. World view refers to the way people tend to look upon the world to form a picture or value stance about their life and the world around them (Leininger, 1988). Environment and language are integral components of this world view. According to Leininger (1988) the world view and life patterns of a cultural group form the basis for their conceptions and convictions about health and illness experiences. Seven dimensions of cultural and social structures are identified as having direct and reciprocal influence on holistic well being and care expressions, patterns and practices. These are : technological factors, religious and philosophical factors, kinship and social factors, cultural values and lifeways, political and legal factors, economic factors, and educational factors. The model is open, with bi-directional arrows indicating reciprocal influence between and amongst dimensions as well as broken lines indicating flexible demarcations between the various dimensions. Leininger (1991) also points out the need to be aware of ethnohistorical dimensions of the cultural group studied, as all the sociocultural factors are dynamic and in constant evolution.

The lower part of the model depicts diverse health systems which impact on

Figure 1

Leininger's Sunrise Model to Depict Theory of Cultural Care Diversity and Universality



Code ↔ Influences

Leininger, M. (1991), page 43

wellbeing. Leininger (1991) distinguishes between the generic or indigenous health care system and the professional nursing care system. Care is held by Leininger (1990) to be both a universal and diversified concept, defined and expressed according to cultural context. She further postulates that care is the unifying and distinct characteristic of nursing (Leininger, 1991). Of interest to the student researcher are the culturally learned and transmitted generic health care practices used by native women during the health experience of menopause. These are the skills and knowledge used by women to support, assist, facilitate and enable this passage.

According to Leininger, using favorable aspects of the generic care system as the basis for professional nursing care, could lead to people receiving beneficial, satisfying, and culturally congruent health care. Conversely, if this linkage between generic and professional care does not occur, cultural conflicts, non compliance behaviours, cultural stresses, imposition practices and other unfavorable problems will arise (Leininger, 1970, 1978, 1984, 1985a, 1991).

Through the use of three modes of action, nurses can collaborate with clients to promote well being during health experiences. These modes, used in accordance with the culture care data obtained in the upper part of the model are:

- Culture care preservation or maintenance of generic care practices;
- Culture care accommodation or negotiation;
- Culture care repatterning or restructuring.

According to Leininger (1991), the concepts of health and well being are embedded in culture, as are health practices based on beliefs and values. Health experiences and health care practices are seen by Leininger as having both universal and diverse features accross cultures. The culture care theory provides the student researcher with a broad general framework within which to understand the health experience of menopause, including health care practices, as lived and described by native women.

The theory of culture care diversity and universality has been developed with

the help of 54 studies of different cultures. Among these are studies of North American Indian Cultures, facilitating understanding of some of the values, care meanings, and actions common to these cultures (Appendix 1). Harmony with nature and respect for each other are predominant values underlying the care meanings and action modes which were discovered in these studies.

Native Women and Their Culture

Demographic Data

In 1991, 522,000 aboriginal women lived in Canada, representing 4 % of the total feminin population. As in the general population, they are in a slight majority compared to men, constituting 51.4 % of the aboriginal population (Moore, 1991). Forty seven percent of these women described themselves as uniquely of aboriginal origin, either North American Indian, Metis, Inuit, or a combination of these. This same year, 36 % of aboriginal women indicated only North American Indian as their ethnic origin. Most of these women are status Indians according to the Indian Act. An explanation of this distinction between being status or non status, of major importance for many natives, follows.

The Indian Act did not treat women and men in the same way. Before 1985, aboriginal women who married non-aboriginal men, thereby lost their Indian status, and were therefore no longer considered band members; neither could they transmit Indian status to their children. However, the situation was the opposite for aboriginal men who married non-aboriginal women: these women were granted status by marriage. This explains the fact that today, there are white women who are considered status Indians. In 1985, the law was modified to permit a large number of women and their children to recover their status, and in some cases to again become members of their bands. Besides those women who had lost their status through marriage, other women who had been obliged to renounce their status in exchange for the right to vote, or to join the military, were able to recover their status

following this amendment to the law (Moore, 1991).

Fifty-four percent of Indian women claiming only North American Indian heritage live on reserve or Indian territories. Other Indians of mixed origin and non status Indians are much less likely to live in these areas. Thirty-three percent of native women live in rural areas compared to only 15 % of other women in the general population (Moore, 1991).

In Quebec, there are 72,975 native women, representing 14% Canada's native women and 2.1% of the feminine population in the province. On the average, native women are younger than non native women, only 3% of them being over 65 in 1991, compared to 13% of non native women; 10% of native women, versus 20% of non native women are between 45 and 64 years of age. Life expectancy of native women is substantially lower than that of non native women - 74 years as compared with 81 years in 1991. However, life expectancy for native women is rising rapidly, increasing 8.1 years between 1975 and 1991, as compared to 3.4 years for Canadian women in general. As for women in general, status native women have a longer life expectancy than men of the same ethnic origin (Indian and Northern Affairs, 1992).

In 1991, the majority of native women, 76%, reported using mostly English at home, compared to 11% who use French, and 11% who use a native language most often (Moore, 1991).

In terms of their family situation, most native women between the ages of 15 and 64 live with their families. This proportion is similar to that found in other populations. Native women are, however, twice as likely to be single mothers (15% versus 7%) and less likely to be living with a partner (53% versus 63%) than other populations. In general, native women have more children at home than other women. Twenty-three percent of native women had at least three children at home as compared to 14% for non natives (Moore, 1991).

Native women generally have a lower educational level than other Canadian women. In 1991, only 6% had university education compared to 13% of non natives. They are also less likely than other women to have completed high school (24%

versus 18%).

Among native women, the proportion of those employed outside the home is lower than for non native women. Forty-seven percent of native women worked outside the home compared to 54% of non native women. As is the case for many women, a large proportion of native women worked part time. About half of employed native women work in traditionally feminine professions, about the same proportion as other women (Moore, 1991). They are slightly less likely than other women to hold managerial positions or practice a liberal profession (12% versus 15%) (Moore, 1991).

Ethnohistory

From their very arrival in North America, Europeans brought with them their ideas of colonialism and cultural imperialism. This was the meeting of two cultures, one holding a philosophy of domination, the other of non intervention (Langlais, 1991). At contact (the term used by many native people to designate the arrival of Europeans), native peoples proposed the treaty of the Wampum as a guide to interactions between natives and non natives. This treaty represented the recognition of two equal peoples, each with their own laws and customs, living in mutual respect and harmony side by side, allowing for the possibility of collaboration but not for domination:

> Il s'agit du traité des voies parallèles, le Wampum-à-deux-rangs. Les rangs marquent les sillages de deux canots, celui du peuple autochtone et celui du peuple européen, chacun avec ses lois et ses coutumes. Tous deux naviguent sur la même rivière, sans tenter de conduire le canot de l'autre (Langlais, 1991, p.4).

Europeans however, opted for domination: taking possession of territories, driving back the native peoples into more and more remote areas, creating reserves, passing treaties, banishing ancestral rights, suppressing natural spiritual ways while imposing their religions and undermining traditional native government born of clan

mothers by imposing a white style of "democratic" government. Today, there remains a rift between natives who continue to support the traditional style of government and those who support the white style of government in the form of "band and council" (Langlais, 1991).

For over two hundred years, paternalistic and ethnocentric policies and administrations have governed interactions with Canada's aboriginal peoples (Thomlinson, 1993). Currently, there is a strong activist climate on some Indian reserves, with a mounting movement towards self-government and self-determination. Communities are in transition and are at different stages of development.

In an attempt to regain control over their lives and improve their poor health status, aboriginal peoples are also demanding control over their own health care (Thomlinson, 1993). According to Thomlinson (1993), many if not most would probably prefer to receive their health care from native health care workers who understand and share their cultural beliefs, values, and practices. Unfortunately, this ideal is not yet attainable due to a dearth of native health care practitioners (Thomlinson, 1993). The extent to which traditional native health values are respected and traditional ways practised in any community depends on its particular history and cultural experiences. According to Malloch (1989), on many reserves people have lost much of their health related spiritual cultural traditions in the wake of Christian religions and western medical values and practices. There are still however, some native people practising native traditions, including medicine; although many of these are elders, there is a growing interest among younger generations to learn native principles of health and healing (Malloch, 1989).

Native Worldview

Traditional natives base their lives on natural rather than man made laws:

> Une poire est une poire, elle n'a pas à devenir autre chose; un Mohawk est un Mohawk, il n'a pas à devenir autre chose. Chacun doit suivre les

lois inscrites dans sa nature même (Robillard et Vachon, 1991, p. 7).

Traditional Mohawks believe that they are born into the world such as they are, with a pre-determined nature with which they will learn to be in harmony. They do not try to change their nature or transform their lives as western peoples who sometimes feel they are the artisans of their own destinies. Rather, they try to live in harmony with the nature of all things.

Living in harmony with nature is also based on the philosophy of non intervention. Traditional Mohawks do not see themselves as superior to nature. They will never try to dominate, master, or improve it; rather, traditionalists see themselves as equals, related to all aspects of nature: animals, birds, plants, rivers, wind are all relatives. One does not interfere in the lives of these relatives any more than one interferes in the lives of other human beings. Basic needs for food and lodging are satisfied with the help of these relatives in a spirit of gratitude and reciprocity, interfering with them as little as possible. An attitude of thanksgiving permeates traditionalist's relationship with nature:

> Si tu as besoin de manger, si tu dois tuer un animal, traverser une rivière, utiliser une roche, le devoir de non-intervention va t'inspirer d'intervenir le moins possible. Ainsi, tu vas couper une branche après avoir offert du tabac en signe de paix pour réconcilier avec la "famille" de qui tu prends quelque chose: Excuse-moi frère, soeur, nous sommes faibles et nous avons besoin de toi (Robillard et Vachon, 1991, p.7).

Within this worldview, there is neither concept nor name for leader ; the idea of chief is one invented by white men who did not understand the unfamiliar political structure of traditional societies. Rather than a leader, traditional Mohawks refer to a spokesperson of the great law of peace, a natural as opposed to a man made law. This person, responsible for upholding the law of peace, is neither elected nor chosen , but rather is named for life by the clan mothers. Women of experience, being closer to Mother Earth and nature than men, are able to discern who has the required qualities. This person is not a representative, but rather a

spokesperson, who must consult the community every time he speaks; and when he speaks for the community, he does so for the next seven generations to come, and for all of nature. This person, "le royaneur", meaning "the good man or woman" must be spokesperson for his clan, and his nation. Although a man or woman can be named, only the man acts in public. National "leaders" are men. It is the women, however, that supervise him and advise him if he is not fulfilling his role (Robillard and Vachon, 1991; Personal communication with native women, 1997).

This social organisation based on consensus is foreign to western societies. It does not exclude divergence of opinions but rather seeks to find harmony that includes these differences.

Another aspect of social organisation that derives from the native worldview is the absence of a notion of property. The earth belongs to no one, any more than the wind or the clouds. Traditionalists refer to "Mother Earth", in this matrilinear but not matriarchal tradition (Robillard and Vachon, 1991).

Native Health Beliefs and Values

A literature review concerning native culture and concerns leads us to understand that fundamental cultural elements concerning values, beliefs and knowledge related to health and well being exist and are different from those of mainstream Canadian culture. Although it is important to recognize the cultural diversity existing between different native nations (Cook, 1995), it has been found that the underlying values with regards to health are very similar among the native peoples of Canada (Molloch, 1989). Some of these values are reflected in the native perspective of health, as described to the House of Commons (1995):

> Aboriginal peoples generally define health or wellness in a holistic way, as a circle within which there is balance and harmony of inner and external forces. The inner forces most often refer to the spiritual, physical, mental, and emotional aspects of the individual, while the external forces combine the social, cultural, economic, and political environments of a person. The individual is considered through his or her entire lifespan as

> child, youth, adult, elder, and within his or her entire world of family, community, and society. Harmony and balance are emphasized first within the individual, and second, between individuals and their environments (House of Commons Standing Committee on Health, 1995).

Four components of wellness and related health practices were described to the committee by a native health care worker: Elements of the mental, physical, spiritual, and environmental components were described:

> The mental component includes positive thinking, good judgment, exploring creativity, maintaining self respect and understanding one's emotion. The physical component includes respecting our bodies, acceptance of illness, practising routine exercises, maintaining stress level and choosing healthy foods. The spiritual component includes the learning and practice of having faith and believing in a higher power [...] And being respectful and thankful to the higher power for all things. The environmental component includes respect for all land, water, human-animal life and air (Theresa Meuse, 1995, House of Commons Standing Committee on Health, p.11).

Good health is considered to be a "a gift from the Creator" (Malloch, 1989, p. 106). To care for and maintain one's health by following the natural (traditional) ways is a personal responsibility, indicating self respect and appreciation for this gift. Neglect of one's health or self abuse are signs of disrespect for the Creator. All elements must be attended to and kept in balance for good health; neglect in one of these areas can lead to imbalance affecting the others, having a detrimental effect on well being and potentially causing sickness (Malloch,1989; Personal communication with native women, 1997). Imbalance may be due to a number of factors within or outside of one's control , from one's internal or external environment. For example, one may not have eaten the appropriate foods, gotten enough exercise, fasted or cleansed properly. One's own negative thoughts can cause imbalance and sickness, as can an ill spirit indicating failure to observe ways of living respectful to one's spiritual nature. Sickness and imbalance can also be caused by someone else directing negative energy toward us; it is therefore important to protect oneself from

such negativity through the natural ways known to the people (Malloch, 1989). The Earth, considered "Mother", provides all that is needed for wellness: "...whole foods, pure water and air, medicines, and the laws and teachings which show us how to use these things wisely" (Malloch, 1989, p. 106). Combining these gifts from Mother Earth with an "...active lifestyle, a positive attitude, and peaceful and harmonious relations with other people and the spiritual world" results in good health (Malloch, 1989, p.106).

Traditional medicine is one of the expressions of native health beliefs and values. According to the natural ways, medicines coming from the Earth are regarded as sacred gifts from the Creator, calling for proper care and respect in all phases of their use. An offering of tobacco is made before picking medicines or when spiritual healing is sought, in honour of the spirit of the medicine and it's contribution to the life cycle. One is asking for the power of the medicine and offering tobacco in return for it's help. Medicine may not be bought or sold (Malloch, 1989; Personal communication with native women, 1997)

Various conditions must be respected in the harvest of medicines; the person harvesting must ensure that they are taking care of themselves. The time of the moon for picking, by whom, what to pick, picking each medicine in it's own correct time, and picking with intentions of using the medicine's power in a good way are all important elements related to the effect of the medicine. Native medicine works on both symptoms and the cause of illness (Malloch, 1989; Personal communication with native women, 1997)

According to traditional native knowledge there exists good and bad energy, both in medicine and in the natural world. The role of the traditional practitioner is to practice good medicine in order to help, but she or he must also understand negative forces in order to balance them with the positive (Malloch, 1989).

Malloch (1989) draws a comparison between the values underlying traditional native medicine and western medicine (Figure 2). This comparison highlights differences and similarities between the two systems. Many of the underlying principles of the two systems are in direct opposition to each other.

Figure 2 TRADITIONAL MEDICINE and WESTERN MEDICINE:

A Comparison of Values

Traditional Indian Medicine	Western Medicine
Integrated, holistic approach to health; body, mind and spirit interact together to form person	analytic approach: separation of body, mind and spirit (total split between medicine and religion)
emphasis on prevention of sickness	emphasis on disease, treatment
personal responsibility for health and sickness	impersonal, "scientific" approach to health and sickness
health and sickness understood in terms of the laws of nature	health and sickness understood in terms of quantifiable, scientific data
man living in balance with nature, with natural law	man controlling nature, manipulating natural variables
traditional medicine governed by the laws of the Creation: everything we need comes from the Earth-our food, medicines, water, education, religion and laws	Western medicine governed by laws of the State, man-made laws which grow out of a political-economic system
medicine man is accountable to the Creator, to the people, to the elders of his medicine society	doctor is accountable to the government, and to his professional association
medicine is not for sale, not for profit-it is a gift to be shared	medicine is a business, the patient is the consumer, the doctor and the medical industry profit
the land and the people support the medicine man and his practice	the government, the taxpayer and the consumer support the doctor and the practice of medicine
encourages self-sufficiency, self care and responsibility and control by the people	encourages dependency and abdication of self-government by the people

L. Malloch, 1989. Indian medicine, Indian health. Canadian Woman Studies, 10 (1), p. 109.

However, many of the values underlying native medicine are very similar to those now being promoted in nursing: a holistic vision of the person, an emphasis on promotion of health and prevention of illness and personal responsibility for health, are all of interest to nursing.

The ways in which the beliefs and values underlying the native perspective of health are reflected in native women's health experiences and practices related to menopause, remain largely a mystery to non native health workers. An examination of her traditional role provides some insight.

Traditional Role of Native Women

Caring for others in her family and in her community is fundamental to woman's traditional role in society (Personal communication with native women, 1997). Woman is warm, loving and caring (Monture, O'Connor & O'Connor, 1989). Women are also "the strong ones" because they are the "givers of life" (1989, Monture, O'Connor & O'Connor) ; they transmit their strength through the loving energy of family ties to their husband and sons (Personal communication with native women, 1997). According to Malloch (1989) :

> Woman is the Earth, the centre of the circle of life. She brings forth life; she is the caretaker of life. She nourishes, nurtures and heals in the same way the Earth does. Her reproductive power is sacred and she has great natural healing powers that derive from her spiritual connexion with the Earth (Malloch, 1989, p. 106).

The traditional native woman cares for, nourishes and heals her family using the gifts of the earth. She knows and uses the plants and foods necessary for the maintenance of her family's health; she is familiar with the basic home remedies used for the treatment of illness. She transmits important womanly knowledge of health rituals and traditions to her daughters (Malloch, 1989; Personal communiation with native women, 1997). Woman also nourishes the mental and spiritual health

of her children by the natural way she bears and raises them. Some women may be recognized for their knowledge and skill in the use of herbal remedies, although men may also fulfill this role. (Malloch, 1989).

