CULTURAL INFLUENCE ON THE CHARACTERIZATIONS OF HEALTH BY KOREAN WOMEN LIVING IN THE UNITED STATES

A Thesis Presented to

The Faculty of the Valenti School

of Communication

University of Houston

In Partial Fulfillment

Of the Requirements for the Degree of

Master of Arts

By

Gayoung Cho

December, 2011

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ABSTRACT

The number of Korean migrants in the United States is continuously on the rise. As immigrants, they adapt to their new environment, including their understanding of health. This study explored the experience of Korean women living in the United States with respect to their perceptions of health and attempted to develop a substantive theory that explains the basic social process of adjusting to new life. Specifically, this study was undertaken to address the following questions: "How do Korean women living in the United States characterize health? and “To what extent does Korean and/or American culture affect such characterization?”

This descriptive qualitative study utilized the grounded theory design. Accordingly, data collection comprised of purposive and theoretical sampling methods. In-depth, semi-structured, audio-taped interviews were conducted with a total of 20 Korean women in 20’s who have lived in the United States for at least two years. Interview data were transcribed verbatim and analyzed using Strauss and Corbin's constant comparative method.

Findings indicated that Korean women use various methods of coping with new cultural environment and understanding toward health. Three main categories of health perceptions emerged: Physical health, mental and emotional health, and social health.

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Chapter One

Introduction

Health has been a core concept in numerous studies in the health services field (e.g., Benisovich & King, 2003; McCarthy et al., 2004; Resick, 2008; Yoho & Ezeobele, 2002). For example, Yoho and Exeobele (2002) considered the notion of health and culturally understanding of health is crucial to healthcare providers as well as healthcare recipients for having satisfying outcomes. Fadiman (1998) showed that how individuals view health lead to different treatments and other outcomes. The author introduced the struggle of the Lees family from the Hmong in the United States and highlighted the importance of cross-cultural idea of health:

> I sat on the Lee's red folding chair for the first time on May 19, 1988. Earlier that spring I had come to Merced, California, where they lived, because I had heard that there were some strange misunderstandings going on at the country hospital between its Hmong patients and its medical staff. One doctor called them "collisions," which made it sound as if two different kinds of people had rammed into each other, head on, to the accompaniment of squealing breaks and breaking glass. As it turned out, the encounters were messy but rarely frontal. Both sides were wounded, but neither side seemed to know what had hit or how to avoid another crash. (p. 2)

Fadiman (1998) noted that health providers need to understand the concepts of health culturally. "Health providers need to understand that as powerful an influence as the patients' culture and culture of biomedicine is equally powerful (p. 261)." Culture dictates how we understand the idea of health.

The concept of health has been evolving over the past decades. Siegmann (1976) indicated that health is defined based on a society's health problems and its capacity to deal with them. Hence, the changing nature of health problems and the development of health technology to deal with them over time are the major reasons for the evolving concept of health. Yet, the lack of agreement exists even among contemporary health researchers, thereby revealing the complex nature of health.

The traditional medical care professional's task was to identify the cause of health problem and solve it effectively. In earlier times, health problem largely meant diseases that were attributed to a supernatural being's intrusion or punishment for the violation of social regulation and taboos (Risse, 1978). Later, Hippocratic medicine was predicted of based on careful cause-effect observations. The knowledge of cause became essential to the goal of medicine (King, 1963). This Hippocratic tradition has contributed to the natural science that developed through the middle and modern ages and bloomed in the 20th century. It has played an important role in building the concepts of health among the Western publics.

However, human health may be too complicated to be fully understood only through the natural scientific approach. Thus, for example, today many researches in the health communication field have examined the concept with multicultural values (e.g., Benisovich & King, 2003; Coleman, 2009; McCarthy et al., 2004; Yoho & Ezeobele, 2002).

In 1948, the World Health Organization (WHO, 1958, p. 1) issued one of the most widely quoted and accepted definitions of health. Health is "a state of complete physical, mental, and social well-being and not merely the absence of disease and infirmity" (p. 1).

Health in the broad sense of the WHO definition is an optimal function of the human organism to meet biological, psychological, social and spiritual needs (Constitution of the World Health Organization, 2006).

Another frequently quoted definition of health is that of Dunn (1961). He said that health just means a disease-free state. He concluded that health is a wellness state having various degrees, of active meanings, not a matter of dichotomy. Dunn (1961) implied that there be no optimum level of wellness per se, but the direction in progress toward a higher potential of functioning that is high-level wellness.

However, the health professions using a medical model are concerned with health in the narrower sense as optimal functioning at the biological and psychological levels, yet in the context of the integration of all levels of needs (Ashley & O'Rourke, 2002). According to Ashley and O'Rourke (2002, p. 52), "Health is optimal functioning of the human organism to meet and integrate biological, psychological, social, and spiritual needs. Here, human health is seen as involving much more than biological functioning."

In short, no one meaning of the term health has been universally accepted. Health is difficult to define because it involves value judgments; it is subjective, dynamic, and abstract, and is culturally bound (e.g., Benisovich & King, 2003; Coleman, 2009; McCarthy et al., 2004; Yoho & Ezeobele, 2002). In particular, a number of studies have emphasized that the meaning of health is culture-laden (e.g., Benisovich & King, 2003; Coleman, 2009; McCarthy et al., 2004; Yoho & Ezeobele, 2002).

Although health is the universal concept, the individual's meaning of health depends on the cultural groups each person belongs to. One's health awareness and behavior is tied to one's cultural orientation. According to Yoho and Ezeobele (2002),

understanding cultural norms and boundaries is important to provide effective healthcare. Health providers typically serve as the primary caregivers in most clinical setting, which exposes them to a variety of cultures and cultural behaviors that maybe markedly different from their own. Leininger (1999) advocated the concept of culturally congruent care that is meaningful and fits with the patients' cultural belief and lifestyle. Therefore, it is inevitable that understanding of health varies form country to country or one ethnic group to another.

Recently, immigrant women's health issues emerged as public health issues (Remennick, 2003). Immigrant women often experience barriers to accessing and receiving health care (Meleis et al., 1998). According to Meleis with her colleagues (1998), these barriers are related to lack of understanding by healthcare providers in the country of destination about the health belief, values, and practices that the new arrivals bring with them form the country of origin. Furthermore, healthcare providers in host country are challenged to provide immigrant population with culturally appropriate disease prevention and health promotion interventions (Resick, 2008).

One particular ethnic group of people with different cultural orientation is Korean women. The 2009 Census data indicated that there were approximately 1.4 million Korean Americans in the United States (the U.S. Census Bureau, 2009). That is, there are a substantial number of Korean women. However, we know little about their views of health. Once they grew up and moved to the United States, would they maintain their original perceptions or awareness of health? Would they change their views of health as they have exposed to American culture? There have been an increasing number of Korean women living in the United States, but little has been studied about their health

and their views of health. Thus, we need to find out the essence of the meaning of health for Korean women living in the United States to provide an interpretive understanding of the ways in which they managed health.

Thus purpose of this study is to understand how Korean women living in the United States characterize health and the potential ways in which culture or environment affect their characterizations of health. To do so, I turn to Sharf and Kahler's (1996) culturally sensitive model of communicating health as a guiding framework for inquiry and analysis. In the next chapter, I describe about the culturally sensitive model of communicating health, immigrants' health, and Korean cultural characteristics. In Chapter three, I detail my methodology, followed by my presentation of results in Chapter four. Then, in the final chapter, I discuss the implications of these findings, identify key limitations, and offer suggestions for future research.

