

Grandmothers' Voices: Mi'kmaq Women and Menopause

by

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for the degree of Doctor of Philosophy

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DEDICATION

I would like to dedicate this thesis to all of the wise women in my life – especially to the old women, who have passed on wisdom that was earned through life circumstances infinitely more difficult than those we enjoy today. I thank them for giving me a perspective that is grounded in reality. To my mother, who ended her journey just as I was completing this thesis - thank you for your gift of strength – I know it was well earned. Please know that, above all others, your gift has served me well and I honour you for it.

To my elder sister Carol Ann, whose teachings have always been a strong influence in my life; in return for your many gifts to me, I offer my respect and love. One of the most valuable lessons I learned from you is that women are the centre of life; the strength of a family and a community can be found in the embrace of its women. Standing firm in the face of poverty and pain, giving comfort to the young and the old; a pillar of soft flesh and firm resolve, women are the blood of a family, the roots of a community, the heart of a nation.

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*Old Woman is watching, watching over you.
In the darkness of the storm, she is watching over you;
with her bones become a loom, she is weaving,
weave and mend sacred sisters,
weave and mend.
I have been searching lost, alone.
I have been searching for so many years.
I have been searching Old Woman
and I find her in myself.*

(Cameron, 1981)

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ABSTRACT

As a determinant of health, culture represents an important influence of women's mid-life and peri-menopausal experiences. The purpose of this naturalistic inquiry was to explore the mid-life experiences of Mi'kmaq women. The research followed a participatory model and addressed ethical issues of ownership, control, access, and possession. Forty-two Mi'kmaq women from five First Nations in Nova Scotia participated in group discussions about their perceptions and experiences of mid-life change. Qualitative data were made amenable to analysis through the Atlas ti program and themes were sought through an inductive process.

Findings revealed themes of vision, balance, and relationships. Women's mid-life vision encompasses an evolving perspective of life, self, and the peri-menopausal transition. This vision is informed by past generations, by women's life experiences, and by the limited resources available to First Nations women. Balance emerged as a central determinant of women's perspective, experience, and response to mid-life change. The holism with which First Nations women view health was evident in their construction of experiences within physical, emotional, social, and spiritual domains. The context and substance of women's relationships also plays an important role in shaping their mid-life experiences. Community and kinship networks represent the foundation upon which women understand and experience all aspects of health, including those related to peri-menopausal change.

Interpretation of findings was based on the unique cultural, historical, socio-political, and medical contexts within which First Nations women experience mid-life change. Barriers and opportunities for achieving optimal health are created through these multi-dimensional contexts. Bi-cultural tensions seem to represent a particular challenge for First Nations women seeking mid-life balance.

The inclusion of a First Nations perspective contributes substantially to a multi-dimensional, inter-relational model of mid-life change, which can inform research, policy and practice. Further inquiry into the additional obstacles faced by Aboriginal women is essential and a more balanced and interdisciplinary research agenda is required. Programs and services must be based on indigenous values and program inertia must be in the direction of intergenerational capacity building, rather than perpetuation of medical dependence. Finally, programs must incorporate opportunities for women to engage in diverse strategies toward health and healing.

CHAPTER ONE: INTRODUCTION

Celebrating the sacred wisdom of old women is central to the philosophies of Indigenous cultures that venerate age and its corresponding evolution of mind and spirit. Within these cultures, mature women distinguish themselves as esteemed elders, while young women look forward to golden years of deference and respect. Unfortunately, this is not the fate of western women, many of whom fear age, sometimes more than they fear death. Western media and medicine reflect its abomination of elder women. And so, we deny our age and condemn our maturing bodies. We rage and bargain and mourn in vein. Wisdom, beauty and respect do not find a place in our vision. Within this toxic vision, our journey ends in the singular event of menopause.

Many have written and spoken about the path women take on their journey of change. They have debated about whether menopause is a beginning or end, an enemy or friend. But few have written or spoken about the path taken by women of our First Nations. Through this research, I hoped to walk with the grandmothers and discover their path. Yet, the activities required of me did not always suit the rhythm of Indigenous world views and so I walked very carefully. There are obvious tensions in pursuing academic research within a pluralistic paradigm. Nevertheless, a wise woman once told me that, “tension is not necessarily bad; not always something that must be resolved. It must, however, be acknowledged”. And so, I acknowledge that this research was difficult, that these volumes are dialectic, that the rigidity of science often competes with the holism of indigenous paradigms; that this research required the coalescence of divergent ways of knowing, which may create more controversy than camaraderie. But I was resolved to pursue this exploration so that those who care to listen may hear the grandmothers’ voices. In doing so, I continue to straddle ideologies, to view the world through many sets of eyes.

One belongs to western colonizers, who have fashioned a lens that suits their colonial predilection for division and control. Another belongs to our First Nations people, who seek to view the world in its entirety; without borders and boundaries that separate the soul from the body, the past from the present, the grandmothers from their children. Another lens has been fashioned by my own life experiences as well as those,

which have influenced my learning. This plurality of vision has not been easy, nor has it evolved without cost. These volumes are necessarily be filled with the tension that comes from engaging multiple paradigms. I have done my best, however, to present each so that we may better understand how they have shaped the experience of First Nations women on their journey through mid-life change.

During the past 20 years, women's mid-life health and menopause have increasingly become the focus of research (Formanek, 1990; Greer, 1992; Kaufert, 1990; Love, 2003; Northrup, 2002). The conclusions drawn from the ensuing aggregate data, however, are by no means convergent or even complimentary. The manner in which mid-life change is conceptualized, observed, interpreted, and reported has been fashioned by several disciplines, each having constructed a distinct lens through which to view this biologically and socially constructed phenomenon. Specific language, assumptions, and methodologies shape each lens and create a framework for the development of diverse theories. These divergent perspectives direct not only the questions that have been asked but also the questions that have not been asked. The manner in which menopause then becomes constructed, inevitably dictates the degree to which it is given value in society and is intimately associated with the allocation of responsibility for accommodating mid-life change. Individualized, reductionist perspectives of mid-life change emphasize women's obligation to "manage" their menopausal experience and assume responsibility for any difficulty they may encounter (Doyal, 1995).

Until very recently, what researchers knew about menopause was limited to the interests of clinical researchers and epidemiologists, for whom class and ethnicity were not particularly useful "variables". The lack of race or class analysis gave rise to limited conceptual models that presume a social vacuum in which health behaviours are freely chosen outside the context of individual lives. Lack of research about the perceptions and experiences of ethno-culturally and socio-economically diverse women has produced a pattern of "structured ignorance" (Mills, 1997). In general, white, middle class women have more access to information about menopause, thus facilitating the education and "enlightenment" of the most privileged so they may turn one critical eye toward medicine and the other toward the equally lucrative market of alternative and natural therapies (deSouza, 1990).

Within most gerontological literature, “the elderly in question are usually white, seldom black, and never Indian” (Thompson, 1994, pg.91). Consequently, we know very little about the health of elders in general and First Nations elder women in particular. This is almost certainly a reflection of western society’s general disregard for older people and its specific neglect of First Nations people. The pool of research from which to draw conclusions about the health of First Nations elders is both narrow and shallow. Not only is the literature exceedingly sparse, but information is often difficult to locate because, although deserving, it is seldom published in major journals. In particular, First Nations people often lack access to government databases about their own health (Assembly of First Nations, 1999).

Within biomedical disciplines and systems, the specific neglect of First Nations women’s health occurs at both a macro and micro level. It begins with the ethnocentricity of health literature, which assumes that First Nations people, regardless of gender, experience the same type and degree of marginalization and its consequent effects. This practiced ignorance denies the existence of specific health issues facing First Nations women by assimilating them into general discussions of Aboriginal¹ health. When First Nations women *are* included as subjects in medical and social science research, their experiences tend to be restricted to a select list of health problems such as diabetes or to social pathologies like suicide and substance abuse (Kelm, 1998). Circumscribed research becomes even more narrowly focused on the disproportionate burden of ill health First Nations women suffer relative to national averages. Their reproductive health is systematically restricted to issues of maternity, childbirth, and breast-feeding, to the exclusion of other life cycle issues (Dion Stout, 1999). The constrained nature of these health agendas emphasizes individual and lifestyle determinants, rather than historical, economic, political, and social contexts.

The absence or under-representation of First Nations women in population surveys and clinical trials means that little or nothing is known about these women, for whom life circumstances have a major impact on their health, to the extent that their life expectancy is 7-12 years less than non-Aboriginal women (Amick, Levine, Tarlov, & Walsh, 1995). Moreover, medical professionals know relatively little about how life

¹ Aboriginal refers to First Nations, Inuit, and Metis people. (Statistics Canada, 1993).

circumstances may impact First Nations women's perceptions and subjective experiences of health issues (Doress-Worters & Siegal, 1994). This ignorance, coupled with middle class and racial bias, also means that the cultural beliefs and traditions of First Nations women are not well received by health care professionals and few community supports exist to provide them with information or to support alternative health therapies (Bullough & Bullough, 1982; de Souza, 1990). When information and services are not directed toward their experiences or needs, the assumption seems to be that non-white women outside the middle class do not require information or assistance during mid-life. Consequently, there has been little support for the development of culturally appropriate Aboriginal women's health programs (Adams, 1995).

In its broadest form, feminism seeks to identify and influence social, economic and political structures that are detrimental and oppressive to women (Berger, 1999; Dickson, 1990). Women's health scholarship has exposed the tradition of viewing male physiology and behaviour as normative and women's as deviation from that norm (Martin, 1992). Most notably, this scholarship has revealed the mind-body dualism and physical reductionism of the biomedical model as well as the doctrine of specific etiologies that characterize this model (Doress-Worters & Siegal, 1994). Nowhere has this resistance to the practice and consequences of biological determinism been more evident than in feminist research concerning women's health over the life cycle, which has inspired a number of qualitative studies concerning women's perceptions and experiences of menopause (Davis, 1983; Berger, 1999; Beyene, 1989).

Feminist researchers have discovered that the extent to which women view mid-life change as positive and/or negative may depend to a great degree on the way in which their social roles are structured (Doyal, 1995; Greer, 1992; O'Leary Cobb, 1994). Studies have also revealed that women's menopausal experience may be influenced by social determinants such as culture and socio-economic status (CIAR, 1991). Unfortunately, most studies have remained rather narrowly focused on issues most salient to white women of the middle class. This assumption of a homogeneous menopausal experience ignores the diversity of women's every day circumstances and the influence of social determinants (Burger & Boulet, 1991; Greene, 1984). In particular, studies that do not account for women's ethno-racial background, socioeconomic status, existing

health status, life circumstances, or cultural context fall short of contributing meaningful information about their menopausal experience (Goodman, 1990).

The modest cultural lens of menopause research tends to focus distally on international comparative studies, while ignoring the lived experiences of women within the culturally diverse country of Canada. By and large, the experiences and conceptions of diverse ethno-cultural women, as influenced by unique historical, economic, political, and social contexts, have been excluded. This situation is perhaps most evident in the case of First Nations women who continue to struggle in relative isolation, for a voice in health research that many middle-upper class, non-Aboriginal women have the privilege to take for granted.

Purpose and Scope

The purpose of this study is to explore Mi'kmaq women's perceptions of mid-life health, with particular emphasis on menopause. Specifically, through this study, I have attempted to answer the following questions:

1. What issues become most important to Mi'kmaq women during midlife?
2. What are Mi'kmaq women's beliefs and attitudes about menopause?
3. What contributes to Mi'kmaq women's understanding of mid-life health and menopause?
4. What socio-cultural determinants influence Mi'kmaq women's experience of mid-life health and menopause?

The scope of this study included 42 Mi'kmaq women aged 38 to 83, from five First Nation communities across Nova Scotia.

Significance

According to Dion Stout and Kipling (1998), "there is a severe dearth of material related to Aboriginal women's health through the life-course, with the bulk of research attention directed toward infants and women of child-bearing age" (pg. 11). In particular, there is a conspicuous absence of literature related to Aboriginal women's

experience and understanding of mid-life health issues such as menopause.

Contemporary menopause theories related to aging, sexuality and social roles within families and communities do not always reflect the reality of First Nation women's lives. As a consequence, we understand little about these women whose lives seem to be enveloped by silence. In acknowledging this we are forced to question how and why we have come to conceptualize women's health in general and their menopause in particular. But who will question the basis of theories that are grounded in the reality of "us", rather than "them"? At best, one might speculate that there are simply too few of those without power and too many of those with it, as has always been the case, to adequately challenge established theories.

The lack of dispute by First Nations women should not however, be interpreted as identification with a white, middle class norm (Klein & Ackerman, 1995). Neither must their silence be defined as acquiescence or contention. In many cases, First Nation women's voices have been externally suppressed but sometimes they are the authors of their own respectful silence, directed by cultural norms around drawing attention to one's self or discussing private matters in a public way. Nevertheless, we must be careful not to assume too little or too much, for only they are authorized to interpret the absence of their voice. The most we should do is simply give First Nations women a forum in which to share their understanding of life and health and aging, if it is their wish, and learn what we can from their words.

It is my hope that this study will join the small but growing voice of women who use their *own* language to create their *own* conceptual framework for understanding their *own* lives. Perhaps the most significant element of this study is that it challenges a cultural monopoly on menopause theories. Indeed, the significance of this study begins with its capacity to provide a platform upon which First Nations women may begin to voice their *own* theories. More broadly, the findings of this study contribute to limited knowledge about First Nations women and particular issues related to their menopausal experience. Ideally, the findings may be used to inform program and policy decisions related to the health of elder women of the First Nations. Moreover, these findings provide a foundation for future research involving other Aboriginal women.

Through the use of diverse research principles, this study creates a rich, contextual framework for understanding the perceptions and realities of First Nation women's midlife experience. By employing participatory techniques, I attempted to ensure a more balanced and harmonious relationship between the research practice and the research practitioners (i.e. everyone involved in this study). Through the principles and practices of qualitative research, I was better able to embrace Aboriginal concepts of knowledge as cyclical and dependent on relationships, the existence of many truths, and an acknowledgement of equality and relatedness among all living things (Kelm, 1998).

Personal Perspectives: My Position in the Research

A number of experiences have brought me to this research; to the manner in which it was conducted, the approach taken in its analysis as well as the interpretation of its findings. Some of my experiences have been physical, while others involve my life (past and present), my family and my current position as an academic researcher. The following is an attempt to share some of my personal experiences, which I feel might have influenced this text. My paradigmatic and methodological position will follow in the methods section.

In the Heat of the Night

One can't help but appreciate the irony. Lying awake at 5AM, my body heating and cooling like a poorly timed dryer, my mind spinning like it's fraternal washer, all the while attempting to compose the next section of my dissertation about the serenity and joy of peri-menopausal change!

It began during the winter of 2002; after almost six years of reading and research about the menopausal transition, I awoke one frigid, December night in a blistering sweat. Quite suddenly it seemed - some internal register had jacked up the temperature in my pajama top. I quickly removed the offending garment and lay there feeling an odd sense of elation. I had arrived - my first hot flash. I was sweating with the big girls now; I was a crone, on my journey toward the wisdom and maturity of elder hood - corny to be sure but also very fulfilling.

I have spent much of the past six years trying to figure out why women view this rite of passage, this harbinger of old age, as both a blessing and a curse. I did not fully

understand this love-hate relationship, however, until that first night, when my body turned against me and presented a very new picture of this experience – one I could now see from the inside (a rather hot and disconcerting place). The vision was both gratifying and disturbing, at once instructive and dreadful.

More than a year has passed since my first ‘trial by fire’. I have now completed all of the interviews for my doctorate research and have finished writing about what can only be described as a curious disconnect between women’s simultaneous discomfort and delight with the peri-menopausal transition.

I have arrived. The journey, I fear, is not always the gentle warming that I imagined. The lack of sleep may be my undoing and the loss of control leaves me feeling a little caged. But the timing could not be better and so, I give you my vision – now as one of the countless flushing, flashing, sweating, and tired middle-aged women. Yet, I can easily flip that coin and tell you about the clarity of my vision these days; about the big changes I have made in my most intimate relationships, of the self-love and self-worth I finally found, somewhere in my tired eyes, my aging face and my tormented body.

My Research Journey

The personal journey I have taken in pursuing this research has left me with feelings of joy, ambivalence and sorrow, which are too profoundly personal to share with so many, so I will save them for those with whom I know they are safe. Suffice to say that I depart this project having been dramatically changed by it. To explain this transition, I believe I must share something of the past, which has shaped me.

Family

I come from what some might refer to as a “disadvantaged” background. My father finished grade six and began working in the woods, cutting and hauling trees, when he was eleven years old. While my father’s abuse of alcohol did not impair his ability to earn a living, it is safe to say that it created a number of problems for his family. He drowned in 1986, while drinking on his boat. My mother was one of six children, all of whom were taken from their mother at a young age because she neglected to care for them. My mother was raised by her paternal grandparents, both of whom she loved and

respected. She lost her grandmother when she was ten and at the age of 14, she left home and worked as a kitchen “girl” until she married my father when she was 19. She bore five children by the time she was 25 and we lived poor as long as I can remember. My mother was a very proud and somewhat hard woman. She was a harsh disciplinarian and raised us with her own particular code of ethics, which were based on values of stoicism, practicality, a familiarity with the natural world, as well as an irreverence for hierarchies created by race or social class. I grew up loving and fearing my mother. On the one hand, I deeply respected her strength and her pragmatism, yet I was never certain of her feelings for me. Her fierce temper was accompanied by a remoteness, which I still find difficult to process emotionally.

Throughout my childhood and well into my adolescence, I remember sitting with my sisters in the kitchen, listening to my mother and her sisters talking about life (typically how hard it was) and their families (typically how substandard their husbands were) and reminiscing about the past. Although we never tired of hearing the same stories year after year, I often wondered why they held such meaning for her. It wasn’t until I reached my own adulthood (my early thirties) that I understood how important the past is in shaping who we are. My sisters and I continue the tradition of reminiscence and our own daughters sit quietly, visit after visit, year in and year out, listening to our stories and I imagine, learning something new and wonderful each time.

Culture

Upon embarking on this research, I experienced some measure of ambivalence about where I might fit in an endeavor involving two communities (academic and Aboriginal), both to which I am peripherally connected. The discovery of my place has been both enlightening and uplifting. Initially, I imagined that this experience would help me discover a cultural niche, into which I might comfortably settle. I have lived most of my life desiring a more firm cultural foundation than the one provided by my mother and father, both of whom share European and Aboriginal ancestry. While my mother raised her children with many of the values and beliefs of her Native ancestors, I grew up surrounded by Euro-Canadian ideals and attitudes. My subsequent bi-cultural perspective is also the product of many years of cultural accommodation, resulting from choices made many generations before my birth. Ironically, it seems that I am left in

much the same position I occupied upon initiating this research – functioning reasonably well in both cultures but belonging to neither.

The gift given to me by the women in this study however, has been one of acceptance – that this place is likely the one best suited to me and that, rather than feel like an outcast in either, I should listen more carefully to the lessons I can learn from both and, more importantly, to the opportunities it provides for me – to act as a bridge between two worlds of understanding, both of which I can see with reasonable clarity. I am happy to say that it is a message I have taken to my heart. Rather than feeling rejected, I have felt completely accepted; not as “one of their own”, for I am not, but as someone with whom they will entrust their experience - to share with those who may not have the vision that has been their gift to us.

In choosing to use methods that represent both Euro-Canadian and Aboriginal practice, I hoped to embrace the concept of pluralism. Nevertheless, I was raised in Euro-Canadian society and have, despite my best efforts, likely acquired many of its biases. So, I have looked to the grandmothers to frame these volumes. It is the grandmothers’ life experiences and their perspectives, which have informed this project so it will not be surprising if much of what I write about is foreign to western eyes. Ideally, it is a story that they can call their own; not one that may necessarily be compared to the stories of Euro-Canadian women but one that reflects the unique vision of First Nations women. It is my hope that the words of the grandmothers will reveal that vision to all who wish to discover it.

CHAPTER TWO: LITERATURE REVIEW

This literature review is divided into two sections. In the first section, I provide a comprehensive summary of information concerning the historical, conceptual and cultural features of menopause and menopause research. This material did not necessarily form the theoretical basis for analyzing the findings. Nevertheless, this information base has informed my understanding of mid-life change and has likely influenced the perceptions of my research participants. Consequently, it is essential that this information precede any discussion of Aboriginal health and the intersection of western and Aboriginal cultures.

In the second section of this review, I explore themes that are relevant to an examination of Mi'kmaq women's perceptions of mid-life change, as a process embedded within unique historical and cultural contexts. The multi-faceted nature of First Nations health necessitates a comprehensive review. Therefore, I have included sub-sections related to conceptions of health, traditional healing, cultural and historical contexts as well as past and present health issues. Although very little appears in historical or current literature regarding First Nations women and menopause, I have also included books authored by First Nations women, which include information relevant to a discussion of this phase of women's reproductive life. Specifically, I have included a discussion of traditional gynocracies² as well as conceptions and practices around menstruation. The review concludes with a discussion of the impact of colonialism on women of the First Nations and a synopsis of the issues most relevant to present-day First Nations women.

Menopause

Defining the Process

In 1996, the World Health Organization (WHO) defines menopause as the permanent cessation of menses, resulting from loss of ovarian follicular activity and characterized by endocrinological, biological, and clinical features. The fundamental

² The most distinguishing characteristics of gynocracies are the centrality of women to social well being as well as the deference and authority granted to women. In particular, gynocracies are characterized by matrilinearity, matrilocality, matrifocality as well as maternal control of production (Gunn Allen, 1986).

construct of this process differs significantly across disciplines in which it is alternatively defined as a natural process and a pathologic deficiency, a disease and a determinant of disease, a biological event and a social process, one that is directed by endocrinological fluctuations and by the changing social roles of mid-life women (Berger, 1999; Kass-Annese, 1999; Kaufert, 1990; Lock, 1993). Despite these contentions, however, most research continues to be conducted from a disease perspective – “the search for symptoms”.

According to most experts, including the World Health Organization (WHO), a clear distinction needs to be made between peri and postmenopausal women. In 1996, the WHO defined the various phases of women’s menopausal transition in the following manner:

Premenopause represents the entire reproductive period prior to the menopause, not just one or two years prior to menopause.

Peri-menopause is loosely defined as the period immediately prior to the menopause and the first year after menopause.

Menopause is defined as permanent cessation of menstruation resulting from the loss of ovarian follicular activity.

Postmenopause reflects a period dating from the menopause, although it cannot be determined until after 12 months of spontaneous amenorrhea.