In traditional culture some women fulfill the role of midwife. According to the natural ways, the sacred natural event that is birth must be protected rather than interfered with:

> Women are the caretakers of the birth process. This is a responsibility and a power which women have. A midwife is a mother herself who knows the power on the female side of life...She helps other women [throughout pregnancy and delivery] to also discover and take responsibility for their female power. On the other side of the pain experienced in childbirth is knowledge, strength and power (Malloch, 1989, p.108).

According to traditional ways, parents, grandparents, and even great-grandparents have a responsibility for children's well being. By living and behaving according to the natural ways, they can avoid risking injury to the children for whom they are responsible (Malloch, 1989). Traditionally, woman is the first teacher; as woman, mother, and grandmother, teaching is an important part of her role. There is no use of persuasion or force in her teaching, but rather, a benevolent surveillance of the acquisition of knowledge and the revelation of the nature of the person. Teaching is often done by example and learning is experiential. The native philosophy of non intervention applies also to child raising, teaching and learning (Robillard and Vachon, 1991). Many elders and traditional people speak of learning in this way: "as I have come to understand this." This is important to comprehend if one wants to come to understand traditional people (Monture, O'Connor & O'Connor, 1989).

Teaching and learning is a circle, congruent with other aspects of native philosophy; it is inter-generational, inter-active with all beings:

> Even as grandmothers we never stop learning. We go to our Elders and to our daughters and to our grandchildren. We see that there is continuous

> teaching all around us. We know you can learn important lessons from the smallest living thing to the most vicious human being or animal (Monture, O'Connor & O'Connor, 1989, p.39).

Clan mothers are traditionally elder women designated by women in general; part of her role is to be a teacher. Clan mothers orally transmit tradition and culture to future generations that it may not be lost. Some native women today feel that they also have a larger role to play in the healing of the Earth, for their own survival and for that of all peoples. As women, they want to teach their own people self respect through an understanding of their own history and the injustices that they have suffered. They also want to teach all nations to work together, to heal the earth (Monture, O'Connor and O'Connor, 1989; Personal communication with native women, 1997).

Native culture is in transition. Historical conflicts between Indian and white ways of life are, understandably, still not resolved. But as health care workers who choose to work with native peoples, we must develop an acute sensitivity to, and respect for, their cultural ways. This can only occur by acquiring knowledge, the type of knowledge we hope that native women will be willing to share with us.

In Canada, for diverse historical and other reasons, information about native peoples, their culture and values, is not widely known by non natives. Most available information about the health of native peoples focuses on problems, including physical and sexual abuse, substance abuse, suicide, and a host of physical illnesses (Standing Committee, House of Commons, 1995). Little research has given us knowledge about their positive health care practices and traditional ways of being well through life experiences like the menopause.

In the following section, the student researcher will present some of the perspectives from which the experience of menopause has been considered.

Different Perspectives of Menopause

The Biomedical Perspective

Among the many perspectives from which the menopause has been considered, in North American society, the Western biomedical model remains dominant and influential on women's health experience. This model represents the cornerstone of what Buck and Gottlieb (1991) refer to as the decremental perspective. Current medical literature discusses menopause as a pathological and deficient state. It is not uncommon to find a discussion of menopause in medical texts under the heading of "disease of estrogen deprivation" or and "functionless organs" are used (Martin, 1991). Furthermore, Beyene (1986) points out that menopause is indexed in the International Classification of Disease. Utian (1990) contends that the medical community now has "overwhelming evidence" supporting the contention that the climacteric is a "true endocrinopathy that adversely affects women's health"(Utian, 1990, p.2).

The domain of sex endocrinopathy emerged in the 1930's and 1940's, laying the foundation to support the modern day biomedical view of menopause as a hormone deficiency state. Once menopause was linked to hormone deficiency, it logically followed that the medical treatment should be hormone replacement therapy (Bell, 1987). The first descriptions of menopause as a deficiency disease coincide with the development of synthetic estrogen (Fishbein, 1992). Robert Wilson's publication in 1966, Feminine Forever, reinforced the deficiency theory. Wilson (1966) promoted the view that by taking estrogen throughout her lifetime, a woman could avoid menopause.

Today, medical literature continues to promote the use of hormone therapy, not only for the relief of menopausal symptoms, but also as a means of prevention of osteoporosis and cardio-vascular disease (Barret-Connor, Wingard and Criqui, 1989; Hutchinson, Polansky and Feinstein, 1979; Richelson, Wahner and Melton, 1984). Epidemiological studies have documented the benefits of hormone

replacement therapy for women at risk for osteoporosis (Prince, 1991). This is the current major biomedical rationalisation for women taking hormone replacement therapy (Bell, 1990). However, its benefits in reducing cardiovascular disease remains controversial. Even less clear are the long term effects of hormone replacement therapy on women's health (Stampfer, Colditz and Willet, 1991). Results of long term clinical trials, which have traditionally been the hallmark of medical research, do not yet exist to provide data to evaluate the claims of estrogen manufacturers. The first such study, The Women's Health Initiative, is in progress, but will not yield results until the year 2008 (Love and Lindsey, 1997). In spite of this, hormone replacement therapy is being widely used.

According to Mishell (1987) various factors continue to reinforce the medical perspective in mainstream culture. Women's experience of menopause, often associated with aging, occurs in a culture that is both sexist and ageist. In addition, political, social and economic forces perpetuate the medical deficiency view, so that women are pharmaceutical company's targets for a campaign promoting lifelong use of estrogen. Love and Lindsey (1997) suggest that this insistence on considering menopause as a disease implies first, the need for medication, (because diseases are treated) and secondly, it infers that older women are an aberration:"premenopausal women are normal, postmenopausal women are not" (Love and Lindsey, 1997, p.18).

Currently, it is within this dominant medical context that women in the mainstream culture experience menopause. Are native women also as susceptible to influence from this perspective?

The Sociocultural Perspective

In the 1970's, social scientists began to react to the dominant medical model (Dickson, 1990b), taking a stance against the treatment of human experiences as medical problems, a practice behavioral scientists have labelled medicalisation. Voda (1986) states that the underlying assumption of research within what this

author refers to as the sociocultural paradigm, is that women are not different from men, and that there is no consistent relationship between biochemical or physiological changes and behaviour. The menopause itself is seen as having little or no effect on women; if there is a problem, it is a societal one. Whereas the biomedical perspective individualizes the problem, this perspective claims social accountability (McCrea, 1981 in Dickson, 1990 b). Therefore women's experience of menopause has been largely a social construction based on society's beliefs and attitudes. Most of these beliefs and attitudes were formulated in the Victorian era, a period of rapid social change influenced by the industrial revolution. At this time, women's status was elevated by their reproductive capacity - to provide future workers. Advanced education was frowned upon while motherhood was glorified. Menopause, signaling the end of this highly desirable state, was seen as a catastrophic loss. It was end of a woman's usefulness, a horror in the woman's life cycle (MacPherson, 1981). From this perspective, women are still suffering the detrimental effects of these Victorian attitudes.

Today, youth and beauty are highly valued and are pursued by Western women throughout their lifespan. From this perspective, ageism, sexism, and a double standard of aging based on gender are seen as symptoms of a sick society, impacting negatively on women's experience of menopause. However, hormonal influence on this experience is often ignored by certain authors adopting this perspective. According to McElmurry and Huddleston (1991), some feminist views discount women's experiences like hot flashes which are significant and problematic to many women.

Female socialisation is seen to play an important role in symptom formation (Koster, 1991). Girls and women learn throughout their lives how to react to menopause (Quinn, 1991). Female stories, one of the ways women and girls acquire such information, may have a profound effect on succeeding generations. Bernard (1981, p.463) describes female lore as "the body of traditional facts, or beliefs or superstitions about whatever subject." Female lore includes a wide variety of

experiences having to do with menstruation, love, childbearing and men. However there are few positive female stories concerning menopause in Western culture (Quinn, 1991). Weideger (1976) found that, in fact, women have traditionally kept this part of their lives a secret, indicating a menopause taboo. Since mothers, sisters, friends, teachers and even famous women have been silent about menopause, Western women's beliefs have therefore been constructed by those of the surrounding society. The student researcher is interested in learning about the possible existence of native female lore, and its effect on the menopausal experience of native women.

Studies have examined the relationship between certain societal factors and menopause. Socio-economic class has been found to have effects on symptom reporting, although research results are contradictory (Standing & Glazer, 1992; Van Keep, 1986). The same is true of studies concerning the relationship between employment status and quantity of symptoms (Hunter, Ballersby and Whitehead, 1986 in Fishbein, 1992). So far, research has not clearly distinguished factors that differentiate women who report symptoms and consult physicians from those who do not (Bell, 1990).

Implicit in the sociocultural perspective is the assumption that behavioral variability in menopause is primarily the result of sociocultural factors. Biology is viewed as a neutral given (Koeske, 1982). This perspective, like the biomedical one, has been criticized for reducing the experience of menopause to one of measurable variables, in this case sociocultural (Dickson, 1994).

The Anthropological Perspective

The anthropological perspective depicts menopause as a physiological event that is also a cultural act (Oakley, 1979,in Kaufert and Syrotuik, 1981). Griffen (1982) identifies a crucial relationship between an individual and her or his culture: This author states that certain physiological changes, like menopause, occur universally in the human organism during the life cycle, but that these changes occur

only through a filter of cultural expectations, and for the most part they are experienced in conformity with those expectations.

There exists a wide range of reactions to and repercussions accompanying this time of life, within and between cultures. In many non-industrial societies, the changes brought about by the onset of middle age appear to be generally positive for women (Brown & Kearns, 1985). Kaiser (1990), in an analysis of ethnographic data concerning fifteen cultural groups of women, concurred that, overall, postmenopausal women in non-Western societies enjoy enhanced social status, political power, and psychological well being for a number of reasons: these include freedom from menstrual taboos, seniority in the domestic unit, new role opportunities, participation in the male domain of power, greater decision making authority, respect and responsibility accorded to elders, and the sense of having fulfilled the social duty to bear children. The common underlying theme, according to Kaiser (1990), is a form of positive recognition of the postmenopausal woman, that is apparently lacking in the modern societies surveyed. Menopause is welcomed as a time of natural transition, a time to reward a woman's achievements, and publicly acknowledge her new, socially valued role. In contrast to such gains, Kaiser observes that in Western societies, menopause is depicted as a time of loss of youth and sexuality, the process of aging is devalued or denied, and negative stereotypes persist, all stressors for menopausal women.

In some cultures, increased power and status for women following menopause occurs because of the end of menstrual taboos. In studies of both Mayen and Greek women, Beyene (1986) found that rituals and taboos restrict their lives because of the power of menstrual blood. In both these cultures, women look forward to the freedom associated with menopause as well as to the respect accorded to older women. Many African and Islamic societies share menstrual taboos, as well as strictly defined gender roles. Furthermore, in Moroccan society, women are perceived as excessively sexual and damaging to men. As a result, the sexes are separated for the most part during a woman's childbearing age. Once a woman

reaches menopause, she is freed of menstrual taboos, and, considered to be asexual, is permitted to move freely in the male world unveiled and may participate in their social gatherings. This is interpreted as heightened social status (Beyene, 1986).

Healing powers are attributed to older women in certain societies, leading to increased social status as well as new roles after menopause. Biesele and Howell (1981, in Theisen and Mansfield, 1993) report that among the ! Kung of Southern Africa, the healing power of women becomes highly developed and respected in older age. According to Beyene (1986), the Maya of Mexico can also experience this positive consequence of menopause. Among Native American Navajo, post-menopausal women may become midwives and shamans, and participate in religious ceremonies, because of the lifting of menstrual taboos. The high status role of hataalii or ceremonialist is only available to menopausal women (Wright ,1982). Plains Cree women are also known to be allowed to exercise shamanistic powers only after menopause (Griffen, 1982).

Menopause is, in some cultures, associated with the right to exert authority over kinsmen. Brown (1982) states that in Moroccan Muslim society, the aging mother-in-law had domestic power by law over her daughter-in-law and her household. Similarly, among ginni-ma in Bingali India, the woman becomes senior woman in the house after menopause, controling the material and labor resources of the domestic economy while benefiting from increased status in the community (Kaufert, 1982).

Another issue found in cross-cultural studies of the menopause concerns expression of symptoms. The underlying assumption of some of the earlier anthropological studies seemed to be that hormonal changes had little effect on women, and that cultural attitudes are responsible for either discomfort or a comfortable transition. Flint (1975) found that women in India had few problems during menopause, compared to millions of Western women with incapacitating symptoms. These women were permitted significant role changes, and were no longer secluded and veiled following menopause, experiencing increased social

prestige. Flint postulated that the presence or absence of psychic or somatic distress among perimenopausal women depended upon whether the menopause brought about positive change in status as in the Rajput caste or negative change as in North American women.

The question of cross-cultural symptomatology is, however, more complex. Many societies exist in which an increase in status does not increase the likelihood of well being and less symptoms (Scharbo-DeHaan, 1993). Lock (1986) identified Rajput, Maya, Japanese and North Africans in Israel as cultures where there has been reported a near absence or absence of somatic symptoms. In other cases, especially pertaining to North America, Europe, Zimbabwe and India, there is high symptomatology reported. Lock concluded that there are some biological and socio-cultural differences, but that some of the variation was also due to poor research methods. Wright (1982), in his study of 80 Navajo women, discovered that both traditional and acculturated women reported physical and psychological symptoms, although acculturated women were found to exhibit a clear pattern of more psychological symptomatology. Reporting of symptoms by traditional women was found to be affected by health, economic level, and menopausal status. The physical stress of hard work and the harsh climate were felt to be the keys to symptom experience in these women. In acculturated Navajo women, it was posited that the psychological adjustment, the degree of the acculturation process, and the lack of kin support, rather than physical stress, determined symptom experience. Wright concluded that the best predictor of menopausal symptomatology was the individual woman's attitude toward menopause. Similarly, Kearns (1982) studied 100 Native American Papago women of Arizona to generate a broad information base about the general topic of menopause and these women's attitudes toward it. Kearns discovered that the Papago had no word for menopause, although it was the general consensus that it was the beginning of old age. It was difficult to accept because it meant the end of childbearing. Ninety-eight percent of Papago women said menopause was never discussed in their culture, leading Kearns to postulate that

menopause was a taboo subject. In terms of symptomatology, women reported hot flashes, fever and irregular menstruation. From this study, Kearns concluded that Papago attitudes and knowledge of menopause appeared to be governed by traditional values and practices to a large extent. Several recent cross-cultural studies have also investigated symptomatology. Moore and Kombe (1991) studied Tanzanian women: incidence of symptoms was high and similar to that recorded in Western societies. In a study of Mayan women, Dill (1994) found that post-menopausal women did not recall any significant symptoms, and in fact denied having had hot flashes, in spite of having endocrine assessments similar to those of North American women. No evidence of osteoporosis was found among these women.

Anthropological investigations have revealed that in some cultures, menopause elicits a variety of negative responses. Although we know that in much of the Western world, the menopause is an event that women have been taught to dread, this also occurs in some non-Western cultures. These negative reactions are often due to role loss or role transition to a less desirable one. Alternately, a culture may not acknowledge menopause at all, thereby limiting a woman's knowledge and ability to understand her experience (Griffen, 1982). In Ghana, a post- menopausal woman may lose the role of wife because her husband may take a younger wife. In Ireland, until recently, the belief that there was no further role possible following menopause prompted some rural women to confine themselves to their beds (Griffen, 1982). Among the Sinkaietk, a group of the Salish Indians from the Pacific Nothwest, a cultural perception that death may occur in conjunction with or as a result of menopause has been found. Yoruban women hold a belief that menopausal women are actually pregnant, but witch-craft is preventing a normal pregnancy. The same belief has been found among Twi women (Griffen, 1982). Using semi-structured psychiatric interviews, Maoz, Dowty, Antonovsky and Wijsenbeek (1970) interviewed 55 women of varied ethnic origins, in Israel to explore responses of a range of women to changes in the menopause. Their findings indicate that the

majority of European women felt that menopause was a natural event, but that they had negative attitudes toward it. The researchers postulated that the negative attitudes were associated with a lack of occupational roles, and other life problems. Only the Arab and Oriental women demonstrated a positive attitude towards menopause. Oriental women reported that their positive attitude was due to a lack of desire for additional children. These findings did not confirm the researcher's expectations that a history of successful response to earlier sexual experiences would be predictive of a positive response to menopause.

In studies of Japanese women, Lock (1986) and Rosenberger (1986) found that the menopausal syndrome is considered by doctors to be a luxury disease, a problem that only occurs in middle and upper class women with too much leisure time. Lack of a clear social role, of utmost importance to the maintenance of individual identity in Japan, is considered the main contributing factor to women's troubles at menopause (Lock, 1986). This author points out that these Japanese women, the first generation to face middle age in a nuclear, rather than extended family, will not be able to look forward to the usual rewards of increased power, status, and comfort that would have come with running an extended family. Thus, the middle aged woman's social role is unclear, her productivity is questioned, and her menopause treated as a luxury disease. Both Lock (1986) and Rosenberg (1986) discovered that the hot flash, considered by Western medecine to be a universal menopause symptom, was infrequently reported by Japanese women. However, stiff shoulders,which is considered almost the equivalent of stress, was reported by half the Japanese women. These authors noted that Japanese doctors prefer a psychosomatic explanation of symptoms, considering any non specific symptom as menopausal, possibly reflecting psychological imbalance or weakness.

Menopausal meanings, taboos, and sex roles appear to change within and between cultures depending on the value of the reproductive role, or the value of older women in society. Menopause is depicted as either a time of loss or gain, depending on its cultural connotations. Symptomatology also seems to vary, and

continues to intrigue cross-cultural researchers in both anthropology and medicine. Women's individual, subjective menopausal experiences are only beginning to solicit interest.