Chapter Two

Literature Review

This chapter presents a review of literature related to the meaning of health. I first describe a culturally sensitive model of communication health, followed by detailed discussion of layered meaning of health, and research questions.

A Culturally Sensitive Model of Communicating Health

As noted, defining health is a complex issue. Sharf and Kahler's (1996) culturally sensitive model of communicating health can help us understand and define health. Although this model was specifically designed to increase understanding the issue of health between patients and physicians, it has particular relevance for individuals attempting to make sense of their conversations about health with anyone, including family, friends, providers, and peers (Geist-Martin et al., 2003). The model focuses on the sources of meaning and sources of understanding that comprise communication about health and illness in five layers that reciprocally influence the others in the process of communicating. These five layers include: (a) ideology – core values and basic organizing principles; (b) sociopolitical – group differences and bases of power; (c) institutional/professional – commodification of health care; (d) ethnocultural/familial – mind/body/spirit/wholism and patterns/customs/rituals; and (e) interpersonal – individual differences (Geist-Martin et al., 2003; Sharf & Kahler, 1996). For purposes of this study, and in accordance with Geist-Martin et al. (2003), I've divided my discussion of the model's five layers into two overarching categories of meaning: (a) sociological, which includes ideological, sociopolitical, and institutional/professional layers and (b) ethnocultural, which includes ethnocultural/familial, and interpersonal layers.

Specifically, I examine the literature related to American and Korean ideals, characterizations, and practices of health.

Sociological Layers of Meaning

Cultural ideologies contribute to how women view themselves and define health. There is a no doubt being healthy means the state of absence of disease and absence of physical deformity (WHO, 1958). However, many women may consider the meaning of health is related to being physically beautiful and thin. These make women have certain perspectives of health; that is, having a beautiful body and being thin is the same value as being healthy. Many women do not feel good about their bodies. The dissatisfaction with the body is almost like an epidemic that's spreading throughout the society to a point that it's considered almost "normal" to be unhappy with their body and unhealthy (e.g., Bell& Morgan, 2000).

People have been interested in appearance, but women in particular feel the need to have a certain body image in order to have healthy image. Having a certain body shape is considered as healthy, and this kind of pressure has been encouraged by the media and through advertisements. Everyday, women are being bombarded with healthy images and products by companies and television with beautiful and skinny models making one feel bad for not looking like the model (e.g., Baker, Sivyer, & Towell, 1998; Botta, 1999; Garfinkel & Garner, 1982; Harrison & Cantor, 1997; Hofschire & Greenberg, 2002) .

Body image becomes a basic component of the concept of our personal identity and ourselves (Thompson et al., 1999). It is based on how we feel about our body and what we see in the mirror. The culture in which we live determines how we appear but also how we are expected to appear (Thompson et al., 1999). If we feel that we don't fit

the body image expected by society we generally try to change it. Females consider their weight and body shape as the same thing as being healthy. According to Maynard (1998), they strive for the "perfect" body and judge themselves and others by their looks, appearance, and above all thinness (p. 1).

The society portrays the ideal women as smart, popular, successful, beautiful and thin (Maynard, 1998). Pressure to measure up is great, and is constantly reinforced by family an friends, as well as popular media. Women still are taught that their looks will determine their success and even health.

With a positive body image, a woman feels she is healthy. With a negative body image, a woman has a distorted perception of her shape and size, compares her body to others, and feels shame and unhealthy. According to Shields and Heinecken (2001), a women's dissatisfaction with her body affects how she thinks and feels about herself. They noted that "A poor body image can lead to emotional distress, low self-esteem, dieting, anxiety, depression, and eating disorders" (p. 88).

Dissatisfaction with their bodies causes many women to strive for the thin ideal. The number one wish for teenage girls is to be thinner, and girls as young as 5 years old have expressed fears of getting fat (Body image and advertising, 2000). At any one time 50% of American women are dieting (Body image and advertising, 2000). Some researchers suggest depicting thin model may lead girls into unhealthy weight-control habits because the ideal they seek to emulate is unattainable for many and unhealthy for most. One study found that 47% of the girls were influenced by magazine picture to want to lose weight, but only 29% were in fact overweight (Body image and advertising, 2000). Research has also found that stringent dieting to achieve an ideal figure can play a key

role in triggering eating disorders. Women who are already dissatisfied with their bodies showed more dieting, anxiety, and bulimic symptoms after exposure to media and advertising images (e.g., Maynard, 1998; Peterson, 1987; Tompsen, McCoy, & Williams, 2001).

Lakoff and Scherr (1984) said that "the covers that, like advertisements, like billboards, wield so much power create expectations of what the modern women supposes she could and should be" (p. 112). Why standard of beauty being imposed on women? Current societal standard for a female beauty emphasizes the desirability of thinness at a level that is impossible for most women to achieve by any healthy means.

Ethnocultural Layers of Meaning

To visualize concepts of health in the literature, a logical space called "health space" was introduced (Ware, 1995). Many health researchers have noted the dimensionality of health is an important feature in the definition of the concept. More precisely, the dimensionality refers to distinct components of health requiring separate measurement and interpretation (Ware, 1995). At any given time interval, the health space consists of distinct dimensions.

In defining dimensions of health, not all researchers adhere to the same basis. Two different types of "axis" in distinguishing various dimensions emerge from the literature. For example, the discussion of functional disability in terms of physical, emotional, cognitive, and social functions (Jette & Branch, 1985) implies two different axes: (1) conceptual and (2) operational. Conceptual axis refers to clarifications of impairments and disability. Impairments are anatomical or physiological abnormalities of body parts, organs, or systems of the body. Impairments can occur in any organ or system

of the body such as the musculoskeletal, cardiovascular, pulmonary, and sensory systems, among others (Jette & Branch, 1985). On the other hands, operational axis related to physical, social, emotional, and cognitive function (Jette & Branch, 1985).

These axes may be viewed as the frame of the health space they delineate the boundary and sections of the health space. Hall and his colleagues (1989) supported the three dimensions of health by empirically generating 6 factors of health among the elderly from a comprehensive data set: functional health, emotional health, physiologic health, familial and non-familial social activity, and cognitive functioning.

There may be some disagreement with regard to the inclusion of a social dimension in the health space along the conceptual axis. Ware and his colleagues (1986) excluded the social dimension from personal health because of: (1) the involvement of social contacts and social resources beyond the individual and (2) the greater difference in individual preference for social health than for physical and mental health. Likewise, Bergner (1985) identified five dimensions within physical and mental health excluding direct reference to social health; within this framework, some aspects of social health were proposed merely as factors affecting other aspects of health.

Furthermore, health researchers have scarcely recognized spiritual health as a distinct dimension on the conceptual axis. Hoyman (1962) proposed three dimensions of health as physical fitness, mental health, and spiritual faith. Some researchers suggested that spiritual health be an indicator of emotional status (Bergner, 1989) or incorporate it into social health. The soul consists of mind, emotion, and will as the inward parts of all human beings, while the spirit, the hidden part, is composed of conscience, fellowship and intuition (Lee, 1968). Hence, mental health pertains to the realm of the soul. These

references point out that the spirit not only exists but also forms a distinct realm within each human being. Consequently, it would be reasonable to include the dimension of spiritual health within the concept of health.

Ware and his colleagues (1980) identified an integrative dimension referred to as the general health perception which reflects all the dimensions of health. The dimension offers unique subjective information about health. Researchers usually tap into this integrative dimension by requesting from individual's personal evaluations of overall health- a dimension not captured by the other dimensions of health, specifically, the physical, the mental, and the social (Ware, 1987). Such personal evaluations are valuable because they reflect "unique individual values" for each dimension of health given by different people (Ware & Young, 1979).