(Kittell, Kernoff, Mansfield & Voda, 1998).

One of the difficulties with this definition is its perplexing time lines, which seem to overlap, yet are defined as separate intervals. For instance, how can pre-menopause extend up to the time of menopause, and post-menopause begin immediately after menopause, if we define peri-menopause as a period of years surrounding the cessation of menses? The qualitative evidence is overwhelmingly clear, the transition is of primary relevance. Yet, in true Cartesian fashion, we continue to focus on a single event in time, rather than on the process of change.

In the case of defining women’s mid-life experience, language really does shape reality. The primary descriptor in almost every definition is *menopause*. Yet, menopause represents a single event, in a process spanning many years. We know that women’s mid-

life transition closely resembles puberty, which typically lasts between five and seven years (Northrup, 2002). Yet, the process of pubertal change has not (at least, to my knowledge) been labeled peri-menarche; nor have women over twenty been called post-menarchal; nor has pregnancy become commonly referred to as gestational amenarche – my meaning becomes clear.

According to Hyde, DeLamater & Byers (2004), puberty “is not a point in time, but rather a process...it is the stage of life during which the body changes from that of a child into that of an adult, with...the ability to reproduce sexually (p.116). In defining the menopausal transition, some researchers have suggested that we use the term climacteric, which may be used equally for men and women. Not surprisingly, this term never caught on in lay use which, given its resemblance to the sexually saturated word ‘climax’, is hardly a surprise. So, we are left with the language of every-day women, who say “change of life” – it is simple, it is elegant - it is enough!

Those who determine what is worthy of investigation necessarily influence what we “get to know” about menopause (Kaufert, 1990). Diverse disciplinary perspectives direct not only the emphasis of research and the types of questions asked but also the methodology used to gather data. Over time, each discipline constructs its own lens for viewing phenomena. Distinct language, assumptions and methodologies shape these lenses as well as what and how findings may be interpreted. Physicians and other clinicians tend to use a biomedical model, while social scientists such as psychologists, sociologists and anthropologists hold to a more socio-behavioural perspective. Needless to say, these disciplines are often at odds with each other over the definition, conceptualization, observation and interpretation of phenomena such as the climacteric (Payer, 1991). Clinicians examine the physiology of menopause, while psychologists study its relationship to emotional disturbances. Sociologists explore the changing roles and social transitions women undergo during the climacteric, while anthropologists view it as a culturally bound transition.

At varying times throughout history, the biomedical model has been used to associate the climacteric with a bevy of “symptoms”, ranging from digestive problems to lasciviousness (Bell, 1987). During the 20th century, however, attention has been directed toward the proximal and distal effects of “ovarian failure”. Clinical researchers

also tend to work from models that are universal rather than those bound by culture, time, and place. Moreover, sampling biases severely limit the extent to which findings can be extrapolated to a diverse population of mid-life women (Greene, 1984). For example, research based on non-clinical samples of women reveal very different findings than those using clinical samples. However, many researchers continue to make broad generalizations from small, selective clinical samples of predominantly middle class, white women (Kaufert, 1990).

A biomedical/deficiency model links physical and psychological experiences at menopause to estrogen depletion (Berger, 1999). Scientific/medical discourse emphasizes the relationship between sex hormones (most notably estrogen) and a staggering number of physical and psychological symptoms (Dickson, 1990). Through the biomedical model, science creates a somewhat restricted view of women as a product of their reproductive and endocrine systems. Biomedical models tend to limit analysis to discrete variables and rarely account for the ephemeral nature of women's experience (Kass-Annese, 1999).

Rather than viewing each woman as an amalgamation of her past and present physical, emotional and social circumstances, biomedicine reduces them to a collection of discrete organs and systems that can better be examined in isolation from one another (Greer, 1992). Use of the term "symptom" lends itself to a disease model in which this natural, predestined process is shrouded in the vernacular of deprivation and disease (Berger, 1999). The conceptualization of menopause as a deficiency disease has also led to a dismantling of the life cycle and separation of women's embodied experiences from the context within which those experiences occur. In an evaluation of women's menopausal experiences, only biological variables are considered relevant, while the everyday circumstances of women's lives are deemed unworthy of consideration.

Although it is currently the most popular model, the deficiency theory is inadequate for a number of reasons, one of which is that the "symptoms" of menopause typically manifest years before the final menses and therefore may precede the most dramatic decline in estrogen (Berger, 1999; Formanek, 1990; Greer, 1992). Recent research also indicates that the absence of menses does not always coincide with a profound deficit of circulating hormone (Goodman, 1990). Moreover, citing increased

rates of heart disease and osteoporosis in women over fifty to support this theory does not account for women who experience menopause in their 40s and may, therefore, be post-menopausal (and therefore “estrogen deficient”) for up to ten years. Nor does it account for women who have not yet finished menstruating (Luoto, Kaprio & Uutela, 1994). Finally, the deficiency theory exhibits little utility in adequately explaining the substantial number of women who experience no discomfort or disease related to menopause or the significant differences in “symptom” presentation reported globally as well as cross culturally within North America (Berger).

Although the psychological model adds breadth to the rather narrow perspective of the biomedical model, its focus remains on the individual woman. In this case, her temperament and past behaviour become the determinants of her current menopausal experience (Greene, 1984). Greene’s “Vulnerability Model” suggests that individual symptoms and complaints are a product of adverse situational factors (psychological, socio-demographic and socio-cultural) that create vulnerability in women with a particular biological and psychological profile.

The socio-cultural model generally minimizes endocrinological and psychological elements of menopause, while emphasizing the influence of aging and women’s changing social roles. In particular, this cultural perspective places women’s climacteric experience within social, political and economic contexts. Within this model, climacteric experience is influenced by socially constructed gender roles, as well as beliefs and expectations of a particular culture at a particular time (Lock, 1993). Unfortunately, the application of this model remains somewhat limited and has only recently gained popularity.

Western Perspectives and the Medicalization of Menopause

By the mid 20th century, the lowly ovary had become firmly entrenched as the sole dictator of women’s physical, psychological and social health. The field of sex endocrinology exposed female hormones, once safe inside our bodies, to standardized measures, against which post-menopausal women fell short – enter a deficiency disease. (Bell, 1981). The endocrinological nature of women could finally be observed, correlated and controlled. Researchers looked for, and “coincidentally” discovered,

alleged causal links between the cessation of menses at mid-life and any number of debilitating disorders and diseases (Berger, 1999). The increasing dependence of physicians on scientific techniques further restricted medical practice to measuring and subsequently “replacing” hormones in mid-life women (Bell, 1987).

Once menopause became classified as a hormone deficiency disease, medical professionals flourished in a newfound market, all practicing under the guise of caregiver to mid-life women. During the 1950s, estrogen therapy was conceived, developed and marketed to women as “better living through chemistry”. With the appearance of editorial neutrality, multi-national pharmaceutical companies paid the bill for subtle advertising through magazine articles. With funding from the multi-nationals, clinicians like Robert Wilson and his book entitled “Feminine Forever” (1966) contributed to the deficiency theory in which women needed to be “estrogenized” from menopause until death. With the assistance of hormone replacement therapy (HRT), women could be guaranteed perpetually moist vaginas and indefinite sexual availability, thus ensuring their valued membership in a gendered society (Greer, 1992). During these early years, with little economic independence and political voice, women were indoctrinated into the biomedical neutrality of science (Doress-Worters & Siegal, 1994; Lee, 1996). As a social construct and therefore one of multiple concepts of reality, menopause as disease became widely accepted and thus experienced (MacPherson, 1981). On the whole, women acquiesced to their assigned role of “sufferer”, which provided at the very least an outlet for the pain, disappointment and frustration they experienced, not from menopause, but as a result of oppressive, sexist and ageist social, economic and political structures (Greer).

Most recently, menopause has been linked to the killer diseases of western society (e.g. heart disease and cancer). As such, the “endocrinopathy” of menopause has been viewed as not only a danger to mid-life women but as a major drain on health care systems (Wich & Carnes, 1995). The ensuing expectation is that individual women will take responsibility for their diseased state and expend every potential resource to ensure that they do not become a burden to society. This message is of course, subtly embedded within a more palatable declaration that “this is for your own good”. The power of consumerism has become especially potent within doctor’s offices in which the flood of

“new and improved” pharmaceuticals is met with an equally fervent market response. Physicians were pressured to push the latest, greatest hormonal product to an ever-expanding population of mid-life women, eager to embrace the notion that life begins at 50 (Berger, 1999).

Recently, however, there has been growing concern about the risks of HRT to mid-life women’s health. In July of 2002, a study of the health implications of HRT, conducted within the US government funded Women’s Health Initiative (WHI), was abruptly halted due to findings that suggest increased risk for women on long-term Prempro (a popular estrogen/progestin pill) (Northrup, 2002). Sixteen thousand healthy, postmenopausal women were randomly assigned to either Prempro or a placebo. In year five of this eight-year study, women on HRT were found to have increased rates of breast cancer, heart attack, stroke and blood clots. The 2002 findings from the HER (Health and Estrogen/Progestin Replacement) Study also indicate that, among women with pre-existing heart disease, HRT, specifically Premarin and Provera, tends to increase the risk of subsequent heart attack in the first year of use. On the same day that the WHI cancelled its HRT research, the National Cancer Institute released findings, which demonstrated a two-fold risk of ovarian cancer in women on estrogen for more than ten years (Northrup, 2002). As a result of these findings, physicians are becoming somewhat more cautious about readily prescribing exogenous hormones.

Menopause and Culture

To fully appreciate the multi-dimensional nature of mid-life change, we must engage women of diverse cultures and attempt to view this process through their eyes. In this way, we acknowledge that this phenomenon, like many others, is painted upon a socially constructed canvas that cannot be understood outside its frame. Indeed, the more distant we are from the world in which each woman’s experience is ensconced, the greater the risk that we might misinterpret it (Amick et al., 1995; Berger, 1999; Lock, 1993). Certainly, “one of the dangers of seeking universal application is inappropriate extrapolation from cases that we understand, or think we understand, to cases about which we know little or nothing” (Waldram et al., 1995, pg. 178). This discussion is prefaced by an acknowledgement of the temporal, geographic, and practical

heterogeneity of cultures, which limits the extent to which broad generalizations can be made.

One body of literature defines culture as historically and geographically bound patterns of shared beliefs, values, and behaviours (Amick et al., 1995). Culture also encompasses the physical, psychosocial, economic, political and spiritual dimension of lived experience (Paul, 2000). Culture saturates women's health related experience in the sense that biology and culture are shaped and changed by one another (Lock, 1993). Culture may alter a woman's physiology in terms of the quality and quantity of her diet, the degree and type of activities she pursues, her health behaviours as well as the number and timing of children – all of which may indirectly influence her menopausal experience (Burger & Boulet, 1991). For instance, regular menstrual cycles are not experienced by women who spend the majority of their reproductive years pregnant or lactating. For these women, menstruation is an occasional occurrence and many enter menopause during their final lactation or pregnancy with no intervening menstrual period (Berger, 1999; Kaufert, 1990).

The heterogeneity of women's response to the climacteric is due in part to the characteristic mores of particular cultures (e.g. beliefs, social structure, and traditionality). The process of socialization influences women's perceptions of their role as women, mothers and citizens as well as beliefs about their bodies and their sexuality. This process begins in childhood and by adulthood, women have internalized many normative expectations about the socially acceptable and desirable roles of their particular culture (Lock, 1993). In this way, women's beliefs about the cultural expectations of menopause may become self-fulfilling prophecies. Cultural beliefs influence the construction, experience and interpretation of menopause. For instance, western culture tends to be grounded in values of separation, independence and autonomy. Consequently, themes of individual loss take root in this culture in which individualism may have priority over social relationships (Burger & Boulet, 1991; Lock). Themes of loss, mutilation and mourning may, however, have little utility within cultures in which family continuity is embedded in social life and the procreative activities of a single woman are thus transcended.

In most western cultures, the process of aging has become profoundly and irrevocably gendered (Lock, 1993; O'Leary Cobb, 1994). Unfortunately, glorification of female youth often signals a devalued social status for mid-life women, for whom middle age has become subsumed by the singular event of menopause. The notion of "coping" rather than acceptance pits women in a futile battle against biology and the inevitability of aging (Dantan, 1990).

The initial challenge faced by most researchers is in defining terms such as "healthy" or "normal", which are temporally as well as culturally contextual, making it especially difficult to establish a universal definition of menopausal health. The notion of "normal" is typically based on an existing average. In western culture however, it often becomes confused with a particular point on a continuum toward excellence, to which we should all aspire in a culture in which youth and sexual attractiveness to men are considered "normal" (Burger & Boulet, 1991). Globally, western images of menopause as a deficiency disease are influencing women to use HRT as the "magic bullet" in treating uncomfortable experiences, purported to be caused by reduced estrogen and to prevent diseases that are implicated in this hormonal diminution. Sadly, the notion of youth as privileged over aging has also over-shadowed the traditional value of age in some non-western cultures (Chirawatkal & Manderson, 1994). Exceptions in North America can be found among some ethno-cultural groups of women including First Nations women, whose culture continues to embrace the value of age (Berger, 1999).

During the 1980s and 1990s, several researchers conducted cross-cultural studies in an attempt to discover the diversity of women's menopausal experience. They were particularly interested in talking to women living in traditional cultures in which the biomedical model of health had not taken primacy over more holistic models. The findings of research conducted by those such as Beyene (1989), Lock (1993) and Martin, Block, Sanchez, Arnaud & Beyene (1993) demonstrated the wide diversity of menopausal experiences within and across cultures as well as the influence of cultural values and views of the female body, sexuality and reproductive processes. One of the most important findings of these cross-cultural projects is the diversity, and in some cases, marked absence of experiences such as hot flashes, once thought to be a universal manifestation of declining estrogen at menopause.

Perhaps the most influential cross-cultural comparison of menopausal women may be found in the work of Margaret Lock (1993) who, along with others (Avis, Kaufert, [Lock], McKinlay, & Vass, 1993), reported a marked difference between the experiences of women from different cultures in which non-western women not only experienced significantly different “symptoms” but report fewer and less severe symptoms as well.

In Lock’s 1993 study of menopause among Japanese women, participants experienced low occurrence of hot flashes, when compared to Euro-Canadian and Euro-American women. The women in Lock’s study used the term “konenki” to refer to a natural process of balancing the body through this transitional period of change, rather than one of loss through estrogen depletion. In 1994, Boulet, Oddens, Lehert, Vemer, & Visser also conducted a study of women in Hong Kong, Indonesia, Korea, Malaysia, the Philippines, Singapore and Taiwan and found wide variance in experiences as well as a low overall incidence of most experiences reported to be typical menopausal symptoms by western women. Berger conducted a similar study in 1999, with a group of Filipino women. In her report of the findings, she indicates that the women who participated in her study did not view menopause as a deficiency disease but rather, a natural process of aging and a time of advantage through enhanced social status associated with age. Among these women, menopause also represented freedom from menstruation, childbearing and household responsibilities.

In 1990, Kyra Kaiser traveled to five countries in Europe (Belgium, France, Great Britain, Italy, and West Germany) and compared the experiences of menopausal women in 15 different socio-cultural groups. She found that the degree to which women positively or negatively experienced peri-menopausal change was influenced by cultural norms around aging, women’s social status, and political power. Dona Lee Davis (1983) explored the experiences of women living in a Newfoundland fishing village and discovered the value of stoicism as a cultural influence of women’s understanding of menopause and mid-life health. The harsh conditions of remote village life appear to encourage a pragmatic attitude, which shapes women’s perception of peri-menopausal change. Although this remote community held strong individualistic values common in many western societies, women’s role in the fishing industry afforded them more equality

than other Euro-Canadian women might achieve (Davis). In Martin et al.'s 1993 study among Mayan Indian women in Yucatan, Mexico, participants reported no experience of hot flashes during the peri-menopausal transition. During this phase of life, this group of women reported experiencing relief from the taboos associated with menstruation as well as from the burdens of childbirth and housework.

In 2002, Robert Webster published the findings of a literature review, which attempted to summarize research conducted on First Nations women's experience of menopause. After an extensive review, Webster uncovered a handful of publications, spanning one hundred years (1891-1991). Most of the studies included very small samples and made only vague reference to First Nations women's menopausal experiences, in many cases, never clearly defining menopause. However, I have included a brief description of the studies for the sake of providing context to the current study.

It appears that the first account of First Nations women's menopausal experience was recorded in 1891, within an American study on North American Native women's reproductive status. The authors of this report determined that a) the menopausal transition had little effect on women's life, b) it occurred between age 40 and 57 and c) it lasted up to eight years (Currier, 1891). In a 1935 study of Ojibwa women (Hallowell & Irving, 1991) as well as a 1963 study of women from the Northwest Territories (VanStone), researchers also found that menopause had little impact on women lives or their social roles. In 1961, Shimony's study of the Iroquois people revealed that, while menopause did not disrupt women's lives, they did use chamomile tea to prevent excessive peri-menopausal bleeding. A 1939 study (Goldfrank, 1951) of Blackfoot women found that women received most of their information about menopause from peers, while a 1995 study of Copper Inuit women by Stern and Condon, reported that the majority of women received information from their mothers and grandmothers. Finally, a 1991 study of eight Mohawk women's perception of midlife revealed this time of life as being one of shifting priorities, reflecting on the past and planning for the future, as well as finding personal, meaningful time and enjoying relationships (Buck & Gottlieb, 1991).

People of the First Nations

The most important point to make in any description of the First Nations of Canada concerns the diversity of this population. Aside from a wide variety of languages, customs and beliefs, the vast geography of Canada has contributed substantially to the dissimilarity in past and present social, economic and political features of these distinct Nations. Approximately 60% of First Nations people who are registered under the Indian Act, live on reserves, 64% of whom are under the age of 25 (Lemchuk-Favel, 1995). The most affluent reserves (estimated at approximately 200), as defined by higher relative education and employment status, tend to be those closest to urban centres. Of the 604 First Nation bands in Canada, 112 are located in the remote north. In these isolated reserves, as well as some others, education and employment opportunities as well as economic development have been inadequate and living expenses are extremely high, creating relatively high levels of poverty with consequent poor health (Lemchuk-Favel).

A major limitation of most health research is that it fails to address the heterogeneity of the several hundred different First Nations cultures across North America. In keeping with the interdisciplinary theme of this project, I have attempted to distill information from diverse fields and integrate the perspectives of diverse First Nation cultures. The goal of this review, however, is not to impose a conceptual framework for interpreting information gathered during the proposed inquiry of Mi'kmaq women's understanding of mid-life health and menopause. Rather, much of this information will be used as a conceptual template for considering their perceptions, within the context of the potentially conflicting ideologies of Aboriginal and western systems.

"It is in the nature of colonizing societies to create images of those they colonize, images of noble savages and of lowly heathens, images they use to help tell them who they are and who they are not" (Klein & Ackerman, 1995, pg. 24). While negative images must always be challenged, utopian images also create false reality. A romantic stereotype is, after all, a stereotype. Unrealistic expectations, be they positive or negative, can only lead to misinterpretation and misunderstanding, likely to the detriment of those being stereotyped. It is particularly dangerous to glorify the past so much that

we imply its superiority over the present. Lakota writer Vine Deloria Jr. (1969) suggests that “the massive volume of useless knowledge produced by anthropologists attempting to capture real Indians in a network of theories has contributed substantially to the invisibility of Indian people today...Not every Indian can relate themselves to this type of creature who, to anthropologists is the “real” Indian.” (Klein & Ackerman, 1995, pg. 86). Ultimately, the portrayal of Aboriginal people of the past or present, as either the demonized or idealized other, necessarily leads to inequities (Klein & Ackerman).

Assumptions of First Nation communities as isolated, self-contained societies, bound in a “timeless stratum designated as traditional” (Klein & Ackerman, pg. 2), create utopian images that generally lack the complexities inherent in any human society. “Indigenous knowledge is an adaptable, dynamic system based on skills, abilities, and problem-solving techniques that change over time depending on environmental conditions...” (Battiste, 2002, p. 11). Like every other, Aboriginal cultures are dynamic and like most, are also pluralistic in the sense that many constituents, including interaction with Europeans over the past 500 years, has brought about change (Cruikshank, 1990).

Cultural Themes of Indigenous Peoples³

The most noteworthy preface to any discussion of Aboriginal peoples is that a universal Aboriginal paradigm does not exist. Despite diversity of geography, language, and social structure, however, Aboriginal peoples do share many values, which are philosophically distinct to their cultures. Nevertheless, this discussion must be framed in a plurality that encompasses certain similarities between each Nation’s or group’s worldview.

Indigenous societies have always possessed sophisticated systems of knowledge, philosophy, medicine and government (Battiste, 2002; Gunn-Allen, 1986). A gestalt paradigm is often reflected in value themes of holism, which emphasize the complete person in the entirety of their life; personalism, which places value on individual autonomy and freedom; relationality, which acknowledges responsibility toward self,

³ Indigenous peoples are defined as “Those who have a historical continuity with the pre-invasion and pre-colonial societies that developed on their territories”. (Summit on Indigenous Peoples, 2003)

community, environment and cosmos, as well as balance and harmony between the sacred and the secular, which acknowledges the sacredness of existence as well as unconditional reverence and respect for humans and non-humans alike (Gunn-Allen; Klein & Ackerman, 1995; McMillan, 1995).

Many Indigenous knowledge systems are predicated on the belief that knowledge is cyclical and dependent on relationships, including those between and among natural and supernatural entities. There is an existence of many truths, manifest in subjective life experiences. The humility of Indigenous cultures is evidenced in belief systems that not only acknowledge all life as equal and related but that recognize humans as the least important beings in the cosmos (Oakes, Riewe, Koolage, Simpson, & Schuster, 2000). Perhaps the most fundamental element of Indigenous belief systems is that humans are innately good and strive to attain greater spiritual development through interaction within natural and super-natural realms. This belief is reflected in cultural imperatives characterized by a reluctance to show anger, or to censure or interfere in the affairs of others; the avoidance of confrontation and adversarial positions, waiting until the time is right, particularly in conflict resolution, respect for praise as well as gratitude, an endeavour to achieve peace and harmony, and a resolute commitment to maintaining balance between and among the physical and spiritual worlds (Brant, 1990; McMillan, 1995; Oakes et al.).