In the only study found concerned with Canadian native women and menopause, Buck and Gottlieb (1991) sought to examine the midlife experiences of these women in light of their total life experience. They asked a group of eight well Mohawk women, aged 45 to 54 years, about their experiences at this time, the extent to which these experiences were problematic, and the factors influencing the nature of these issues. The experiences of Mohawk women at midlife related to the concept of time, along expected, developmental, personal, and meaningful dimensions. The women described four major issues related to the concept of time: it is time for me, being where I should be, time for myself, and my time is spent meaningfully. Buck and Gottlieb concluded that Mohawk women view midlife as a time for shifting priorities from previous commitments such as child-rearing, to themselves. The notions of being on a developmental time trajectory, and of expected life experiences at midlife, emerged from this study. The value of personal time and its meaningful use was also expressed. Buck and Gottlieb concluded that the role of time and timing of life experiences are important when developing theoretical models of midlife.

There are no studies, to the student researcher's knowledge, specifically investigating the *health* experience of native women at menopause and their *health care practices*.

Experiential Perspective

In this section the student researcher will review several qualitative studies eliciting women's perspectives during menopause, studies in which women's menopausal experiences were the focus.

Within the last decade, researchers, principally nurses, have realized the importance of examining the menopause transition within a naturalistic paradigm

(Lincoln and Guba, 1985) using qualitative research methods. Through this type of research, the woman's perspective is allowed to emerge .

Davis (1986) studied the meaning of menopause in a Newfoundland outport fishing village, attempting to use both standard quantitative menopause survey instuments and a qualitative approach. The former were found to be of limited utility in this cultural context. A qualitative approach, however, revealed the importance of sociocultural context in the lived experience of these women. This author found that indepth analyses of the following sociocultural factors were essential to gaining understanding of the experience of menopause of these 38 harbour village women: a) the continued importance of the fishery and the idealized image of outport Newfoundlanders as a "tough race"; b) the expectation that women should endure hardship and solve problems rather than create them; and c) the strict enforcement of an egalitarian ethic throughout the community. The study revealed that the meaning village women attribute to menopause makes it a non-event, a normal part of the aging process. It is seen as a potentially difficult stage to be lived through by using the coping skills and tough nature that have been forced on all women in the community. Although attitudes toward the menopause may be negative, it does have meaning as a status enhancing task - as another challenge to be overcome by a long suffering and very tough race. "Nerves" and "blood," both multipurpose complaints in local semantics, may be problematic during "the change," but are not exclusive to it. "The change" is something to be gotten through as best one can. Davis stresses that the nature of the menopause experience and the related semantics regarding nerves and blood can not be understood apart from these women's village culture.

McKeever, (1988) in an early experiential study involving 30 Caucasian American women, discovered that accessing embodied experiential knowledge of women's experience was difficult due to the American cultural stigma associated with aging and the rational, theoretical explanations of menopause found to be pervasive in this cultural context. Four informal explanatory models of the

menopause were elicited from this study. Some women understood the menopause from a "matter of fact" perspective , while others understood it as "aging." This study was among the few that reported health care practices of women during menopause. McKeever (1988) found that underlying cultural beliefs and the meaning attributed to menopause influenced the particular practices of North American women. Some women used thinking and the power of the mind to negotiate the menopause, while others were vigilant about body breakdown.

Quinn (1988), using grounded theory, identified four categories of response to the menopause experience among American perimenopausal women: a) Tuning into me, my body, my moods - describing awareness of physical and emotional changes that initiated the beginnings of menopause and highlighted the uncertainty accompanying the experience; b) Facing the paradox of feelings - reflecting the thoughts, perceptions and feelings experienced by perimenopausal women; c) Contrasting impressions - describing the assimilation of information about the menopause, and formulation of the woman's own meaning of this natural process; d) Making adjustments- reflecting changes made by women to incoporate their changing bodies, lives, and feelings. She found that most women have confidence in and trust in their own beliefs about menopause as a natural process, contradicting what they believed was society's pessimistic view of the process. Health care practices of these mainstream culture American women were identified; they included dietary changes, taking calcium, monitoring self medication, and adjusting their lives to meet changing energy needs. Practices did not include self breast examination.

Keller (1990) studied menopause as an aspect of womanhood and a portion of the life-cycle in the context of four American women's lives. Personal narratives were analyzed using grounded theory, revealing individual interpretations as each woman told her story from a different conceptual framework. These women could not specifically identify from whom they had learned about menopause. It was found that if they talked about menopause at all, it was limited, and with friends.

Aging, relationships, and their menstrual cycles were described as inextricably interwoven with their menopausal experience.

Capazzoli (1990) used a phenomenological approach to describe the experiences and perceptions of eight women who were in different phases of menopause. Each woman's experience was different, although the experiences shared commonalities. Women anticipated and recognized the menopause as a natural or normal event. It was not considered stressfull either physically or psychologically, and was not seen as an illness. Menopause was seen as one event among others in the transition to middle age, occuring concurrently with other, often more significant life events. Eight emerging themes included: silence, caring, self care, lack of information, loss, signs of the menopause, self image and sexuality, and woman-physician interactions.

Five themes emerged from Dickson's (1994) phenomenological study of two African American and eight Euro-American women between the ages of 42 to 53. Hot Flashes and Other Annoying Things refers to annoyances identified by the women, such as changes in temperature perception, bouts of forgetfulness, sleep disturbances and changes in sexual activity. A lack of control over these annoyances was a source of frustration for these women. The theme: Periods or Period-All Part of Being a Woman , reflected the ambiguity women experienced about the end of cycling as periods became irregular. The theme : Hormone Therapy- Friend or Foe? addressed the often skeptical attitudes of these women toward hormone use; they were not interested in using hormone therapy until they perceived a problem that hormone therapy could help. Getting Older or Getting Better? This fourth theme discussed the menopause as a marker of the aging process for women; women's perceptions of menopause were colored by society's negative view of aging, although some were able to accept aging and move into a fuller more satisfying life. Overcoming the Silence of the Last Taboo is the final theme, reflecting the fact that women are beginning to speak out more openly about the menopause .

Two qualitative studies concerning the menopause experience of women in

other cultures were found. Tlou (1990) examined the perimenopausal experience of 25 women in Botswana using symbolic interactionism. These women were found to perceive menopause as a natural occurrence over which only God had control, a relief from menstrual bother and expense, and freedom from unwanted pregnancy. Tlou (1990) discovered that middle-aged Botswana women sought help and information from older relatives and nurses to validate their experiences. Traditional medicines were used to treat symptoms that these women associated with menstrual irregularity.

In another study, 20 rural women in Thailand studied by Chaiphibalsarisdi (1990) perceived menopause as a natural occurrence that could not be controlled, and as an event related to menstruation, sexuality, and childbearing. Severity of symptoms were judged by the criteria of ability to perform daily work. Self care practices of peri-menopausal and menopausal Thai women were elicited. Among Thai women who perceived menopause as natural, no special self care activities were reported; they tried to remain strong, continue normal activities, sought comfort in same sex family members, and used traditional remedies. Health professionals were consulted in order to confirm menopause and to obtain Western medicine for severe symptoms.

Health care practices were also examined in a study of 200 employed peri-menopausal Egyptian women, 42% of whom were nurses. Women were found to attempt to manage their problems mainly by taking over-the-counter drugs and self-prescribing (75%), doing nothing (56.5%), and going to a doctor or health insurance office (40%) (Mikhail and Ragheb, 1995) .

McElmurry and Huddleston (1991), in a critical review of research concerning self care and menopause, concluded that both concepts are in the early phases of research development. These authors stress the need for cultural sensitivity to menopausal women, and encourage nursing research combining the concepts of self care and menopause as a lived experience.

An examination of these four perspectives from which menopause is studied

provides an overview of current knowledge in this area. In the context of this study, the student researcher is particularly interested in experiential knowledge with a cultural flavour. No studies were found examining the experience of menopause from the perspective of native women.

The literature review reveals the importance for health practitioners to be attentive to biological, social, cultural and spiritual considerations in order to understand the universal but unique health experiences of the women they encounter. It is in this spirit that the student ventures into this investigation.

CHAPTER THREE

METHOD

The third chapter is devoted to the research method used for this study. Ethnographic research will be discussed briefly, followed by a presentation of Leininger's ethnonursing research method. Selection of subjects, called informants in ethnonursing, will be explained. The data collection method and some of Leininger's research enablers will be presented. Methods of analysis used to examine the data will follow. Finally, evaluation criteria, the limits of this study and ethical considerations will be discussed.

Ethnography and Ethnonursing

In order to study the health experience of menopause as described by native women, a qualitative research method was used. Qualitative research strives to understand the significance reflected in human experiences (Kérouac, Pepin, Ducharme, Duquette, and Major, 1994). According to Leininger (1991), experiences assume their meanings in context.

An ethnographic people-centred approach (Spradley, 1979) is appropriate to learn from a cultural group like North America native women. Ethnography, originating from the field of anthropology, consists of a complete or partial description of a cultural group. Historically, the term is applied to a specific group of people who share a large number of similar cultural and social characteristics, and who demonstrate solidarity amongst themselves based on common factors like language, residence, social relations, political and religious beliefs and practices (Hughes, 1992). Rather than "studying people," ethnography means "learning from people" (Spradley, 1979). Leininger (1985b) describes ethnography as a systematic research process, one of observation, description, documentation and analysis of lifeways or patterns of a culture or subculture in their particular environment.

Leininger has developed the method of ethnonursing, specifically for the discovery of knowledge of interest to nursing (Leininger 1970, 1978, 1985b, 1988, 1990). It is a naturalistic, inductive, and largely "emic" open inquiry discovery

method that can be used to discover elusive, complex, and often unknown dimensions of health experiences (Leininger, 1991). The term "emic" (Pike, 1954 in Leininger, 1991) refers to the local or insider's views of people, whereas "etic" refers to the outsider's view of a culture.

Ethnonursing was the method chosen by the student researcher in order to understand the health experience of native women, as well as their health care practices, and underlying values and beliefs. Using this method, the student researcher's task was to learn from native women, who were seen as teachers sharing their experiences, insights and knowledge with her (Leininger, 1991).

Since inclusion of the cultural context is an essential aspect of ethnonursing research, the researcher considered ethno historical, biosocial and cultural values, and language expression, of the native women (Leininger, 1991).

Informants

The ethno nurse researcher works with key and general informants in order to gather data (Leininger 1985b, 1991). Key informants, those who are living the experience, are generally interested in and willing to participate in the study. They are held to be people who reflect the norms, values, beliefs and general lifeways of their culture. General informants also have ideas about the domain of inquiry, which they are willing to share. They may, however, be less fully knowledgeable about the domain of inquiry. In this study, key informants were seven native women who felt they are undergoing the midlife transition of menopause. Many other native women met in the context of various phases of this project were considered to be general informants. The information obtained from these women was noted in the student researcher's field journal. However, only data from the interviews with the seven key informants was subjected to the process of analysis.

The following criteria were used for selection of key informants:

1. Be a native women having a close connection with a Mohawk territory in Canada.

2. Be of an age where the idea of menopause, as applying to themselves, has entered their consciousness.
3. Be able to express themselves in English or French
4. Accept to participate in the study.

The Mohawk women in this study all had a close connection to one of two native territories, although two of them no longer lived permanently in the place they still referred to as "home." Of these seven women, four were experiencing natural menopause while three had undergone hysterectomies for reasons including cancer, and fibroids causing excessive bleeding. Two of these had undergone the surgery before the age of 40. Six of the seven women are mothers and four of these are also grandmothers. Two women are married to native spouses, one to a non native. Of the other four, one woman is a widow and three do not live with partners. All the women interviewed are status Indians although some had at one point in time had their status contested for various reasons. They were all born of two native parents, on native lands. Of the seven, five live in their original community permanently while two others consider native territories as "home" to which they return regularly although they now live elsewhere. Several of the women had lived for varying periods of time outside of their home communities over the years.

Among these women, educational levels varied from some primary school to post-secondary. In the past, some of these women had done domestic work, teaching, and child care; at the time of the interviews, employment included work as a cook, making traditional crafts, teaching, transport, community service and social service. Five out of the seven women work outside the home; some are combining further education with work. All of the women speak their native language and most are trilingual, speaking English and French as well.

Entering into a culture that is not our own is known to be difficult. Considering the ethno-history described in chapter two, recruitment of informants was a difficult and time consuming process. The student researcher started

establishing contacts in January 1996. Eventually, references made by word of mouth among the student researcher's acquaintances yielded three contacts in December 1996, after having had little luck through more formal venues. A key contact made in this way then led to the recruitment of the other informants. Cook's (1995) prediction that a contact person respected by the community is essential to gaining access proved true in this study.

The Ethnographer

In the context of ethnographic research, ethnohistorical information regarding the researcher is significant to the understanding of both the research process and to the interpretation drawn from findings. The student researcher conducting this project is Canadian born but of Lithuanian background, this cultural specificity being significant to her. She has always been intrigued by and drawn to cultural differences. During her childhood, she was in frequent contact with native people who worked on her parents' farm. As a nurse, she worked with native people of different nations in isolated northern communities on several occasions ; during these experiences, she admired the strength of native women and identified with their force of character. At the time of this study, the student was herself experiencing menopause, still in mourning for her own mother, and on the verge of separation from her daughter leaving for college. A white, western, menopausing woman; a daughter, a mother, a sister, a friend, a nurse, a student...all these facets of the ethnographer influenced this research project.

Data Collection

Interviews

In-depth interviews served as the main data collection method for this study of the experience of menopause as described by native women. Interviews were conducted at various places selected by the informants, including their homes, the researcher's home, and different community centres. Bilingual, the student

researcher was able to offer the choice of French or English as the language in which the interview would be conducted. All but one informant preferred to be interviewed in English.

An interview guide was constructed by the student researcher including open and semi-structured questions in order to elicit the health experience, generic health care practices, and underlying values and beliefs of the informants (Appendix 2). This general guide, which was used loosely and informally, was inspired through the readings of similar qualitative studies and the author's intuitive though limited knowledge of native women. It was revised and approved by three researchers experienced in the use of qualitative methods. The interviews proceeded in an informal manner, with a few general broad questions. The guide served as a reminder for the researcher in order to insure that all the areas of interest were discussed. This approach has been recommended in ethnographic research in order to avoid being too directive with the informants (Murphy, 1993). With native populations, this may also be an approach of choice as it more closely resembles their communication style as opposed to more directive and formal methods. Explicit direct questions do not exist in many native languages, since this type of interrogation could be perceived as offensive. In exchanges between natives, questions are always asked in a way that gives the other the choice to answer, or not (Babyish Atkinson, 1990).

Differences in style of communication are important considerations when working with native peoples. The student had in the past worked with people of other native groups and was able to draw on her experience for this study. The non traditional appearance of these women did, however, sometimes lead the student researcher to forget these differences and disrupt communication somewhat. Fortunately, the student researcher was familiar with the moments of silence common in native people's communication; they sometimes represent periods of reflection. Silences are not uncomfortable in native conversation. In addition, native people do not, in general, talk for the sake of talking as is the custom of some

in the mainstream culture. Communication is also not necessarily linear as in western societies. Sometimes a question is not answered immediately, to be reflected upon and returned to later; or the subject may appear to be changed, when in fact it is related to the question. Sometimes questions will go unanswered; no response is an answer in itself (Babysh Atkinson, 1990).

In this study, five of the seven key informants were interviewed once, for a time lasting between one and two and a half hours. Two were interviewed a second time for between one and a half to three hours. Apart from one informant who had to abort the interview process for health reasons, the number and length of the interviews was determined by the interviewer and informant when they felt they had covered the area of inquiry. General informants were not formally interviewed but supplied information noted in the student researcher's personal journal. Four out of the nine interviews done were audio taped with the informants' permission. Only three of informants preferred that the interviews not be taped. In these instances, the researcher audio-taped her recollections of the interview immediately upon leaving the scene in order to retain as much information as possible.

Field journal

In personal audio-taped and written journals the researcher recorded her impressions, questions, fears, errors and successes. Cultural information obtained from general informants was also noted. These notes served as an important source of information for the researcher in the analysis of her experience.

The student researcher was able to establish a certain relationship of trust with some of the women interviewed as indicated by some of their gestures and comments:

> *These are things that I thought I would have trouble with saying, but I'm not having much trouble, am I? [...] It's hard sometimes, because a lot of people don't understand...I see that you do have a very strong cultural background, you're very naturally inclined (Barbara)*

I don't trust most people [...] I don't know why I talked so much, I'm surprised myself (Mary)

When I heard your voice over the phone, and now that I see you, I can see that you're alright...white people are not all the same (Lenora)

J'ai des bonnes intuitions, et je vois que vos intentions sont bonnes, vous voulez apprendre, c'est bien (Ann)

In past experiences in other native communities, the student has had similar reactions from women.

Many women expressed emotion during the interview; some cried about past hardships that they and their people have endured. One informant offered a gift to the student at the end of the interview. Using a custom from her own Lithuanian culture, where food is an important symbol of friendship and good will, the student researcher offered a gift of food to the women when coming to the interview. One informant expressed surprise and asked how the student knew that this was appropriate and all the other informants appeared pleased with this gesture.

The native women interviewed understood that the student researcher herself was in the thralls of menopause at the time of this study. Without distracting from the focus of the interviews, this element seemed to help develop a certain complicity between the student and the women. Some even offered advice to the student researcher to help her with her own menopause.

Participant - Observation

According to Leininger's ethnonursing method, participant observation is an important facet of data collection. In the context of this study, opportunities for acting in the capacity of participant observer within the communities of these women was limited. The researcher was able on several occasions to attend meetings

destined to promote understanding between native and non-native people, on the invitation of one of the informants. These included some traditional ceremonies. In addition, the researcher had the opportunity to participate in related work experiences with native women of other nations during and before the time period of the data collection (June to September 1995; December 1995 to January 1996; February and March 1997). These opportunities to work with native women added both to the cultural knowledge acquired and to improving communication skills so important in this context.