Health can also be socially constructed in the biomedical perspective and the biopsychosocial perspective (Liang, 1986; Wolinsky & Zusman, 1980). The biomedical perspective is a Western perspective in which health means the absence of disease. Although it has been used frequently as a major concept of health in health communication research and practice, this perspective cannot explain various dimensions of health, such as social, behavioral, psychological, and cultural definitions of health. In recent years, there has been increasing interest not only in the physical definition health but also the health conceptions in various ways (Liang, 1986; Wolinsky & Zusman, 1980).

Different from the biomedical perspective, the biopsychosocial perspective includes the physical, mental, cultural, social, emotional, and spiritual well-being of individuals. Bice and Budenstein (1977) utilized three dimensions distinguishing health

status indexes following Sullivan's (1976) classification of types of evidence for morbidity concepts: the clinical, the behavioral, and the subjective dimensions. The foregoing presentations reveal repeatedly three major dimensions along the operational axis: the medical, functional and self-evaluative dimensions. The medical dimension has also been labeled as the "physical definition" (Liang, 1986; Wolinsky & Zusman, 1980); the functional dimension as the "social dimension" (Liang, 1986; Wolinsky & Zusman, 1980) or the "behavioral dimension" (Liang, 1986; Wolinsky & Zusman, 1980); the self-evaluative dimension as the "subjective evaluation" (Liang, 1986). Since the interchangeable use of the terms between dimensions along different axes trends to result in confusion, specific terms for each dimension can prevent further confusion and can enhance efficient communication.

The perceptions of health were significantly different among different age groups, sex, religion, martial status and the location of residence. Kim (1994) studied the meaning of word 'health' in 164 healthy adults. The answers included possibility, strength, life, illness, responsibility, preciousness, mental stability and peace of mind, brightness/freshness, happiness, freedom, absence of illness and death. Park (1996) conducted a survey of 708 adults across Korea to research concepts of health and illness and characteristics of health behaviors. Results indicated that the married, aged, less educated, and the Christian groups showed higher scores on the health concept scale whereas the married, middle high school graduates, atheist and Buddhist were significantly higher on illness concept scale. The author concluded that the survey results did not reflect the traditional approach to health and illness as in the previous studies but rather reflected the recent trend of a mixture of western and eastern (and traditional)

approach to health and illness concepts and recommended additional research. Will Korean women living in America exhibit a similar pattern or perhaps a pattern even more closely to American/western approach to health?

Immigrants' Health

An immigrant to another country may influence a person's understanding of health. Those who immigrate particularly from a non-Western to a Western culture are in a stressful condition that has serious psychological effect on the individual and demands considerable readjustment (Lee & Crittenden, 1990). Acculturation process is an important factor in health of immigrant groups. However, the health consequences of acculturation are actually variable (Yang, 2007). According to Frisbie, Cho, and Hummer (2001), foreign-born immigrants were generally in better health than their U.S.-born ethnic counterparts. In contrast, some studies indicated that lower levels of acculturation related to lower health rating among immigrants (Lee et al., 2000; Shetterly et al., 1996) indicated that lower levels of acculturation related to lower health ratings among the immigrants.

According to Lee and his colleague's (2000) study, the acculturation process seems to be more difficult for especially Korean women. Korean women were less involved physical activity than Korean immigrant men the same age (Lee et al., 2000). The reason for those gender differences is that modern Korean immigrant women must face conflicting demands during acculturation. In Korean traditional culture, women are taught to be wise mothers and good wives. While they attempt to fulfill their traditional roles, they also try to assume a role as wage earner in a new labor market (Im, 2003). This situation may conflict with the old, with the result that Korean women are feel

overburdened than Korean male immigrants (Kim & Hurh, 1988) and don't' have free time to care their health needs. Therefore, the acculturation process is more difficult and complex for Korean immigrant women, one that must be considered in any systematic study into the health of Korean immigrant women (Yang, 2007).

Some insights may be gleaned from findings related to other ethnic immigrants living in the United States. Resick (2008) conducted a survey of 12 Russian-speaking women who also spoke English and had migrated to the United States to research the meaning of health. The author concluded that Russian-speaking midlife immigrant women value and are knowledgeable about health, though less of a priority during immigration. They feel grieve and loss and building a new life and current stressors related to migration and family responsibility. Abdulrahim and Ajrouch (2010) conducted 46 adult Arab immigrants in the United States to examine a self-rated health selection and the culturally embedded rationales individuals employ to construct meanings of health. This study showed that Arab immigrants' self-rated health is determined by two main criteria: presence/absence of health conditions and psychological well-being. They employ culturally embedded rationales to move away from extremes and project a view of good health as a state of balance and poor health as a state of imbalance.

Benisovich and King (2003) examined the meaning and knowledge of health among older adult Russians who have immigrated to the United States. The results show that immigrant Russians experience a sense of stress and helplessness in the United States because they do not understand the English language or the US health care system. It may underlie the immigrants' lack of participation in health practices and in seeking out information about health. Venters and Gany (2011)'s study showed that African

American immigrants in the U.S. are generally healthier than African American of the same age. However, health insurance and language difficulties are often mentioned barriers to care for African immigrants. According to them “the newness of chronic disease and the Western medical model must be investigated among African immigrants” (p.341).

Weerasinghe and Mitchell (2007)’s study well showed how important to study the meaning of immigrants’ health:

> ⋯ the diversity that exists within and between cultures imposes heavy dimensions on the health care system, requiring a complex and resources-intensive process to guide a shift toward greater cultural sensitivity and responsiveness through awareness and accommodation of ethnocultural health belief. (p.326)

They also noted that understanding the multiple meanings of health as viewed by immigrants and their influence on the interactions with health care professionals is important. Because it can lead to insight into ways to improve immigrant women’s access to health care, compliance, and satisfaction (Weerasinghe & Mitchell, 2007).

Korean Cultural Characteristics

Spencer-Oatey (2008) defined culture as “a fuzzy set of attitudes, beliefs , behavioral conventions , and basic assumptions and values that are shared by a group of people , and that influence each member 's behavior and his /her interpretations of the `meaning ' of other people 's behavior” (p.2). There seems to be little doubt that culture plays a central and complex role in our daily lives. The knowledge of the aspects of

culture is essential in order to understand why people in different countries perceive and behave differently.

Korean culture has specific characteristics in their communities. Generally, they have been shaped by Confucianism, which stresses harmonious relationships between parents and child, husband and wife, young and old (Hofstede & Bond, 1987; Huang, 2000). Influenced by Confucianism, Koreans value harmony within family, community and society as a whole (Chung & Lee, 1989). They have strong ties to family and value education, hard work, and ambition to excel. Commonly cited virtues in traditional Korea include filial piety respect for elders, benevolence, loyalty, trust, cooperation, reciprocity, and humility (Hofstede & Bond, 1987; Huang, 2000).

The family is basic to the life of Korean culture and has historically been a key element in fostering collectivism as a Korean culture value (Hofstede, 1991). The importance of the family in Korea has been greatly reinforced by Confucian philosophy, which emphasizes family relationships as fundamental to the entire social fabric and influences individual attitudes and behavior (Macdonald, 1996). Koreans regard family as the basic social unit and consider harmony at home the first step toward harmony in the community and in the nation as a whole. Many Koreans consider themselves extension of their families and often regard the welfare of the family as more important than that of individual members. Therefore, the individual is not a separate individual with a solid entity, but rather a partial individual within the social relationships (Chung & Lee, 1989).