Since time immemorial, Indigenous cultures and histories were passed from generation to generation through an oral tradition. Story telling or narrative was used extensively as a teaching tool. Within many Indigenous cultures, narrative symbolizes holism in the sense that stories function to connect that which is central to individual, community and social processes (Cruikshank, 1990). Through stories, myths and legends, elders symbolically describe socially appropriate behaviour as well as share knowledge, philosophy and instruction without direct censorship (Battiste, 2002; Brant, 1990). The non-punitive social practice of narrative is a feature of many Indigenous cultures from which other cultures could learn a great deal. Another unique and enduring characteristic of Indigenous stories is that they are dynamic in the sense that they evolve over time in much the same way that people and cultures do. Stories are also contextual and may be tailored to better fit the circumstances under which they are told as well as process-

oriented so they may guide decision making and problem resolution (Leavitt, 1995; Waldram et al., 1995).

The old adage, “with age comes wisdom” is particularly meaningful in Indigenous societies in which elders are generally respected. In many cases, the term elder is bestowed on individuals who have earned this title through their contribution to families, communities and nations. However, the term elder may also refer to someone of a certain age (40, 45, or 50) and even a modest difference in age implies greater wisdom that is naturally afforded greater respect. It is generally accepted that the ability to apply knowledge, to teach and to heal evolves with age. In this way, “elders are not born, they are not appointed, they emerge as the sum total of the experiences of life, they are a state of being” (Stiegelbauer, 1996, pg. 50.) The community recognizes elders as symbolizing a connection with the past, with knowledge, language, tradition, stories and ceremonies (Stiegelbauer). Grandmother is a generic term used to address older women in a respectful manner. As a rule, younger women listen carefully to senior women, taking their advice seriously and looking to them as role models (Couture, 1996; Dickason, 2000).

Among the most prominent cultural themes pertaining to a discussion of women’s health is the conception of self, which is often independent of gender. In fact, among many First Nations, there exist traditional cultural values that embrace stereotypically feminine principles (Gunn-Allen, 1986). Likewise, with the exception of some Northwest Coast cultures, there is a relative lack of social hierarchy in defining interpersonal relations; this includes relationships between men and women. Finally, when compared to the early traditions of Euro-Canadian culture, positions of power were relatively available for both men and women within many Indigenous social systems. Among various Indigenous peoples, the nature of power is believed to be essentially akin to living or being alive and making a difference in the world. Within this paradigm, gender does not constitute the fundamental basis of living power (Kass-Annese, 1999).

The Mi'kmaq

Historical and Political Context

During the past 400 years, descriptions of the social, economic and political lives of Mi'kmaq people have been reported by a number of individuals, both First Nations and Euro-Canadian, as well as academic and non-academic. The resulting body of literature has not always been congruent in terms of content or context. Therefore, it is essential that we remain somewhat flexible in terms of the degree to which we ascribe to one version of the historical record over another. For the purposes of creating some historical context to my discussion of Mi'kmaq women's mid-life experience, I have relied primarily on the work of Paul (2000) and Prins (1996), both of whom have produced historical documents, which are generally well received.

The traditional territory of the Mi'kmaq people includes Nova Scotia, eastern New Brunswick, Prince Edward Island and parts of Quebec. This territory extended from Cape Breton Island in Nova Scotia to the St. John River in New Brunswick, and to the Gaspé Peninsula (Prins, 1996). The Mi'kmaq language belongs to the Algonquian language family and is closely related to that of the neighbouring Maliseet Nation. Before the imposition of the reserve system, Mi'kmaq people practiced seasonal migration within their hunting and fishing territories, in which they moved to the coast to fish through the spring and fall, then inland to hunt during the winter months. An abundance of food permitted substantial population growth and the development of complex cultural and political structures, consisting of a Grand Chief or Sagamore, district chiefs, lower chiefs and citizens (Paul, 2000).

The Mi'kmaq people continue to be as diverse as any other group who share a common race or ethnicity. Yet, the history of interactions between the Mi'kmaq people and European colonizers is similar to that of most other First Nations people (Prins, 1996). The Mi'kmaq people were among the first to have contact with Europeans, with formal trade beginning as early as the 1600s. During the first 100 years of European contact in the 16th and 17th centuries, 75% of the Mi'kmaq died of diseases carried to Canada by Europeans. This "Great Dying" created a devastating snowball effect on the traditional economy, as well as the political and social systems of the Mi'kmaq

population, which reached a demographic nadir of 2,000 toward the end of the 1700s (Miller, 1995).

The near-decimation of the Mi'kmaq permitted accelerated encroachment by Europeans. Between the late 1700s and late 1800s, the newly-formed Nova Scotia government "reserved" parcels of land for the Mi'kmaq, ranging in size from 10 to 16,000 acres. The process of imperial rule intensified in the early 1800s, when Euro-Canadian, Indian Agents were assigned to "oversee" Mi'kmaq affairs in specific "Indian" districts. During this time, the Mi'kmaq were also forced into a system of "internal colonialism", in which the British used a form of indirect rule, through local leaders, to control Mi'kmaq people. Prior to colonization, the Mi'kmaq custom involved "a saqmaq [who] was first among equals" (Prins, pg.174), rather than a ruler of men. Political decision-making involved a participatory approach, in which association was voluntary, institutionalization was minimal and consensus was emphasized over coercion (Prins, 1996).

In 1867, control over Indian affairs was assumed by the newly formed federal government and almost a decade later, the Indian Act was established. Attempted ethnocide occurred under the guise of enfranchisement, a term that ironically means 'to set free'. One can only speculate from what, the Mi'kmaq people were being 'set free' but we do know that, for the first time, Mi'kmaq people did not have the freedom to define their own identity. While many Mi'kmaq children attended public school, approximately 2000 others attended residential schools, such as the one located in Shubenacadie, which operated from 1929 to 1967. After years of subtle and not-so-subtle ethnocide, many of these young people returned to their home communities, no longer able to communicate with their elders, linguistically or culturally (Knockwood, 1992; Prins, 1996).

Social and Economic Context

It has been suggested that traditional Mi'kmaq social structure was based on family, band, and tribal affiliation (Paul, 2000). Leadership was established through custom and kinship but also through example; individuals, who inspired respect and who were knowledgeable and admirable, were those chosen to lead (Prins, 1996). Extended

kin-networks formed fluid bands of 30-300 members, who came together during times of abundance and inter-band marriages were encouraged in order to strengthen alliances (Prins). Patriarchal kin networks typically included a headman or saqmaw, nuclear families consisting of a married son and daughter, their family, as well as matrilineal and patrilineal relatives, who were unmarried or widowed, and perhaps some individuals who were unrelated, such as orphans (Prins).

Despite patriarchal family structures, kinship networks were organized bilaterally (mother and father) and family residence was often established bi-locally (maternal or paternal family), both of which demonstrate the plasticity of social connections among the Mi'kmaq (Prins, 1996). Social interaction was based on the concept of reciprocity – on mutual obligation, which represented the glue that bound large networks of people together. Indeed, fluid social networks spanning Canada and the United States continue to exist between the Mi'kmaq and other First Nations people (Prins).

Traditionally, work responsibilities were assigned in a pragmatic manner (Paul, 2000), which created some degree of gendered labour. In general, men performed strength-based work such as hunting, while women engaged in childcare and household chores and, like most women across cultures and history, Mi'kmaq women did the bulk of the work (Prins, 1996). Yet, unlike European cultures, this sexual division of labour contributed to complementarity and egalitarianism among men and women, who gained respect through age and through excelling at specific tasks or as a result of some outstanding quality (Morrison & Wilson, 1995). Beyond the subsistence activities of hunting, fishing and gathering food, weaving represented both a practical and artistic activity for both men and women, who used leather, sweet grass, reed or rushes, to create baskets, bags and bowls used for storage and travel (Prins).

During and after colonization, the subsistence activities of the Mi'kmaq people shifted from migratory fishing, hunting and gathering, to wage labour as well as some farming, typically mixed with supplementary hunting and fishing. However, many of the reserves were located on barren land, which prohibited even subsistence farming, so men and women remained active crafts people, producing baskets, barrels and wood items for sale. With the exception of a few larger communities that are relatively close to urban

centres, reserves continue to be economically marginalized and somewhat dependent on government subsidies and Department of Indian Affairs jobs (Prins, 1996.)

Traditionally, elders, grandparents and parents taught through modeling and through stories. These processes ensured the continuity of Mi'kmaq culture, history, knowledge and language. In addition to representing a form of entertainment, story telling was considered a critical component in the development of intellectual, social and spiritual maturity (Paul, 2000). The oral history of the Mi'kmaq people indicates that physical punishment was not traditionally used in child rearing (Paul, 2000). Paul suggests that this practice emerged from egalitarian values and the respect afforded to all members of the community, regardless of their age. In addition to respecting all human beings equally, the Mi'kmaq people maintain a reverence for the natural world, evidenced in their respectful behaviour toward all things natural (Paul).

According to most authorities, Indigenous and non-Indigenous value systems differ substantially, particularly in relation to individual versus group fulfillment, personal gain versus sharing, competition versus cooperation and power versus generosity (Weaver, 1998). This is equally true for the Mi'kmaq people who, despite 500 years of European occupation, have preserved their social values of communal society, sharing, social protection, civility, generosity, hospitality, and tolerance for diverse views, even if such views differ vastly from their own (Paul, 2000). Value is placed on those who contribute to the group, as well as those who focus on the needs of others (Barrios & Egan, 2002).

Spiritual Context

The moral values of the Mi'kmaq people are demonstrated through the following quote, in which a Jesuit describes the Mi'kmaq reaction to French customs. "You are always fighting and quarreling among yourselves; we live peaceably. You are envious and are all the time slandering each other; you are thieves and deceivers; you are covetous, and are neither generous nor kind; as for us, if we have a morsel of bread we share it with our neighbor" (Biard, 1611, in Pins, 1996).

Acceptance remains a principal value of the Mi'kmaq people, which was demonstrated intra-culturally through the lack of stigma related to two-spirit people as

well as those with mental illness (Paul, 2000). Inter-culturally, the Mi'kmaq people have responded creatively to many challenges, particularly those resulting from interactions with Euro-Canadians (Prins, 1996). Values related to acceptance and stoicism were also incorporated into traditional medicine and healing practice, which seeks balance between suffering and strength. "Traditionally, the Mi'kmaq believe that some of the most powerful "medicine" came in visions induced by some difficult ordeal" (Prins, pg. 72).

The pluralistic practice of the Mi'kmaq people, extended to matters of faith, which resulted in a blending of traditional Mi'kmaq beliefs with those of Christianity (e.g. Sun - Holy Father; Grandmother moon - Virgin Mary) (Prins, 1996). In addition to those who continued to practice traditional spirituality, many Mi'kmaq people were converted to the Roman Catholic faith. "St. Anne, the virgin Mary's mother, was the original patron saint of New France and became the patroness of converted Wabanaki Indians, including the Mi'kmaq" (Prins, pg.172). Every year, the feast of St. Anne continues to be celebrated on July 26th in Chapel Island by many Mi'kmaq people (Prins).

It has been suggested that early "conversion" to Christianity represented a form of kin-making in the eyes of Mi'kmaq – as a way of forming alliances and kin-like networks, which provided mutual advantage to the French and Mi'kmaq who did not fully relinquish traditional cultural beliefs and ceremonies (Prins, 1996). According to Biard (1886), "They accepted baptism as a sort of sacred pledge of friendship and alliance with the French"(Prins).

Cultural Dynamics

The cultural and political revitalization of the Mi'kmaq people began in the late 1960s. Consequently, many of the women who partnered in this research are old enough to remember the changes wrought by attempts at assimilation, such as the introduction of the 1969 White Paper. This failed attempt prompted the Mi'kmaq, as well as other First Nations across Canada, to establish provincial organizations such as the Union of Nova Scotia Indians and, some years later, the Confederacy of Mainland Mi'kmaq, in order to resist political coercion by the federal government (Prins, 1996).

In the early part of the 20th century, the Mi'kmaq people were outnumbered, economically disadvantaged and socially marginalized. In fact, many did not expect

them to survive as a distinct cultural group. Some even speculated that the long and sustained contact with Europeans had all but assimilated the Mi'kmaq people into western culture. Yet, through cultural resistance as well as retention of some of their ancestral lands, the Mi'kmaq people have survived and even thrived. They have retained much of their cultural heritage and many more are rediscovering the unique and valuable features of their traditional language, customs and spirituality.

Like many others, Mi'kmaq culture is dynamic and as such, elements of that culture have evolved over time. This has important implications in contemporary times, when traditional values have less influence within current political, social, and economic domains, particularly those influenced by the bi-cultural environment, within which many Mi'kmaq people now live (Prins, 1996). Rather than acquiesce to western hegemony and assumed cultural superiority, many Mi'kmaq people have employed cultural accommodation, in which they learn ways to live and succeed in the dominant culture, yet retain their own cultural identity (Paul, 2000).

The Health of First Nations People

With the exception of cancers of the kidney, gallbladder and cervix, overall cancer rates are lower among First Nations people than other Canadians. However, chronic conditions such as lung cancer, heart disease, hypertension, respiratory illness, diabetes and arthritis tend to be higher among First Nations elders than other Canadians in the same age group (Statistics Canada, 1993; Assembly of First Nations, 1999). According to national statistics, the standardized death rate for First Nations people is two times higher than the general population, making the average age of death some 20 years lower than Euro-Canadians. It is important to note that life expectancy is measured through averages and the fact that Aboriginal people die more often from accidents and violence during youth, necessarily lowers the average life expectancy for this group (Waldram, Herring & Young, 1995). A critical examination of the way in which present day statistics are reported reveals the continued portrayal of First Nations people as diseased and sickly, thus reinforcing a colonial stereotype (Royal Commission on Aboriginal Peoples, 1993; Frideres, 1988).

It is especially important to note that the incidence and prevalence of disease varies widely by region (Oakes et al., 2000). For instance, the Atlantic region has the highest rates of diabetes among First Nations people (8.7%), whereas rates of this disease among First Nations in British Columbia and the Yukon are lower than national Aboriginal averages (Lemchuk-Favel, 1995). Likewise, rates of suicide and substance abuse vary depending on geographic region (i.e. isolation) as well as socio-economic status, household size and industrial activity (Royal Commission On Aboriginal Peoples, 1993). In fact, most of the chronic health conditions listed above have been closely linked to inter-related social determinants, including culture. Upon reflection, it becomes clear that the disproportionate burden of morbidity and mortality experienced by First Nations people is associated with adverse economic and social conditions that are inextricably linked to their unique history of colonial oppression (Young, 1984; Kelm, 1998).

The destruction wrought by early epidemics was not restricted to increased mortality and morbidity but extended to alteration of migration patterns as well as diverse socio-cultural changes at the individual and group level. Epidemics affected fertility rates in the sense that many women who survived became infertile and many young people died, leaving fewer potential partners with which survivors could rebuild populations (Oakes et al., 2000). Sometimes, it became necessary to form new groups which blended distinct Nations (e.g.: Cree, Assiniboine and Ojibwa), making it more difficult to define and thereby protect territorial boundaries. Despite the terrible loss of life, the devastation of these epidemics extends far beyond the number of those whose lives were cut short. A missing person becomes a missing piece of the circle, which cannot be simply replaced (Kelm, 1998).

The most recent health profile of First Nations people (including the Mi'kmaq) has been prepared through the First Nations and Inuit Regional Health Survey (FNIRHS) (1999). This survey included an adult sample size of 9,870, with a male-to-female ratio of 41:59. For the purposes of this project, I have focused on health information relevant to First Nations women between the ages of 45 and 65, who are referred to in the FNIRHS as elders. According to the Regional Health Survey (1999), without controlling for socio-economic status, the health profile of elder First Nations women is relatively

poor, compared to the health profile of other Canadian women, as presented by the National Population Health Survey. Table 1 summarizes prevalence rates for health conditions among First Nations and Canadian women in three age groups. Table 2 presents information related to education, self-rated health, co-morbidity and attendance at residential school among First Nations women in three age groups.

Table 1 – Prevalence rates (% of total sample) for health conditions among First Nations (FN) women and Canadian (C) women in three age groups.

	45-54		55-64		65+	
	FN	C	FN	C	FN	C
Cardiovascular Disease	25%	6	12	3	30	18
Hypertension	30	12	37	18	58	35
Diabetes	24	3	33	7	32	8
Arthritis	33	18	45	33	57	45

Table 2 – Health-related information on three age groups of First Nations women*

	45-54	55-64	65+
Education*	18% < grade 6	40% < grade 6	60% < grade 6
Self-rated health as good or excellent	40%	28%	28%
Reported at least one chronic health condition	72%	80%	92%
Attendance at residential school	40%	42%	33%
Co-morbidity of diabetes and cardiovascular disease*	33%	25%	25%

Definitions and Perceptions of Health

In order to understand the health and healing behaviours of some First Nations people, we must appreciate traditional beliefs and perceptions of disease, which may involve the manifestation of disharmony between natural and supernatural realms (Oakes et al., 2000). However, before any attempt is made to describe Indigenous concepts of health, it is essential that we also appreciate language as a foundation for understanding

* Data on education and co-morbidity includes both men and women

the world. Through language, Indigenous philosophies construct the existential whole as a sequence of intra-dependent and reciprocally related domains. For instance, in many Indigenous languages, the earth and nature have been linguistically constructed as processes rather than elements (Leavitt, 1995). In European lexicons, rain is constructed as a distinct constituent of nature, while among many Indigenous languages “the process of water falling from the sky to meet the earth” is more appropriate. (Leavitt; Young, 1984).

Indigenous metaphysics situate the body in a domain in which physical and spiritual realms overlap. Hence, we are individually and collectively shaped by activities in both realms that requires healing which is liminal or “possessed of the ability to move between and among these states” (Kelm, 1998, pg. 84). Complete health is achieved only through harmony with the Creator, family, community and nature (Long & Fox, 1996). This harmony extends to the ancestors as well as the children not yet born, thus symbolizing respect for ancient wisdom and a connection to the super-natural, but also concern and care for the environment that must, one day, sustain our children’s, children’s children.

As a model for understanding health, this paradigm symbolizes the totality of life, encompassing both physical and spiritual realms as well as the domains of introspective thought, feelings, knowledge, enlightenment and wisdom (Long & Fox, 1996). Within this context, a circle is often used to represent the cyclical and dynamic nature of the physical environment, of birth, growth, death and decay, of the mind, heart, body and spirit (Leavitt, 1995). The counterpoise of the circle also represents the duality of Indigenous consciousness, of male and female, of help and harm, of physical and spiritual. Finally, the circle symbolizes the intimate connection between beliefs, knowledge, feelings and actions as well as those between the individual, family, community, culture and cosmos. This paradigm of unity, inter-relatedness and balance, differs significantly from western, Cartesian based notions of health, which deconstruct the whole in order to isolate and examine its individual parts (Long & Fox, 1996).

Healing

To date, there is no conclusive evidence that a gender bias existed in the healing roles of early indigenous cultures. Indeed, an important caveat to any discussion of Indigenous healing is that early Euro-Canadian accounts of the healing practices of Indigenous peoples display a male bias and also demonstrate the observers' disregard for female healing roles as well as their limited contact with First Nations women (Miller, 1995; Waldram et al., 1995).

Beyond conspicuous philosophical differences, the fundamental distinction between the biomedicine of western culture and traditions of Indigenous healing is one of epistemology. Western allopathic medicine tends to fragment and de-personalize healing while emphasizing the diagnosis and treatment of symptoms rather than the exploration of health from a holistic perspective. Biomedicine is empirical, positivistic and skeptical. Young medical practitioners receive brief, intense training in a predominantly written pedagogy and are instructed to employ rigorous testing in a constant quest for new knowledge that refutes past traditions (Long & Fox, 1996).

Conversely, Indigenous healing is time-tested in the sense that it is informed and guided by traditions of the past upon which new knowledge and practice is added. Skilled and knowledgeable individuals teach the next generation. The acquisition of knowledge and experience occurs gradually over the life course so elders are often revered. Elders also figure prominently as living role models, oral historians, teachers, cultural workers, ecologists and environmentalists. The most efficacious feature of traditional healing begins with its definition of illness, which is both socially constructed and culturally defined as occurring in physical, emotional, social and spiritual domains. There is a high degree of individualism and idiosyncrasy in traditional healing, making its practice contextual and dynamic (Waldram et al., 1995).

Indigenous medicine is based on a rational and coherent set of beliefs and practices that were once well integrated within Indigenous societies and served important social and religious as well as medical functions. Indigenous medicine, like every other system of medicine, is also based on a rational understanding of the cause and potential treatment of disease. In general, illness and disease might have a natural origin such as injury or may result from spiritual or social circumstances. Consequently, the central

theme of healing practice is the restoration of physical, social and spiritual constituents of the individual, family, community and nation (Waldram et al., 1995).

The extensive healing practice of Indigenous medicine includes plant and animal preparations, special diet, fasting, meditation, spiritual counselling and dream interpretation. Group ceremonies include sweat lodge, shaking tent, healing circles, powwows, drumming circles, sun dance, workshops and teaching. Traditional plant and herbal medicine, based on a disease theory of natural causation, includes formulas that prevent illness, relieve symptoms and reduce infection (Lacey, 1993). In cases where bad medicine is believed to cause illness, the healing power of a spiritual healer or Shaman may be sought. In general, the most appropriate approach to healing is to seek a healer or healers who can perform the necessary ceremony and/or treatment (Long & Fox, 1996, Waldram et al., 1995).

In many instances, Indigenous healing has been described as “medicine”. However, the division of medicine from spirituality is misleading in that these elements function together to constitute holistic healing (Waldram et al., 1995). No simple dichotomy exists between the natural and super natural; rather there is a metaphysical unity of existence. Within Indigenous healing traditions, illness may be an indication that balance and harmony must be restored in the social order, with treatment often granting individuals an opportunity to evaluate their behaviour. Among the Ojibwa, the cause of major illness was once sought within the web of interpersonal relations in all beings, to the extent that treatment may have included confessing past transgressions (Waldram et al.). In this way, Indigenous healing may have served the additional function of reinforcing the social and moral order, thereby benefiting both medical and cultural contexts.

Prior to the imposition of western medicine, the treatment of everyday illness and injury was common knowledge among most Indigenous peoples so that the services of medical specialists were not always required. Nevertheless, certain individuals within communities possessed special knowledge related to particular healing practices. It was believed that medicine men and women acquired super natural support and direction for their healing activities. A Shaman, however, had the extraordinary ability to enter a deep trance in which he received counselling by spirits that bestowed strong healing power

upon him. Other individuals acquired extensive knowledge of botanical substances and early European settlers, traders and missionaries often sought these Indigenous herbal remedies. In fact, approximately 170 drugs still listed in the *Pharmacopoeia* of the United States have their origins in Indigenous medicine (Waldram et al., 1995).