A description of the four phases of Leininger's observation - participation - reflection model used in ethno nursing follows. The interface of this model with the student researcher's experience is discussed.

The first phase of this model consists of primary observation and active listening, the second of primary observation with limited participation. Within this study, these phases were experienced simultaneously at the time of first contacts made with native women in various contexts, and the student's observations of women's reactions to the proposed study; these phases involved telephone and face to face contacts with native and non native women in various contexts related to the study. Making contacts with potential general and key informants was part of this phase. The third phase of the model involves primary participation with continuous observation; in this study, this phase represents the actual meetings with women for interviews. The final phase consists of primary reflection and reconfirmation of findings with informants which involved the time in between interviews and the beginning of indepth analysis.

Stranger to trusted friend enabler

Leininger has developed what she terms "enablers" as part of the ethno-nursing method. Leininger's stranger - friend model is one that is appropriate to this study (Figure 3). It was designed with the belief that the researcher should assess her relationship with people being studied. Leininger predicted that the researcher

Figure 3 **Leininger's Stranger to Trusted Friend Enabler Guide***

The purpose of this enabler is to facilitate the researcher (or it can be used by a clinician) to move from mainly a distrusted stranger to a trusted friend in order to obtain authentic, credible, and dependable data (or establish favourable relationships as a clinician). The user assesses him or herself by reflecting on the indicators as he/she moves from stranger to friend.

Indicators of Stranger **(Largely etic or outsider's views)**	**Date Noted**	**Indicators as a Trusted Friend** **(Largely emic or insider's views)**	**Date Noted**
Informant(s) or people are :		**Informant(s) or people are** :	
1. Active to protect self and others. They are "gate keepers" and guard against outside intrusions. Suspicious and questioning.		1. Less active to protect self. More trusting of researchers (their "gate keeping is down or less"). Less suspicious and less questioning of researcher	
2. Actively watch and are attentive to what researcher does and says. Limited signs of trusting the researcher or stranger.		2. Less watching the researcher's words and actions. More signs of trusting and accepting a new friend.	
3. Sceptical about the researcher's motives and work. May question how findings will be used by the researcher or stranger		3. Less questioning of the researcher's motives, work and behaviour. Signs of working with and helping the researcher as a friend.	
4. Reluctant to share cultural secrets and views as private knowledge. Protective of local lifeways, values and beliefs. Dislikes probing by the researcher or stranger.		4. Willing to share cultural secrets and private world information and experiences. Offers most local views, values and interpretations spontaneously or without probes.	
5. Uncomfortable to become a friend or to confide in stranger. May come late, be absent and withdraw at times from researcher.		5. Signs of being comfortable and enjoying friends and a sharing relationship. Gives presence, on time, and gives evidence of being a "genuine friend".	
6. Tends to offer inaccurate data. Modifies "truths" to protect self, family, community, and cultural lifeways. *Emic* values, beliefs, and practices are not shared spontaneously.		6. Wants research "truths" to be accurate regarding beliefs, people, values and lifeways. Explains and interprets *emic* ideas so researcher has accurate data.	
* Developed and used since 1959 : Leininger.			

Leininger, M. (1991). Culture care diversity and universality: A theory of nursing. New York: National League for Nursing Press, page 82

should move from stranger to friend in order to obtain accurate, sensitive, meaningful and credible data (Leininger, 1991). This model served as a gauge for the researcher's progress, and as a tool to help her remain aware of her own behaviour and that of those being studied. Reflections to this effect were recorded in her personal journal.

Data Analysis

Leininger's four phases of ethnonursing analysis for qualitative data were used to interpret the data of this study (Figure 4). Using this model, the student researcher began analysis of data on the first day of research. At each phase, data were processed continuously and reflected upon as recommended by Leininger (1991). The interview data from the nine interviews were submitted to an intensive, inductive, circular process of analysis. Notes from the student's field journal, and participant observation notes were also reviewed. The first phase consisted of data collection, recording, and preliminary interpretations: audio-taped interviews and the student researcher's recorded recollections were copied verbatim by the researcher allowing the beginning of analysis. Audio tapes were reviewed a second time to discern subtleties of language and expression. Data were first classified according to areas under study, following the interview guide. Data were then compared for differences and similarities in the second phase. In the third phase, recurrent patterns and specificities with respect to meaning-in-context of the experience emerged through the extracts chosen as significant for each of the areas under study. In the final phase, the themes were discovered from the patterns found in the data, and then refined with the help of an experienced researcher, to describe globally the experience under study.

Qualitative criteria of evaluation

Specific criteria have been developed by Leininger and confirmed by other researchers for qualitative paradigmatic investigations like this present study. The evaluation criteria used in this study include credibility, recurrent patterning,

Figure 4

Leininger's Phases of Ethnonursing Analysis for Qualitative Data*

Fourth Phase

Major themes, Research Findings, Theoretical Formulations, and Recommendations
This is highest phase of data analysis, synthesis, and interpretation. It requires of thinking, configuration analysis, interpreting findings, and creative formulation from data of the previous phases. The researcher's task is to abstract and present major themes, research findings, recommendations, sometimes theoretical formulations.

Third Phase

Pattern and Contextual Analysis
Date are scrutinized to discover saturation ideas and recurrent patterns of similar or different meanings, expression, structural forms, interpretation, or explanations of data related to the domain of inquiry. Data are also examined to show patterning with respect to meanings-in-context and along with further credibility and confirmation of findings.

Second Phase

Identification and Categorization of Descriptors and Components
Data are coded and classified as related to the domain or inquiry and sometimes questions under study. *Emic* or *etic* descriptors are studied within context and for similarities and differences. Recurrent components are studied for their meanings.

First Phase

Collecting, Describing, and Documenting Raw Data (Use of Field Journal and Computer)
The researcher collects, describes, records, and begins to analyse data related to the purposes, domain of inquiry, or questions under study. This phase includes : recording interview data from *key* and *general* informants; making observations, and having participatory experiences; identifying contextual meanings; making preliminary interpretations; identifying symbols; and recording data related to the phenomenon under study, mainly from an *emic* focus, but attentive to *etic* ideas. Field data from the condensed and full field journal is processed directly into the computer and coded. Leininger, M. M., (1987, 1990, and current revisions in 1991).

Leininger, M. (1991). Culture care diversity and universality : A theory of nursing. Qualitative Criteria for Evaluation. New York : National League for Nursing Press, page 95

transferability, confirmability, and meaning in context. Saturation, another possible criteria, did not strictly apply.

Credibility refers to the accuracy and believability of findings, mutually agreed upon between the researcher and informants as reflecting their true experiences of the transition of menopause and reflecting their beliefs, values. The student verified her comprehension of the information given as the interviews progressed, in the second interview when applicable, and in some cases in telephone calls. General cultural information was often validated in literature pertaining to native culture.

Recurrent patterning refers to recurrent patterns to the experience and or health practices within native lifeways - that were repeated and consistent in their occurrence. The patterns are described within each theme.

Transferability. Although the goal of qualitative research is not to generalise this criterion looks for any general similarities that might appear under similar contextual and environmental conditions. The student researcher found both similarities and differences within values and attitudes of the women studied when compared to other native populations with whom she has had contact.

Confirmability means reaffirming what the researcher heard saw and experienced with respect to the menopause as a health experience for native women. With selected informants, the student researcher reaffirmed certain ideas and understandings. Intersubjective validity was assured by the verification of analysis and interpretation by and discussions with an experienced researcher.

Meaning in context refers to data that becomes understandable as one comes to learn about the total context in which an experience evolves. Gaining emic and etic knowledge about the cultural context in which these women evolve shed light on their experiences of menopause.

Saturation refers to the accumulation of all the possible information about native women's health experience of menopause, to the where information is becoming repetitive and redundant. Although some redundancies could be found,

in a study of limited size such as this one, saturation was neither expected nor achieved.

Limits of the Study

The historical conflictual relationship between Canada's native peoples and the larger Canadian society are not yet resolved. The fact that the student researcher is not a native woman could have been a barrier to this study. Recent political conflicts between Aboriginal nations and the rest of society lead natives to be, understandably, reticent and suspicious of the researcher's motives. Negative experiences in the past with other researchers adds to this reticence. The researcher had considerable difficulty making contacts and finding informants in the community. When contacts were finally established, time constraints prevented the student researcher from spending more time establishing relationships with the women and from pursuing the study as far as she would have liked; in the end, the list of contacts was not exhausted due to time constraints. The time limit in the context of a master's study is unfortunate and limits the study.

Ethical Considerations

In order to protect the fundamental rights of all participants in this study, principles of enlightened consent were respected. Verbal and written explanations about the reasons for the study, the goal, the nature and length of the study and the extent of informants implication were provided to each participant (Appendix 3). Informants were advised that they may withdraw at any time; none of the informants chose to do so once they had agreed to participate. They were advised of the confidential nature of the study, and of the use of fictitious names when information was recorded. As previously mentioned, interviews were audio taped only if acceptable to participants; these tapes and written notes are in the possession of the researcher and used for the sole purpose of the study. These materials will be

destroyed following the study.

The key informants were asked to sign the written consent letter in two copies prior to beginning the interview. One copy was kept by the informant, the other by the student researcher. All but one informant agreed to sign the letter; the reason for refusal of this informant was not clear, but she did express the desire to participate in the study.

CHAPTER FOUR

PRESENTATION OF RESULTS

In this chapter, the student researcher will explain the analysis and interpretation of the data collected during this study exploring the health experience of menopause as described by native women, expressed in terms of their underlying beliefs and values and including their health care practices. The analysis will be presented according to the emerging themes. A discussion of values in regards to religion versus tradition, important to the comprehension of the experiences of these women, precedes a brief examination of the persistent effect of native ethnohistory on the health experience of these women. Presentation of the themes follows.

Religion Versus Tradition

One of the seven structural and cultural dimensions of Madeleine Leininger's Sunrise Model proved indissociable from the health experience of menopause of the interviewed native women. Values related to traditional spirituality, philosophy of life, and religion, revealed themselves as significant dimensions underlying these women's health experiences. In order to comprehend their experiences of menopause, it is essential to reflect upon these elements.

All of the women interviewed were *"raised in the church,"* by parents or grand parents they described as *"religious"* or *"very religious."* None described their upbringing as traditional, or long house. Several of the native women in this study reflected sadly on the loss of cultural identity experienced by native peoples. Many, but not all expressed the opinion that this was due largely to the influence of the church. Some of these women are examples of the rekindling of interest in traditional culture among native peoples. For others, the fact that they have not integrated many traditional ways in no way dampens their cultural pride.

Barbara emerges as the spokeswoman for traditional native culture in this study. Although she was raised as Catholic by her mother, life events led her to choose a different spiritual path: Her spiritual-cultural search began after a near

death experience associated with childbirth. This significant physical and spiritual experience sparked existential questions, marking the beginning of her quest for both cultural knowledge and the meaning of life. She sought out elders and others in her home community, guardians of cultural knowledge. She sought understanding about her cultural roots and re-appropriated what she refers to as "*the natural ways.*" Her return to tradition caused strain within her family. "*She [my mother] was raised by nuns and had lost a lot of her culture [...] it's hard for her to understand my being this way.*" (Barbara defines culture as *"your natural spiritual ways").* It is clear to her that religion and the practice of *"natural ways"* are incompatible: "*A lot of native women have the Catholic religion rather than the culture [...] Religion was set by man in order to suppress.*" From her perspective, *" [...] a lot of cultural ways were lost because of religion."* She believes *"[...] the natural ways of life [...] holiness [...] spirituality, that is what culture is, it's what we were put here for.*" By describing the traditional medicine wheel Barbara explains the native belief that all cultures once practised the now nearly forgotten natural cultural ways:

> *The medicine wheel is made up of all the people of the world [...] the red, the white, the yellow, the black and brown. All culture is based on the people of the earth. All [similar cultural] groups stem from one cultural background [...]. We [native people] still have a strong part of our culture because we've only lost it [...] five hundred years ago, [whereas other cultural groups] have lost their culture over a few thousand years [explaining their incomprehension of natural cultural ways].*

Barbara believes that if all groups of people lived and practised their cultural spiritualways, the world would not be in such turmoil. The preservation and transmission of traditional native culture is an important preoccupation for this woman who is teaching her daughters their culture; she hopes that more native women will reappropriate this knowledge and return to their cultural roots.

Ann, raised in a religious family, also demonstrates considerable cultural

knowledge and cultural pride; some of this was learned at home and some in a deliberate search for information later in life. She recalls feeling excluded from both cultures all her life because of her affiliation with the Catholic religion; part of her life's work is to eliminate the type of discrimination to which she was subjected. She explains her feeling of exclusion:

> *On était considérés comme des Indiens blanc parce qu'on pratiquait la religion catholique [...] j'avais souffert d'exclusion toute ma vie de la part des amérindiens et des blancs, [...] ça ne devrait pas exister.*

Ann inhabits both native and white worlds and has made a conscious decision to integrate her native cultural ways with the practice of the Catholic religion ; unlike Barbara, she does not consider them incompatible although she acknowledges the role of the church in her people's loss of culture. Her understanding is that many elements of religion are man made, having nothing to do with "le créateur" or "le grand esprit." Like Barbara, Ann also feels that the loss of traditional native spirituality has taken a terrible toll on native cultural pride and sense of identity. According to Ann, spirituality is as basic a need as food for her people. Spirituality being inextricably linked to well being, she attributes many of the health and social problems experienced by natives to its decline. She now works to infuse native cultural pride, and to diffuse cultural information to natives and non natives alike in the hopes of promoting peace and understanding between the peoples. She acts as a social and cultural advocate, explaining to mainstream society the reasons behind native people's behaviour, and reminding them of past and present injustices.

Two other women, Norma and Lenora describe themselves as beginning students of traditional ways. Norma describes her upbringing : *"We were brought up, sent to church .... I was raised more in a white way [...] My grandparents were very religious people. [...] I wasn't brought up with all the native values. [Out of respect] I [still] don't talk to them about anything else [traditional ways]."* In her

family of origin, she learned that religion and native traditional spirituality were incompatible. She summarizes the differences in the spiritual practices between her family and those of the traditional or "long house" families in the community: "*We believed in church, they believed in [going to traditional native] dancing.*" Over the past ten years, Norma has begun a deliberate search for her native identity. "*I started looking at things differently...I started searching, who am I?*" She is now learning from a female relative raised and versed in traditional ways. Her reaction to this new acquisition of cultural knowledge is enthusiastic: "*I'm just learning it now, and it's like...the doors are opening*!" In Lenora's family, two generations are now reappropriating their cultural heritage: she is acquiring cultural knowledge from her adult son who is himself learning about his native heritage in a Mohawk school. Within her family, she is the only one to have rejected the church, because of its effect on her cultural heritage: "*I resent that [religion] was imposed on us when we were young.... we didn't know about the old [traditional] ways. [...] My grandfather was a traditional chief, but he was led around and controlled by his Catholic wife.*"

Another informant, Jean, who describes herself as "*very religious,*" admits to having little knowledge of traditional ways, "*I wasn't raised that way.*" She does not, however, think they are incompatible. Although she does not have very much knowledge of "*the old ways,*" she respects them as "something sacred." Jean, unlike Norma, has fond memories of her upbringing "*in the church. [...] I went to school with the nuns, I loved them, I used to follow them around.*" Religion remains important to her and influences her conduct: "*they call me the nun.*" She does not presently express an interest in learning more about traditional native ways. Although Jean espouses religion and admits little knowledge of traditional ways, she demonstrates strong cultural pride. The interest of her daughter Deborra for traditional culture was not elucidated explicitly although she did discuss certain aspects related to traditional values, beliefs and practices. Another informant, Mary, spoke of being raised in the Methodist church; she still reads the bible

although she no longer attends church. She considers herself a spiritual person. The extent of Mary's interest in and knowledge of traditional cultural ways was not clear due to an interruption of the interview process.

All of the informants spontaneously discussed issues related to religion, spirituality, and tradition. The link between the values underlying these issues and the health experience of menopause will be made in the next section.

Effects of Ethnohistory

Throughout this study, the student researcher noticed the spontaneous return of informants'conversations to topics of a political and ethnohistorical nature. Many of the women spontaneously spoke with emotion about past and present injustices leading to near annihilation of their people. The loss of cultural identity and pride has led to many social, physical, mental and spiritual problems afflicting native peoples today. These elements can not be passed over in silence even though their effects on these women's experience of menopause is perhaps indirect. The pain they continue to experience permeates all aspects of their beings and can not but impact on their wellness. To enter into relationships with these women in the context of health care, it is important to be aware of their ethnohistory, acknowledging injustices, and being sensitive to their pain. Perhaps it is only with such an attitude of openness that non native health care practitioners can accompany these women on their path to wellness.

Emerging Themes

The following five themes emerged during analysis of the information shared by the women concerning their experience of menopause:

- Native women experience menopause as natural, a part of the life cycle of a woman.
- Native women experience menopause as a time of vulnerability to negative energy.

- Native women experience menopause as a time for sharing knowledge, wisdom, and memories.
- Native women experience the manifestations of menopause with confidence and equaminity.
- Depending on their integration of traditional ways, native women experience different health practices.

Theme 1: Native women experience menopause as natural, a part of the life cycle of a woman.

In interviewing native women and during related experiences, the student researcher was repeatedly told that menopause was a natural part of being a woman. Barbara explains, *"It's nature taking its course, it's your natural common ground."* All the women in the present study considered menopause to be natural.

This is the time called "tensatnhateni" in the Mohawk language, which translates as "a change in life." Several women referred to menopause this way. For the two women using the Mohawk term, this seemed to refer to a *physical* change, the end of menstruation. Two informants referring to "a change" hinted but did not elaborate on the possibility of other changes as well, such as a change of interest in sexuality, and emotional changes.

This natural event of menopause is seen as a part of "the circle of life," a traditional symbolic representation of the life process in native culture (Appendix 4). Women are an integral part of the circle, they are the "givers of life," and are traditionally responsible for life as explained in chapter two. Ann explains that menopause is simply another point along this circle :

C'est la normale de la femme, c'est un cycle que la femme doit subir...c'est le cercle de la vie.