Like other East Asian countries, South Korea is heavily influenced by Confucianism, tradition of male superiority in Confucianism is still very much alive in people's belief. According to Javidan and House (2001)'s research, Korea have the

lowest percentage of women participating in the labor force and less women in poison of authority. The following table shows the country ranking on gender differences.

Table 1
Country Rankings on Gender Differentiation (Javidan & House, 2001, p.294)

Most Gender Differentiated Countries in GLOBE		Medium Gender Differentiated Countries in GLOBE		Least Gender Differentiated Countries in GLOBE	
South Korea	2.50	Italy	3.24	Sweden	3.84
Egypt	2.81	Brazil	3.31	Denmark	3.93
Morocco	2.84	Argentina	3.49	Slovenia	3.96
India	2.90	Netherlands	3.50	Poland	4.02
China	3.05	Venezuela	3.62	Hungary	4.08

Attitudes toward sex roles in the Korea and the traditional concept of male superiority remained prevalent, even though women's social position has improved and their participation in social life has increased. Females lagged significantly behind males in post–middle school education, although progress has been made for both sexes. Education, however, does not tell the whole story and Korean women still have a long way to go in their struggle for equality. Many middle- and upper-class women with college degrees are inactive at home after marriage, often against their wishes. Although most working women take jobs out of economic necessity, their work status does not necessarily affect the male-dominant authority structure of the family. In the workplace, discriminatory practices against them in hiring, pay and promotion remain strong: few reach supervisory, managerial, or administrative positions. Upon marrying, working women are expected to retire from most corporate-sector jobs.

The Confucian principles of family relationships, which were projected into the community and national life and given important social value, are perhaps as remote and

strange to some of the younger generation of Koreans today as they are to Westerners. The Korean family during the pre-modern period, however, remained essentially Confucian as an ideal and in practice. Moreover, even after liberation, Korean family law emphasized the importance of blood relations and the authority of the male household head (Park & Cho, 1995).

Culture refers to the total pattern of human behavior in society. It affects everywhere in our lives, people are not able to in any meaningful manner behave or react without culture. The knowledge of Korean society and culture will help understanding their notions and values of health.

Research Questions

In light of the above discussion, I propose the following two research questions (RQs):

RQ1: How do Korean women living in the United States characterize health?

RQ2: To what extent does Korean and/or American culture affect such characterization?

Chapter Three

Methodology

This study used a qualitative, thematic approach to data collection and analysis by conducting in-depth, semi-structured interviews. According to Strauss and Corbin (1990), "grounded theory is used to develop largely sociological explanations of the variability in social interactions" (p. 34). It is an appropriate method in which the participants' views are sought, listened to, and valued (Crooks, 2001). Crooks (2001) said grounded theory provide the broad lens for meaningful research into women's health issues. He's (2001) stated the following:

> Grounded theory methods allow the researcher to see women as full members of their social, political, economic worlds; to understand the lives and activities of women; to understand women's experiences from their own particular points of view; and, finally, to conceptualize women's behaviour as meaningful and as a direct expression of their world views. (p.7)

Crooks (2001) also noted that "Providing a voice for women through grounded theory research about women's health holds promise in helping us to understand the experience of illness, health, or health seeking" (p.26).

Therefore, this qualitative research approach (i.e., grounded theory study) seems to be appropriate to the current research. I interviewed Korean women in their 20's and get them to talk about their thinking of health.

Grounded Theory as a Method

This study mainly asks the questions "How do Korean women living in the United States characterize health?" and "How are these characterizations influenced by Korean

and/or American cultures?" It aims to understand how views of health are influenced by culture and national identity and contribute to the development of growing field of health promotion programs for Korean migrants.

Grounded theory is an approach in qualitative research to discover existing problems in a social scene and how these problems are handled by the persons involved (Burns & Grove, 2001). Gidding and Wood (2000) described the grounded theory approach as a method capable of exploring and understanding the processes that occur, in such a way that explanations of phenomena are grounded in reality. Therefore, the grounded theory approach is appropriate to use because, first, it allows the processes of a social group, in this study Korean women living in the United States, to be discovered and emerge from the participants' perspective (Glaser, 1992); and second, it enables the researcher to develop a theory that has been derived from data, systematically saturated and analyzed through the search process, and that will further the understanding of social and psychological phenomena (Chenitz & Swanson, 1986).

There are two types of grounded theory: substantive theory and formal theory (Strauss, 1987). A theory is simply a description of relationships among concepts. A substantive theory is one that evolves from a study of phenomena in one context or setting while a formal theory develops from an existing substantive theory in a range of situations or settings.

It is suggested that grounded theory offers a well recognized and systematic approach to studying the human experience (Strauss, 1987). Given that this study is concerned with the life experiences, in particular, of young Korean women living in the United States, it seems fitting to employ a grounded theory methodology.

Study Participants

I interviewed 20 Korean women in their 20s who are currently living in the United States. Interviewees were recruited via a snowballing technique that involved contacting friends in the Korean community whom the researcher knew and requesting them to refer other friends who are eligible to participate in the study. Eligible participants included Korean females in 20's who have lived in the United States for at least two years. Although somewhat speculative, two years of residence could afford enough exposure to local American culture and therefore the potential change in their perceptions of health. Upon meeting prospective participants, the researcher showed and explained to them the IRB informed consent form approved by the University (see Appendices A, B, & C). After gathering consent and demographic data, an interview was arranged according to the participant's convenient place and time.

Interviews

Data were collected through in-depth, face-to-face and semi-structured interviews. The interviews were tape-recorded with the interviewee's permission, and the researcher also took field notes. Audio recordings are helpful in capturing details in content as well as subtle nuances in voice inflection, pauses or hesitancies, and patterns of speech. The filednotes method is important to participant observation.

Attentive and non-judgmental listening techniques were used during the interviews that averaged around 50 minutes of interview time, ranging from forty minutes to one hour. The questions were open-ended and semi-structured in order to place emphasis on the participant's understanding and life experiences related to health,

including the feelings they had to face in their new environment. The interview schedule is presented in Appendix C.

Before each interview session, the researcher informed the respondents of the purpose of the interview and probed for more information on their personal experience, feelings and opinions as they brought up the topics.

Because the primary language of the respondents is Korean, translation and back translation of consent forms as well as the interview data were conducted. The translation was independently verified by two other translators who are fluent in both English and Korean.

Data Analysis

After transcribing and translating the interviews into English, the gathered data were analyzed using a conventional qualitative content analysis method (Strauss & Corbin, 1990). Based from data collected and analyzed, concepts were formulated and categorized according to themes using constant comparative analysis using the three level system coding: open, axial, and selective coding (Strauss& Corbin, 1990), which are further elaborated next using excerpts of transcripts used in the coding process.

Open Coding

The first stage, open coding, involves "breaking down, examining, comparing, conceptualizing, and categorizing data" (Strauss & Corbin, 1990, p.61), often, in terms of properties and dimensions. The transcripts of the interviews were repetitively and thoroughly read to obtain a sense of each participant's contextual background and relevance. The data were manually coded line by line and sorted into categories according to their similarities and relationships. One aim in generating codes is to name

them, such as 'Physical aspect of health,' 'Mental and emotional factors of health' or 'Social aspect of health.' Glaser (1978) called this approach to analysis 'grounded theory' and suggested that using this process often helps the researcher to consider what it is that participants are doing, which then facilitates the constant comparison of experiences (Chenitz, 1986; Glaser, 1978). In order to carry out open coding rigorously, the first seven steps of Eaves'(2001) framework were used: (1) line-by line in-vivo coding was carried out; (2) shorter code phrases were then developed to capture the main idea of what informants said. The following is an example of the open coding process.