Originating with the Ojibwa, the Midewiwin or Grand Medicine Society represented one of the only structured religious and medical systems of early Indigenous peoples. One of the unique features of this hierarchical organization was the custom of initiation, apprenticeship and promotion, the last of which occurred only at considerable cost to the practitioner. The fundamental axiom of the Midewiwin was “attitude and conduct produces long life”. Within this basic premise, practitioners’ education included anatomy and surgical procedures. Indeed, “their skill in the care of wounds, fractures and dislocations equalled and in some respects exceeded that of their white contemporary” (Waldram et al., 1995, pg. 82).

Early use of Indigenous healing by Euro-Canadian people might have resulted in an integrated health system, based on conceptions of illness and health that bridged the two cultures. However, the colonial agenda of early Euro-Canadians stifled any cross-cultural medical discourse. In many instances, the practice of Indigenous medicine was defined as witchcraft and/or fraudulent, its practice eventually outlawed and punishable by incarceration (Frideres, 1988; Kunitz, 1994; Waldram et al., 1995). Despite this, many First Nations people continued to rely on traditional healing, although they often required non-Indigenous medicine in the treatment of epidemic diseases for which they had little immunity and few medical resources. It is also not surprising that elements of Euro-Canadian religion and healing were incorporated into Indigenous traditions as early Nations were not “single cult spiritualists”, but readily accepted the notion that others could appeal to those within the spiritual realm for guidance and healing (Paul, 2000).

Recently, medical pluralism, or the use of more than one system, is common practice among people world-wide, depending on their beliefs about the etiology of disease, the need for symptom relief, and their trust in the respective systems. In Canada, Indigenous health practices have become increasingly incorporated into the allopathic medical care system. Provincial governments are beginning to acknowledge the value of traditional healing, re-spiritualization and the renewal of cultural identity. In some cases,

an informal referral system is now in place between physicians and traditional healers in which cultural understandings of health and illness are mutually validated (Kelm, 1998).

Gender and Indigenous Peoples

The examination of gendered experiences within historical, economic, and social contexts has become standard practice among most non-Aboriginal feminist scholars (Greer, 1992; Klein & Ackerman, 1995; Martin, 1992). Yet, we have not been particularly attentive to the Eurocentric paradigms that influence this scholarship. Specifically, among Indigenous cultures, concepts of autonomy, complementarity and egalitarianism may be more useful than those of domination and inequality currently employed in feminist discourse. This is particularly true of issues pertaining exclusively to women in which there is sometimes an implicit assumption that gender issues are the same across cultures. Gender is a highly variable concept that changes across time and culture; this is as true for Aboriginal women as it is for all women. For example, within most Indigenous cultures, family is not the exclusive domain of women but rather the heart of society. Neither is the role of mother inherently subordinate; instead, it represents an essential role in providing for the welfare of the community. This practice is also seen in other cultures, where several people, especially grandmothers, share this role (Berger, 1999; Lock, 1993; Starck, 1993).

Menopause is a gendered issue by virtue of its exclusivity to women. However, women are not a homogenous group and we cannot affix the same gender lens to this process in women of diverse cultures. Culturally bound perceptions of reproduction, gendered social roles, sexuality and relative power must, therefore, form the basis of an analysis of aging and reproductive change among women (Klein & Ackerman, 1995). By way of illustration, the “empty nest” theory makes a number of class and cultural assumptions, the most notable of which is that children will leave a nuclear family at a given age, that being the age at which mothers are traversing the climacteric. In the case of First Nations people, children of mid-life women might range in age from 5 to 35, depending on the age at which their mother gave birth, which might be anywhere from age 15 to 45 (Green, Thompson, & Griffiths, 2002).

Within many indigenous cultures, there exists wide diversity with respect to women and power. For some nations such as those in the Plateau and Sub Arctic regions in Canada, hierarchies are traditionally weak, while others such as the Iroquois, allocate a great deal of formal and informal power to women. Northern Athapaskan and Plains Nations have sometimes been characterized as having higher degrees of male authority, while those from the Northwest Coast form hierarchies based on family and clan affiliations. Theoretically, each distinction frames gender relations in a very different cultural context. If no one has power over anyone, then men do not overpower women so that gender complementarity becomes the norm, rather than gender hierarchy. Even within societies in which males appear to dominate through political power, women often wield informal power in the form of influence (Klein & Ackerman, 1995; Miller & Churchryk, 1994). The diversity of gender relations among Indigenous cultures, by and large, disproves the universal subordination hypothesis and contributes to the debate about relative gender equality in certain band societies. While gender is a central concept of cultural systems, rather than being closely linked to either biology or power, within Indigenous cultures, it is more often tied to egalitarian roles and responsibilities (Klein & Ackerman).

The Consequence of Contact

Over the past 400 years, most Indigenous societies across the world experienced a similar pattern of colonial encounter. Diversity in the detail of these encounters (i.e. duration, location and action) is subordinated by outcomes critical to the lives of those involved and includes themes of conquest and forced assimilation into Western European society. No single First Nation was spared dramatic alteration of economic, political and social structures, nor drastic changes in disease patterns and general health (Klein & Ackerman, 1995).

Subsistence represents a critical component of national health and a lack of access to land soon became reflected in the increasingly poor health of Indigenous peoples. Prior to colonization, Indigenous groups moved locations regularly to ensure hygiene, access to resources and social order. With the reserve system, seasonal dispersal of small family groups became confined to one location year-round (Kelm, 1995). In general, these reserves were insufficient to sustain food production through either agriculture or

ranching and these relatively small tracts of land typically lacked access to water or sewage disposal. Water rights and services were often contingent on meeting Euro-Canadian needs first, which, when combined with over-crowding, facilitated the spread of disease on reserves. Despite external forces, culpability was placed with Indigenous peoples, believed to be resistant to adopting European modes of living (Waldram et al., 1995).

The early intrusion of white settlers and the conversion of traditional hunting territories to pasture land severely restricted Indigenous peoples' access to established resources. Encroachment and mechanization also frightened game away, while unscrupulous trappers stripped traditional lands of fur-bearing animals. Many forms of Indigenous hunting and fishing were banned in the interests of growing western capitalism (Waldram et al., 1995). In fact, most government regulations appear to have been designed to support capitalist industry at the expense of Indigenous self-sufficiency. The demise of the fur trade and ever-increasing restrictions to reserve land, forced many First Nations people to engage in wage labour. However, racially discriminatory hiring and wage practices meant that they existed on the margins of Euro-Canadian society, often in abject poverty (Kelm, 1998; Lemchuk-Favel, 1995; Waldram et al.).

According to Kunitz, "Contact induced diseases were as much a prelude as an aftermath of European domination" (1994, pg. 8). Smallpox, measles, whooping cough, tuberculosis, diphtheria, typhus, yellow fever, influenza and dysentery represented diseases to which Indigenous peoples had never been exposed, thereby leaving them defenseless through either biological or medical means. Devastating epidemics decimated entire populations, spreading through trade routes or in advance of the colonizers, often carried by people fleeing before them (Oakes et al., 2000; Kunitz).

Early western medical aid to Indigenous peoples became immersed in an agenda that sought to justify and sustain Canada's colonial relations with the First Nations (Kelm, 1998). The Indian Act of 1876 directed the Minister of Indian Affairs to create and enforce regulations regarding the suppression of communicable disease, reserve sanitation as well as the provision of medical treatment and health services. However, the Indian Act was more permissive than directive with respect to obliging Indian Agents to appoint doctors or the federal government to assume financial responsibility for health

services. In fact, the federal government refused to accept legal obligation to provide health care to First Nations people, despite the widespread, albeit capricious and sub-standard care of First Nations people by government doctors (Waldram et al., 1995).

For the most part, early Indigenous health policy was based on notions of racial superiority, assimilative goals and the irrational fear of inter-racial contagion. Disease prevention initiatives sought only to minimize the colonial burden of sick Indigenous peoples and to contain disease, thereby protecting Euro-Canadian people (Kelm, 1998). With the exception of Treaty 6, which had an explicit provision between the Blackfoot Nation and the federal government, First Nations people in most provinces were given the impression that medical services were a treaty right because they often received care when required as well as from doctors who accompanied Indian Agents distributing annual funds (Kelm; Waldram et al., 1995).

Although they remained unconvinced of the universal efficacy or superiority of non-Indigenous medicine, Indigenous peoples soon recognized the need for this medicine to cure European diseases. This practical rationale was coupled with its symbolic meaning of acceptance into what First Nations people considered a pluralistic society; one in which they thought to function without encumbrance as respected, Indigenous peoples, not assimilated members. As medical pluralism became established practice among Indigenous peoples, early missionaries and doctors were frustrated in their goal to reconstruct Indigenous bodies according to medical paradigms and to wrest them away from their spiritual healers (Kelm, 1998).

In fact, non-Aboriginal medicine played a key role in the colonization of Indigenous peoples by virtue of the rationale given for involvement in their lives and intrusion into their bodies (Kelm, 1998). Medicine was instrumental in not only shaping ideas about Indigenous peoples and their communities but in perpetuating a medical discourse that described them as inherently pathologic, making the provision of health care a colonial obligation. Health could only be guaranteed through assimilation and Indigenous bodies soon became sites of a pitched battle between missionary doctors and traditional healers, with Indigenous souls representing the ultimate trophy (Kelm).

Colonial and assimilationist agendas were often couched within the vernacular of Christian humanitarianism. Medicine was seen as “one of the most effective agencies in

spreading the glorious Gospel of the Blessed God” (Thomas Crosby, 19th century Methodist missionary) (Waldram et al., 1995, pg. 104). Moralizing and humanitarianism became the framework upon which the colonial project was constructed and missionaries were granted the “right to rule” through good deeds, with medicine symbolizing “humanitarian domination” (Kelm, 1998).

The colonial partnership between religion and government was formalized in 1867, when churches were given control over education and residential schools became the primary instrument of assimilation. The ideology, which provided a rationale for these schools was rooted in the notion that Indigenous peoples required physical as well as spiritual healing. Colonial education was designed to support and facilitate economic and social transformation as well as to eradicate Indigenous family and kinship structures (Kelm, 1998; Miller and Churchryk, 1996). Children were removed from their home communities for extended periods of time, thereby disrupting social networks and cultural influences. Attempts were made to indoctrinate them into a system, which stripped them of their Indigenous identity and transformed them into second-class Canadian citizens and low-wage labourers (Kelm).

With few exceptions, residential schools were poorly funded and under-staffed, which meant that children were often poorly fed, ill-clothed and over-worked. Tuberculosis (TB) was rampant in many schools, its spread often facilitated by the appalling conditions. Children frequently returned to their home communities infected with TB, spreading the disease to others. In 1907, the Department of Indian Affairs (DIA) reported that in the previous 15 years, between 25 and 35% of students had died, mostly from TB (Waldram et al., 1995). In the early 1900s, then DIA Deputy Minister, Duncan Scott stated that 50% of First Nations students never lived to “benefit” from the education they received. While many parents objected to the absence of their children from home (sometimes for as long as 10 months a year) and the harsh conditions, in withholding their children from school, they often risked imprisonment (Assembly of First Nations, 1999; Kelm, 1998).

Within the walls of residential schools, Indigenous languages, customs and dress were forbidden and children often paid a terrible price in the form of harsh physical punishment for small or unwitting infractions. The legacy of sexual abuse also clings to

many First Nations men and women who were forced to attend residential school as children. Despite all of the physical and psychosocial hardships endured by individuals, the greatest loss is to entire Indigenous cultures, languages, stories and spirituality, which may never be fully restored (Kelm, 1998; Knockwood, 1991).

Indigenous Gynocracies

Present-day, Indigenous cultures represent diverse social systems, some which were and are more women-centered in ideology than not (Gunn-Allen, 1986). In fact, prior to contact with Europeans, gynocracy was the primary social structure among several Indigenous cultures that “are as yet unmatched in any contemporary industrial, agrarian or post-industrial society on earth” (Gunn-Allen, pg. 212). Gunn Allen claims that feminist notions of power as it ideally accrues to women finds its roots in tribal societies. The most distinguishing characteristic of gynocratic tribal people is the centrality of women to social well being. In particular, gynocracies are characterized by matrilinearity, matrilocality, matrifocality as well as maternal control of production. Among the clan-based societies, membership was dependent on matrilineal descent. To know your mother’s line was to understand its attendant history, traditions and place in the world as well as your own reality, significance and relationship with the universe (Gunn-Allen). The traditional model of many First Nation societies depicts women as central and the distribution of power as egalitarian. Elderly women were honored, respected and protected as the primary social and cultural resource and ideals of beauty did not exclude gray hair and wrinkles (Gunn-Allen).

The deference and authority granted to women, however, did not sit well with patriarchal colonizers and the assault on gynocratic systems was waged on sacred and secular levels (Carter, 1997; Gunn-Allen, 1986). In some cases, missionaries attempted to displace females as creators of life and replace them with a male creator or “Great Spirit”. Secondly, the deprivation of an economic base led to dependence on white institutions in which male dominance prevailed. An example of this influence may be found among the Montagnais-Naskapi of the St. Lawrence Valley, who underwent re-socialization by missionaries. They convinced First Nations men that women had no

place in tribal politics and should be at home, under the authority of men, who should, in turn, be under the control of priests (Gunn Allen).

Early ethnographers further accommodated a sexist agenda by excluding Indigenous women from the historical record or providing only the most cursory description of their lives. In their reports, ethno-historians often assigned male gender to leaders regardless of their actual gender. This false record reinforced patriarchal beliefs about the inferiority of First Nation cultures as a less evolved state of patriarchy. To date, Aboriginal studies continue to represent the biases of patriarchy in attempting to re-contextualize the traditional features of gynocracy so they appear patriarchal (Gunn-Allen, 1986). For instance, women's control over the production of non-food items is not made explicit. Rather, these tasks are described as menial and beneath the abilities of male hunters (Morrison & Wilson, 1995). Through the oral history of Indigenous peoples however, we learn that women played a vital role in social and economic life. Critical, female-controlled sustenance activities included hunting small game, fishing, gathering food stuffs and products used in shelter and food preparation, preserving meat and other food, making clothing, utensils and equipment, assisting in building shelters as well as looking after camps, children and elders. Some suggest that, unlike the solitary work of men (primarily hunting), women worked communally, thereby enhancing their collective power (Cruikshank, 1979; Miller & Churchryk, 1996).

Menstruation

As a prelude to a discussion of menstruation and Aboriginal women, I feel compelled to emphasize the way Euro-Canadian anthropologists have misinterpreted the so-called "menstrual taboos" of some Indigenous cultures. In many cases, menstrual proscriptions have been described as being based on beliefs about the contaminated nature of menstrual blood in general and menstruating women in particular (Rathus, Nevid, Fichner-Rathus, & Herold, 2004). Non-Aboriginal anthropologists believed that menstruating women were barred from ceremonies and segregated because they were considered unclean or spiritually unfit (Gunn-Allen, 1986). The inaccuracy of this rendering provides yet another example of the ethnocentricity of some non-Aboriginal

researchers and the negative light this bias casts upon the beliefs and practices of Indigenous societies (Kelm, 1998).

Throughout much of pre-contact history, the relative strength and equality of women framed the structure of gender relations within Indigenous societies from the Pomo of California to the Mi'kmaq of Atlantic Canada. Among many cultures, the womb was considered a source of power that women carried within their bodies, which did not diminish with time. In fact, old women were believed to be most wise and powerful. This power transcended mere biology to encompass thought, healing and spiritual communication. "Among [these] tribes, the occult power of women, inextricably bound to our hormonal life, [was] thought to be very great; many hold that we possess innately the blood-given power to kill with a glance, with a step, or with a judicious mixing of menstrual blood with somebody's soup" (Gunn Allen, 1986, pg. 47). Among the Pomo of California, medicine women could not practice until they had reached a level of maturity in which life experiences had concentrated their power so that its diffusion did not interfere with control of their healing (Gunn Allen).

Within many indigenous societies, menstrual blood was considered sacred and often referred to as "the water of life". Within these traditional cultures, sacred often implied taboo. In this case, blood was ritually empowered to further empower or to destroy and must not be approached or touched by those weaker, lest they suffer. The exception being women who were themselves imbued with blood and who were by way of its sacredness, powerful (Gunn-Allen, 1986). Women at the peak of their fecundity were believed to possess power greater than that of men. In fact, male shamanistic power could be overwhelmed by the presence of a menstruating woman. Conversely, many important ceremonies could not take place without women present (Gunn-Allen).

The segregation of men or women was usually dependent on individual ceremonial traditions, some requiring virginal, tumescent, mature or post-menopausal women, depending on beliefs about the power and position of women within the phases of womanhood. These practices were derived from tribal views of reality, rather than male-dominated views imposed on women. Some taboos concerned only the activities of men, including a prohibition against the presence of men near drying roots (Cruikshank, 1990). Among Northwest coast Nations, a female shaman with Salmon Power was often

called upon to persuade salmon to return to a specific fishing territory. Among other groups, a menstruating woman might be employed to drive deer in the direction of the hunters. In many cases, women did not have to wait until menopause to begin healing activities (Klein & Ackerman, 1995).

The power of menstruating women was controlled through various proscriptions concerning their behaviour. One of the most widespread practices was the use of a menstrual dwelling, separate from the main living space and used exclusively by the women of a distinct family. It is important to note, once again, that this restriction represents a single component in a constellation of social prohibitions that were not confined to women. For instance, among the Nations of the Plateau, various activities could disturb the power attracting salmon upstream, including the presence of someone who had recently lost a family member or a man expecting his first child (Klein & Ackerman, 1995).

Among the First Nations people of the Yukon, menstruating girls were forbidden to step over their brothers or to wash their clothes with boys' because these activities would destroy a boy's strength, especially while he was maturing. Some of the Plains tribes did not permit women to cross the path of a hunter, for fear her essence would frighten away the game he might encounter (Gunn Allen, 1986). In many cultures, upon reaching puberty, men often sought power through a vision quest. During this ritual, a young man would go out into the wilderness in search of an animal guide that would grant him spiritual power and wisdom throughout his life (Leavitt, 1995). This quest for external power was not deemed necessary for women because they possessed innate power through their ability to produce life as well as the essential materials of human existence. Men, on the other hand, possessed only physical power to supply the raw materials of life in the form of semen or slaughtered animals (Klein & Ackerman, 1995). Some theorists propose that this belief in the disparity of male and female spiritual power provided a mechanism for balancing the disparity in their physical power (Klein & Ackerman).

Many Indigenous women took great pride in their stoicism, particularly during labour and delivery with many returning to their work within days of giving birth (Cruikshank, 1979). Among women of the Yukon, young women underwent a period of

exclusive training during menarche and puberty. In a special camp, erected some distance from the main camp, a young woman would stay in the company of other women and would undergo instruction and rituals designed to develop her moral character and strengthen her work ethic. A special diet of tough meat and berries was meant to ensure that she remained strong and hardy throughout life. This was one of the few times in her life when a woman received individual attention and was likely the only time she was isolated from her community. At the end of this training period, the entire community participated in a celebration to welcome her back as a woman (Cruikshank, 1990).

Colonialism and Indigenous Women

According to Carter, Indigenous “women [have] not always [been] free to project their own images or identities, nor [have they been] free to author their own text fully” (1997, p. xv). On the whole, Indigenous women have been ignored in past and present accounts, while attention has remained rather narrowly focused on the experiences of a genderless Indigenous people. When accounted for in the early historical record, Indigenous women were typically portrayed as virtual slaves or beasts of burden. Later, as the encroachment of white settlers and the depletion of natural resources led to contentious relations between Indigenous peoples and colonial society, Indigenous women were depicted as the antithesis of white women in both their moral and physical conduct, often being cast as treacherous and depraved perpetrators of evil (Carter).

Indigenous women are presently engaged in an internal and external struggle to redefine themselves based on the wisdom and rituals of traditional societies. This process involves the re-emergence of traditional images of feminine power in place of western, deprecating sexual/fertility images as well as rejection of reductionist, dualistic perceptions of reality, which separate women’s biology from their spirituality. In this way, Indigenous women are advantaged over western women in that, positive female images form part of their traditional mythos (Gunn Allen, 1986).

The process of European colonization has been particularly deleterious to the health of Indigenous women. Loss of many traditional customs and beliefs, due to colonial oppression, is associated with loss of self. For example, colonialist powers often imposed changes in leadership roles within communities, which eroded many

matrilineal cultures by advocating for women to be disregarded and disrespected. Missionaries, within the context of “healing” Indigenous bodies and souls, attempted to reconstruct families according to a nuclear, patriarchal model, detrimental to the autonomy of women. Colonial education also promoted a rigid male hierarchy that consumed traditional Indigenous family and kinship structures while attempting to transform women to suit European gender norms (Dion Stout, 1999; Royal Commission On Aboriginal Peoples, 1993).

Colonialism also brought about changes in the pattern of women’s work. Prior to contact, small group life favoured co-operation and continuity between generations. Within this system, women played a central role in the social life of communities and families. Gender relations in most Indigenous cultures were egalitarian, with women and men often performing complementary subsistence activities. However, depletion of resources, restricted access to traditional lands and adaptation to reserve life severely disrupted established social structures (Miller & Churchryk, 1996).

Prior to European contact, most Indigenous women maintained equal status within their communities, often reflected in their representation as notable political constituents. The Great Law of the Iroquois provides an excellent example of the centrality of female energy in decision making and economic power. Article 22 of the Law states that “the lineal descent of the people of the Five Fires (the Iroquois Nations) shall run in the female line. Women shall be considered the progenitors of the Nation. They shall own the land and the soil. Men and women shall follow the status of their mother” (Gunn-Allen, 1986, pg. 36). Among coastal Algonkians, women often held leadership roles and were able to inherit chiefly office, often being referred to as Sunksquaws (queens) (Gunn-Allen). With the imposition of the Indian Act, however, came the intrusion of a patriarchal system that altered traditional political customs and social practices. The Act imposed regulations that restricted First Nations women’s rights of inheritance and post-marital residence as well as access to land, resources and housing. During this de-gynocratization of Indigenous, women were “buried under the weight of class hierarchies, male dominance, war and loss of their homeland” (Gunn-Allen, pg. 38). The legacy of the Act’s exclusion of women is evident in enduring inadequacies in educational and employment opportunities as well as poor representation

of women in First Nations organizations and self-government discussions (Royal Commission On Aboriginal Peoples, 1993).