Deborra, a 39 year old grandmother, told us about her position on the circle of life:

The circle of life; it starts when you're born, until you die. There's

different phases you go through: your youth, your adolescence and adulthood, and then grandparents. So for myself, I'm three quarters of the way around.

Four of the seven menopausal women of the study were at the grandmother phase on the circle of life. One who was not yet a grandmother assumed that role with other children, those of children she had raised, as well as with a nephew. Even the one childless informant did some grandmothering of grand nieces and nephews. All seemed to find joy in this role. The significance of this role will be further explored under theme three.

Menopause is also seen as part of getting older. All of the women accepted the inevitability of this. The oldest woman in the study expressed some apprehension related to aging, whereas a younger woman anticipated the wisdom and sense of accomplishment that she felt accompany this time of life. The following descriptors reveal these contrasting attitudes:

C'est parce que je vois des gens qui ont de la difficulté, qui sont perdus ou qui sont tout changés, Alzheimer[...] je me demande, comment vais-je devenir[...] est-ce que je vais parler seule dans la rue?[...]dans ce sens là, j'ai peur de vieillir[...] mais il faut suivre le cours de la vie (Ann).

Life is to grow old and to learn [...when you are older] you have so much knowledge within you...you've gotten up to a point where everyone is going to be coming to you to learn. I look forward to getting older (Barbara).

Menopause is an experience that is often accorded little significance other than natural, and minimal extra attention by many native women. One informant said:

I don't think they [native women] perceive menopause at all.[...] I've never heard any other native woman talk about menopause [...] (Deborra).

Several suggested that a preoccupation with this phase of life was more characteristic of non native, white women, as opposed to native women who do not

focus on it.

The experience of menopause, as part of the natural life cycle of woman, incorporates menopause in the context of menstruation and of woman's continuing lunar cycles. Native women's experiences of menopause and menstruation reflect their oneness with nature and their perception of being in synchrony with Mother Earth. One informant described the person as an energy field that can be trained to be in synchrony with nature:

> *Mooning is the time when a woman is having her menstrual period[...] it's called mooning because in general, women should all moon with the full moon; women can train the cycle to be in chronicity with the full moon...we are all energy masses and all energy can be trained to follow ways that it wants to (Barbara)* .

According to native beliefs, there is positive and negative energy everywhere in the universe. Menstruation is seen as the time for women to dispose of any negative energy they may have accumulated over the month through cleansing. This time of cleansing, eliminating is essential to the accomplishment of woman's caring-healing role in a positive way. Mooning is also an important time of rest and regeneration.

> *This is a time set aside for herself. It is a time when you rest, you meditate, you concentrate on your strength ; it's mother moon, father sun. The moon is when a woman is getting all her energy and her power in order to be able to do all that she does for her family and her community (Barbara).*

For these reasons, during the time of mooning, women do not carry out their caring-healing role; they are excluded from ceremonies because of the powerful movements of energy characteristic of this time; they may not work with medicines. At menopause, mooning continues, but differently; rather than the duration of menstruation, now mooning only encompasses the duration of the full moon. Valuing their caring healing role, traditional native women see this as an advantage of menopause, now *"being set back for only two days" (Barbara).* During this time

of mooning, the native woman will perform certain cleansing rituals which will be discussed under the theme of practices.

Traditional native women demonstrated awareness of and sensitivity to themselves in relation to nature. Women explained that they continue to be under the influence of the moon in menopause, still perceiving their lunar cycles despite the absence of menstruation, and even in spite of having had a hysterectomy. This self awareness will be further discussed under theme three.

Some women, including one who did not learn traditional ways, and another that did but also embraced religion, welcomed menopause as a type of liberation from menstruation which carried negative connotations and discomfort. These women did not perceive menstruation as a time of regeneration and rest. All women mentioned that menstruation was also a taboo subject in their culture, as was menopause. Lenora explains:

> *We were raised in the church; menstruation and menopause were taboo. I remember when I got my first period, I never would have dared ask my mother what was happening.*
> *I'm glad not to have that (monthly periods) anymore; it was a bother[...] messy and dirty.*

Ann, an informant who inhabits both worlds, also expressed a certain relief associated with menopause:

> *[Lorsque la ménopause est arrivée] c'était une très bonne chose...je me disais, enfin c'est fini [...]après il y a eu comme une libération; parce que[...] des fois j'étais malade[...] moins bien disposée [...] pendant les menstruations (Ann)*

Within this first theme depicting menopause as a natural part of woman's life cycle, the following patterns emerged among the native women participating in this study:

•Menopause is associated with woman's position on the circle of life, often

associated with the stage of grandmother.

•Menopause, a natural event, a part of being a woman, is accorded little extra attention.

•Menopause is related to the natural aging process.

•Menopause is related to menstruation and the lunar cycles.

•Menopause for some is a liberation from menstrual bother and discomfort.

Theme 2: Native women experience menopause as a time of vulnerability to negative energy

As discussed in chapter two, traditional native people hold beliefs concerning the existence of positive and negative energy in both the external and internal environment, which affect health and well being. One's own negative thoughts, or those directed towards us from someone else, can lead to imbalance and sickness. An ill spirit, due to failure to live in ways respectful to one's spiritual nature, can have similar effects (Malloch, 1989).

For some native women, the menopause represents a time of potential inner destabilisation, a time of vulnerability to negative energy perceived as internal or external to self. Hormonal changes are seen as being responsible for an imbalance leading to greater susceptibility to negativity as explained by Barbara in the following extract:

> *I find that it's a time in your life when all your hormones are getting kind of crazy... Throughout menopause you get uneven [your lunar cycles become irregular] I guess you could say it's a time where you are more susceptible to the negativity that surrounds you. [Women who are not helping themselves] are very sensitive, vulnerable and wide open to everything that surrounds them (Barbara).*

Since menopause is a time of vulnerability, Barbara explained that it is even more important at this time of life for women to help themselves; to *"sit down with*

themselves and get over [any] negative feelings. " Traditional ways that a woman can help herself are discussed under practices.

Imbalance during menopause can go so far as to lead to potential *"craziness"* according to some native women. At this time, a woman may feel that she is not her normal self, experiencing previously unthought thoughts and having unexplained fears. The experience of accompanying a relative through what she considered to be severe menopause combined with the idea of potential craziness acquired from older female family members caused one woman apprehension as she was coming into menopause. Norma told us the story of her cousin's experience. Her cousin's doctor had confirmed that her problems were due to menopause:

> *She couldn't believe what was going on, she felt like she was going crazy. It was like somebody was talking to her, and nobody was there; she had all these thoughts and she was scared; it got so bad with her that she was afraid to walk out the door, she was afraid to go shopping [...eventually] her fear started getting less and less; but someone had to be there to coax her, to hold her hand. You had to talk to her constantly, to tell her that everything was alright, would be alright (Norma).*

Norma had learned about menopause being a time of potential craziness from older female relatives, her mother, aunt, and grandmother; perhaps her cousin did also. She remembers being about sixteen when she heard her mother referring to her aunt going through menopause:

> *She was having weird feelings and feeling funny; so she called it a time of being crazy....It's hysteria, like your hysterectomy; it all has to do with the inside of your womb, all that part of your body changes, so she says they call it a hysterectomy, and part of that word...is you get hysterical (Norma).*

The word hysteria is derived from the Greek "hustera", meaning uterus. Hysteria was described by Hippocrates as an illness specific to women deprived of sexual relations. In the Middle Ages it was equated with diabolical possession of the spirit (Larousse, 1994). Norma is the only informant to have referred to menopause in

terms implying possible illness: *"[...]the only cure for this is[...]"*

The following patterns surfaced under the second theme depicting the menopause as a time of increased vulnerability to negative energy emerged:

- Menopause is a time of hormonal changes that can lead to imbalance and vulnerability.
- Menopause is a time of sensitivity and potential susceptibility to internal and external negative energy.
- Menopause is a time of potential craziness associated with the physiological changes occurring in relation to the uterus.

Theme 3: Native women experience menopause as a time for women to share their knowledge, wisdom, and memories.

One of the informants explained that in traditional native culture, the years leading up to menopause are seen as years of training, involving learning and experience cumulating in the wisdom that makes menopausal women sought out as advisors. Through her role of bearing and educating children, caring for her family and others, woman is accumulating the valuable training leading to wisdom in later years. Elder women are respected and important members of communities where tradition is followed; therefore, growing older confers increased status and holds no negative connotations. The following descriptors illustrate this facet of the experience:

> *It's a time of graduation...everything that you've accomplished and learned was a training; and now after all these years...everyone is going to be coming to you to learn (Barbara).*
>
> *The older she gets, the wiser she gets, and the more powerful she will be... so after menopause, she is more or less sought out, one of the strongest, one of the wisest (Barbara).*

This is where you're a ripened apple, you're in the prime of your life, it's when all of you is shining through...it's very precious and should be kept that way (Barbara).

When asked her thoughts about women who are concerned about the "loss of youth and beauty" associated with menopause, Barbara said *"feel sorry for them; [they are] very shallow women [...who] need to find themselves."* For Barbara, *"everyone [and] everything is beautiful in their own way."* The very purpose in life being "to grow old and to learn," concern with the loss of youth and beauty is almost absurd.

All the native women expressed the desire to share their knowledge and experience with others, notably their children and grandchildren for the majority. They said they have:

- memories to create:

  There are things that I want to share, for them to remember, to share with them. I want to make sure there is that memory with them (Norma, referring to her grandchildren).

- values to instill:

  I want to help the children to know who they are, and to respect themselves and others(Jean, referring to her mission in life, raising her grandchildren).

- traditions to transmit:

  I am grateful I have followed [the practice of traditional natural ways]; for women who do follow, it's something that is of second nature when it does come to their daughters...my daughters are growing with all of this. It's something that just comes naturally to them, they automatically know [about natural ways] (Barbara).

We are reminded of the role of the native woman, discussed in chapter two: Women are "the strong ones"; they are the teachers, teaching what they have come to understand throughout their lives. In native tradition, youth seek out answers and

strength in their elders. Being a grandmother means having a "second chance to teach" (Monture, O'Connor& O'Connor, 1989).

Two informants are interested in sharing their wisdom also with those of their own generation. Ann shares her wisdom by making it her mission at this time in life to teach natives and non natives alike about the history and identity of her people in order to promote understanding and rekindle native cultural pride. Barbara expressed interest in the transmission of traditional knowledge to other native women that they might re-appropriate their natural ways.

This third theme describing the menopause as a time for sharing knowledge, wisdom, and memories reveals the following patterns:

•Menopause is a time of graduating, of growing wiser, stronger, and more powerful.
•Menopause is a time for sharing what women have come to understand, with children, grandchildren, and others.

Theme 4: Native women experience the manifestations of menopause with confidence and equanimity.

> **Equanimity**: evenness of mind: that firmness of mind or calm temper which is not easily elated or depressed (Webster, 1954) Composure, calm (Little Oxford, 1986).

The women in this study described a number of different manifestations of menopause, both physical and emotional, often similar to, though sometimes different, from those described in numerous previous studies whose focus was symptoms, as discussed in chapter two. Some women have no manifestations other than the end of menstrual periods. The specificity of their experience of menopause manifestations lies in *how* these native women live with their encounters of manifest signs of "*a change in a woman's life*." All the native women demonstrated

an attitude of equanimity towards the manifestations, which varied in their presentation from almost non-existent to potentially disturbing. All were also confident of being able to cope with any manifestations that might arrive.

One informant, Lenora, said emphatically that she has never experienced any manifestations other than the abrupt end of her menstrual periods: *"They just stopped suddenly with no warning, when I was 50."* She compared the end of her time of monthly cycling with it's beginning: unexpected, without forewarning, totally surprising: she never really did believe that she would ever be menopausal herself. Now in menopause, she has "*decided not to worry."* Through the trials in her life and what she believes to have been stress induced illness, she has come to understand that by not worrying about things, one minimizes the possibility of being harmed by them. Although having no manifestations of menopause herself, she is solicited for advice by her sisters-in-law, all non native, on how to deal with theirs. She is of the opinion that white women in general have more "complaints," "trouble," and "symptoms;" as for native women, she told me: "*Most native women will probably tell you they have nothing."* She was the only informant who *"had nothing."*

Jean, taking hormone therapy since her hysterectomy, also states that she has no manifestations of menopause at present. Describing herself as strong and hardworking, she insists that she feels "physically....exactly the same as I did 30, 40 *years ago...no different."* She remembers having had some *"mild hot flashes before taking them [hormones] but not like you, not that bad,"* she said, observing the student researcher. She remembers, however, having heavy bleeding before her hysterectomy. She had assumed she was miscarrying ,before discovering she had fibroids. Jean attributes her easy passage into menopause not to hormones, but to the fact that she is living in a lively household full of children and has an important, all encompassing life task, that of raising her three grandchildren. Her mission being to care for and positively influence the lives of these children, this strong-willed, determined woman, has no inclination for self preoccupation. Asked about

how she would deal with any possible manifestations of menopause now that she is considering stopping the hormones, she replied: *"I'll stick it out, I'll deal with it on my own; I feel strong enough....I don't need anything else."*

Norma, the informant who ten years ago helped her cousin going through a difficult menopause, is now in the midst of this phase herself. She describes a number of manifestations that she associates with menopause:

> *I started breaking out in sweats.... every other night....I would have to get up.... in the tub ....and try to sleep again. I have a hard time sleeping.... then I feel like I can't breathe and I'm opening the door, trying to get some air. And then I find that for no reason, I'm extra sensitive, I want to cry for no reason at all...it's like I'm afraid of something and I don't know what.... I was always sore, my breasts were sore and I didn't understand why.*

In spite of being somewhat apprehensive about menopause, having witnessed a cousin having a difficult time, she demonstrates a firmness of character in dealing with its manifestations and radiates confidence about being able to control them:

> *[...] I can handle this myself [...] What works for me is to [...] have a positive attitude [...] keep an even temper [...] keep busy, [...] push myself [...] and continue with life.*

Ann remembers that her menstrual periods ceased at age 46; but it has only been within the last two years, that she has ever had the experience of hot flashes; also, as when she was younger, she continues to feel more irritable as her time of mooning approaches. She is 68. She is one of the two informants who discussed the importance for a woman to have an awareness of self in both body and spirit, that she feels is quite common among native women. She and Barbara both describe the experience of still regularly feeling their lunar cycles: Ann experiences this 20 years after her last period. For Barbara, since her hysterectomy the manifestations occurring during her lunar cycle seem to be increasing. She described cramping of her ovaries and painful breasts as she is "coming into mooning." In addition to an

awareness of their lunar cycles, both of these women also spoke of intuition. Being able to detect positive and negative energy around them and sometimes emanating from others; this capacity helps them to protect themselves.

The fourth theme revealed the following patterns of experience concerning the manifestations of menopause among the women studied:

- Some native women experience no manifestations other than the end of menstrual periods.
- Some native women experience physical manifestations including hot flashes, night sweats, not being able to breathe, fatigue (related to not sleeping due to night sweats), sore breasts, cramping of the ovaries, and weight gain.
- Some native women experience emotional manifestations including increased sensitivity leading to crying "for no reason," irritability, and unexplained fears.
- Some native women perceive their lunar cycles in spite of being well past menopause (according to medical definition) or having had a hysterectomy.
- Native women meet the manifestations of menopause with confidence, composure, and strength of character.

Theme 5: Depending on their integration of traditional ways, native women experience different health practices.

Native women described health care practices, both general and relating more specifically to menopause. Some of these are traditional, whereas others resemble practices of the mainstream culture. It is sometimes difficult to differentiate the cultural origins of certain practices because of the influence of white culture blended with native heritage. The degree of integration of traditional ways is reflected in the women's health practices.

As mentioned earlier, well being is a holistic concept for native people; it involves the physical, emotional, mental and spiritual aspects of the person, seen

as an integrated whole and includes an intimate reciprocal relationship with nature foreign to most members of the main stream culture. One perceives a feeling of connection with all things natural which is reflected in traditional practices.

Barbara, an informant who has reappropriated many cultural ways, was the only one in the present study who described a traditional ritual for women. She portrayed a rite of cleansing to eliminate negativity, important for menstruating and menopausal women during their phase of "mooning," described under theme one:

> *After a woman is in menopause, she will do what I am doing right now...not mooning naturally, I have to do other things to help myself, in order to cleanse my body at this time [...] There will always be a place in the wood where there will be a big rock [...] coming from the core of the earth, because a lot of energy is coming from the earth , you want to be seated on [it] ; a rock that will have a lot of moss around it to absorb. Take a bottle of water[...] from a stream or spring [...] natural is better[...]and sit [...] at night [...] with the full moon, pray to the moon to cleanse your water so that when you drink it, it then cleanses you. So rather than completely naturally [if I was menstruating] I'm cleansing myself through my water.[...] we bring ourselves to another state of consciousness when we do this [...] and the more we do it, the more we want to do it (Barbara)*

This cleansing ritual can be used by all women, the practice varying slightly according to whether one is still menstruating or not. It involves using water and earth, two of the elements along with fire and air that work in harmony in nature. It illustrates perfectly the "earth based spirituality" (Rowlandson, 1996, p.4) and the holistic indivisible nature of native women. This practice was described by Barbara, identified by the student researcher as the spokeswoman for traditional ways because she seems to have assimilated them more than the other women of the study. None of the others identified traditional health rituals specific to women, although several spoke of general practices.

Bathing is another traditional cleansing practice important for native women in that it also helps eliminate negativity and promotes relaxation. This practice is used at anytime of the cycle by women. The addition of sea salts or certain plants, like cedar, to the bathwater, helps promote well being and relaxation. During mooning, however, nothing is added to the bath water.