Table 2
Open coding process

Transcript	Open-code	Re-code
"Frankly speaking, being healthy is one of my life goals. For me, being healthy is keeping a desirable weight as well as physical beauty. I used to be fat, and I once suffered from malnutrition because of my wrong ideas of losing weight and health care. So now I'm paying more attention on health, physical exercises, and keep an ideal weight. Also, I want to be healthy internally, like I want to have ambitious and have positive attitude toward everything."	one of my life goals	a life time goal
	keeping in a desirable weight as well as physical beauty	Keeping in a desirable weight
	suffered from malnutrition because of my wrong ideas of losing weight and health care	Keeping physical beauty
		Suffering from malnutrition
	paying attention on health, physical exercises, and keep an ideal weight	doing physical exercises
		Keeping an ideal weight
	want to be healthy internally, like I want to have ambitious and have positive attitude toward everything."	being healthy internally
		having ambition having positive mind

In the next phase of open coding, concepts found similar in nature are grouped together under the term categories, and Eaves' (2001) systematic framework was still utilized. At this stage, concepts emerging from the data such as, ' being healthy internally' and ' having ambitions and self-affirmation' were grouped together under the category of

‘ Mental and emotional factors health’ and ‘keeping in a desirable weight,’ ‘keeping physical beauty,’ ‘keeping an ideal weight’ and ‘suffering from malnutrition’ were grouped together under the category of ‘Social aspect of health’. At this point, a research assistant was recruited of trained to code identified themes to overall emerging categories, physical, mental and emotional, and social aspects of health. The assistant was not knowledgeable about the study. An independent coding was done for the entire set of themes. All differences were discussed and resolved. The intercoder reliability was high, Cohen’s kappa=.88.

Axial Coding

Strauss and Corbin (1990) define axial coding as "as a set of procedures whereby data are put back together in new ways after open coding, by making connections within categories." To ensure that axial coding was carried out systematically, the eighth step of Eaves’ (2001) framework was used. This means that linkages were made amongst categories. During this step, the researcher reflected on and examined relationships in the data by using the constant comparison technique. In addition, the literature was explored to examine and compare relationships among categories. A sub-category that emerged as part of ‘Social aspect of health’ was ‘Health related to lifestyle,’ which reflected the idea that Korean women associated being healthy with lifestyle and cultural values.

> *“For health, compare to living in Korea, I more care about eating behaviors. I try to eat in a balanced manner, have Korean style meals, and take as many fruit as possible.*”

Further, Strauss and Corbin’s (1990) paradigm model was used to link categories in terms of conditions, context, action/interaction strategies, and consequences. Strauss and

Corbin (1990) argue that there is a need to understand both the structure why events occur, and the process: how a person acts/interacts in order to capture the dynamic and evolving nature of events. For instance, when exploring what the category 'Health related to life style' involved, it was initially thought that it may be an action/interaction. In other words, a response to 'Social aspect of health,' which involved reflecting on what Korean females associated being healthy with.

Selective Coding

When no new relationships between categories emerged from new data, selective coding occurred. It seeks to integrate and refine theory with the goal of discovering a central core category (Strauss& Corbin, 1990). These are fully explained in the Results chapter. As the processes took shape, the core category emerged and was selected and it is systematically related to other categories. Its relationship with other categories is validated and refined (Strauss & Corbin, 1990).

Chapter Four

Results

This study explored how Korean women living in the United States characterize health and the potential ways in which culture or environment affect their characterizations of health. This chapter presents results from content analysis of interview data. It first summaries characteristics of participants, followed by details theme categories.

Characteristics of participants

Interviewees shared a lot in common. They were a relatively homogeneous group of people. Table 3 presents specific demographic characteristics of the participants in areas of age, immigration length, educational level, current occupation, marital status, and immigration status. The women were listed according to the order they were interviewed. Pseudonyms were used for each of the twenty participants in order to keep their real identities confidential. The ages of the women ranged from 20 to 29. Five of them had graduate degrees or currently graduate students and fifteen of them had college degrees or currently college students. Two of them were housewives, sixteen of them were students and only 2 of them were currently employed during the time of the study. Five were married interviewees, and four of them were permanent residents.

Table 3
Demographic characteristics of participants

Interviewee	Current age in years	Length of migration in years	Education level	Current occupation	Marital Status	Immigration status
A	21	2	College	Student	Single	Korean
B	24	2 and half	″	″	″	″
C	27	3	Graduate school	Housewife	″	″
D	29	4		Student	Married	″
E	25	2 and half	College	″	Single	″
F	21	2	″	″	″	″
G	27	3	Graduate school	″	″	″
H	28	4	″	Company worker	Married	Permanent resident
I	27	3	College	Housewife	″	″
J	25	2	″	Student	Single	Korean
K	26	2	″	″	″	″
L	29	2	″	″	″	″
M	27	2	″	″	Married	″
N	29	2	″	″	″	″
O	22	4 and half	″	″	Single	Permanent resident
P	20	4	Graduate school	″	″	Korean
Q	24	5	″	″	″	″
R	25	2 and half	College	″	Single	″
S	21	3	″	″	″	Permanent resident
T	29	4	″	Company worker	Married	″

Theme categories

Three main categories and 9 subcategories of theme were generated from the data, and relationships among them were identified using the paradigm model recommended by Strauss and Corbin (1990). The basic components of the paradigm model and the categories are presented in Table 4.

Table 4
Theme categories

Categories	Sub-categories
Physical aspect of health	Health as the absence of disease and/or physical deformity
	Health as functional capacity
	Health as an enabling factor to reach life's potential
Mental and emotional aspect of health	Health as a source of happiness and stress-free
	Health as self-affirmation
	Health as having personal interests
Social aspect of health	Health related to life style
	Health as beauty
	Health related to family

1) Physical aspect of health

a. Health as the absence of disease and/or physical deformity

Interviews began with the question, "How do you define health?" As expected, the varied answers were offered based on individual life experiences. Most Korean women included statements that were similar to the physical aspects of the WHO definition (1946), namely that health is a state of absence of disease and absence of physical deformity. As Jina, a 25-years-old, put it,

"I think… (pause) health means the absence of disease. To me, health is a state that doesn't have any symptoms or pain."

Korean women's conception of health thus could not be separated from illness, and when they talked about health it was mostly related to the absence of ill-health. Min (age 27) clarified this,

> *"The word 'health' has a meaning for me that I am not ill and free from physical deformity."*

b. Health as functional capacity

Korean females also associated health with their functional capacity such as being physically able to do things without feeling tired and body's ability to recover fast after a rest. They illustrated the great importance of managing the everyday life situation and having physical capacity to master daily task. A couple of participant articulated as follows,

> *"Being healthy means that I have abilities to support myself in many ways, such as physically, mentally and financially."*
>
> *"I believe I am a healthy person since I am able to go through my day and accomplish what I have to do or want to do without any physical or mental encumbrances."*

c. Health as an enabling factor to reach life's potential

Most women in Korean culture felt that health was fundamental to life, a source of energy giving motivation and enthusiasm. Health among Korean women was also perceived as an enabling factor to reach one's life potential. Sil said "I have to be healthy to be able to do all the things I want to do in life." Youn, a 28-years- old, added "When I am healthy, everything seems possible."