The health of Indigenous women continues to reflect “multiple jeopardy” within economic, social and political domains. According to Health Canada’s First Nations and Inuit Health Branch (1999), First Nations women experience much higher rates of diabetes and circulatory disease as well as all types of accidents, suicide and homicide. As well, age adjusted death rates from cervical cancer higher among First Nations women than Euro-Canadian women in Canada (Population and Public Health Branch, 1998). The Department of Indian and Northern Development’s (DIAND) 1996 profile of Aboriginal women reported that in 1991, 15% of Aboriginal women were unemployed, compared to 9.9% of non-Aboriginal women. This rate is even higher for women living on reserve (26%), where sources of income are primarily government transfers, part-time employment and low paying jobs (Dion Stout & Kipling, 1998).

Ideally, the preceding review of literature provides some context to an examination of First Nations women’s mid-life health. One notable gap in this literature, which First Nations authors have attempted to fill, relates to the strength, resiliency, and diverse capacities of First Nations women (Buck & Gottlieb, 1991; Klein & Ackerman, 1995; Miller & Chuchryk, 1996). I am pleased to say that these capacities also became evident in the findings of this research, which will be presented and discussed in later chapters. The following chapter describes the methodological approach, methods and analysis strategies employed in this research.

CHAPTER THREE: METHODOLOGIES AND METHODS

Definition of Terms

In order to adequately explain the experiences reported by the women in this study, I did have to reach some conclusions about how to reference biochemical and physical changes, which transpire during women's mid-life transition. Therefore, when referring to those times, events or processes, I have used the root term *menopause*. However, when referring to the mid-life transition of women, which includes peri and post menopause, I have used terms such as the *change of life*, *mid-life transition*, or *mid-life experience*, which more adequately illustrate the multiplicity of change occurring in women's life during the years preceding and following menopause (Ballard, Kuh & Wadsworth, 2001). The terms *research partners* or *participants* has been used to indicate the women who shared their perceptions and experiences for this study.

Purpose

The purpose of this research is to explore the perceptions (physical, psychological, emotional, social, and spiritual) of mid-life health, with particular emphasis on the menopausal transition among mid-life Mi'kmaq women. In particular, my objective was to gain an in-depth, holistic description of the mid-life transition from a First Nations' perspective. The ultimate goal of this study is to provide an account that evokes "verisimilitude" (being there) in readers with respect to the experiences of research participants (Creswell, 1998). This position is based on the assumption that "if we can appreciate each other's views, we can see the whole picture more clearly. To heal ourselves or to help heal others, we need to reconnect magic and science..." (Hammerschleg, 1988, pg14).

Introduction

The study of Aboriginal health is unavoidably imbued with cultural assumptions, contradictions and consequent dialectic tensions. By virtue of its multifarious nature, the study of health is interdisciplinary, often combining the perspectives and methodologies

of epidemiology, anthropology, sociology, psychology and philosophy. Similarly, the multi-factorial nature of menopause made this study especially conducive to interdisciplinary inquiry that combines the principles of both basic (knowledge generating) and applied research (Mays & Pope, 1995). This study represents basic research, in that the findings contribute to knowledge sharing within academic communities. Specifically, the findings provide a description of mid-life change, as seen through the eyes of Mi'kmaq women, that contributes to the development of theory. The findings also possess utility in terms of generating recommendations that may influence professional development for health care providers, as well as the development of culturally appropriate educational materials, activities and programs directed toward First Nations women.

In addition to my ontological assumptions and epistemological perspective, my own life experiences, knowledge of menopause as well as skills related to the research process and the resources at my disposal have distinguished my "system" of research from others (Patton, 1990). The specific features of my inquiry were also dependent on the questions I chose to ask, the methods I chose to employ and, while certain individuals consented to participate, the population from which to I chose to solicit that participation. Consequently, it is essential that I make explicit my research agenda, perspective, assumptions, and reflections (Patton, 1990).

Paradigmatic Perspective

The paradigmatic framework for this research observes the ontological and epistemological assumptions of constructivism, which advocates the existence of multiple realities (Guba & Lincoln, 1994). This naturalistic ontology also implies that reality does not have meaning in isolation of the context within which it is experienced and that the act of observing influences that which is observed. It further supports the notion of a complicated and reciprocal configuration of reality, rather than one of simple cause and effect (Guba, 1990). This ontology parallels Indigenous beliefs about the multiplicity and inter-relatedness of reality. My research identity involves acceptance of complex, multiple realities, which are more thoroughly revealed through holistic inquiry. It is also

my estimation that the ultimate goal of this inquiry is a degree of understanding “*verstehen*”, rather than prediction or control (Patton, 1990).

Constructivism – My Evolving Gaze

During the latter stages of my analysis, I happened to be talking with a colleague whom I greatly admire and respect. During our conversation, I revealed my dismay at the relative mediocrity of my Master’s thesis as well as the disturbing clarity of this hindsight. Her response put into words what I had only, until that time, experienced as a vague shift in my perspective. “A useful thesis is often an incidental bonus of graduate work”, she replied. “The real product is a more sufficiently skilled researcher.” I pondered that statement for weeks, marveling at the clarity with which it described my own growth.

It has been my experience that philosophical discussions of methodology generally include a reiteration of some abstract literary articulation, which graduate students typically fail to fully understand – so I thought I’d try something different; my own interpretation of constructivism, from my own subjective reality. I found this process helpful in not only clarifying the process for myself, but so that others understand the position I have taken with respect to my approach to research in general and analysis in particular.

Reality is a product of multiple human constructions, woven from the fibers of individual and collective context, perception and action. Each construction evolves over time and exists for as long as it is useful or until a new construction takes its place as a more reliable or relevant representation of reality. Relativity is transformative and transactional. More simply put, each interaction represents a new negotiation, which creates the context, text and sub-text of human understanding, which is thus experienced within existential and embodied domains (Guba & Lincoln, 1994).

As a researcher, I am challenged to present a stable construction, (while acknowledging its fluidity) which defines and refines reality from the perspective of research partners and myself. My task is to interpret constructions through a process, which considers the entirety of human reality in relation to the minutia of human existence and lived experience. This hermenutic process involves careful consideration

and sharing of my discoveries, in an effort to distill a construction, which gains sophistication and relevance through reflection and consensus. It is important to note, however, that any understanding of this text is interpretive. Therefore, my aim is to provide a glimpse of women's reality by emphasizing the context, text and sub-text of their experience as it was presented to me.

The most notable element of my evolving perspective has been the specific contribution made by the women who shared their stories with me. During the process of talking and listening as well as reading and thinking, I have come to understand that, beyond acknowledging the social construction of reality, we must accept its plurality. What follows is an attempt to explain this newly-formed constructivism; a perspective that not only seeks subjectivity but one that turns a full 360 degrees in its inquiry of the phenomenon I have chosen to examine.

My evolving conception of constructivism, within the context of menopause research, involves the acknowledgment that life is literally and figuratively about flesh and bone. Flesh is transient and unstable without its connection to the supportive structure of bone. Bone gives substance to flesh and provides a template, upon which it grows and is nurtured. My challenge has been to distinguish the "bones" of women's lives, while maintaining the "flesh" of subjective experience. Yet, this transformation must never be complete, for First Nations women would no longer see their lives reflected in the pages I have labored over. In remaining tied to the "flesh" of the grandmothers' stories, however, I risk criticism from those who believe that my conceptualizations should take precedence over those of the women – a position I fervently oppose. So, we have woven this story together – it is a blending of women's words and emic (insider) understandings with my own academic postulations and etic (outsider) hyperbole.

Within western philosophy, the origin of pluralism can be found in the writings of Christian Wolff (1679-1754), who initiated what is now a centuries-old debate about the utility of discovering truth within contradictory positions for the same concept. Arguments in favour of pluralism hold that traditional notions of consensus, particularly in terms of truth, are rigid and self-limiting. Philosophical diversity (i.e. pluralism) embraces divergent responses to a given question or issue, some of which might actually

be contradictory (Rescher, 1993). This philosophical position represents the basis of my analysis and interpretation as well as the foundation upon which many of the participants appear to understand life and approach mid-life change.

In an effort to present the plurality of women's experience, I attempt to engage multiple lenses, thereby sharing a vision that is multi-dimensional as well as transparent with respect to the perspectives that shaped its focus. I believe this pluralistic vision not only fits the interdisciplinarity of my research but also matches the plurality with which First Nations women view their world of experience. This multiplicity notwithstanding, the most critical point I wish to make in prefacing my presentation of the findings is that my interpretation and tentative understanding of women's reality represents a circular process that might never end, except that the protocol of my inquiry requires some termination of iterations, for the purpose of sharing my insights with others.

Epistemological Perspective

My research identity as explorer of others' realities and the subsequent premise of this research situates me within the subjective domain of an epistemological continuum. This position also forms the basis of Indigenous philosophies regarding knowledge and healing. From this epistemological position, I fashioned a research design, which reflects my conviction that the relationship between those who possess information and those who pursue and would procure that information is interactive and irreducible (Guba, 1990). I present myself as a fully engaged learner whose primary goal is to conduct an inquiry that provides a contextually rich and in-depth account, the findings of which may also contribute to the development of theory, policy and practice.

Methodological/Theoretical Approach

Qualitative Methods

During the past 30 years, there has been a notable emergence of menopause research. While creating a new knowledge base from which to inform programs, services, and medical techniques for mid-life women who are experiencing difficulty, this research has focused primarily on the patho-physiology of “estrogen deficiency” and the functional capacity of the aging ovary (Greer, 1992; Martin, 1992). As such, the preponderance of menopause research has been limited to clinical studies and, to a lesser extent, cross-sectional surveys. Although this type of quantitative research describes an important component of women’s reality, it does little to facilitate a full interpretation of its meaning in their lives. One of the principal limitations of epidemiological and clinical studies is that, while researchers may present data that are quantitatively authentic, they are unable to identify and understand the broader meaning attached to data or to take into account the everyday lived experiences of those from whom they are extracting information. Ironically, these methodological approaches tend to decontextualize and therefore limit our understanding of the very processes that most affect health.

More recently, researchers have begun to use qualitative methods to explore this uniquely female process from the perspective of the women who actually experience it. Creswell describes qualitative methods as representing “an inquiry process of understanding based on distinct methodological traditions of inquiry that explore a social or human problem. The researcher builds a complex, holistic picture, analyzes words, reports detailed views of informants, and conducts the study in a natural setting” (1998, p.15). Qualitative methods provide greater depth in terms of how these experiences are knit into everyday life. In taking account of social and cultural contexts, qualitative methods may lead to enhanced understanding of individuals’ experiences from their own perspective (Dickason, 2000). Strength lies in the qualitative researcher’s ability to generate rich and detailed information about the everyday life of individuals; ideally, leaving their unique perspectives unaltered.

My account of Mi’kmaq women’s perception of mid-life change includes both an *emic* (that of the women) as well as an *etic* (that of myself) perspective (Denzin &

Lincoln, 1994). Inclusion of an endogenous (or, in the case of Mi'kmaq women, Indigenous) view, in the form of women's own expressive language, better reflects their unique perspectives (Creswell, 1998). In addition to presenting the local knowledge of my research partners, I attend to the tacit knowledge they conveyed through their interaction with me (Guba, 1990). In doing so, my report presents a more authentic account of their respective realities and illustrates my esteem for the women who partnered with me in this research (Vidich & Lyman, 1985).

Research Identity

Selection of naturalistic inquiry reflects my preference for exploring phenomena about which relatively little is known or that have been “over-researched” from the perspective of a particular methodological tradition (Morse & Field, 1995). Although I value the work of quantitative researchers and their efforts to test hypotheses that are based on established theoretical frameworks, I prefer the application of qualitative methodological principles. This includes the use of inductive analysis to support the development of “working hypotheses or extrapolations” (Patton, 1990) that are empirically grounded in the patterns and relationships of contextually rich data (Creswell, 1998).

The title of qualitative or naturalistic researcher also reflects my preference for gathering narrative information in an environment that is familiar and comfortable to my research participants. My qualitative approach to research is accompanied by my presumption that reciprocal human interaction represents the most appropriate and effectual method with which to gather information about women's experience. Whether seated in a community kitchen over lunch and tea or in the circle of a healing lodge, I humbly solicited entry into the lives of Mi'kmaq elder women, thereby inheriting an intimate familiarity with both the substance and context of their lives.

In acknowledging and anticipating the inter-subjective nature of my relationship with research participants, I recognize these women as “more than data sources and [myself as] more than [a] data-collecting instrument” (Mitchell & Radford, 1996, p.52). However, I also acknowledge that human instruments and processes are “bound” by a host of individual and contextual values, beliefs and behaviours (Patton, 1990). Indeed,

the role of values in qualitative inquiry is such that this process is virtually "value-bound" (Guba, 1990). Consequently, I have been required to address, interpret and report the specific value contexts of this research in my analysis.

Design

The emergent nature of qualitative inquiry necessitated the development of a research design that accommodates the multiple realities of and unpredictable interactions between research partners. The flexibility of my design was evident in its emergence throughout the research process, which included minor modification of the discussion guide and process, in response to my interaction with research partners and their respective needs (Guba, 1990). Available resources in the form of time, technology and funding as well as my skill as a researcher and the patience of my research partners and committee members shaped the ultimate design of this study, the elements of which are described below. The overall design represents an amalgamation of diverse (Indigenous and Eurocentric) methodological principles.

Ethnographic Principles

The practice of culture, a uniquely human construction, endows the world of cultural participants with symbolic meaning. According to Berg (1995), ethnography is the work of describing culture. Ethnography has been conceptualized in various ways by a number of experts and often includes "the study and analysis of indigenous peoples' viewpoints, beliefs and practices... behaviours and processes..." (Leinger, 1985, In Berg, p.38). Ethnographic approaches contextualize and emphasize the social and cultural meaning of experiences. Ethnographic methods involve talking to people about how they experience the world, how they understand and organize their behaviour and how they go about living their lives (Berg).

Many aspects of this research fit within a general ethnographic framework because the design involved components essential to understanding mid-life health and the peri-menopausal transition from an Indigenous perspective. It also placed me in the midst of those with and from whom I gathered information (Berg, 1995). This research fit best within the framework of micro-ethnography in that it focused on a particular and

salient element in the lives of a distinct group of women (Berg). My offering is descriptive in terms of the “real” world of mid-life Mi’kmaq women, as well as analytic in the sense that I propose a potential extrapolation of beliefs, attitudes and experiences that might be shared by other First Nations women. These suggestions are based on current, albeit limited, written information about the historical traditions of Indigenous peoples.

The research design’s embrace of ethnographic principles assisted me in emphasizing distinct norms, beliefs, attitudes, and behaviours that form the cultural context of Mi’kmaq women (Patton, 1990). This enhanced cultural understanding emerged from sustained contact with women in diverse First Nations in Nova Scotia. In addition to repeated meetings with women who agreed to act as community facilitators, I facilitated each group discussion as well as socialized with participants before and after groups. During the course of this study, I also established relationships with many of the community facilitators and participants, the outcome of which is my continued collaboration on community projects. During the past three years, my participation as a member the Mi’kmaq Health Research Group and, more recently, the Atlantic Aboriginal Health Research Program as well as my work with the Canadian Aboriginal AIDS Network has provided me with many opportunities to observe and learn about Aboriginal cultures in general and Mi’kmaq culture in particular.

Participatory Practice

Historic and current information suggests that there has been an absence of political will, on the part of the federal government, to facilitate social justice, self-determination and self-reliance among First Nations people. The proposed 1969 assimilationist policy, sometimes referred to as the “White Paper,” triggered an Aboriginal political movement, which included participatory research, as a force for progressive social change (Dickason, 2000; Jackson, 1993; Park, Brydon-Miller, Hall, & Jackson, 1993). Participatory research has since been conducted under the auspices of the Aboriginal people’s movements in general and by several sub movements in particular (e.g. status, non-status, Metis, Inuit, women and urban). However, participatory research has yet to be adequately utilized in the area of First Nations health.

Until very recently, First Nations people were not invited to participate in health research beyond their role as data sources (Dickason). However, opportunities, such as those provided through the Canadian Institutes for Health Research – Institute for Aboriginal Peoples' Health, are building capacity among Aboriginal researchers as well as within Aboriginal communities to pursue research that is culturally appropriate and meaningful (Canadian Institutes for Health Research – Institute for Aboriginal Peoples' Health, 2004).

Participatory research is intimately linked to Aboriginal philosophies through the value of narrative, local participation, learning through action, collective decision making and empowerment through group activity. This philosophy also embraces participation of diverse senses and capacities, including the physical, emotional, psychological, spiritual and social. The products of participatory research are often self-reliance, consciousness, and the creation of useful information (Jackson, 1993).

Through the use of participatory principles, this study design reflected my deep respect for the intellectual and intuitive capacities of First Nations women (Lather, 1991). Inviting the participation of community women in the recruitment of participants, modification of the discussion guide as well as collection and analysis of data ensured a participatory approach to this research. Indeed, through this collaborative mode of research, I attempted to "distribute power more equitably among the various" research partners (Glesne & Peshkin, 1991, p.100). Nevertheless, there is some diversity in the extent to which women chose to participate in various components of the project. For instance, some women chose to sit in on discussion groups, while others engaged more fully in reflecting on my interpretation of the data.

Feminist Principles

This research design also incorporated praxis-oriented, feminist traditions of inquiry in terms of my focus on accounts of women's realities (Lather, 1991). Specifically, I attempted to (a) encourage an inter-actional exchange through my rejection of the traditional separation of subject and object (i.e. participant's questions were answered in an equal, two-way exchange of information), (b) where applicable, continuously and reflexively attend to the significance of culture and gender, (c) attend to

ethical concerns related to potentially detrimental interpretations of my research findings, and (d) emphasize the empowerment of women by integrating participation and consciousness-raising into the research process (Bowles & DuelliKlein, 1983; Cook & Fonow, 1991; Kirby & McKenna, 1989).

Indigenous Principles

In designing this study, I attempt to incorporate Indigenous epistemologies by acknowledging the wisdom of elders and the value of story telling as a vehicle of teaching, learning, and sharing (Battiste, 2002). The participants of this study favoured group discussions as a means of sharing their experiences and engaging in reciprocal learning and healing. I also recognize that much of my learning came from listening to and observing the women who partnered in this research and not necessarily from the literature that previously shaped my perspective, nor from Eurocentric methodologies that assume the inferiority of experiential pedagogy (Battiste).

Participant Selection

This study included six groups, totaling 42 Mi'kmaq women, ranging from 38 to 83 years of age, from five First Nation communities in Nova Scotia. A number of sampling techniques, including purposive, snowball and opportunistic sampling were employed. Facilitators from each participating community were asked to contact five or six women and invite them to participate in a group discussion about mid-life health and menopause. Each of the facilitators purposefully recruited women who were within the specified age group and who were experiencing or who had experienced menopause. They also recruited these women using snowball sampling (one person suggested another who might be interested in participating) or opportunistic sampling (whoever happened to be available and wanted to participate), or both (Patton, 1991).

According to Kuzel, "in qualitative inquiry, sampling is driven by the desire to illuminate the question under study and to increase the scope or range of data exposed...to uncover multiple realities" (1992, p.33). Therefore, the issue of sample size is secondary to the meanings and theory generated by information rich data (Kuzel). In particular, the findings of this study provide an in-depth description of Mi'kmaq women's

understanding of mid-life health and menopause as well as a breadth of detailed information from women across Nova Scotia.

Initially, I intended to include only women who had experienced “natural” menopause (i.e. no hysterectomy). However, I soon discovered two important things a) “natural” menopause is a construct, which has been defined by those who have not experienced this process and b) if I had attempted to adhere to that criterion, I would have encountered some difficulty recruiting participants. In the course of recruitment, I discovered that a substantial number of First Nations women have undergone at least a partial hysterectomy (removal of the uterus, with retention of the ovaries). I am uncertain about whether this is an outcome of the recruitment strategy used by community facilitators (convenience and snowball techniques), a cohort affect related to the age of these participants, or a reflection of the relatively greater number of First Nations women who undergo hysterectomy. Future research related to this particular issue is warranted.

Upon reflection, it was fortuitous to include women who have undergone hysterectomy. Their exclusion in past research highlights our continued obsession with figuratively “cutting out” women’s uterus for the purpose of studying the effects of estrogen deficiency. The absence of hysterectomized women’s voices in much of the menopause literature implies that they have nothing to say about menopause. This likely emerges from a persistent belief, on the part of researchers and clinicians, that this process is rooted in women’s reproductive organs. In addition to contributing to a more holistic model of mid-life change, which may or may not involve cessation of menses, hysterectomized women provide a window into the relationship women have with their uterus and the significance that organ represents, in terms of women’s self concept. This contribution might inform a model, which acknowledges the socialization of women around their identity in terms of their sexual and reproductive organs.

Within this group of women, the age of natural menopause ranged from 40 to 60, with most falling around age 50. I found it very helpful, to fully understanding this process, to talk with women who are at different stages of the experience. Those just entering peri-menopausal change, could speak most clearly about their expectations, while those in the throes of change could describe their perception of the experience. Women who are post-menopausal were able to reflect on how the experience affected

them and how they had changed as a result of the experience. Very old women represented one of the most valuable sources of knowledge in terms of the historical relevance of this issue and the ways in which our understanding and experiences have changed.

Although the point has already been made in a discussion of the study sample and methods, it is worth reiterating that the experiences of this group of women do not necessarily reflect that of all Mi'kmaq or other First Nations women. Volunteer bias is a particularly important limitation in that women who participated in this study may be those who have experienced some degree of difficulty. However, a substantial number of the women reported few, if any, negative experiences. A more extensive study, with a larger, more representative sample, will be necessary in order to generalize these findings. Nevertheless, they do raise a number of issues regarding the sexual and reproductive health of First Nations women and the need for further research.

Data Collection Strategy

The use of qualitative methods enabled me to gain a more in-depth understanding of Mi'kmaq women's perception of mid-life health and peri-menopause as well as the unique contextual (i.e. personal, social, economic, political and cultural) determinants of those perceptions. To achieve these objectives, group discussions represented a methodologically sound and culturally appropriate approach to gathering information about the meaning Mi'kmaq women assign to menopause, to defining the multiple perspectives that impact their mid-life health experience, and to relating those experiences to the larger social context (Denzin, 1978). Moreover, this qualitative method allowed women to express their own perspectives using their own words, thereby strengthening any theory that has emerged from the data (Patton, 1990). The women who participated in this study were offered the option of participating in a one-on-one interview but all of them indicated a preference for group discussions.