The use of fire and particularly smoke were described by Barbara as important elements related to cleansing, dispersing of negativity, and healing . She mentioned the use of candles, and the burning of sweet grass or tobacco as important cleansing practices eliminating negativity to promote well being in general. Ann also mentioned the use of sweet grass for purification in traditional ceremonies.

General traditional health care practices involving the earth were described by more of the women. One of the grandmothers, Jean, who claimed to know little about traditional ways, did have knowledge of and had used plants, for example in caring for children. Ann spoke at length about Mother Earth's gifts and native people's wise use of these:

> *Notre mère la terre...comme une mère qui prévoit tout pour ses enfants, la terre, elle, prévoit tout pour nous* [...] *Et puis remarquez l'autochtone[...] il avait l'intelligence d'utiliser tout ce que la terre pouvait nous fournir.*

Many general traditional practices for general health, well being and for healing involve the earth and its products, plants, both wild and cultivated. For Ann, gardening, gathering and using plants is a wellness activity, passed on from her mother:

> *C'est ma mère [qui m'a enseigné] tous les produits de la terre que l'on peut utiliser; dans le jardin chez nous, nous mettons d'abord tous les plants pour la santé, l'oignon, l'ail, le persil, la ciboulle.*

Gardening itself, the contact with the soil, sitting on the ground, the contact with the earth, are activities supporting Ann's wellness. She alone mentioned this activity as health promoting. From her mother she learned about the use of plants for healing various problems. Plantain leaves can be used to control bleeding; the

potato, an important food for natives according to Ann, is also used in direct application to relieve pain, for example headache. Juice made of boiled raspberry branches helped digestion; pine gum can be used to heal sores, as well as for respiratory ailments. Pine was also named by Barbara as being effective for respiratory ailments. Several women mentions sage, considered to be an effective remedy for women having problems with excessive bleeding and painful periods such as those sometimes associated with pre-menopause. Blueberries are a traditional healing food for women, helping particularly to strengthen in the reproductive process according to Barbara. She stressed the importance of positive intention in the preparation of these foods and other plants for healing, the importance of positive as opposed to negative energy, since medicine can also be used in a negative way.

The preparation of food for others and eating well are two activities related to general wellness for some women. Some had adopted the mainstream definition of "eating well," others had not: one woman mentioned that she tries to *"eat light and get all my vitamins"* whereas another said that variety is important, listing *"[...] meat, potatoes, fried bread"* as components of a healthy diet. Another, influenced by her son's interest in nutrition, now eats "lots of vegetables and tofu." One woman related her food preferences to traditional native food customs: she explained how in the past, native peoples cooked their food on stone, producing meals that were dry in texture and naturally low-fat. She feels that her preference for dry low fat foods is perhaps part of her cultural heritage. This woman spoke with gratitude and respect, of food as the Earth's gifts for the people.

Some women reported no particular health care practices at this time of life, but several referred to using positive attitude to deal with this and other life experiences. Deborra reflects this attitude demonstrated by several of the women:

> *I don't do anything out of the way[...] but I always make a point of having a positive attitude [...] I have a strong will and a strong mind [...] I can go through it[...] if everything is in balance, your emotional, spiritual,*

physical and mental being is all intact then nothing should bother you .

[To keep everything in balance]...what I do for myself is to have a positive outlook on life. I've gone through so much in my life that it's kept me strong, kept me going. It's the way native women perceive things in their life [...] I can go through anything [...] It's all mind over matter (Deborra)

A native health care worker who spoke to the Standing Committee on Health confirmed that the mental component of aboriginal wellness includes positive thinking as one of the elements of cultural wellness practices (Theresa Meuse, Brief to the Committee, 1995)

Informants living presently outside of their native home communities mentioned that "going home" was an important activity promoting well being. For one informant, going home means, among other things, participating in regular meetings of the clan mothers and elders, where traditions are transmitted. Ann experiences joy in observing the signs of rebirth of traditions, seeing in this renaissance a renewed hope for wellness for her people. She herself experiences wellness by regularly participating in traditional ceremonies which often include traditional dancing; it is of utmost importance to her that all be able to participate, as the wellness of her people seems to be part of her own:

On danse ici des fois, après la spiritualité, [on] prend le tambour et puis on danse en cercle, on fait seulement le pas de la joie pour le moment, le pas traditionnel, que même les plus âgés seraient capable de faire; c'est important que tout le monde soit capable de le faire[...] on danse en cercle, le cercle symbolise l'harmonie, la paix; ça symbolise la tradition aussi, l'amérindien fait tout en cercle, en honneur des quatres directions, en honneur des quatres éléments (Ann).

For another informant, going home includes participating in healing circles, an important practice for well being among native women. Women's healing circles involve the sharing of experiences and mutual support:

A group of women that sit together and talk, it just helps, like therapy [...]

just women sitting together in a group and talking about things. There's not necessarily a leader; if you want a topic you write it down and we put it in a basket, and every week we pick out a topic. [...] All different ages [come to the circle] it's good when there's all different groups, cause then you get all the different opinions, all the different understandings, it's benificial; there's no leader in charge because we're all helping each other out, talking together openly, alone is where you're getting so much out of this (Barbara).

According to Barbara, a healing circle where women could share their experiences of menopause could reassure women of the normality of it all:

I could just picture a group of women sitting together who have had this, menopause, like half the women who have been through it, and the other half who are coming through it, the energy alone would be beneficial (Barbara)

Non traditional health care practices were also mentioned by the informants. Several women mentioned working hard as being important to well being; Jean considered that *"all the running up and down stairs, doing laundry and cooking meals"* were responsible for her hearty good health. Ann spoke of walking twenty minutes a day to stay well, which she does on her doctor's recommendation. She also "avoids exaggeration," such as going out in the cold without proper clothing, and accords herself regular periods of rest alone doing preferred activities. Incorporating practices of another culture, the practice of massage such as shiatsu, is recommended by Barbara for relaxation. Several of the women practise breast self exam, having been taught by either a doctor or nurse.

Several of the women talked about the use of hormone therapy during menopause. Three of the seven women mentioned that they did not feel it necessary to be taking hormones at this natural phase in the life cycle, notably Barbara and Ann, who have assimilated to different degrees, traditional ways. Norma, a recent student of traditional ways was of the same opinion. She said: *"My ancestors*

didn't use anything, I don't need anything either." The other student of traditional ways, Norma, had used hormone therapy for a short period of time on the advise of her doctor, but had stopped taking them when she did not notice any particular difference in her symptoms while taking them. The three women more inclined to accept hormone therapy were those two identified as probably having integrated less of the old ways, and one who's level of integration was not apparent.

The women of this study described a number of wellness practices that they used. Few of these practices are particular to the time of menopause, other than the western medical practices of taking hormones; some, however, are specific to women. Some of these practices are traditional in nature whereas others can be linked with main stream or other cultures. Traditional wellness practices include:

- Traditional spiritual cleansing ritual performed by women during the full moon ; for younger women, this would ideally coincide with their menstrual periods.
- The practice of bathing with or without (during mooning) the addition of various healing substances, to eliminate negativity, promote wellness, relaxation, and healing.
- Cleansing rituals: The use of burning and smoke by burning sweet grass or tobacco to disperse negativity. The use of candles for the same purpose.
- Physical contact with the earth promotes wellness and healing: rituals involving the earth and other elements, and gardening, involving touching the earth, are health promoting activities.
- The respectful use of nature's gifts including foods and plants both cultivated and wild; these may be ingested, used topically, or in cleansing baths.
- Participating in cultural traditions promotes wellness and healing: Attending meetings of the elders and clan mothers, participating in ceremonies including traditional dancing, taking part in a woman's healing circle, "going home" to native territories, all promote wellness and healing.
- Maintaining a positive attitude to deal with life's difficulties.

Non traditional activities or those which can be identified also in western culture include:

- Eating well, including the notion of eating a low fat diet, getting sufficient vitamins.
- Performing breast self exam.
- Regular structured exercise like walking 20 minutes a day, periods of retreat from everyday activities in order to rest, and avoidance of "exaggeration."
- The use of hormones prescribed by doctors for menopause.

The findings in this chapter answered the question posed in this study: What is the health experience of menopause as described by native women, in terms of their values, beliefs and practices? From the descriptors, the student researcher elucidated five themes which seem to reflect the experiences of these women. These included: native women experience menopause as natural, a part of woman's life cycle; native women experience menopause as a time of vulnerability to negative energy; native women experience menopause as a time for sharing knowledge, wisdom and memories; native women experience the manifestations of menopause with confidence and equanimity; and, according to their integration of traditional ways, native women experience different health practices. A discussion of these findings follows.

CHAPTER FIVE

DISCUSSION

This last chapter consists of a discussion of the themes that emerged from the analysis and interpretation of the data relative to the health experience of menopause as described by native women. These findings will be discussed in light of Leininger's theory and method, and in relation to other studies. Finally, a review of this study's contribution to nursing knowledge and implications for further nursing research will be presented.

About the Informants

The native women in this study shared certain demographic characteristics, with some variations, with the larger group of native women. The choice of language for the interviews was predominantly English, with only one informant choosing to speak French, reflecting statistics concerning language discussed in chapter two. Most of the women in this study lived with their families, as do most native women of the same age range; within the group, three women were single, one was widowed, and three were living with partners, reflecting a range of native women in general. Compared to native women in general, the women of this study had a proportionately higher level of education and were more likely to work outside the home. There was however, a wide range of educational levels among these women. As is the case for native women and for women in general, these women generally worked in traditionally feminine professions.

In Light of Leininger's Theory and Method

The present study was conducted using an ethnonursing approach in order to explore the health experience of menopause as described by native women. The method proved effective for eliciting the type of experiential cultural information desired. Examination of the results in light of Leininger's theory of diversity and universality led to insights and understanding into the interacting and far reaching effects of various cultural and social elements on native women's experiences of

menopause. By seeking, among native women, cultural information related to this universal experience, the student researcher attempted to learn about the differences and similarities of their experiences of menopause among themselves, and between native women and women in general. Both the theory and the method contributed to meeting this goal. The five themes which emerged from this study were:

- Native women experience menopause as natural, a part of the life cycle of a woman.
- Native women experience menopause as a time of vulnerability to negative energy.
- Native women experience menopause as a time for sharing knowledge, wisdom, and memories.
- Native women experience the manifestations of menopause with confidence and equanimity.
- Depending on their integration of traditional ways, native women experience different health practices.

Among the dimensions of social and cutural structure influencing native women's health experiences of menopause, religious and philosophical elements appeared to have the strongest influence as discussed in chapter four. Women's perceptions of the menopause experience varied according to their degree of acculturation into and identification with mainstream culture and religion, or native spirituality and traditional ways. These women's experiences constitute a reflection of the blended influences of these different cultural traditions on unique individuals. The values, beliefs and practices associated with the menopause experience both reflected and varied with, cultural identification. A significant finding of this study is that, regardless of their chosen cultural path, spirituality emerged as being consistently meaningful in the lives of the women interviewed, whether expressed through traditional cultural ways, through western religion, or through a creative blending of the two.

Native philosophical views, and traditional beliefs and values about health, were most strongly reflected in the experience of the informant who rejected

religion, and who was considered by the researcher to be the spokeswoman of what this woman herself referred to as the natural ways. In her description of health practices, she alone described women's rituals associated with lunar cycling, and other practices used to dispel negative energy, elements of native philosophy which she integrated into her daily life. Another informant, who had considerable cultural knowledge but who also espoused the church, did not appear to be quite as familiar with these concepts nor did she discuss such practices. Both of these women, however, similar in having considerable cultural knowledge, reflected the notion of native spirituality in their vision of the world and incorporated native spirituality in their lives. For both these traditional women, spirituality is indissociable from any other aspect of their beings, including health, and their health experiences of menopause. For Barbara, spirituality *is* culture. These women are also different even though they both value and integrate native philosophy into their lives. Ann, unlike Barbara, does not reject religion as incompatible, but rather, creatively blends it with her native spirituality, transcending any man made conflict of values separating the two. She does, however, reflect some values of the mainstream culture in her attitudes (sees menstruation as a nuisance) and health practices. Other women in the study also spoke of religion; those describing themselves as religious did not have very much knowledge about traditional culture and did not express the experience the menopause through the traditional perspective. Although expressing respect for native spirituality and traditional ways, they did not seem to incarne native philosophy nor did they describe practicing cultural ways as Ann and Barbara did. Spirituality, however, expressed through religion, was also vital to these women.

Regardless of philosophical and spiritual affiliation, all the women shared the experience of menopause as natural. Less traditional women were, however, more likely to seek western medical intervention as a health practice at this time. Barbara, considered traditional, mentioned being sceptical about much of western medicine. Nevertheless, all of the women had had contact with the western medical

system at some time, illustrating the need for health care pratitioners to have cultural knowledge.

In this study, the student researcher learned how women's beliefs, values and practices are both similar to and different from those of their mothers and grandmothers. While one woman spoke of having learned some traditional cultural ways from her mother who was also very religious, she did not share as much specific traditional cultural information as another who deliberately acquired it through elders, saying that her own mother had lost much of her culture because of religion. For some women, acquisition of beliefs about menopause from their mothers and other female relatives was quite evident, as was the case for the informant who believed that menopause is a time of potential craziness. This woman stressed that her upbringing was very much influenced by values of the mainstream culture. One could speculate that the beliefs of most, if not all, of these women reflect a blending of those transmitted through the family and those assimilated through contact with white culture and western medicine due to the proximity of the two groups.

Among native women, topics like menstruation and menopause appeared to be taboo subjects, and were not openly discussed. Perhaps this could be attributed to religion which appears to have rendered taboo all subjects connected with sexuality. However, as discussed by Kaiser (1990), in some traditional societies untouched by western religion, menstruating women are also surrounded by taboos. During this study, most of the women did not discuss sexuality openly, although some did make some references to it.

Many women were familiar, to varying degrees, with the traditional use of plants as healing substances. This appears to be a health practice that has survived in spite of the apparent loss of many other cultural ways. One could hypothesize that perhaps in fact, this is simply one practice that native women are willing to discuss readily, due to the recent and growing acceptance in mainstream society for natural health remedies. It is possible that certain other practices and rituals are

considered of too sacred a nature to be shared with outsiders. Health practices, both traditional and non traditional described by the women of this study, reflect that this time in life is not a pre-occupation for them. Many natural remedies may be used at this time as at any other. Traditional practices specific to women, however, reflect the fact that menopause is the natural continuity of menstruation or mooning.

Equanimity and force of character are two qualities observed by the student among women of native populations, those of this study, as well as others she has met in work related experiences. Native women have often, for various reasons, experienced loss, pain, abuse and turmoil in their lives well before menopause. Native women often rise to the challenge of life's difficulties with strength and equanimity. In this study, the student researcher observed these same qualities in native women's experience of menopause.

World view represented in the upper part of the semi-circular sunrise model, graphic representation of Leininger's theory, refers to the way people tend to look out upon the world to form a value stance about their lives and the world around them (Leininger, 1988). Differences in elements of the world view can affect one's health experience of a life transition such as menopause. One aspect of world view involves one's relationship with nature. In the context of this study, where traditional culture is so closely linked to nature, it is appropriate to examine this element more closely. According to Kluckhohon and Strodtbeck (1961), there are three perspectives from which this relationship can be perceived: destiny, in which the human person is subjugated to nature in a fatalistic, inevitable manner; harmony, in which people and nature exist together as a single entity; and mastery, in which it is believed that people are intended to overcome and control natural forces. In spite of the traditional native world view of harmony with nature, in this study, no one uniform perspective could be identified as being shared by all the women. Acculturation into and identification with the mainstream culture colour the perspectives of the women to varying degrees. All three perspectives seem to be represented among the native women in this study and their experiences of

menopause, although the first two are most prominent. The perspective of harmony is reflected in the first theme, menopause is a natural part of the life cycle of woman, and in the traditional practices used to maintain and create wellness both in general and during menopause by those women having adopted traditional ways. The perspective of destiny, in which the person is subjugated to nature in an inevitable manner also seems to be present as manifest in the second theme emerging from this study: menopause is a time of vulnerability to negative forces. Several of the informants spoke of the inevitability of aging and menopause: "what will be will be;" and "there's nothing you can do." This contrasts with the mainstream North American view of domination over nature as reflected by the biomedical model of menopause; it is seen as something to be conquered, hopefully avoided altogether. In contrast with this perspective, these native women do not believe that they can avoid or delay menopause and or aging, nor do they express the desire to do so. Some, however, believe in the possibility of influencing their experiences of menopause, through sheer will power and positive attitude, which could be interpreted as reflecting the perspective of mastery.

Native women demonstrate considerable diversity in their perceptions of the experience of menopause while sharing certain commonalities among themselves, as well as with women of the mainstream culture. Acculturation into the mainstream or reappropriation of traditional ways appear to be significant factors colouring their perceptions of the experience. Through these women, we are witness to the dynamism of culture as it evolves over time and place.

In Relation to Other Studies

As discussed in chapter two, Buck and Gottlieb (1991) present two current views of midlife, the decremental and the developmental. At the beginning of this study, the student researcher thought that perhaps the former better reflects the menopause experience of native women. In the context of this study, the women's perceptions of the experience of menopause seemed to reflect both perspectives;

overall, however, the developmental perspective was supported in this study, as it was in that of Buck and Gottlieb, with a similar population. As discussed in the first theme, all of the women consider this time of life as part of the natural and normal evolution of woman; for many, it is also a time of wisdom and increased status and respect. Some women are pursuing studies and careers important to them; some are actively studying traditional cultural ways. Many are experiencing purpose and satisfaction from the traditional role of child raising and caring for others. In this sense, the developmental view better reflects these women's experience. Women do however, as discussed in the second theme, also consider this to be a time of increased vulnerability, and even potential craziness during which one must take care to protect oneself in order to avoid problems. This vulnerability seen through traditional eyes, is a natural consequence of hormonal changes and is experienced as susceptibility to negative energy, natural element of the native woldview. This vulnerability is experienced as a challenge that women are able to respond to and meet by helping themselves. This attitude is reflected in the third theme, women experience manifestations of menopause with confidence and equanimity. One informant reflected what could be interpreted as the decremental view, referring to menopause as a time of potential craziness, possibly even inferring a state of illness: "the only cure for this." This informant was notably a woman who described her upbringing as "more in a white way." The myth of women potentially becoming crazy in menopause is reminiscent of the decremental biomedical view of some years past, leading us to hypothesize that this idea stems from acculturation with mainstream culture, either directly or through it's influence on their mothers and grandmothers from whom they acquired some of their beliefs.