2) Mental and emotional aspect of health

a. Health as a source of happiness and stress-free

Korean women associated health with being healthy in both a physical and mental/psychological sense. Especially, most women associated health with happiness and stress-free. Yoomi, 21-years-old said "I think I'm healthy because I know how to manage stress." Miran (age 28), added,

> *"Health is really not just being free of disease but that you feel well and think that you have a satisfactory life. That you enjoy life and the people around you and that you are happy with what you do. That is health for me."*

b. Health as self-affirmation

Korean females associated health with feeling good about self, being confident, and having a positive self-image and self-acceptance. It was related to one's body image, perceived social acceptance and success. One Korean woman pointed out that in a case of physical deformity, being healthy meant that one should be able to accept one's physical condition and having a healthy mind. Sil, a 29-years-old stated,

> *"…For me health is to be positive about many things. I think to be healthy; people should not be too depressed, have to be positive, brighten things up and find the bright side of things. I am a rather positive person, so I think I'm healthy. In my opinion, health is not just being free of disease but that you have a satisfactory life and have positive mind. Even sick people are satisfied with their life and happy with what they do, I'm sure they're healthy. That is health for me."*

c. Health as having personal interests

Korean women associated being healthy with having or taking interests in things other than partner or house chores. This was more so when they compared themselves with their friends who were either married: “I’m relatively healthy because I’m interested in many things. Girls around my age have babies so their interest lies only in children.” Korean women perceived that their mothers took no interested in their own health but only their family’s. However they felt differently and they wanted to be responsible for themselves when they got married. Married Korean women expressed that they had no time to think of themselves and pointed out that it was their prime role to look after the family. Nobody seemed to resent the fact that they had no time for themselves, and in some cases people felt guilty having their own time outside of the household duties. Korean women considered themselves very lucky having more time for themselves so they could pursue hobbies or personal interests.

3) Social aspect of health

a. Health related to life style

Korean women associated health with life style, particularly with healthy dietary practice and exercise. Korean females were conscious about their own dietary practice and most reported that they had tried to have Korean traditional meals in the United States to be healthy and stay healthy. Sun, a 28-years-old, said,

> *“Compare to living in Korea, I more care about eating behaviors. I try to eat in a balanced manner, have Korean style meals, and take as many fruit and vegetable as possible.”*

They were very conscious of their eating habits and body weight in assessing their health status. A Korean female assessed herself as being 'not healthy' due to her large appetite even though she exercised everyday. They thought that they should have Korean traditional style meals to be healthy and reported feeling guilty when they ate 'take out' foods or at the 'fast food' outlets. Some participants commented,

> *"To be healthy, usually, I say no to snacks and fast food. And I calculate calories and quantity of meals."*
>
> *"I think food is the important factor to be healthy. In my opinion, it is very important to have three meals a day for Koreans. I try to have Korean style meals instead of American style food such as fast food and take out food. I feel better when I have Korean food as a meal but when I have fast food I feel unhealthy and I'm worried about my weight."*

Korean women usually listed food first in response to the question, 'What kinds of things do you do to be healthy?' They also mentioned exercise and rest to be healthy. They were very concerned that they don't have opportunities for walking. Joo, a 25-years-old, reported,

> *"In Korea, I walked everyday. I used the public transportation so I had to walk to the station. I guess I almost walked from 20 to 35 minutes everyday. It means I didn't need to make a time for exercises. However, here, I drive a car and don't have opportunities to walk anymore. Sometime walking to the parking lot is the longest way to walk for day. It makes me feel so bad and I'm worried about my health."*

Bora, a 24- years-old, said “Since I don’t have a chance to walk as much as in Korea, I have regular workouts at gym, or occasionally take group exercises like yoga or steps. It makes me feel healthy and free from stress.” Twenty four year old, Jin stated “For my health, I exercise regularly and get enough sleep.”

b. Health as beauty

Korean women commonly associated health with beauty. Among Korean women being healthy was associated body shape and weight. Joon, a 29 years old, stated “Koreans love to be skinny, well, actually bonny and be underweight, I am quite sure we think about health and beauty as a same context.” The 27-year-old Nari said that keeping ideal weight and physical beauty is important factors to be healthy, she reported,

> *“Frankly speaking, being healthy is one of my life goals. For me, being healthy is keeping a desirable weight as well as physical beauty. I used to be fat, and I once suffered from malnutrition because of my wrong ideas of losing weight. So now I’m paying more attention on health, physical exercises, and keep an ideal weight.”*

They thought that Korean females living in Korea were more conscious about their weight. They felt that there was a strong social pressure to look skinny in Korea. Yoon, a 21-years-old, stated “In my culture, people are obsessed with being skinny.” Korean females considered that Koreans are strict to have skinny body and different standard of being skinny from Americans. Some participants said,

> *“I think keeping slim is especially important to Korean females. When I was in Korea, many Korean female friends of mine are always talking about losing weight. It’s like a life-long goal…… On the one hand, for American women or*

American culture, weight is not a big thing to be attractive or healthy. I think being slim is much more important in Korea. I guess women are supposed to be slim in Korean culture."

"I would say it's much easier to be considered overweight than here in U.S. normally fat people in Korea may be considered only a little chubby here. In Korea, skinny is more desirable compared to American culture."

Korean females who are currently living in the United States thought that Korean women living in Korea were more conscious about their appearance. They experienced having to dress up more and being skinny when they were in Korea. It was common that Korea women felt social pressure to 'look good' and 'look skinny' and this was strongly associated with social acceptance. Some participants stated,

"When I was in Korea, I more care about my appearance and weight compare to living in the United States. Every woman in Korea was so skinny and it's not that they are healthy but they look healthy and confident. I think Korean women associate looks and being slim with health. However, since I have lived in the United States, I less care about my weight and more care about my real health."

"Americans seem giving "healthy" a high weight for being attractive. A lot of American females would like to tan their skin color to show healthiness, instead of white as the dominant standard for beautiful skin color in Korean culture. Korean men always want their mate to be little and slim to make themselves seem strong and show their masculinity. Years ago, I even heard from a male friend of mine that 'good girls should not weigh more than 50 kilogram."

The media were perceived as being responsible for marketing health in a way that has made health synonymous with beauty. Sue, a 28-years-old, said,

> *"In Korea, there is big influence on certain body images from mass media, especially some magazine advertising. Also, some movie star or fashion models in media provide an image that extra slim seems healthy and perfect for women."*

c. Health related to family

Health was associated with looking after the self and/or family well in Korean culture. Among Koreans, it was more associated with work capability and being efficient. For Korean females who had a job, the ability to work well, confidence at work and taking care of their family were related to being healthy. Among married women in Korean culture, being healthy meant more capability of fulfilling their roles as a family caretaker. All married Korean women strongly associated a housewife's good health with their family's happiness and peace within the family. Sil said "Being healthy means having confidence and enthusiasm to carry out my role as a housewife." Sora mentioned about her mother and how importance her health for the whole family. She said,

> *"Mom needs to be healthy and work very hard. If not, there will be a lot of problems at home."*

Chapter Five

Discussion

This chapter presents the discussion. It describes a summary, discussions of results, implication, limitations, and conclusion. The summary of this study is first described.

Summary of Study

Previous researches have identified the general health perception which reflects diverse a dimensions of health. The dimension offers subjective information about health. Personal evaluations of health are valuable because it showed “individual values” for health given by different people and environments. Overall results of previous studies the physical, the mental, and the social (e.g., Jette & Branch, 1985; Liang, 1986; Ware, 1987; Ware & Young, 1979; Wolinsky & Zusman, 1980).

This study explored the experience of Korea women living in the United States with respect to their perceptions of health and attempted to develop a substantive theory that explains the basic social process of adjusting to new life. Similar to previous studies, the Result of study is divided into three parts: the first part is about physical health; the second part is about mental and emotional health; the last part is about social health. The study showed that Korean women use women use various methods of coping with new cultural environment and understanding toward health.