Groups

Group discussion is not always an appropriate method of qualitative data collection (Kreuger, 1994; Mays and Pope, 1995). In fact, cultural sensitivities regarding

certain topics may make group discussion inappropriate. However, in my 1997 study of Black, Mi'kmaq and Caucasian women's perceptions of menopause, I discovered participants' desire to hear and share the experiences of other midlife women through group interaction (Loppie, 1997).

Women should group together...Let's get together and discuss it, see how we feel, what we think it's about.

If we encourage women to get together with their friends...creating groups of women together. Women know how to do that and love doing that, just being together and being supportive...

You could encourage women to do that and could facilitate groups, you could train other people to facilitate groups and spread it around..."

"I think learning from other women, you would see that there's a great diversity of experiences..."

It's an ideal situation...with peer counseling...self-help...an extended friendship network...

(Loppie, 1997, p.166-167)

In particular, the Mi'kmaq women who participated in that study suggested group discussions as an ideal method of engaging women from the community.

...It's more like a talking circle. That's a beautiful way. You can get the community going...(pg. 61)

...As Native women...when we're going through our menopause...[we] go to sweat lodge or to talk in circle. (pg. 61)

...I would like to have a talking circle for some of these women... (pg. 173)

Group discussions represent an ideal method of gathering more data and in this study, provided greater breadth of information about women's perceptions (Kreuger, 1994). Nevertheless, facilitating these group discussions required specific process and facilitation skills (Kreuger; Mays & Pope, 1995). The distinct cultural and geographic features (i.e. communities across Nova Scotia) of this study sample were such that substantial knowledge, time and effort were required to locate and recruit an appropriate

group of research participants. In an effort to address these limitations, as well as to ensure the comfort and responsiveness of participants, I networked with Mi'kmaq community groups across Nova Scotia and recruited community facilitators who are similar to participants in age and ethnic origin (i.e. First Nations ancestry).

Through the use of group discussion as the primary method of gathering information, I hoped to move beyond mere cultural sensitivity, and toward a more authentic form of culturally based research. The basic difference between culturally sensitive and culturally based research is that the former simply attempts to account for cultural diversity, while the latter is grounded in the philosophy of a particular culture (Burger & Boulet, 1991). Group discussion proved to be an ideal method of bringing women together who have previously been neglected in research and providing them with an opportunity to share their experiences in a safe, compassionate, respectful environment that recognized their strength and resiliency, while providing a means of healing and empowering themselves (Dickason, 2000).

One of the things that struck and delighted me most about these women was their capacity for laughter – at themselves and at life. Outside my mother, my aunts and my own sisters, I have not encountered a group of women who laugh so easily. Good-natured teasing and easy laughter made most of these groups a truly enjoyable and entertaining experience.

The process of the groups seemed to encourage discussion of sensitive subjects, as members might have felt less inhibited because others were willing to talk, as well as convey mutual support and develop and qualify their perspectives. Women shared stories of their family and community as well as their life experiences and history. In particular, shared past experiences was particularly important as it created an environment of safety and support (Wadsworth, 2000). The sharing of experiences was informative for many of the women involved, not only in terms of information about menopause but also in gauging their own experience against that of other women. Listening to the stories of other women, often triggered memories and responses or helped women to recall their own experiences (Wadsworth).

Question Guide

The goal of employing a question guide was to provide a framework for participants to express their own understanding of this phenomenon (Mays & Pope, 1995; Patton, 1990). Patton suggests that the utilization of this research tool represents an effective strategy for focusing the interaction of research partners. In an effort to confer some consistency with respect to focusing discussions, I developed an initial semi-structured guide for use during group discussions (Appendix A). This guide served as a checklist of topic areas I wished to explore and took the form of a list of questions for reflection and comment.

The initial research questions provided the basis upon which I developed the preliminary discussion guide. Ideally, this guide provided a systematic and comprehensive framework within which individual women's perspectives emerged (Mays & Pope, 1995). The wording and sequencing of the guide facilitated a flexible and culturally appropriate approach. In particular, the questions were respectful of women's knowledge and were amenable to adaptation to the contextual characteristics of each meeting (i.e. degree of formality, level of prior knowledge about menopause). After generating a list of questions that would elicit the most contextually rich responses, they were sequenced in such a way that general issues precede those more specific to menopause (Patton, 1990; Sheatsley, 1983).

Despite careful preparation of the discussion guide, I made some changes as a result of a review by facilitators as well as feedback from participants (Krueger, 1994). In this way, I ensured that a) the discussion guide was flexible, b) the language was comfortable for participants, c) the issues were clear and meaningful to participants and d) the guide was not culturally presumptuous or biased (Mays & Pope, 1995; Patton, 1987). More importantly, I adjusted my facilitation style to suit the inter-personal context of each group. For the most part, women appreciated a more relaxed, conversational style, which best suits me as well.

Data Collection Process

Strategies for gaining access to this particular population included: acquiring the support and endorsement of each community, networking within each community,

matching the age, gender and culture of recruiters and/or facilitators. It was also essential that I become familiar with relevant cultural values and norms as well as culturally appropriate approaches to research with First Nations people (Berg, 1999). It was particularly important to understand potential barriers to participation, including language – not just those related to linguistics but also to cultural meaning. Similarly, through adherence to the principles of OCAP (ownership, control, access and possession), I attempted to address issues related to distrust of researchers and the research process, skepticism about the value of participation for the community, confidentiality as well as the recent flood of research in First Nation communities, which competes with First Nations women's multiple responsibilities and might have impacted individuals' willingness to participate in the research process (Berg).

After initial consultation with the Mi'kmaq Health Research Group and approval by the Mi'kmaq Ethics Watch (described below), my initial contact was with Health Directors or Community Health Representatives (CHR) in selected communities. If required, I also requested approval to conduct research from the Band Manager or Band Council. During my initial meetings with key informants and facilitators, I explained and discussed a) the purpose of the study, b) the risks and benefits to participating research partners, c) strategies for collecting data and ensuring confidentiality, d) payment of honoraria, e) potential audiences and application of the findings, f) modification of the interview guide, and g) any questions or concerns that arose. I also provided them with a letter that described the study in detail (Appendix B). The process of ethical review and preliminary community visits took approximately eighteen months.

The community facilitators were asked to contact five or six women in their respective communities and invite them to participate in a group discussion. During these discussions, they provided women with information about the purpose of the study, the process of data collection (audio-taped groups) the responsibilities, risks/inconveniences and benefits of participation, assurances of confidentiality, and any additional information potential participants required or requested. Each participant also received a copy of the information letter. Local community centres and health centres were chosen as the most convenient place to conduct the groups; community facilitators and participants negotiated the dates and times. This sharing of decision making power as

well as open communication were critical components of this participatory research process (Kirby & McKenna, 1989).

As a qualitative researcher, I am obliged to establish some level of rapport, confidence and trust with my research partners. By partnering with women who are well respected and well connected in the selected communities, I established some measure of credibility and legitimacy for the proposed project. My research relationship with various community groups began in 1997, when I invited women of diverse backgrounds to participate in my master's thesis research. Through my continued involvement with members of the Mi'kmaq Nation, I hope to develop greater rapport with Mi'kmaq women in the sense that our "relation [is] characterized by harmony, conformity, accord, [and] affinity" (Mish, 1989, p. 1882). Therefore, I continue to receive instruction from these women regarding distinct cultural norms and behaviours, so that my current and future interaction with research partners is sensitive and respectful.

Before each discussion, participants were asked to verify that they understood what the study was about. They were also asked to give their consent to participate in the group discussion and to be audio-taped (Appendix C). For women whose first language is Mi'kmaq, I offered to have the facilitator or another woman from the community act as an interpreter. However, all of the women indicated a preference for conducting the groups in English. In an effort to respect various levels of literacy, I also reviewed the introduction letter and the consent form aloud. Participants were also given the option of providing either written or oral consent. Finally, for those women who did not feel comfortable discussing this issue in a group setting, I offered the opportunity to participate in a one-on-one interview. This was not necessary as all of the women indicated that they felt comfortable participating in the group discussion.

It is sometimes suggested that the provision of honoraria may be construed as unethical inducement to participate in research. Although I attempted to ensure that women were not coerced or unfairly persuaded to participate in this study, I believe that it is important to acknowledge women's contribution to research through an honorarium. Therefore, I offered thank-you gifts (\$50.00 to each community facilitator and \$25.00 to each participant). I also provided hospitality items (i.e. snacks) for each discussion and, when required, I reimbursed travel expenses up to \$10.00 per person.

The time between receiving final ethics approval from Dalhousie and conducting my first group was approximately ten months. A number of factors contributed to this, including the fiscal year-end activities of the reserve communities (February – March) as well as summer vacations (July – August). Perhaps the most important factor was my status as an unknown in the communities. Despite my genetic connection to First Nations people, I have no formal status and neither my family nor I were raised on reserve. The added hindrance of my status as a university researcher, created a barrier to trust that only time and respectful persistence could overcome. Some communities were more receptive than others – these were the first to participate. Yet, my work with the MHRG as well as various presentations about mid-life change and First Nations women enhanced my familiarity with communities and them with me. As a result of my research and presentations, I have been asked to work on other community projects, which I have gladly accepted.

My first group began with a lunch so that I could get to know participants before we began our talk. Some of the women also remained after the discussion, to ask questions about issues that came up in the group. My second group began with snacks and a visit, which also extended beyond the group discussion. The third and forth groups were held at a community center on the same day and were separated by a Christmas tea/lunch. The fifth group lasted most of the day, because a workshop and a supper, at which I was given a lovely woven, sweet grass cup and saucer, followed our discussion. The final group began with a visit at the home of the community facilitator. We also had a light snack and social before that group, at which the women invited me to return for a community workshop as soon as I could.

All but one group agreed to be audiotaped. During this discussion, I took notes and wrote up post-interview notes to capture the main themes. By and large, the women were very enthusiastic about the opportunity to share their experience and to learn more about mid-life change. Our talks were comfortable, relaxed and lighthearted – the women laughed a lot and made me feel very welcomed and most want me to continue to develop a project that would share this information with other First Nations women, particularly younger women.

During the pre-group visits, I told the women about myself; who I am, where I am from, why I was doing the project. Before each group, I also distributed information packages and verbally explained the project, reviewed the information letter and consent form, and gave the women an opportunity to ask questions or discuss concerns. After the consent forms were signed and collected, we began the discussion.

As evidenced in the interview guide (Appendix A), the first question generally created an atmosphere of comfort because it was very general and asked women to talk about what was most important to them. The remaining questions were loosely organized by the guide but mostly by the direction of women's talk. I soon discovered that these women were not in a position to directly answer questions about social determinants, yet much of their discussion about life and change, indirectly and intuitively answered those questions more eloquently than a prepared response.

In keeping with OCAP (ownership, control, access and possession) principles and respect for the role of research partners in the inquiry process, women were asked to talk about: why they decided to participate in the study, what they hope to get out of the discussion, what information they would like to take away from the meeting, and how they would like the research findings to be used and disseminated (Lather, 1991).

Journaling

Throughout the research process, I kept field notes (e.g. observations, memos, etc.) as well as a data collection journal that chronicles such things as materials, time and location of groups as well as physical space required (Patton, 1990). In addition to keeping these records, I recorded my reflective impressions, reactions, and interpretations in a personal journal. These notes include a) feelings about my relationship with various research partners, b) intuition about the meaning of particular conversations, c) comments about the quality of group discussions, responses and observations, d) working models, e) notes about potential avenues of discovery (e.g. data sources, questions, literature), f) possible early links within the data, g) my reactions to others' remarks or behaviour, and h) speculation about the meaning of events or interactions (Miles & Huberman, 1994). After each meeting, I debriefed with the community facilitator and received feedback about the process and content of our group discussions. Although the initial feedback

was overwhelmingly positive, I invited facilitators to forward me any additional comments or questions at any time throughout the study. This feedback has also been positive. In fact, one group was so successful that word spread to another community, in which the women approached the Health Director, requesting that I be invited to conduct a group.

Trustworthiness

Recently, a lively debate has taken place about the relative merit of various approaches to establishing the ‘fitness’ or rigour of qualitative findings. Although a number of likely alternatives have been suggested, I found it useful to employ Lincoln and Guba’s (1990) trustworthiness framework. According to these well-respected authorities, qualitative research designs must address threats to quality in terms of truth-value (whatever we determine truth to be), applicability, consistency, and neutrality. Consequently, in this study, threats have been addressed through research activities intended to improve the quality of findings, thereby establishing credibility, transferability, dependability, and confirmability, respectively (Guba & Lincoln).

Credibility

Guba and Lincoln (1990) describe credibility as a convergence of the actual constructed realities of research partners with those presented by the researcher. I have attempted to ensure the integrity, validity and accuracy of my findings, primarily through the method I selected for gathering data. I addressed further threats to credibility through a) facilitator debriefing, b) negative case analysis, c) progressive subjectivity, d) member checks, and e) prolonged engagement and partnership with community facilitators (Patton, 1990).

The process of prolonged engagement and partnership included initial contact by phone or in person with Health Directors and/or health staff, follow-up packages including all relevant research materials, follow-up phone calls to discuss questions or concerns, preliminary meetings with Health Directors and/or health professionals (three communities), development of partnership agreements, on-going communication with community facilitators in the form of phone calls, emails, faxes, and visits, follow-up debriefing after each discussion group, post-group workshops and group learning

sessions, follow-up packages for feedback on content and analysis, community visits to present findings and receive feedback, as well as plans for future workshops on mid-life change and related issues in participating and other communities.

I established the "provision of reciprocity", suggested by Locke, Spriduso and Siverman (1987) by giving community facilitators and participants an opportunity to review their transcript, my code list and a summary of my organization of data and interpretation of findings. Guba and Lincoln (1989) describe these "member checks" as the "most crucial technique in establishing credibility" (p.239). Finally, I monitored my evolving constructions through a process of "progressive subjectivity", which involved documenting reflections regarding my awareness, attitudes, preconceptions, values, and biases within this document and in a personal journal. Guba and Lincoln suggest that this system of self-monitoring ensures that my constructions do not take precedence over those of my research partners.

Transferability

Guba and Lincoln describe the process of ensuring transferability as one in which the researcher checks "the degree of similarity between sending and receiving contexts" (1994, p.241). This process is particularly relevant to qualitative inquiries in which the cultural context of various research projects may differ substantially. The most widely accepted and effective technique for addressing threats to transferability is a "thick" description of the context within which research takes place (Goetz & LeCompte, 1984). Consequently, I have attempted to ensure a contextually rich account of the sampling strategy, fieldwork and analysis so that other researchers can determine the applicability of this process in addressing similar research questions. I have also included both a general description of Aboriginal cultural imperatives, history and socio-political contexts as well as a specific description of those elements of Mi'kmaq culture and history. These descriptions will illuminate those elements of my analysis, which might be generally applied to First Nations women, as well as those, which apply more specifically to Mi'kmaq women.

Dependability

Dependability is analogous to the notion of reliability in positivistic inquiry. In addressing threats to dependability, researchers are challenged to confirm "the quality and appropriateness of the inquiry process" so that others understand changes in methods as well as the development of constructs (Guba & Lincoln, 1994, p.243). I have addressed this issue by documenting the procedures and processes of data collection and analysis. This record includes the logic and process of my decisions related to research design, methods, and analysis so that external reviewers can easily examine it in order to judge the overall quality of my findings (Patton, 1990).

Confirmability

In addressing threats to the confirmability or "neutrality" of my research products (interpretation of the findings), I am challenged to confirm that the "interpretation, and outcomes of [my] inquiry are rooted in contexts and persons apart from" myself (Guba & Lincoln, 1994, p. 243). Consequently, I must establish "that the data (facts, figures and constructs) can all be traced to original sources..." (Guba & Lincoln, p. 243).

I have ensured the confirmability of my interpretations by detailing the coding techniques I used to link my findings to participants' actual words. I have also included my reflections on the impact of my initial and ongoing perspective as well as any inconsistencies and gaps in the findings (Guba & Lincoln, 1994). Finally, my interpretation of the data includes a caveat related to the limited generalizability of the findings. Although the issue of generalizability is not relevant to many constructivists, other individuals might need assurance that I am not attempting to generalize the findings to all Mi'kmaq or First Nations women.

Ethical and OCAP Considerations

As a researcher, I have an ethical responsibility to ensure that the processes and products of my inquiry do not adversely affect research partners. Accordingly, I began by ensuring that information was respectful of all levels of literacy and comprehension (Social Science and Humanities Research Council, 1998). This was accomplished by providing participants with a verbal as well as plainly written description of the issues

that required their consent. I ensured that informed consent was obtained, in which participants acknowledged their understanding of the nature and purpose of the study, the benefits, risks, or inconveniences of participation, their role and responsibilities in the inquiry process, their right to withdraw at any time without penalty, and the degree of confidentiality that was maintained (see Appendix C). In the case of group discussions, where confidentiality cannot be guaranteed, participants were made aware of the possible consequences. I further ensured that women were not coerced or unfairly induced to participate and that I provided an accurate account of their perceptions that is respectful of the Mi'kmaq people (Ellis, 1994; Glesne & Peshkin, 1991; SSHRC).

I demonstrated my respect for OCAP (ownership, control, access and possession) principles by offering to engage in a meaningful partnership with participating communities. In particular and where applicable, I offered to formalize this relationship through a partnership agreement that outlines conditions under which some of the communities agreed to partner in the research (Appendix D).

Support from the Mi'kmaq Ethics Watch, Health Directors and participating women confirmed my intention that participation in this study would not pose inordinate risk to the participants or to the Mi'kmaq people collectively. The research questions were mainly focussed on women's thoughts, feelings, and experiences of mid-life and menopause. In fact, I made every effort to ensure that participants were not inconvenienced or offended by the methods used to gather this information. Most importantly, I have ensured that presentation of the findings is respectful of the Mi'kmaq people, their beliefs and their traditions. I have accomplished this by offering my analysis framework to community facilitators and requesting their input about dissemination of the findings of the study.

Confidentiality

Participation in a group discussion cannot be anonymous. Although the facilitators and I agreed to keep participants' identities confidential, we cannot guarantee that the other women in each group have kept identities or comments private. The written transcript of each discussion does not include the participants' names, nor will any report or publication reveal their identity through use of their real name, the name of their

community or any other information that might identify them or their home community. In the case of group discussions, where confidentiality cannot be guaranteed, participants were made aware that other participants might disclose information they shared. We attempted to address this issue by asking that everyone who participated in a discussion respect the privacy of others in the group.

Ethical Approval

Approval for this study was granted by the Dalhousie Ethics Committee and the Mi'kmaq Research Ethics Committee.

“The Mi'kmawey L'nui Skmaq or Mi'kmaw Ethics Watch was established to review proposals for research conducted among and with Mi'kmaw people using the Mi'kmaw Principles and Guidelines for the Protection of Mi'kmaw Heritage and People. These principals and protocols expect researchers to follow the highest standards of research with sensitivity and respect to protocols appropriate to Mi'kmaw people and their communities...” (Mi'kmaq Ethics Watch, 1999).

Dissemination of Research Findings

The findings of this research will be available in a number of forms, and will be offered to those who participate in the research as well as those who might wish to further disseminate the information. The information may be used in journal publications, newsletters, workshops, and future research projects. Permission will be sought from the participating communities to further develop the research findings and any royalties will be shared equally with the research partners. It is also my hope that I may work with Mi'kmaq women in developing educational materials (e.g. workshops) from the research findings that might be helpful to others who are looking for information and support around mid-life change. Ideally, I would like to work with facilitators in summarizing the findings in a brochure, aimed at providing menopause information to Mi'kmaq women.

I intend to consult with various individuals and groups (e.g. Health Directors, facilitators, and the Mi'kmaq Health Research Group) about the most appropriate manner of disseminating the findings to First Nation audiences. A summary of the research findings will also be presented to the Nova Scotia Health Research Foundation, for dissemination to various health program and policy audiences.

Analysis

Analysis of a phenomenon so deeply embedded in perceptual nuance and subjective meaning requires substantial degrees of abstraction. Otherwise, we might see yet another “skim milk” description of menstrual changes, hot flashes and urinary incontinence. I desired something more; to fully understand women’s blood, sweat and tears – to appreciate the heart of this experience, which binds them so closely to their bodies, while encouraging them to transcend physical boundaries and engage in more spiritual pursuits.

Unfortunately, the process of analysis is often discussed in hushed tones, like some ancient religious doctrine, which many profess to follow but few fully comprehend. This is problematic for many reasons, not the least of which is that it frightens new researchers, effectively withholding opportunities to practice the type of contemplation that is required of analytic thought.

For me, analysis is like love; we may conceptualize it, describe it, and discuss it at myriad levels of abstraction. Yet, each individual will fall in love - and conduct analysis - in their own way, each time somewhat differently; sometimes more fully, other times more passionately and still other times more selfishly. Success however, requires that we begin anew each time, with a fresh perspective. Both activities also involve human “baggage”, whether it is emotional or theoretical; both rely on the ability to engage our intuition and control our predilections. Success depends on our capacity to adequately judge when, how and to what degree these activities are required. Like love, analysis rarely occurs “at first sight”. The initial meeting is tentative, the goal to become familiar with the nuances and idiosyncrasies of the text. Next comes long, quiet moments, in which we become increasingly involved – each iteration more intimate than the last, until we feel completely connected.

My search is for meaning that lies deeper than words – a fluid dance, involving both the women and me; each giving over something, each expecting something in return. For my part, I desire a full understanding – a moment or two of clarity, in which I feel the essence of women’s experience. For their part, I suspect that my receipt of this gift will suffice – I will however, pass it along to others, who I hope will also receive it with a respectful mind and an open heart.

I wish to emphasize that my interpretation of the findings is grounded in methodological principles of analysis as well as my intuitive learning, which is based on “deep” listening and observation of what was being conveyed to me beyond women’s words. I cannot explain this process in the language of science but I feel it at a deep and honest level that I hope will be accepted as my own learning, rather than as objective, empirical evidence of some generalized conclusions.

Preparing for the Journey- Data Management

The information gathered during this study was made amenable to analysis through systematic management (Neuman, 1997). I began by establishing a paper filing system that included confidential material such as community facilitators’ names, addresses, and phone numbers as well as completed audio- tapes and coded transcripts. Process files include: working concepts and frameworks, initial and emergent reflections on meanings and processes, relevant excerpts from the literature, and materials related to phases of the research (community information packages, process notes, preliminary and ongoing analysis notes, self memos, community contacts and Mi’kmaq ethics documents).

Audio-taped discussions were transcribed verbatim. Participants' names and other potential identifiers were not included in the typed transcripts. I further instructed the transcriber to type my voice (the facilitator) in bold font, while un-bolded font was used for the participants' voices.