As presented by Buck and Gottlieb (1991), in the decremental perspective, one of the themes focuses on "the empty nest syndrome," the term used to describe the change in child rearing responsibilities as children leave home, a change thought to be difficult for midlife women. For the majority of women in this study, child rearing responsibilities continue through remaining children at home and through

grandchildren they are either raising or involved with in a teaching, guiding role. For some women in this study, childbearing and guiding responsibilities fill them with a sense of purpose and well being; others are engaged in other caretaking activities. This aspect of the experience of the women of this study is reflected by the third theme (time for sharing knowledge, wisdom and memories), and contrasts with the findings of Buck and Gottlieb (1991) in a study with a similar population of Mohawk women. Most of those native women described this time as one of shifting priorities from meeting others' needs, to satisfying their own. Continuing to care for others is a strong theme among the women of the present study. Speculation on the reasons for such a difference in findings in apparently similar populations brings to mind a variety of possibilities: among other possibilities the difference could be related to some undetected difference between the two populations, to the content and phrasing of questions, to researchers' diverging interpretations, or to the level of trust developed.

Data from the present study leading to the emergence of the first (as natural) and third (as a time for sharing) themes revealed that some native women experience menopause in ways similar to women in many non-western societies as discussed in the review of literature in the anthropological perspective. A common underlying theme found in studies done among 15 non western societies reviewed by Kaiser (1990) is a form of positive recognition associated with the time of menopause. This is in contrast to western societies where menopause is often associated with the loss of youth, beauty and sexuality, the process of aging is devalued or denied, and negative stereotypes persist. Women of native culture share the values of some of these non western societies, contrasting with those of western mainstream culture. Shared values among women of non-western societies in regards to aging women probably explain their similarity of experience: The onset of middle age in these cultures often means increased status and respect. In native culture, it offers the possibility of becoming a respected and sought out elder of the community. Traditionally, elder women, in particular clan mothers, held a

certain power in the sociopolitical well being of the native community, due to their role in naming the spokespersons. In addition, in native culture as in other non western societies, menopause lifts menstrual taboos and extends the time that women may practice healing and caring with traditional medicines and participate in ceremonies. In much of the western world, menopause is an event that women have been taught to dread. This is not seen in a society, like native society, where older women are valued, and where menopause is defined as a time of gain, rather than a time of loss. It is interesting to note that at no time did any of the native women interviewed mention the time of menopause in terms of a decline of youth, beauty, or sexuality. In contrast, these dominant western values often are related to mainstream women's sometimes difficult menopausal experiences. The fact that the person is seen in a holistic, indivisible way, along with the association of native woman with strength and power may help explain this. In western society, woman is often looked upon as a desirable sexual object to be possessed; in traditional native culture, woman are, at least theoretically, accorded a greater measure of respect.

In spite of these differences, native women's experiences of the transition of menopause do share certain commonalities with those of some mainstream North American women. As Leininger (1991) predicted, women experience both differences and similarities in their health experiences across cultures. Capozzoli (1990) studied eight North American women to learn about their experiences of menopause. Like native women, all of these women of the mainstream culture anticipated and recognized the menopause as a natural and normal event; for these women as for some of the women in the present study, it was not considered stressful physically or psychologically. In a study of mainstream American women by Quinn (1989), menopause was also seen as a natural event, supporting the first theme emerging from the present study. As revealed in the present study, Dickson (1994) found that North American women expressed scepticism about the use of hormone therapy during menopause until they perceived a problem that such

therapy could help. Many native women in this study were similarly unwilling to use hormone therapy or on the verge of stopping it, although some of their reasons were different: for some, their unwillingness stemmed from the fact that their ancestors had not "needed anything;" for others, similarly to the women in Dickson's study (1994), no beneficial effect was perceived; another reason was the perception that they were "strong enough to do it alone" and a fear of side effects like cancer that one informant had read about. Similarities in findings like these, between mainstream North American women and native women, may be explained by an exchange of information between cultures living in close proximity, including the ease of access to information in a technological era. Similarities can also be attributed to an evolution in contemporary women's attitude towards her health and well being since the beginning of the women's movement, including a certain scepticism in regards to the biomedical model and a search for alternative approaches. This change in attitude has in fact brought contemporary western health concepts in line with many age old native ones. Native people's holistic view of health, based on traditional cultural foundations, is consistent with contemporary western health concepts as they have evolved today (Standing Committee on Health). The World Health Organisation for example, defines health in terms of complete physical, mental, and social well being and not merely the absence of disease (Declaration of Alma-Ata, 1978). In native tradition, caring for one's health is a personal responsibility; the notion of empowerment of women in order that they assume this responsibility is one that is shared by native women (Standing Committee on Health) as well as those of the mainstream (Brown Doress and Laskin Siegal, 1987).

In regards to the health practices described by native women experiencing the menopause, a variety of both traditional and western approaches emerged in this study. Some women in this study referred to a positive attitude as a factor helping them traverse this experience. In a study of mainstream women McKeever (1988) found that underlying cultural beliefs and meanings of menopause influenced the

particular practices used by women. She found that women who understood menopause in a "matter of fact" perspective used thinking and the power of the mind to negotiate menopause. This understanding may be associated with that of native women, who look upon menopause as a normal, natural and inevitable event, and who similarly use a certain mental attitude (positive thinking) to deal with this phase of life. This is in contrast to those mainstream women in McKeever's study who understood menopause as aging, with all its negative western connotations, and who were therefore vigilant about body breakdown in their health practices; this attitude was notably absent among native women, who hold many positive associations with aging, and who do not express obsession with body breakdown; such obsessions are in fact regarded as almost absurd and pitiful.

Newfoundland women in a fishing village were found to attribute a significance to menopause similar to that attributed by the native women of this study; these village women said that menopause was a non-event, a normal part of the aging process. It was also seen as a potentially difficult stage to be lived through by using the coping skills and tough nature that have been forced on all women in the community. Similarly, many native women spoke of the trials of their lives, of "all they had been through," thus feeling confident that they could therefore get through this natural experience with the positive attitude and strength of character that they had been called upon to use so often in the past. Like the women of Newfoundland, native women use coping skills and their tough nature to get through the transition of menopause; but unlike them, native women did not generally admit to menopause being a difficult time.

By considering this study in relation to others, the student researcher has shown that these native women share certain aspects of their menopause experiences with other women, both western and non western, native and non native, illustrating the universality of the experience. The experience of menopause as natural is among the similarities discovered. The diversity of the experience is illustarted, among other aspects, by the significance of spirituality in the lives of these women, and the

importance accorded to sharing wisdom and knowledge at this time in life. In the following sections, this study's contribution to nursing knowledge and practice will be explored, and reommendations made concerning future research.

Contribution to Nursing Knowledge and Practice

McCain (in Dickson, 1994, p.19) says "menopause is so much more than the machination of hormones, it is longer and wider and much deeper than the happenings in the physical self." To the student researcher's best knowledge, there exist no other studies specifically exploring the menopause as a health experience with a group of native women. This first study thus provides a glimpse into the breadth and depth that this and other health experiences may represent for this group of women. Experiential cultural knowledge previously unfamiliar to nurses of the mainstream has been revealed through the present study. Such knowledge could serve as a base of understanding from which to explore with native women, their real health concerns and needs during this transition and beyond. This study revealed that regardless of cultural affiliation and of the women's opinion concerning the health care system, all, at some point, contacted health care professionals. It is important that these health care professionals have specific cultural knowledge.

The importance of spirituality in the lives of native women, be they traditional or not, is a significant finding of this study. In an increasingly secular and materialistic society, where spirituality has limited impact within the health care system, it is importance for nurses to consider this factor in their holistic care of native and other women. We learned that for native women, menopause is natural, experienced with simplicity and acceptance as the inevitable continuity of woman's life on the circle. It is experienced in the context of their native philosophy and in the greater context of numerous other preoccupations. We also acquired first hand information about the emotional tole of political struggles and a troubling ethnohistory on the lives of these women. We learned that pain permeates the very

pores of many native women and cannot be separated from their health experiences. Health care practitioners will understand their non pre-occupation with an event that is becoming increasingly popular in the mainstream society.

These findings provide experiential support to the idea of the importance of considering cultural values and beliefs of all women that, as primary health care practitioners, we may accompany through this transition. According to transcultural nursing scholars, enhancement of a clients' health care practices is contingent on the nurses ability to use culturally based beliefs and values as an integral component in the collaborative planning and implementation of care (Boyle &Andrews, 1989; Giger, 1991; Henkle& Kennerly, 1990; Leininger, 1991). In this study the student researcher has acquired knowledge about some generic health care practices used by traditional native women throughout their adult lives and continuing into menopause. The cultural knowledge acquired in this study, could serve a base for practitioners from which to explore with native women, their health concerns and needs during this transition and beyond. Nursing actions aimed at preserving and supporting holistic traditional care practices supporting wellness could help more native women experience the menopause transition with harmony.

Native women are increasingly interested in assuming responsibility for their health. They are desirous of relevant information, open to exploring alternatives and sometimes willing to blend them with their traditional ways. As non native primary care practitioners with a holistic approach and a focus on health promotion, nurses can provide relevant, objective information to these women, so that they may make enlightened decisions about their health practices. Such a role demands that nurses relinquish the biomedical model and embrace their own.

In addition to its contribution to nursing knowledge, the exploration of native women's perceptions of the universal experience of menopause, including their health practices and underlying beliefs and values, has enriched the body of *women's alternative knowledge* about this health experience. Women have expressed the desire for experiential knowledge from other women, about the

menopause transition (McKeever 1988). The information gathered during this study represents such knowledge which could possibly help other women, native and non-native, to understand their own experience; it could also provide ideas for coping with this life passage. Women of different backgrounds may feel compelled to search back into cultural natural roots for glimpses of ways of coping with this inevitable universal female experience; as women, this study may incite us to investigate the possibility of re-kindling female ceremonies, rituals, and rights of passage. It may serve as an inspiration to women of the mainstream culture who often experience this normal womanly passage with shame instead of pride. We are also invited to reflect upon the possible benefits of women sharing with each other their experiences of life passages common to us all. Women learning from women about the menopausal health experience of those of other cultures, similar and different, could provide perspective, support, and possibly facilitate this passage for certain women. By borrowing and blending ideas and practices, women may come to find new ways of coming to understand and deal with this universal experience.

Recommendations For Researchers

The student researcher proposes some recommendations to others considering similar studies. Gaining entry into native communities by establishing key contacts and then establishing the trust necessary for effective research is a process requiring considerable time. Ideally, such research should take the form of a true ethnography, including the use of participant observation to a much greater degree than was feasible in the context of this master's level study. We believe the researcher should, ideally, live and work in the community, an unrealistic goal in the context of this study.

The attitude of learner is an important one to bring to such encounters, and is appreciated by native women. The motives of white researchers have been questioned in the past and there remains reticence on the part of many for this reason. An understanding of the ethno-historical context by the researcher is vital

to a successful meeting of the two cultures.

Some women express resistance because they do not feel it appropriate to share such cultural information with those outside the culture. The student researcher was told that this could particularly be the case with some older native women. Some native women of the younger generation are however, more open to sharing this cultural information holding the belief that the sharing of this type of information could help promote understanding and be of benefit to all women. There is also the belief that this information should be made public in the hopes that other native women, who are not aware of their traditional culture, may learn about it and practice cultural natural ways to their benefit. The researcher should be mindful of the privileged nature of the information native people share, and take care to transmit it as respectfully and accurately as possible.

It is important for researchers to remember the principle of exchange, the offering of something in return for the time and information shared. For traditional women, the offering of food or natural things that can be used for healing are seen as appropriate. Things perceived as being bought, of monetary value, or the actual exchange of money, are not appropriate .

Ideally, research about and among native peoples should be conducted by native researchers. Presently, there is a dearth of native nurses prepared to do so. The profession of nursing should therefore continue to be promoted and supported among native peoples. Native nurses and other health care workers, holders of important cultural knowledge, should be encouraged to share their knowledge with non-native colleagues. Non-native colleagues should be sensitized to the wealth of cultural knowledge such colleagues could share with those expressing the desire to learn.

This study gives rise to a number of areas of interest for future nursing research. The topic of sexuality was notably absent from this study, not because the researcher was unaware of its relevance, but rather because it's exploration would have required a longer time frame permitting the development of a closer

relationship with the women. The exploration of the significance of sexuality for menopausal native women is a possible venue for future nursing research.

Due to social and familial changes within native families, the role of native women is evolving as more of them pursue education and employment out of choice or necessity. Nurse researchers could explore the impact of this changing role on native women's health as they enter into the next century.

This study has sparked interest about the intergenerational transmission of health beliefs and knowledge between women. Nurse researchers could explore the transmission of beliefs and knowledge within families, from grandmothers, to mothers to daughters, and its impact on health.

Finally, the knowledge obtained in this study invites nurse researchers to explore the native philosophy underlying health experiences like menopause in light of the conceptual frameworks of theorists like Martha Rogers and Rosemarie Parse. These two theorists of the school of the unitary being (Kérouac et al, 1994) hold visions which appear compatible with native worldview and may offer interesting realms of exploration for nurse researchers interested in working with native women. It would also be of interest to explore native women's health experiences from a phenomenological perspective.

In this chapter, the student researcher has discussed the findings of this study, in light of the chosen conceptual model and research method, and in relation to other similar studies reported in the literature. The contribution of this study to the body of nursing knowledge and to the practice of nursing has been explored. Finally, the student researcher has presented some recommendations concerning fiurther research.

CONCLUSION

Looking Forward

Madeleine Leininger realized almost 40 years ago how important it is for nurses to gain cultural knowledge about the people they care for. In the present study, the student researcher was able to experiment with this theory with a group of native women. This experience proved to be one that verified the validity of her message, and led to an even greater appreciation of its relevance to nursing practice.

With the wave of health care reform sweeping the country, we dare to hope that nurses will be on the leading edge, assuming an increasingly prominent role in the health care of women throughout their lifespans. We anticipate opportunities for women to have direct access to nurses as holistic primary health care providers. Those of us at the frontier of this movement should, however, be vigilant and rigorous in maintaining the holistic caring approach that so uniquely defines nursing.

Meeting an increasingly diversified population within our practices, to question the relevance of transcultural nursing is no longer appropriate. It is now timely that nurses integrate transcultural nursing principles into their practice in order to continue the profession's legacy of providing the most appropriate health care for people in the face of their evolving needs. The application of knowledge such as that gained through the present study and other transcultural nursing research will help maintain this direction.

LIST OF REFERENCES

Alexander, C. (1987, February). The cultural basis of well-being. Aboriginal Women's Council of Saskatchewan, 10-12.

Barret-Conner, E., D. Wingard & M. Criqui (1989). Postmenopausal estrogen use and heart disease risk factors in the 1980's. Journal of the American Medical Association, 261, 2095-2100.

Bell, M. (1995). Attitudes toward menopause among Mexican American women. Health Care for Women International, 16, 425-435.

Bell, S. (1987). Changing ideas: the medicalisation of menopause. Social Science and Medecine, 24, 535-542.

Bell, S. (1990). Sociological perspectives on the medicalisation of menopause. In Flint, M., Kronenberg, F., and Utian,W. (Eds.) Multidisciplinary perspectives on menopause (173-178). New York: Academy of Sciences.

Bernard, J. (1981). The Female World. New York: Free Press.

Beyene,Y. (1986). Cultural significance and physiological manifestations of menopause: a bicultural analysis. Culture, Medicine and Psychiatry. 10, 47-72.

Bobbish Atkinson, H. & Magonet, G. (1990) L'expérience de la Baie James. Ministère de la santé et des services sociaux du gouvernement du Québec: Québec.

Boyle, J. S. & Andrews, M. (1989). Transcultural concepts in nursing care. Glenview, Ill: Scott, Foresman & Co.

Brown Doress, P. and Laskin Siegal, D. (1987) Ourselves, growing older: Women aging with knowledge and power. Simon and Schuster: New York.

Brown, J. K. (1982). Cross cultural perspectives on middle aged women. Current Anthropology, 23 (2), 143-156.

Brown, J. K., & Kearns, V. (1985). In her prime: A new view of middle- aged women. Massachusetts: Beergin & Garvey Publishers, Inc.

Buck , M. and Gottlieb, L. (1991). The meaning of time: Mohawk women at midlife. Health Care for Women International, 12, (1), 41-50.

Capozzoli, E. (1992). In our own words: personal perceptions and experiences of the menopause. Doctoral dissertation abstract. The Union Institute.

Chaiphibalsarisdi, P. (1990). Self care responses of rural Thai perimenopausal women. Doctoral dissertation abstract. University of Illinois at Chicago.

Cook, L. (1995). Gaining access to Native American cultures by non-native nursing researchers. Nursing Forum, 30, (1), 5-10.

Davis, D. (1986). The meanings of menopause in a Newfoundland fishing village. Culture, Medicine and Psychiatry, 10, 73-94.

Dickson, G. (1989). The knowledge of menopause: an analysis of scientific and everyday discourse. Doctoral dissertation.

Dickson, G. (1990a). The metalanguage of menopause research. Image: Journal of Nursing Scholarship, 22, (3), 168-173.

Dickson, G. (1990b). A feminist poststructuralist analysis of the knowledge of menopause. Advances in Nursing Science, (3), 15-31.

Dickson, G. (1994). Fifty-Something: A phenomenological study of the experience of menopause. In Munhall, P. (Ed). In women's experience, 117-157. New York: National League for Nursing Press.