Discussion

Throughout the results section, the adjustment process understanding how Korean women living in the United States characterize health and the potential ways in which culture affect their characterizations of health were explained using Strauss and Corbin's

(1990) conditional paradigm. This discussion reviews the categories that emerged during analysis and highlights how they fit with existing literature. The present study identified three major categories concerning Korean immigrant women's understandings of health as they adjust to life in the United States. These categories are further elaborated and validated based on studies below.

The first category, physical aspect of health, was further divided into three sub-categories: health as the absence of disease and/or physical deformity, functional capacity, and an enabling factor to reach life's potential. Although there has been increasing interest in the health conceptions in various ways, such as social, behavioral, psychological, and cultural health (Liang, 1986; Wolinsky & Zusman, 1980), the physical definition of health was still the primary value for Korean immigrant women in their 20's. People seemed emphasize the relationship between good psychological wellbeing and physical health, they tended to measure health in terms of its physical elements, such as visit to the doctor to care their physical symptoms and disease (Chan et al., 2006). The importance of physical health is supported by Lee et al. (2010)'s findings that most of Korean immigrants in New Zealand complain of physical health problems some time after migration. Meadows and her colleagues (2001) studied health and health-related experiences of a sample of mid-life immigrant women. This study reported that when people discuss concerns related to their personal health, the physical factors appeared to take precedence (Meadows et al., 2001). It shows that health and physical illness as often linked to one another (Walters, 1993; Miles, 1988).

The second category, mental and emotional aspect of health was consisted of health as a source of happiness and stress-free, self-affirmation, and having personal

interests. In contrast to the traditional concept of health, which focuses solely on the physical body, the psychosocial aspect of health encompasses mental, emotional, social, and spiritual elements as well (Haque, 2010; Hoyman, 1962; Kim, 1994; Makoul et al., 2009). Lynn and her colleague's (2001) study showed that emigration affected immigrant women's health in variety of ways, primarily and in more enduring ways through social and emotional mechanisms. Similarly, the psychological factor of health was important when Korean immigrant women define health. It was not just about feeling but also relates to quality-of-life (Makoul et al., 2009) and the capability and ability to manage their life. Caring mental and emotional health for themselves was paramount in maintaining not only good psychological health but also good physical health. Some participants reported that physiological health is more important than physical health. It shows that physical ailments are not perceived as of concern until women's physical health status impacts on emotional or mental aspect of health (Lynn et al, 2001).

The third category, social aspect of health covered health, related to life style, health as beauty, and health related to family. This category showed that Korean immigrant women's health concepts related to their own and new cultural values, such as Korean and American culture. For being healthy, body-oriented protocols is important, such as avoiding smoking, abstaining from drinking, eating 'good' foods, getting sleep, and exercising which are related to life style (Blaxter, 2004; Saltonstall, 1993). According to Saltonstall's (1993) study, females regularly linked healthiness, eating, exercise, and being thin in their health (Saltonstall, 1993). Korean immigrant women emphasized the importance of eating 'good' foods every meal time for health. Although they had more opportunities to have American food, they were trying to have Korean

foods for their health. Several studies showed that women feel the need to have a certain body image in order to have healthy image (e.g., Baker, Sivyer, & Towell, 1998; Botta, 1999; Garfinkel & Garner, 1982; Harrison & Cantor, 1997; Hofschire & Greenberg, 2002). Korean immigrant women's health was also associated with beauty, especially body shapes and weight. They felt social pressure to be skinny and have good looking and this was associated with social acceptance in Korea. After immigration, Korean women said that they became less strict to have skinny body and have a different point of view of body images composed to negative perspectives toward fat people in Korea. They started to care about "real" health not just obsess with being thin. Immigrant women also face a number of changes upon immigration related to social and familial roles and health (Lynn et al., 2001; Resick, 2008). They feel grieve and have stress related to migration and family responsibility. Lynn and her colleagues (2001) conducted a study about immigrant women's health living in urban Alberta, Canada. The authors stated that "Women were faced with the need to adapt their previous behaviors and roles to their new homeland, and to deal with the tensions between the norms of their culture and the newly predominant culture in Canada" (p. 1455). While western culture care more about individual, Korean immigrants care more about family. Korean immigrant women who are married thought that being healthy meant more capability of fulfilling their roles as a family caring. From the Confucian traditions in Korea, all married Korean women strongly associated a housewife's good health with their family's happiness and peace within the family. Thus, Korean cultural influences are still there in their images and perceptions of health. On the other hand, American cultural values (as Korean

women perceived) apparently seeping into their views of health in areas of weight/ beauty/ food.

Implications

The study of Korean immigrant women's health concept is important for number of reasons. Asking about their thoughts with health is consistent with basic value of supporting continuous quality improvement or health program as well as involving the Korean immigrant women who have been relatively ignored despite their quickly increasing size. For Korean immigrant women and service providers, understanding health concepts and culture can be viewed as a direct goal of the health service and care. Furthermore, concepts of health and culture study of Korean immigrant women groups can provide useful information and utilization of the entire service for the female immigrant population.

Goals for the future of immigrant women's research from studies that are similar to and expand upon the ideas of this one are to (1) improve quality of service for this particular group through understanding of their health and culture, (2) understanding of health conceptions of various ethnicities could assist the health care providers in the planning promotion programs to improve the quality of life for immigrants in the United States, and (3) the cultural differences revealed in this study should also have important implications for enhancing understand of health cross-cultures.

Based on this study, it is implicated that further research to assess the perceived understanding health, culture and additional contributing factors must be conducted among different international immigrant woman groups which will aid in planning culture-specific preventive care for each woman group, thereby promoting better health

related quality of life. Understanding Korean immigrant women's perceptions of health which is related to culture will help out not only the Korean immigrant women living in the United States, but also help to understand the immigrant women population. This cross-cultural communication is particularly important for health care providers who are normally trained in the tradition of the Western culture. They should be made aware that Korean women's conceptions of health may be different from those of other ethnic groups redundant.

Limitations

There are several limitations in this research. First, geographical selection for this study excluded Korean women living in other parts on cities the United States. A different residence location environment may affect the process of adjustment and may pose variety different barriers that affect their experiences as immigrant women with respect to health and care services. This may limit the generalizability of findings from the current study and may lack representativeness when applied to Korean immigrant women. Future study could use different samples, such as interviewing immigrant women who are living in different cities. Second, communication with interviewees is not always satisfactory, since most subjects exhibited a varying length of stay in the United States. This may have caused them to fail to fully understand the participant group, thus keeping them from making valid responses. Future research could use representative samples to enhance understand the participant and interview participants successfully. And since this is very personal perspective research, more diverse research methods can be based. A mixed methods approach can supplement qualitative inferences. Lastly, since

this is my first time to interview, it was hard to control my facial expressions when I interview interviewees. It might have influenced how interviewees response.

Conclusions

Findings of this study reveal a dynamic interplay in various health concepts related to physical, mental and emotional, and social aspects in Korean immigrant women's views and perceptions of health. This study contributes on a qualitative basis, for health-care providers and concerned authorities, to better understand the life experiences of Korean women as they live as immigrants or sojourners in the United States. This study found that Korean women associated health with the absence of disease and/or physical deformity, functional capacity, and an enabling factor to reach life's potential in physical aspect of health. Secondly, they included a source of happiness and stress-free, self-affirmation, and having personal interests as mental and emotional aspect of health. Lastly, Korean women associated health with life style, beauty, and family. These findings from research suggest that health providers should consider immigrant women's culture to provide efficient and valuable health care services.