Upon receipt of the typed transcripts, I checked them against the original tapes for accuracy. After making the necessary corrections or additions, I made two electronic copies as well as two printed copies of the transcripts. These copies were stored in a locked file cabinet in my office at the Stairs House on the Dalhousie campus. The printed copies were used as working copies, upon which I made notations and completed hand coding.

After each group, I also listened to the tape to check for clarity and made notes about themes that seemed to emerge. Beyond that, I considered the direction women seemed to take to see if those directions appeared to be taking on a pattern across groups. Relationships emerged as an important theme in the first group, so I re-worked the guide

to allow women to talk more about their relationships. The notion of balance also emerged in women's conceptualization of change – issues seemed to be discussed collectively; women seldom talked about one dimension of experience, without including other dimensions as well. They tended to acknowledge the challenges and the opportunities of mid-life change with equal vigor. Their perspectives and strategies also tended toward achieving balance in all dimensions of their health and lived experience.

With the first transcripts, I began the process of hand coding (attaching labels to words, sentences and/or paragraphs) to reveal common themes as well as to illuminate situations that did not fit within emerging patterns (Neuman, 1997; Patton, 1990). This often led to the re-coding of earlier transcripts, as new categories emerged in subsequent groups. A software program called Atlas ti facilitated coding and subsequent analysis of qualitative data. Following my training on this qualitative data management software program, I imported the primary documents (transcripts) into hermeneutic units (project files). Following this, I electronically coded each document, using the labels I had established during hand coding. Three rounds of fine-level coding established both descriptive and conceptual codes. After several iterations through the coded transcripts, I distinguished patterns in the data, from which I developed conceptual networks, which linked categories in a meaningful way. Various networks were held against the data and those that seemed to best reflect both the essence and the context of women's experience were chosen. When I felt comfortable with how the data were fitting together, I began to read and re-read the transcripts – now in an effort to tease apart the major themes and discover the deeper meaning in women's words. This process was both intellectual and intuitive, and was based on my knowledge of women's health and menopause as well as my understanding of Aboriginal philosophies, First Nations history, as well as Mi'kmaq culture.

Process: Finding My Way

The first goal of my analysis was an in-depth understanding of Mi'kmaq women's subjective perception of their reality. Ideally, the product of this analysis is an account that is rich in detail and context, one that illustrates the diversity of this complex and multi-factorial process, from the perspective of the women themselves. In order to achieve these goals, I was required to engage in what Miles & Huberman refer to as

"iterative cycles of induction" (1994, p. 420). This iterative sojourn through the data allowed me to move from the specifics of the text through multiple layers of abstraction (Creswell, 1998).

During my initial analysis, I followed a modified grounded theory approach, in which I derived themes inductively (Ballard et.al, 2001). The discovery of concepts most relevant to describing and explaining this phenomenon occurred through an intimate examination of the data. In addition to identifying core categories and context, this process represented the initial stage of discerning and verifying the theoretical framework emerging from those constituents. Ideally, the product of this journey through the data is a story that not only represents diverse interpretations of the substance and context of Mi'kmaq women's realities but, through liberal use of direct quotes, one that also resounds with their collective voice.

Qualitative analysis begins with the organization of data into descriptive and conceptual categories, the purpose of which is to create themes that are amenable to interpretation (Neuman, 1997). The analytic process therefore, includes examination of the data for patterns and relationships, development and testing of alternative hypotheses, and construction of a conceptual framework (Morse & Field, 1995; Patton). Induction involves the comparison of specific phenomena in order to arrive at a general principle. Inductive processes are those in which the researcher immerses him or herself in data with an eye toward emerging themes (Guba, 1990). Reliance on inductive techniques may also lead to the development of concepts that are grounded in the data. This process differs significantly from deductive analysis, which draws on past experience and previous research to propose tentative explanations. Deductive techniques are those in which the use of some categorical scheme is indicated by a particular theoretical perspective and is used as a means of assessing a hypothesis (Berg, 1995). Throughout this study, I employed inductive techniques designed to coax recurrent and axial categories, patterns and themes from the data (Patton, 1990).

The analysis began with a technique that Neuman (1997) describes as *successive approximation*, in which I moved through several iterations from raw data and obscure notions toward a more comprehensive story. Successive iterations through the data allowed me to construct a conceptual model that adequately reflects the perception of

participants. "Conceptual baggage" (Kirby & McKenna, 1989) and initial research questions represented a framework upon which I attached evidentiary features of the data to emerging concepts. This process revealed gaps in the data, into which I poured newly acquired information, with the goal of reaching "saturation" (Patton, 1990). I heeded Neuman's advice and acknowledge that transferability of any findings must be contextually conditional and contingent on distinct features of the data. However, I feel secure that my conscientious use of successive approximation has ensured that my "extrapolations" (Patton) are well rooted in confirmable evidence (Neuman).

Coding: Signs of Meaning

My first attempt at coding the data represented what Neuman (1997) refers to as the lowest level of abstraction or open coding, in which I attempted to condense the raw data by attaching labels (codes) to words, phrases, sentences, and paragraphs (clusters). In addition to the endogenous topologies emerging from participants' words, I included exogenous categories that illustrate my own interpretation of their respective realities (Patton, 1987).

This process, which began during the early stages of data collection, with the first completed transcript, encouraged me to stay "open" to the data and attentive to the natural discourse of research partners (Patton, 1990). The benefit of early and ongoing coding was that emerging codes often indicated the direction subsequent data collection strategies should take in terms of discussion questions (Miles & Huberman, 1994). Neuman also suggests that successive coding makes analysis "less a distinct final stage of research than a dimension of research that stretches across all stages" (p. 420). This overlapping process enhanced not only the capacity to generate findings but also the quality of the findings (Patton).

During second stage or axial coding, I focused on the themes that emerged as a result of open coding. Through this next level of coding, I began to contextualize women's perceptions. This process facilitated construction of a framework made up of "conceptual corrals" into which related subcategories were gathered and used in the analysis of emerging themes (Goetz & LeCompte, 1984; Lofland & Lofland, 1984).

After all of the data were collected, I entered the final stage of selective coding. This process involved a thorough search of the data for cases that illuminated previously identified themes as well as "negative cases" that did not fit within emerging patterns (Neuman, 1997; Patton, 1990). I attempted to strengthen the integrity of my analysis by searching for rival or competing themes that supported alternative explanations and, after considering the evidence, decided upon the "best fit".

The examination of transcripts for the purpose of exploring common themes represents a process referred to as thematic analysis, which provides a more comprehensive explanation of the findings beyond random clusters or a single case (Morse & Field, 1995). After each group discussion, thematic analysis was conducted so that emerging themes might inform subsequent discussions. This cross-case analysis further enhanced the transferability of findings with respect to the "relevance or applicability of findings to other similar settings" (Miles & Huberman, 1994). Indeed, the use of "multiple comparison groups", allowed me to highlight the "specific conditions under which a finding occurred" (Miles & Huberman, p.173).

Thoughts on this Rendering

To limit this discussion to women's reproductive capacity, to their ability to bleed, to the presence or absence of the uterus and ovaries is to paint a very incomplete picture – this much we already know. The challenge, for anyone who wishes to transfer their vision to an inanimate medium, becomes one of form and texture. No two renderings will be created or perceived equally. It begins with the choice of canvas, upon which women's experience is expressed. The colour and texture of those experiences must be transferred, and in some ways transformed, while maintaining the context within which they are situated. Using tools carefully chosen for their practicality but also for their comfort, I have attempted to craft a story that captures the substance of women's lives, as they have presented them to me. I am charged with creating a likeness that is both pleasing and realistic; one that illustrates multiple dimensions; a portrait that reveals the essence of women's experience; one that captures both the light and the shadow, caught in one moment in time.

Like any subject who might poise to reveal or to disguise, women present a picture of their lives through words. I have attempted to capture and transfer that strength; the love and fear and sadness, the hope as well as the disenchantment. Only the most skilled artist can faithfully transform life onto a medium, which lacks intrinsic depth. To do justice to the beauty and the pain of women's lives is beyond my skill, but I have done my best, given them my full attention – and with respect and some measure of love, have put my vision to paper. It is my own rendition of what I have seen – a picture that I hope pleases them – one that captures their quiet strength, yet reveals their vulnerabilities – one which might be called a likeness, but like all such renderings, should never assume equality with its living, breathing source.

It might help the reader to visualize a group of women, sitting in a circle, telling a story. Embedded within the details of that story is a lesson – an explanation of life, as seen through their collective gaze. It has been my job, as well as my pleasure and honour, to discover that lesson. Like all stories, the lesson may be different for everyone and we learn only that which we need to know and are able to understand, if we are attentive listeners. In this account, I am relating my lessons to you.

In addition to the privilege of learning from these women, I am required to examine what I have heard and compare it with all that I have previously learned about this experience and decide how the experience of these women might fit with that of women who do not share the same history or culture. I must also relate my lessons to an audience who, by and large, is not familiar with the context of First Nations women's lives and so I must share what I understand of that as well. The obvious tension I foresaw in my introduction of this study did little justice to the weightiness of this issue. The tension of transforming the concepts and consequent understandings of First Nations women, about life and love and change, has proven a most challenging task.

This story is about a journey – actually it is about one leg of women's journey, which begins on the day of birth. We cannot say when it will end, that is for each individual, according to her spiritual beliefs, to decide. This story concerns women's journey through the middle years, in which they pass through peri-menopause and menopause, to become post-menopausal women – older and wiser and, from all that I have heard, much loved by themselves and others.

Limitations

Sampling

Research is full of limitations, not the least of which is represented by the undirected comments of a select group of mid-life First Nations women, who were recruited and decided to participate in a study, which asks them to talk about their subjective experience of peri-menopausal change. However, without this information, we cannot begin to appreciate the salient issues for these women during their middle years. In particular, the cultural lens used to interpret this information reveals some significant differences in the way First Nations women subjectively understand and experience this process, which we now understand, is in no way universally experienced.

The findings of this study cannot necessarily be generalized to all First Nations women or even to Mi'kmaq women who did not participate in the research. Like most, these findings are based on a relatively small sample, from selected communities, of women who, for one reason or another, heard about and chose to participate in, this study. But it is a place to begin to answer some questions and to ask many others.

Most qualitative research uses non-positivist criteria with which to judge the utility and credibility of small purposeful samples. This strategy is used extensively by qualitative researchers in order to achieve a specific research purpose, including gathering information from populations who are hard-to-reach, those who represent distinct groups, those with specialized knowledge or experience, as well as those who are simply willing and able to share their stories (Patton, 1990). All of these criteria apply to the group of women involved in this study.

Use of a purposive sampling strategy restricts the generalization of the findings to this population of First Nations women. In fact, I must acknowledge that this phenomenon is too variable and context-bound to permit broad generalization of the findings. At best, I offer extrapolations or "modest speculations on the likely applicability of findings to other situations under similar, but not identical, conditions" (Patton, 1990, p.489). Like most qualitative researchers, however, my intent is not to produce findings that may be generalized across populations but, in this case, to contribute to the body of knowledge and to enhance our understanding of a living,

breathing reality within the unique culture and context of Mi'kmaq women's everyday lives.

Group Methods

Although the use of group discussion permitted me to increase the sample size over individual interviews, it did not confer generalizability of the research findings. Aside from the self-facilitation of group members who provided valuable cues that promoted discussion, the sharing of information and experiences seemed to make group discussions an enjoyable one for all research partners (Kreuger, 1994; Patton, 1987). One of the most important limitations of group discussion relates to the issue of confidentiality. While facilitators and I assured the confidentiality of participants' responses, we cannot guarantee that all group members will respect the privacy of others (Patton). This limitation was addressed in the consent form women were required to sign before participating in a group discussion.

The dynamics of a discussion group of First Nations women, particularly older women, many of whom were raised with the traditional value and practice of the Mi'kmaq people, may differ from some groups of Euro-Canadian women. In general, interactions between First Nations people are very respectful of others' opinions, particularly in a circle talk (not to suggest that these meetings were talking circles but many women perceived them as such). First Nations women typically do not query one another during discussions, so disagreements were rare (Wadsworth, 2000).

As a general rule, it is considered rude or inappropriate to comment on someone's reflections or comments, so in many cases, ideas that were raised or experiences that were shared were not picked up on for further discussion. Many women would nod or silently acknowledge their agreement but each person's experience is considered worthwhile on its own – without the necessity of corroboration by others. If another woman had a similar experience or idea to share, she often did so after a respectful time had passed, so that her story did not overshadow the first woman's story. This social dynamic is critical to understanding analysis of this data, which included much consensus and similarities, particularly across groups, but differs substantially from focus group processes among some Euro-Canadian women, which tend to prompt discussion among participants. In some cases, cultural norms around non-confrontation may have silenced

some women who do not conform to the group (Wadsworth, 2000). This is a general limitation of group discussions, which is addressed, although never fully resolved, (as is the case with all methodological limitations) through careful question construction, facilitation/probing, and providing opportunities for participants to follow-up with the researcher (contact information, member checking) (Guba, 1990).

Community/Personal Descriptors

Given the relatively small number of First Nations in Nova Scotia as well as the relatively few mid-life, First Nations women, I have not included specific descriptors related to participants or their home communities. Although community and/or personal level descriptors may not identify participants or communities to most Euro-Canadian readers, the likelihood of identification increases substantially among other Mi'kmaq people from Nova Scotia, who might easily recognize specific descriptors such as a participants' occupation or a community's main industry. While some may consider the absence of these descriptors a limitation of this research, I believe that emphasizing this type of description follows a Eurocentric model of identity that might actually detract from the essence of women's lived experience. The rationale for this decision is based on my understanding of indigenous identity, which is not defined by one's economic activity but rather, by one's relationship to others and by the experiences that shape individual and collective life.

CHAPTER FOUR: FINDINGS

Presentation of Findings

The findings of this research have been organized around themes of vision, balance and relationships. Presentation of the findings also includes sub-themes, which represent the conceptual framework, upon which the major themes have been constructed. My presentation of each theme begins with a brief summary of the main concepts, followed by an in-depth analysis of related findings. I have included several quotes in each section in an effort to validate and illustrate the tentative conclusions I have drawn. I have also made an effort to qualify findings in terms of the diversity, subjectivity and degree to which particular perspectives and experiences were shared.

Vision

I have used the term vision to denote the perceptual quality of the following theme. I chose this term over that of “perceptions” or “perspectives” because I believe it best illustrates the depth and texture of women’s insights. The theme of vision has been constructed on four sub-themes, which include life vision, menopausal vision, self-vision as well as the substance and source of vision.

The vision shared by the women in this study is holistic in the sense that it embraces many dimensions of life as well as inclusive because it encompasses the totality of their past, present and future. As such, concepts such as self, others, and menopausal experience cannot be viewed as separate entities but must be conceptualized as interconnected fields of view, which fuse into a single, vast horizon. In sharing their vision, women implicitly reveal a keen awareness of this link between perception and reality. Through their stories, they describe a process through which expectations become woven into the perception of menopausal experience. For some, fear and apprehension become the template upon which physical and emotional changes occur. For others, freedom and self-discovery act as a filter for acceptable changes that might otherwise be perceived as disquieting. Most, however, begin the journey with a vision that includes both positive and negative filters – both of which form the basis of their menopausal reality.

Life Vision

The sub-theme of life vision emerged from women's response to the question, "What becomes important to you at this time of life"? In responding to this question, women revealed a vision of life through their mid-life perspective. Specifically, this theme embraces the elements of life that fill women's mid-life gaze, the experiences that have shaped that gaze, their current understandings of life, how their vision has changed over time, and how they feel about their new and evolving vision.

Women's life vision is rooted in past values that become increasingly meaningful as they experience the change of life. Maturity and wisdom correspond with a more positive perspective and an acceptance of change in many forms. This enhanced vision not only brings women closer to themselves but also to those individuals who have traveled with them. During this life transition, the values learned in childhood become not only a source of strength but also a source of reflection.

Spirituality, but that's been important all my life, not just in mid-life, that's something that's been important - it started when I was young . . .

I really value my mother now and I think that all changed when I was around 40 probably when I was going through the change of life.

I think as you get older, you realize it doesn't matter what you do, you have to live with yourself; you have to live with your own conscience and you have to try to live the best you can every day; and that's the difference now, where before it was like you're looking for an easy way out, if you don't want to live the best way you can and you find a shortcut. You think it was an easy way out of it because when we were young we just weren't aware cause I find that . . . I know we weren't aware.

Women's vision of life involves reflections about the past, including experiences, which have pleased them as well as those that have challenged them. They tend to focus most on the lessons they have learned as well as a growing understanding that change must be accepted. Many women talked about leaving old struggles behind and learning to accept new challenges with a grace that only comes with age. Although the past remains an important component of their life vision, living in the moment becomes more meaningful as women traverse mid-life.

I never think about it til somebody reminds me... Somebody reminds me of my age, I never think about my age. . .but I'm getting older every day. ..but I just live today. .. I don't care about tomorrow, yesterday. . . you can't get that back. . . There are people who do care about getting old. . . I just live today because when I woke up in the morning thank god I said my prayer, thank god I'm alive and I hope this day is going to be good.

But it's true, as you get older you learn from your life experiences, you reach a certain age you don't panic as much as you did when you were younger.

During mid-life, these women begin to seek knowledge with a new respect for their own capacity to learn and in their ability to guide their own learning. With humility that only comes with true maturity, they seek out new ways of knowing, some rooted in the tradition of their ancestors, and some based on the science of modern medicine.

Women try to learn more about their health as they get older – especially their physical health. Staying healthy becomes more important.

I think when you're, especially when you're getting older. . .a person should prepare . . that's one thing I could advise somebody...

Looking at things and being educated I guess, yeah. Understanding maybe both ways of looking at it.

Women's vision of life is also influenced in many ways, by their growing appreciation for the fine balance between the domains of life that define them as women, as mothers, aunts, and grandmothers, as well as daughters, granddaughters, nieces, partners, and friends. Over the course of their lives, women acquire an acceptance of aging, of changing families and changing times and an appreciation that life is filled with uncertainty. Through this acceptance, women's vision of change becomes increasingly positive and the template upon which changes become more balanced. Discovering balance becomes critical to discovering self and embracing change forms the cornerstone of positive experiences.

I guess it all depends on where you are in your life, how you deal with it - so I can see where it can be depressing because you know if you find yourself alone and you are in menopause right - you know you might not have too many positives to

face right, so I think until you can reach acceptance, you can move on, then just accept it as another stage in life.

I guess it was just acceptance right you know . . it's just one more thing that you dealt with. Yeah, just one more part of life. Yeah.

I think it's a part of life you know you've got to accept it regardless where you are what you are right?

Just have to get busy in my life and accept it, so like she said it's a hurdle that so it's coming and I'm just going to have to accept it. So for a younger group to realize that it's a hurdle, but you've got to accept that it's coming.

Women revealed that, in learning to accept the often-disquieting physical milestones of age, they are often compelled to focus more attention on themselves. In doing so, they discover that their gaze upon the world has changed – it has broadened and relaxed; they have learned to see the world through a lens shaped by time and learning. From all that I have seen and heard, it seems that this new vision becomes them; and in this comfortable position and in the light of wisdom, they become even more beautiful to the gaze of others in their family and community.

I think it's a positive experience you know aging. I'm not saying you like growing old. . .there's things about aging that I don't like but you know on the whole, right yeah you know it's . . . It's a pretty positive thing.

What's the word for that . . . the women - there's a word for it; that's our life, that's part of life, that change and just don't get angry or mad, just go with the flow.

Physiological changes - it's something you have to expect, like bifocals, after 40 you get the bifocals, you need them, so it's like you know....you have to be positive about it.

Vision of Menopause

Women's vision of menopause is shaped by myriad influences; by the silence surrounding the experiences of their mother and grandmother, by their expectations of what changes they will experience, the freedom that peri-menopause represents, as well as their own understanding of the physical, emotional and social determinants of menopausal change.

Silence

The women in this study describe a collective silence about women's bodies in general and menopause in particular. Among these groups of women, almost no one's mother ever spoke about menopause, nor did their grandmother or most older women they know. Many of the women told stories of a somewhat traumatic menarche in which no one told them what was happening to their young bodies. The silence of women's menarche seems to have sent a subtle but powerful message more clearly than loud words, that women's reproduction is not a topic of conversation.

I had my first period and mom never even told me anything when I had my first period. . . Same with having children, my mother never told me anything about these birth pains or anything about having a baby until I had my baby and then she sits down and tells me oh this is what happened to me when I had ... I almost told her, "shut up mom", I know now I went through the thing, too late now, I already went through it".

Nobody talks about menopause. Nobody talks about it at all. And if they do is it. . . No, if you talk about it, it's between you and that other woman down there who went for that surgery.

My mother did not tell me about menopause and the periods and all that stuff, you know. . . well here we are sitting here telling you that our parents didn't tell us.

I don't think any. . . like my mother, she never spoke about it, she never mentioned it to me how she was feeling or whether she was going through the change of life and my grandmother or any of the other older women, I never even heard of anybody talking about it on the reserve. Maybe we're the first generation to talk about it.

The edict of silence might be perpetuated by women's beliefs in the power of mothers as role models for behaviour. Women view their mothers as strong and resourceful and in attempting to emulate them, remain silent. In this way, silence is passed from one generation to another, from mothers to daughters. Silence, however, can also perpetuate ignorance – women may become prey to misinformation, fear and uncertainty about their ability to cope with change. The silence of menarche becomes the silence of menopause. Misunderstandings and fear of menarche may be carried through a lifetime and menopause can become the corresponding bookend of that experience. In

silence, fear of disease, loss of control, and uncertainty about the future may become part of women's vision.

There's not much talk about that around here. . .no, no. . .

I didn't know anything. . . it's hard when you don't understand. . .like some of these things. . . that I don't understand, you know even in your body, inside, I don't understand like that part, like . . . it's really hard. . .

You know, mom didn't tell anything. . .and then even the menopause. . .maybe because mom never went through it, she didn't know anything about it so therefore, she didn't tell us, what we heard was from other women. I never went through that, they didn't talk about sex with us or even the change. . .

Women seemed to recognize that the energy and focus required to resist cultural oppression and retain traditional ways of knowing might have kept past generations of women from pursuing information outside their family or community. They acknowledge that the silence of menopause comes from a different place and time, and that the tide is turning with a new generation of women who know what questions to ask and where to find answers.

[In my day], if you let too much out, you felt guilty I think, you were told strictly not to talk you know. I think my generation started, but your generation (younger women) - you start to be freer and what they used to call (Mi'kmaq word) how would you describe (Mi'kmaq word)? "Thick head," they don't know how to listen . . . you're that generation you know when you came up with a new way of thinking.