Dill, P. Z. (1994). Commentary on menopause without symptoms: the endocrinology of menopause among rural Mayan Indians. AWHONN's Women's Health Nursing Scan, 8 (4): 6, abstract.

Elle-Han'sa (1989). The Circle of Life. Canadian Woman Studies, 39, (2&3), 53.

Fishbein, E. (1992). Women at midlife: the transition to menopause. Nursing Clinics of North America, 27, (4), 951-957.

Flint, M. (1975) Menopause, reward or punishment? Psychosomatics, 16, 161-163.

Flint, M. and Garcia, M. (1979). Culture and the climacteric. Journal of Biosocial Science, 6, 197- 215.

Giger, J. N. (1991). Transcultural nursing: assessment and intervention. St. Louis: Mosby Yearbook.

Grimpa, S. (1993, September). Culture shock. The Canadian Nurse, 33-36.

Griffen, J. (1977). A cross cultural investigation of behavioural changes at menopause. The Social Science Journal, 2, 49-55.

Griffen, J. (1982). Cultural models for coping with menopause. In A.Voda, M. Dinnerstein, & S. O'Donnell (Eds). Changing perspectives on menopause, (248-262). Austin: University of Texas Press.

Henkle, J. & Kennerly, S. (1990). Cultural diversity: a resource in planning and implementing nursing care. Public Health Nursing, 7 , (3), 145-149.

House of Commons Canada, Standing Committee on Health (1995). Towards holistic wellness; the aboriginal peoples.

Hughes, C. C. (1992). Ethnography: What's in a word- process product promise. Qualitative Health Research, 4, 439-450.

Hutchinson, T., A. Polansky & A. Feinstein (1979). Postmenopausal estrogen protect agaist fractures of hip and distal radius. Lancet, 2, 705-709.

Indian and Northern Affairs Canada (1992). Health of Indian Women .Ottawa.

Kaiser, K. (1990). Cross-cultural perspectives on menopause. In Flint, M., Kronenberg, F., & Utian, W. (Eds). Multidiscipinary perspectives on menopause, (430-432). New York: Academy of Science.

Kaufert, P. A. (1982). Myth and the menopause. Sociology Health and Illness, 4, 141-166.

Kaufert, P. A., and Syrotwik, J. (1981). Symptom reporting at the menopause. Social Science and Medicine, 15E, 173-184.

Kearns, B. J. (1982). Perceptions of menopause by Papago women. In A.Voda, M. Dinnerstein, & S. O'Donnell (Eds). Changing perspectives on menopause (70-83). Austin: University of Texas Press.

Keller, A. (1990). Menopause-as told by women. Doctoral dissertation abstract. University of Cincinnati.

Kérouac, S., Pepin, J., Ducharme, F., Duquette, A. Major, F. (1994). La pensée infirmière. Laval: Editions Études Vivantes.

Kluckhohn, F. and Strodtbeck, F. (1973). Variations in value orientations. Westport CO: Greenwood Press.

Koeske, R. (1982). Toward a biosocial paradigm for menopause research: lessons and contributions from the behavioral sciences. In A. Voda, M. Dinnerstein, & S. O'Donnell. Changing perspectives on menopause, 3-23. Austin: University of Texas Press.

Koster, Anne (1991). Change of life anticipations; attitudes and experiences among middle aged Danish women. Health Care for Women International, 12, 1-13.

Kuster, M. A. (1997). Significations du soin générique en période post-natale exprimés par des couples d'immigrants Algériens. Mémoire de maîtrise, Faculté des sciences infirmières. Université de Montréal.

Langlais, J. (1991). Les voies de l'avenir: Les Mohawks. Médium Sciences Humaines, 39, 4.

Le Petit Larousse (1994). Paris.

Leininger, M. (1970). Nursing and Anthropology: Two worlds to blend. New-York: Wiley.

Leininger, M. (1978). Transcultural nursing : concepts, theories, and practices. New York: Wiley.

Leininger, M. (December, 1984). Transcultural nursing: An essential knowledge and practice field for today. Canadian Nurse, 41-45.

Leininger, M. (1985a). Transcultural care diversity and universality: a theory of nursing. Nursing and Health Care, 6. (30), 135-143.

Leininger, M. (1985b). Qualitative research methods in nursing. New York: Grune and Stratton

Leininger, M. (1988). Leininger's theory of nursing, culture care diversity and universality. Nursing Science Quarterly, 1, (4), 152-160.

Leininger, M. (1990). The significance of culture concept in nursing. Journal of Transcultural Nursing, 2, (1), 52-59.

Leininger, M. (1991). Culture care diversity and universality: A theory of nursing. New York: National League for Nursing Press.

Leininger, M. (1994). Evaluation of qualitative research. In Morse, J.M. Critical issues in qualitative research methods. Sage Publications.

Lincoln, Y. S. and Guba, E. G. (1985). Naturalistic inquiry. Beverly Hills: Sage Publications.

Little Oxford dictionary. (1986), (6th edition) . Oxford: Oxford University Press.

Lock, M. (1986). Introduction to ambiguities of aging: Japanese experience and perceptions of menopause. Culture, Medicine and Psychiatry, 10, (1), 23-46.

Love, S. and Lindsey, K. (1997) Dr. Susan Love's hormone book: Making informed choices about menopause. New York: Random House.

MacPherson, K. (1981). Menopause as a disease: the social construction of a metaphor. Advances in Nursing Science, 3 (2), 95-113.

MacPherson, K. (1985). Osteoporosis and menopause: a feminist analysis of the social construction of a syndrome. Advances in Nursing Science, 7, (4), 11-22.

MacPherson, K. (1990). Nurse researchers respond to the medicalisation of menopause. in Flint, M., Kronenberg, F., & Utian, W. (Eds). Multidisciplinary Perspectives on Menopause (180-184). New York: Academy of Science.

Malloch, L. (1989). Indian medicine, Indian health: study between red and white medicine. Canadian Woman Studies, 10, 1.

Martin, W. (1991). Metaphors of bleeding in women. NAACOGS Clinical Issues in Perinatal and Women's Health Nursing, 2 (3), 283-288.

Maoz, B. , N. Dowty, A. Antonovsky & H. Wijsenbeek (1970). Female attitudes toward menopause. Social Psychiatry, 5 (1) , 35-40.

McEllmurry and Huddleston, D. (1991). Self care and menopause: a critical review of research. Health Care for Women International, 12, 15-26.

McKeever, L. C.(1988). Menopause: an uncertain passage. An interpretive study. Dissertation abstract. University of California.

Mikhail, B., and Ragheb,M. (1995). Health-related concerns and experiences of employed perimenopausal women in Alexandria, Egypt.

Mishel, D. R. (1987). Menopause: physiology and pharmacology. Chicago: Year Book Medical Publishers.

Monture, P., O'Connor, N., O'Connor, S. Grandmothers, mothers and daughters. Canadian Woman Studies, 10, (2&3) 38-39.

Moore, B., and Kombe, H. (1991). Climacteric symptoms in a Tanzanian community. Maturitas, 3, abstract.

Moore, E. (1991). Les femmes autochtones au Canada. Statistique Canada, Les femmes au Canada, troisième édition.

Morse, J. M. (1994). Critical issues in qualitative research method. London: Sage Publications.

Murphy, S. (1993) Using qualitative methods to evaluate needle exchange. Proceedings from the National Research Council Workshop on Needle Exchange and Bleach Distribution Programs, September 27-28.

Peelman, A. (1991). Les racines réligieuses de renouveau. Les Mohawks: Médium Sciences Humaines, 39, 13-16.

Poitras, E. (February, 1987). The philosophy of Native women. Aboriginal Women's Council of Saskatchewan, 2-6.

Prince, R.L. (1991) Prevention of postmenopausal osteoporosis. New England Journal of Medicine, 325, (17), 1189-1193.

Quinn, A. (1988). Integrating a changing me: a grounded theory of the process of menopause for perimenopausal women. Doctoral dissertation. University of Colorado Health Sciences Center.

Quinn, A. (1991). Menopause: plight or passage. NAACOGS Clinical Issues, 2, (3), 304-311.

Richelson, L., H. Wahner & L. Melton (1984). Relative contributions of aging and estrogen deficiency to postmenopausal bone loss . New England Journal of Medicine, 311, 1273-1275.

Roberts,J., L.Chambers, J. Blake, & C. Webber (1992). Psychosocial adjustment in post-menopausal women. Canadian Journal of Nursing Research, 24 (4), 29-44.

Robillard, D. (1991). Qui sont les traditionalistes? Les Mohawks: Medium Sciences Humaines, 39, 5-12.

Rosenberger, N. (1986). Menopause as a symbol of anomaly: the case of Japanese women. Health Care for Women International, (1-2), 15-24.

Rowlandson, Rebecca (Fall 1996). Religious roots of individualism. Aboriginal Rights Coalition Solidarity Newsletter, 6, (3), 4-6.

Scharbo-DeHaan, M. (1993). The experience of menopause. A feminist interpretive study. Doctoral dissertation. Georgia State University.

Spradley, J. P. (1979). The ethnographic interview. New York : Holt, Rinehart and Winston.

Stampfer, M. J., Colditz, G. A., & Willet, W. C. (1991). Postmenopausal estrogen therapy and cardio-vascular disease: Ten year followup from the nurse's health study. New England Journal of Medecine, 325 (11), 756-762.

Standing,T., and Glazer, G. (1992). Attitudes of low income clinic patients towards menopause. Health Care for Women International, 13, 271-280.

Theisen, S. C., and Mansfield, P. (1993). Menopause: social construction or biological destiny. Journal of Health Education, 29, (4), 209-213.

Thomlinson, E.(1993). Caring for clients in isolated northern settings. In Gault, D. (Ed) A global agenda for caring. New York: National League for Nursing Press.

Tlou, S.D. (1990). The experience of the perimenopause among Botswana women. Doctoral dissertation abstract. University of Illinois .

Utian, W. (1990). The menopause in perspective. In Flint, M., F.Kronenberg & W. Utian. Multidisciplinary perspectives on menopause, (1-7). New York: Academy of Sciences.

VanKeep, P. A. (1986). The climacteric in different cultural contexts. Annual Review of Nursing Research, 4.

Voda, A (1986). Menopause. Annual Review of Nursing Research, 4, 55-75.

Webster consolidated encyclopaedic dictionary. (1954). Chicago: Consolidated Books.

Weideger, P. (1976) . Menstruation and menopause. New York: Knopf.

Werner, O. and Schoepfle, M. (1987). Systematic Fieldwork. New York: Sage Publications.

Wilton, J., and Noonan, M. (1991) A menopause center: bridging the midlife gap. NAACOGS Clinical Issues in Perinatal and Women's Health Nursing. 2 (4), 527-532.

Wilson, R. (1966). Feminine forever. New York: M. Evans & Company.

World Health Organisation. (1978). The declaration of Alma-Ata. Geneva.

Wright, A. L. (1982). Variations in Navajo menopause. In A. Voda, M. Dinnerstein, & S. R. O'Donnell (Eds.), Changing perspectives on menopause, 84-99. Austin: University of Texas Press.

APPENDIX 1

North-American Indian Culture*

Cultural Values are :	Culture Care Meanings and Action Modes are :
1. Harmony between land, people, and environment	1. Establishing harmony between people and environment with reciprocity
2. Reciprocity with "Mother Earth"	2. Actively listening
3. Spiritual inspiration (guidance)	3. Using periods of silence ("Great Spirit" guidance)
4. Folk healers (Shamans) (The Circle & Four directions)	4. Rhythmic timing (nature, land and people) in harmony
5. Practice culture rituals and taboos	5. Respect for native folk healers, carers, and curers (Use of Circle)
6. Rhythmicity of life with nature	6. Maintaining reciprocity (Replenish what is taken from Mother Earth)
7. Authority of tribal elders	7. Preserving cultural rituals and taboos
8. Pride in cultural heritage and "Nations"	8. Respect for elders and children
9. Respect and value for children	

*These findings were collected by the author and other contributors in the United States and Canada during the past three decades. Cultural variations among all nations exist, and so these data are some general commonalities about values, care meanings, and actions.

Leininger, M. (1991). Culture care diversity and universality: A theory of nursing. New York: National League for Nursing Press, page 357

APPENDIX 2

Interview Guide

Do you have any particular word for this time of life that some call the menopause?

Can you remember when you first started to think about the change of life?

What is for you , the change of life? What does it mean to people of your culture?

How would you describe this time in your life?

Is there anybody or anything that helps you feel well at this time of your life - physically, mentally, spiritually, or emotionally?

Could you please tell me some of the things you do to stay healthy particularly at this time in your life? Has any one suggested you do any particular things?

I am wondering if there are any native ways or traditions associated with this time of women's lives? Would you be willing to tell me anything about that?

Could you refer me to someone who can tell me more?

I am wondering if spirituality has anything to do with how you experience this time in life. Would you tell me something about this?

Do you have any particular health concerns or problems at this time, that you think might be related to the change of life?

Would you like to say anything else that you think might help me to understand your experience?

If you had any problems or concerns about the change of life, is there someone you would talk to?

Do you talk about the change of life with other women?

APPENDIX 3

Letter of explanation to informants

Bernice Pleta
[redacted]

Title of study : The Health Experience of Menopause as Described by Native Women

Director : Dr Jacinthe Pépin
[redacted]

I am a nurse studying at the University of Montreal. Being of Lithuanian origin myself, I am interested in the way our culture can affect our health experience.

Since working in Northern Ontario last summer with Native people, I have become interested in learning about Native culture, and how it relates to health. As nurses interested in women's health issues, we are often in situations where we are caring for and interacting with women of cultural backgrounds different from our own. Some of us work with Native women.

I believe that we would do a better job if we had more knowledge about the actual health experiences of women during certain phases of their lives, from their own point of view.

Approaching middle age myself, I would like to learn from you, how you experience the time of menopause, in your own words. I am interested in hearing how you deal with this time of life, what it means to you, and the kinds of things you do to stay healthy.

To do this, I would like to meet with about eight women who would be willing to talk with me individually, to share their thoughts on the experience of menopause. The women would probably be between about 45 and 54. They might still be having periods, or not. They would be women who are getting close to, or who feel they are in menopause.

I would like to spend about 1 to 2 hours in an interview session with each woman. I would ask you some questions, but mostly I would like women to feel free to share their ideas about the experience of menopause with me. Some women might want to spend more than one session talking about their ideas. The interview setting would be agreed upon with the woman, where she is most relaxed and privacy is ensured. If it is acceptable to you, I would like to audio tape our interviews so that I can remember what each person says. The tapes will be kept by myself for the sole purpose of my research, and they will be destroyed following completion of the study. The person's interview will remain confidential; the people will not be identified by name in any written or verbal reports. Women are free to refuse to participate at any time, and may withdraw from the study at any time.

Once again I would like to emphasize that my purpose doing this study is to learn from Native women about how they experience the menopause, and what they do to stay healthy, in order to be able to provide better health services for all women.

APPENDIX 4

The Circle of Life

BY ELLE-HAN'SA

The Creator made the Earth round
She made the Grass and the Trees
the Birds, Fish and Animals
to follow the purpose of Her Creation.
and She made the four races of Mankind
black, white, yellow, brown
and placed them in the East, North, West and South
She made the Sun, the Moon and the Stars
and asked them to form circles
so that we should understand
the Wisdom and Meaning of Life.
Because Life as the Creator meant it
is a circle : from the Creator
to the Creator, the Circle of Life.

The Earth is small and very sensitive
All Creation has to share
the same sources of living,
this is as true as night follows day.
The same Air
that refreshes the peoples of the arctic North
and gives relief to the drought-stricken
peoples of the South
is also filled with the war-cries of the East
and surrounds the polluted cities of the West.
How long will it last?

Freedom means to be in your right element,
to be linked to the purpose of Creation,
to be a part of History, its past, present and future.
the bird is free only in the air.
the fish only in the water.
Have you ever known of birds
that wanted to live under water
or a fish that wanted to build its nest in the trees?

I have. I know of men
who themselves wanted to be Masters of History
who made their Gods silent and ideas
and cut the Earth into square pieces.
Will we survive under these masters?
"If we don't survive as a people
following the instruction and purpose of the Creation
then we must ask: What
is the purpose of survival?"

If you can't fence the air in square pieces
how can you sell the Earth?
But now the Earth, the Water and even the Air
suffers because Man has placed himself
in the centre instead of his God.

Time has come when Man will discover
the darkness around him
that power, intelligence, wealth and glory
is not enough to save his soul.
Then maybe they will listen
to the Wisdom and Understanding of those People
whom they regarded as small and worthless,

the Indigenous Peoples of the Earth.
They will ask for our help
and we must give it:
Unless the Creator is the Centre of the Circle
unless we make Her the ruler of our lives
There will be no equality, no brotherhood
or freedom
among the children of the creation.
Only when we are a part of this Chain
of caring and sharing
will there be peace on Earth.
The only freedom we ever got
is to choose between Yes and No.

The Circle of Life
is to become a part of Eternity.
The Great Spirit links us together,
It made us different
not to control each other
but to contribute,
not to sell or take
not even to give,
but to share.
the Voice of the Creator
we can hear only when we listen,
just like the Wind
that refreshes suffering Mankind
We can't see it, yet it is there.
We don't know from where it comes
or where it goes....

This poem was written by Elle-Han'sa, a Samé, for the First Inuit Circumpolar Conference, Point Barrow, Alaska, 1977. It was presented by Makka Kleist of Tukak Teatret at the opening ceremonies of the 1980 Indigenous Theatre Celebration, and first appeared in Ilummelen, Remmelt, ed., We don't have a machine which serves me coffee.... *(ANDPUA Books for Indigenous Peoples Theatre Association, 27 Carlton Street, Suite 208, Toronto, Ontario M5N 1L2, 1981), pp. 34-35.*

Elle-Han'sa. (1989) The circle of life. Canadian Woman Studies, 10 (1&2), 53.