APPENDIX A

UNIVERSITY OF HOUSTON
CONSENT TO PARTICIPATE IN RESEARCH

PROJECT TITLE
An Understanding of the Ways Culture Influences Characterizations of Health for Korean Women Living in the United States

You are being invited to participate in a research project conducted by Gayoung Cho from the Valenti School of Communication at the University of Houston. This project is part of a master's degree thesis being conducted under the supervision of Dr. Jill Yamasaki.

NON-PARTICIPATION STATEMENT
Your participation is voluntary and you may refuse to participate or withdraw at any time without penalty or loss of benefits to which you are otherwise entitled. You may also refuse to answer any question.

PURPOSE OF THE STUDY
This project aims to understand how understandings of health are influenced by culture and national identity.

PROCEDURES
You will be one of approximately 15 participants asked to participate in this project. If you agree, you will be asked to talk about your personal meanings of health with the principal investigator. Sample interview questions include: 'Please tell me what health means to you' or 'Tell me how your cultural beliefs influence your thoughts about health'. The interview is a one-on-one and lasting approximately one hour. The interview will be audio taped and later transcribed with your permission.

CONFIDENTIALITY
Every effort will be made to maintain the confidentiality of your participation in this project. Each participant's name will be paired with a code number by the principal investigator. This code number will appear on all written materials. The list pairing your name to the assigned code number will be kept separate from all research materials and will be available only to the principal investigator. Confidentiality will be maintained within legal limits.

RISKS/DISCOMFORTS
There are no foreseeable risks to your participation. If you feel uncomfortable at any time, you may stop the interview or refuse to answer any questions. You may also contact the Family Enrichment Clinic (713-780-2833) for culturally sensitive psychological services in Korean if needed.

BENEFITS
While you will not directly benefit from participation, your participation may help to understand the relationships between understandings of health and culture that could ultimately contribute to the development of health promotion programs for Korean migrants living in diverse culture backgrounds.

ALTERNATIVES
Participation in this project is voluntary and the only alternative to this project is non-participation.

PUBLICATION STATEMENT
The results of this study may be published in professional and/or scientific journals. They may also be used for educational purposes or for professional presentations. However, no participant will be identified.

PARTICIPANT RIGHTS

1. I understand that informed consent is required of all persons participating in this project.

2. All procedures have been explained to me and all my questions have been answered to my satisfaction.

3. Any risks and/or discomforts have been explained to me.

4. Any benefits have been explained to me.
5. I understand that, if I have any questions, I may contact Gayoung Cho by email (cgy0723@hotmail.com). I may also contact Dr. Jill Yamasaki, faculty sponsor, by email (jyamasaki@uh.edu) or phone (713-743-3631).

6. I have been told that I may refuse to participate or to stop my participation in this project at any time before or during the project. I may also refuse to answer any question.

7. ANY QUESTIONS REGARDING MY RIGHTS AS A RESEARCH PARTICIAPNT MAY BE ADDRESSED TO THE UNIVERSITY OF HOUSTON COMMITTEE FOR THE PROTECTION OF HUMAN SUBJECTS (713-743-9204). ALL RESEARCH PROJECTS THAT ARE CARRIED OUT BY INVESTIGATORS AT THE UNIVERSITY OF HOUSTON ARE GOVERNED BY REQUIREMENTS OF THE UNIVERSITY AND THE FEDERAL GOVERNMENT.

8. All information that is obtained in connection with this project and that can be identified with me will remain confidential as far as possible within legal limits. Information gained from this study that can be identified with me may be released to no one other than the principal investigator and Dr. Jill Yamasaki. The results may be published in scientific journals, professional publications, or educational presentations without identifying me by name.

I HAVE READ (OR HAVE HAD READ TO ME) THE CONTENTS OF THIS CONSENT FORM AND HAVE BEEN ENCOURAGED TO ASK QUESTIONS. I HAVE RECEIVED ANSWERS TO MY QUESTIONS. I GIVE MY CONSENT TO PARTICIPATE IN THIS STUDY. I HAVE RECEIVED (OR WILL RECEIVE) A COPY OF THIS FORM FOR MY RECORDS AND FUTURE REFERENCE.

I agree to allow the investigator to audiotape the entire interview. Yes ☐ No ☐ Initials: ____

Study Participant (print name): _____

Signature of Study Participant:_____

Date: _____

I HAVE READ THIS FORM TO THE PARTICIPANT AND/OR THE PARTICIPANT HAS READ THIS FORM. AN EXPLANATION OF THE RESEARCH WAS GIVEN AND QUESTIONS WERE SOLICITED AND ANSWERED TO THE PARTICIPANT'S SATISFACTION. IN MY JUDGMENT, THE PARTICIPANT HAS DEMONSTRATED COMPREHENSION OF THE INFORMATION.

Principal Investigator (print name and title): _____

Signature of Principal Investigator: _____

Date: _____

APPENDIX B

Recruitment Script

Hello, I'm writing to invite you to participate in a research project conducted by Gayoung Cho from the Jack. J. Valenti School of Communication at the University of Houston. This project is part of a Master's Thesis, being conducted under the supervision of Dr. Jill Yamasaki, Ph.D, Assistant Professor from the Jack. J. Valenti School of Communication.

This research project will enhance our understanding on the ways in which Korean women in their 20s living in the United States could ultimately contribute to the development of health promotion programs for Korean migrants living in diverse culture backgrounds. You will be one of approximately 20 participants asked to participate in this project. If you agree, you will be asked to talk about your personal meanings of health with the principal investigator in a one-on-one interview lasting approximately one hour. Your participation will help to understand the relationships between culture and health and contribute to the development of health promotion programs for Korean migrants living diverse culture backgrounds.

If you have any questions, you may contact Gayoung Cho by email (cgy0723@hotmail.com). You may also contact Dr. Jill Yamasaki, Ph.D, Assistant Professor from the Jack. J. Valenti School of Communication, faculty sponsor, by email (jyamasaki@uh.edu) or phone (713-743-3631). **This project has been reviewed by the University of Houston Committee for the Protection of Human Subjects (713) 743-9204.**

Gayoung Cho
Graduate Student
Jack J. Valenti School of Communication
University of Houston
713-820-5718
cgy0723@hotmail.com

APPENDIX C

Interview Schedule

OPENING

Thank you for agreeing to this interview. I expect it to take approximately 1 hour, depending on your answers. Please know that there are no right or wrong answers and I am interested in your thoughts, ideas, and stories. So I may focus on the interview and not on taking notes, I would like your permission to tape this interview. Your comments will be strictly confidential. Do you have any questions before we begin?

QUESTIONS

Preliminary questions
-Demographic/background information
-Please tell me about yourself
-When born (age), where born (birthplace), when came to the States, immigration status (student, permanent resident, citizen), education level, what currently doing (job), family and relatives in the States, income level, location of residence (rural vs. suburb vs. inner city), marriage, etc.

1. Please tell me what health means to you.
   - What does it mean to be healthy?
   - What does it mean to be unhealthy?
2. How important is being healthy to you? Please explain.
   - What do you think is the most important thing for staying healthy?
3. Do you consider yourself healthy? Why or why not?
   - What do you do to stay healthy?
   - What makes you (or could make you) unhealthy?
4. Picture someone in your mind whom you consider healthy. It could be a person you know, a friend or relative, or someone famous. What is it about this person that makes him or her seem healthy to you?
5. Tell me how your cultural beliefs influence your thoughts about health.
   - Have your thoughts and/or behaviors about health changed in the US? Please explain.
   - How are thoughts of health similar in Korea and the US? Please explain.
   - How are they different? Please explain.

CLOSING

Is there anything else you'd like to tell me? Once again, thank you for your time. Please feel free to contact me if you have any questions or concerns at a later time.
-Business cards, contact information for the potential future contact

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