No one talks about menopause, so women don't know anything about it. No one talked to their mother about it - this is a time of freedom in women's lives.

Expectations

Many women recognize that their expectations of mid-life change are rooted in the knowledge and experience of others. For some, their expectations are based on stories, which are not altogether positive. In fact, it seems as though silence is broken only with stories of suffering. It is not surprising therefore, to discover that women's expectations often include negative elements of change. Lack of knowledge about menopause might introduce uncertainty into women's vision. Some women may even

become fearful of change when the information they receive is misunderstood or misrepresented. This cycle of misinformation and misattribution becomes a self-fulfilling prophecy. Fear itself can create negative experience – fear can affect what women do to care for themselves and their families and how they view themselves in terms of changing perspectives and behaviours.

And people have said that about menopause too, they say that if you give women a lot of negative information that then they'll say. . .that something will happen and they'll say oh it's one of these things. Gosh, I think I was lucky. Nobody knew anything about that. That's why I'm scared. I think I'm getting hot flashes now.

I'm hearing these things and they're scaring me like at home, I'm usually not mad at my husband or my kids and I don't want to be, like I don't want to be mad at them. I want to be ready, like I want to know what it feels like to have menopause and I told my husband once I'm hearing these things and I told him if I get mad at you and if I start to get mad at the kids, just lock me up in the basement til I stop.

Observing the often-silent experiences of their mothers forms the foundation of many women's expectations about their own peri-menopausal experience. These expectations however, are not limited to the physical and emotional changes they might experience. In addition to representing the foundation of women's beliefs about what to expect of the experience, mothers and grandmothers inform women's expectations about what to expect of themselves, about their ability to cope with change in a way that fulfils others' expectations of them.

My mother didn't. [Interviewer - "Did they talk about it, did they say this is what menopause is?"] My mom never told me. ..Are you kidding? Mom told me to keep my legs closed and she didn't say nothing else after that. . . My grandmother. . . they would never talk about that. You were on your own. My mother never told us anything.

Freedom

Women's vision also includes the concept of freedom; specifically, freedom from the constraints of childbearing and child rearing as well as repeated cycles of menstrual cramping, bloating and bleeding. Many woman emphasized the relative freedom contemporary women have around controlling childbirth. In the past, most women had

children well into their forties, so that menopause occurred at a time when they were still caring for small children and many times, large extended families.

This is a time of freedom in women's live.

I felt like free at last. Hallaluya!

My god I didn't get no period right - no red wings, mother nature - god it was nice you know!

No more periods. . . A lot of women say that, no more periods. . . No more babies. . . Yeah no more babies. . .

And like today, like one time, like my age they don't have these drugs and they don't have birth control so you were having babies until you couldn't have any more.

Many of these women look forward to a time of rest, with less pressure and responsibilities, and with more leisure time during their old age to pursue activities they did not have time for during the busy years of work and/or caring for young children. They also look forward to a time when they can focus more on themselves, of free time to discover what else they can achieve outside the role of “mother”. They embrace this new- found freedom to choose what avenues they wish to pursue – what pleasures they wish to indulge.

When your kids are gone, you have more time to focus on yourself. This is a time for women to discover themselves – outside of the role of mother. This is a time for women to enjoy things they put off when they were raising their families and working. When you have children and/or work, you don't have any time for yourself.

I look forward to being able to relax and no worries. . . no responsibility with kids. . . I look forward. I picture getting old and to sitting back and being able to relax, put my feet up . . .

Freedom is also conceptualized as a relaxation of the social constraints associated with youth and with the perception of young women’s social roles. Many of the women reported worrying less about how other people perceive them. They enjoy the freedom to

move openly, to speak their mind and pursue their own opinions, all of which have become increasingly important to these mid-life women.

I'm free to do what I want to do you know, so that's how I feel.

When I was younger, see I wouldn't say anything but now I'll speak my mind if I don't agree with something, you'll know I don't agree with it where one time I would have just...

Maybe we don't care so much about what people think.

Women seem to have mixed feelings about the issue of mid-life sexual freedom. Although most women appreciate liberation from contraceptives and unplanned pregnancies, they also disclose that their view of sexuality has been altered by misinformation about sexual function during later years. Consequently, some are not able to take full advantage of the relative sexual freedom this time of life offers them. According to this group of women, lack of a sexual partner also impacts women's ability to pursue a satisfying sex life during mid and later life.

And then it's the individual choice really in everything you do. . .what are the advantages of it is knowing that you can't have children anymore you know and you will be enjoying your sex more so hey, give me more you know. . .

I know a lady with menopause - it was awful – she didn't want anything to do with her husband or anything. Yeah I've heard that too. I've seen it happen. . .

Some women used to say something about with men that had vasectomies that they lost their sex drive. ..then it's all in your mind is what the doctor said. It's only the wrong head [head of the penis] (laughter).

Finally, and perhaps most importantly, women perceive a sense of freedom that comes when they give themselves permission to change – when children's lives re-settled outside the home and their role evolves from one of caretaker to one of companion, mentor and friend. They report freedom from stress related to the daily balance of work, of children's lives, of the dynamics of a family that has not passed the growing years.

You couldn't do it before right with the children. . . But they [women] just become a little bit more focused on [themselves] yeah good for them. . .

When your kids are gone, you have more time to focus on yourself. This is a time for women to discover themselves – outside of the role of mother. This is a time for women to enjoy things that put off when they were raising their families and working. When you have children and/or work, you don't have any time for yourself.

I would say like it's more acceptance, you know it's just something you know a stage of life and got to go with the flow and that's how it's been for me.

While desirable to all and attainable for most, actualizing mid-life freedom is challenging for many woman, particularly for those who have fashioned an identity that is rooted in caregiving and family responsibilities. For these women, freedom comes with letting go of responsibilities that children can handle for themselves. For those who still have young children or whose grown children have not achieved a level of independence that permits mothers to relax their attention, freedom remains a distant wish.

The role of mother never ends.

And I think that's part of being. . . that's what we're used to doing, you know and when the kids grow up and they're gone, you don't have to do that anymore

Empty nest depends on how many kids you have – women sometimes have kids late in life so they still have young ones when they go through menopause. Most kids don't move far from the reserve so women see their children and grandchildren.

But, I see it getting worse and not getting better, there's no relaxation and I look forward to that and I wonder where is it. Where's the quality time, you know where do you find that you know. That's what I'm looking forward to as I get older, but I find as I'm getting older it's just more. . .like I find that I'm busier than I was when I was 30.

Determinants of Change

It is clear that women fully recognize the diversity of this mid-life experience. Through their discourse, they reveal the ways in which they have come to understand the change of life, which is based on a balance of influences, including physical, mental, emotional, spiritual and social. As discussed earlier, whether through heredity or

conditioning, many women believe that their mothers' experience influences their own. Heredity is also tied to understandings of the past and of ancestors as having an influence on current experiences. However, according to some women, the number and timing of children may also affect a woman's reproductive system in such a way that menopausal changes will differ, even among women in the same family.

Every woman's cycle is different though. Mostly though you take after your mom. My mom had a hard time. But some of your aunts though you know, we all have the same blood, the same genes.

The person we should ask is our own mothers cause . . . we tend to go through the same cycle as your mother does.

Yeah I would think so because it would probably be passed down. . . you know. . and then whatever's passed down to her she's going to take it as her pattern you know.

I think I had too many children, maybe that's why . . . cause I know it's not normal, it just started off this way - stopped three months and then four months and it's back again to normal like.

Despite their acceptance of the genetic, biological and physiological components of peri-menopausal change, women emphasize contextual elements, which play a meaningful role in this experience. For instance, large families and a busy lifestyle, filled with hard work and many responsibilities, may distract women from changes occurring in their bodies. Even if these changes are perceived, they may become prioritized in such a way that they demand little of women's attention and therefore, are relegated to the category of "non-event".

I have a cousin who she says she never went through it. ..but I says you've been too damn busy all your life to really take note of what was going on in you and that's what I think happened to her. I mean it's not that she had a lot of children or anything but she worked all the time and busy, busy, busy.

But I think too during menopause you had so. . . like I had seven kids in eight years so I didn't worry about not having any more. So anyway, I think women one time had more than a dozen kids. . . Oh yes, we were 12 in a family. So they were so busy looking after their kids, you know they were having menopause while their kids were growing up, they just didn't know, they were too busy.

Family relationships are revealed as having a significant impact on women's vision of peri-menopausal change. Women express particular concern about how this change might influence their relationships and their care of others. Specifically, women propose that the elements of tension versus support, stress versus relaxation, and self-care versus other care in their social relationships, play a significant role in their perception of peri-menopausal change.

I know. . .it [support] helps, it helps a lot. . .but then for something like that you know something personal you want to be alone with someone that you can open up too and that's what's bothering our younger women today. . .they're so down and . . . I think it's the style of life that you're living, you make it your own.

That's what I tell my daughters too. . .if I go too far or if I just lose it, but they knew now this is what's going to happen to me but most of the time I just leave.

...the crabby mood or a bad mood, I'm not going to take it out on somebody else just because if I'm feeling bad why should I take it out on somebody else? I just cuddle myself and be good, be nice.

Self Vision

The women who participated in this study report an overwhelmingly positive vision of their mid-life self. They also acknowledge themselves as a major resource in the development of self-concept. This is reflected in an increased sense of autonomy as well as a desire to focus on their own needs and to find new ways to feel fulfilled. Self-love and self-discovery become increasingly valued, yet self-care remains intimately connected with other care. For, at a time when women begin to recognize the toll that years of selfless care have taken on their body, mind and spirit, they also realize that to love oneself is to love one's family and community.

That's like me, I don't care as long as I'm healthy and I can walk and I can run and play with the grand kids and you know I spend time with them and I don't feel old. I feel like. . .I don't know maybe the same age as when I was having my children.

Fortunately, the wisdom that often accompanies age, brings the gift of acceptance - of an older self, that might not possess the same qualities, which made it beautiful in

youth, but one that possesses beauty, which comes from experience. Women also begin to recognize a deeper beauty that comes from comfort with themselves.

I'm 50 and I feel good . . . I feel great. . . and I'm active in every which way. . . and I just love it.

This is not me, what you see, this isn't me. . . I'm inside of here you know, this is just getting me through this change.

I said "how do you feel now, like you know do you feel older or younger"? I feel the same, like I don't feel like good lord and I'm thinking holy shit you know four years time I'll be doing paperwork - I'll be sixty-five and sixty-five to me is old but I don't feel like it.

You become more comfortable with yourself, the way you are at the time. . . you're not so worried about. . . Yeah. . . accept yourself.

Activity emerged as a component of women's self-concept. Activities seem to enhance women's perception of self efficacy-- in that being able to maintain the same work level as well as pursue activities that enhance their leisure experience, reflect many of the goals they have set for themselves as mid-life women. Activities are seen as an avenue to physical and psychological fulfillment - of distraction and of challenge. Some women described this time of their lives as an "awakening," a time when they were forced to take a closer-than-usual look at themselves, and to take action for change. Whether to accommodate physical changes occurring in their bodies or emotional/relationship changes, women often begin to pursue activities that were impracticable or unattainable in their youth.

I've become important since I've gotten older. I'm more focused on me and my needs because I don't have anyone else to focus on. I'm kind of forced into focusing on myself and it took me a while to adjust to that but it's fun, it's good, I have some time for me and it's almost like a new beginning.

I'm doing more this year than I've done in years and I can notice a difference in myself in stuff like . . . I can't wait to go home from work 'cause I want to go like foolish stuff like snow-mobileing . . .

Yeah, it's an individual awakening like you know. .. I've got to get off the pot or else you know. .. I think it is anyway in my view you know but I notice with a lot of women that's what . . .that's what I see. . .

Women's evolving capacity for introspection brings with it an emerging sense of responsibility to live life to its fullest. Fulfillment is often found in pursuing issues of integrity in all aspects of life. They discover acceptance of themselves - with all their faults and frailties. They discover an enhanced capacity for forgiveness, often including the ability to forgive themselves. They are increasingly able to look back on their lives and see the challenges and the triumphs with equal joy and learning. That learning is enhanced through experience as well as the capacity to view life more broadly. Women want to delve more deeply into themselves as individuals, to examine themselves in the full light of their lived experience, to discover a self buried beneath the layers of all they have been expected to be and all they have become as a result of those expectations.

I feel good, I feel good about myself. . .and I think it's got to boil down to that too you know you have to feel good about yourself.

You say you become more forgiving and. . . Yeah. . .wiser. . . You're able to control your mental health.

All this big stuff, it's nothing big, it's all simple, everything is not important, all that's important is how you interrelate with others you know without really hurting another person intentionally, you know - we all hurt somebody unintentionally at times, but that's what's important.

I know a lot of women that did a lot of things that they should have did a long time ago and have gotten stronger when they got to menopause. ..they got stronger enough to push themselves to do something you know. . .and it took only that to help them over. . .

What's the word for that . . . the women _____ there's a word for it. .. that's our life, that's part of life, that change and just don't get angry or mad, just go with the flow.

According to these grandmothers, to examine one's life in the full light of awareness is both a painful and fulfilling process. These mid-life women possess an enhanced awareness of the ways youth blinds women to responsibility for themselves.

Although this awareness might create tension in their self-concept, it has the power to catapult women into a new epoch of their lives – full of potential but also pain.

Self in Relation

Lived experience is rooted in relationships; whether women traverse the change alone or with the support of others, connection and caring are brought more closely into the focus of their vision. As is the tradition, vision includes everyone — the entire community and family – the past, present and future. During peri-menopausal change, these women report experiencing a greater connection to others; to those closest to them, but also to those who have gone before them.

I really value my mother now and I think that all changed when I was around 40 probably when I was going through the change of life .

My health. My kids. My grandchildren.

My family is important, my friends.

Women's vision also involves an element of reciprocity – of sharing their thoughts and experiences, their fears and their challenges. This vision embraces those younger women who will follow them through this stage of life. Women maintain that with increased knowledge, comes increased responsibility. They view their own experience as a critical element in the learning of younger women. Their growing sense of awareness – that spark of insight, which begins to glow as women traverse their lives, becomes the light that illuminates the way for those who come after them. Their vision of the future revolves around the young women who represent that future; like most mothers and grandmothers, they desire more for these young women than they had for themselves. As elder women, it is their responsibility to pass along the wisdom of their years – so that they might create a more enriched experience for their daughters, their granddaughters, their nieces and other young women in their family and community.

As far as the teenagers, the young girls, the young women, they go through PMS, they don't understand why they're feeling so grouchy or depressed before their

monthly cycle, I think they need to be educated about that. Yeah. .. So they understand what their bodies are going through.

If it could be different for our children. . .they will make more of a big deal about it – they will be more vocal about it. Yeah, I think you're right .

You know I think I've got to talk to my kids about this because I haven't talked to them about menopause because I didn't know about it. . .

My three daughters are in their 30s so I mean you know like they'll ask me you know, whereas I wouldn't have called and asking my mother, you know if she was going through it or anything you know so I think that's the difference.

Women's vision of themselves is sometimes formed as a result of comparing their experiences with those of other women and determining the degree to which they "fit the mould." Comparing their physical experience, particularly hot flashes, with those of other women represents an attempt to determine a "normal" menopausal experience. They appear to gain some comfort in knowing that their experience is not out of the ordinary – one that is not so unique as to warrant much of anyone's attention. This issue was more often than not referred to as balance, in the sense that normal refers to equilibrium – of a process that occurs as it was designed. In order to situate their own experience, some women attempt to gauge it upon what they see and hear from sisters, aunts, cousins and friends. It is interesting to note that they rarely depend on written material to inform their perspective but instead, rely on the lived experience of other women, who are like them and sometimes, of women who they might perceive as very different.

That's one thing they told me, other women would say, well you're going to get fat now. . .I had mine when I was 28, a hysterectomy, and I didn't get fat.

My older sister, she went through hell, it almost gave her a breakdown, but it didn't seem to bother me. I was waiting for this - waiting to put me away, it didn't happen.

Comparisons represent something of a double-edged sword. On the one hand, women may be relieved to discover that this experience is not so fraught with trauma and drama. For many women, realization that the experiences they hear about do not become part of their reality, provides a sense of relief. In many cases, women have lived with the

apprehension that comes from hearing too little information or from hearing too much dramatic, medicalized information that tends to become generalized to all women. On the other hand, if their experience fails to meet some standard that seems to have been set by those around them, they may be left feeling as though the quality of their experience is lacking in some way that reflects on them as a woman.

Yeah, I still experienced hot flashes but I don't think I have it as bad as you know some of my friends' experiences but it did you know go on and off for a period of time.

But that's how I feel but I used to hear a lot of women oh my god this is wonderful, don't make that other woman feel inferior, oh my god, they're so sexual active, oh my god. ..

Euro-Canadian Women

Some women viewed the peri-menopausal experiences of First Nations and Euro-Canadian women as somewhat similar. However, many women believed that their experiences differed from Euro-Canadian women in relation to social and educational issues, social norms, relationships, and belief systems.

I've never discussed it with anyone. I hear lots of women talking about it, they [Euro-Canadian women] just make jokes and stuff like we do. . . I can't see that. .. why there would be a lot of difference. . .

I think it's harder on non-Native women. I notice with the Native women more so than the non-Native in talking about this.

It's difficult to say if it's the same for non-Native women right because I mean I'm trying to think you know since I spent a lot of my years up in a non-Native community, I mean my friends didn't really talk about it all that much either so, it might have been the same on both sides but you know so far as being open about it.

I was thinking maybe we go through menopause differently, cause some White women I heard get very, very angry, upset.

Access to information is viewed as a major difference between First Nations and Euro-Canadian women, with most Euro-Canadian women having more access to information about their bodies in general as well as specific material related to changes

that occur during mid-life change. Moreover, in terms of general health, Euro-Canadian women are perceived to benefit from a health system, which is set up to serve their needs and not necessarily those of First Nations women. Chronic and degenerative diseases, many of which become more problematic as women age, also become part of their experience of mid-life health and menopause. More and higher quality resources in Euro-Canadian communities are perceived as advantaging many Euro-Canadian women with respect to their physical health. Socio-economic status in general is also seen as a resource for better health, in which First Nations women are disadvantaged.

There is more information for non-native women so they know more about it.

To me. . .cause I have talked to non-Natives that had a hysterectomy they say no - that [absence of information and/or support from medical professionals] didn't happen to me.

Because being in a native community it's not easy you know, a lot of it is stressful and a lot of it is. . . it's hard to be. . .like you're talking about you know the mainstream of society, mention anything like colour or anything like. The mainstream of society where middle class and they have so much and they can offer so much and on the reservations it's . . . some reservations, maybe some are better I don't know, but a lot of the reservations their monies is not as high, their incomes are not as high so they have to make do with what they have.

Women also perceive the issue of aging as impacting differences between First Nations and Euro-Canadian women's experience. Many women believe that in Euro-Canadian culture, it is unacceptable to age, thus women's perception of their subjective experience will be more negative. Women feel a sense of compassion for Euro-Canadian women, many of whom they believe must make this journey alone, in a culture that glorifies youth and neglects elders. Euro-Canadian women are perceived as having to experience this change amidst pressure to remain thin and to achieve a narrow standard of beauty, which robs them of the reality of change, and the benefits of old age.

It's like if you're not Native, it's unnatural to get old.

This is getting back to the non-Native woman and Native woman, like I worked for many years and I noticed that the women [Euro-Canadian] were really vain, they just had to look so and oh they had to lose weight, they had to be trim, there

was no....oh if they gained an ounce you know that they were . ..they were always concerned about that, I found that. . .then when I started working with the Native women, I found that they're not as obsessed with their weight, and they're not obsessed with o.k. I went outside without my lipstick on or whatever, and you know maybe they just run a brush through their hair and leave or if they had to run down street.

The message[from western culture] is to value the outer shell and not the inner self. Yeah exactly. . .it's superficial. People are more interested on the outside, the perception – the world, what does the outside look like and not realizing that's not what's important.

Close relationships with grandmothers as well as veneration and respect, which represent an essential element of that relationship, are believed to explain First Nations women's acceptance of aging as well as their connection with and embrace of the grandmother role. According to these women, close connection to one's grandmothers creates a foundation of understanding for the perspective of elders; learning and guidance are part of the wisdom, which is translated into women's experience. Some women perceive Euro-Canadian culture as lacking in respect and care for elders, while First Nations people view elders as an important resource. This cultural difference provides the basis of women's belief about why aging may not be as "traumatizing" for First Nations women, as it may be among many Euro-Canadian women.

And I think that's the difference we see - non-Native society seems to think if you become too old to take care of, you just put them in a nursing home. I see a lot of that, you don't see too many Native people being put in the nursing homes and there are a few mind you, maybe when they get to be 100 and are peeing on the floor.

According to the women, even death, which is a natural consequence of life, is viewed differently in First Nations and Euro-Canadian cultures. Among First Nations people, public and private support systems are such that entire communities may "shut down" following the death of a community member. Few people face death alone; this is seen as a happy consequence of growing old in one's home community, where you are more likely to be loved, respected and cared for by those whom you have loved and cared for. This reciprocity is a cultural value, which is played out very clearly in the treatment of elders.

He said you know I went to a funeral yesterday and he says I was so amazed because there was only one person in the church for this person and then he said I went to another funeral... and the whole community was out and this was a Native community - there is a difference. I find that sad for the larger population...I find it sad for them that they're missing, they're missing something.

Close connection to other community members, particularly women, is viewed as a major source for support and learning. These multiple sources of support are perceived to be generally unavailable within Euro-Canadian culture, which tends to separate people into discreet, nuclear families, living in distant communities, filled with other, unrelated nuclear families. In terms of women's menopausal experience, this limited access and limited sharing translates into limited support during this, or any other, times of change.

I think that's the beauty of being in the community all these places that you can tap into you know and you're always connecting with someone, doing something And I think as a result of that because the way we (Native women) are that we intermingle a lot with each other. .. that's a good learning experience also to grow . . .I think that's good as opposed to having one tiny little friend that you hang on to. [Laughter] We don't cling to one person, there's a mixture and I don't know if it's because we're Native or . . . I don't know but I see that. I think maybe when you're younger you have this one special person but I think as you grow older and you. ..

The Substance and Source of Vision

Women's vision of life, of change and of themselves may be understood in relation to its source and its substance. Women revealed the source of their vision as indirect as well as overt information they receive from both informal and formal sources. Women cited elders as an especially important source of wisdom in terms of influencing their perspective and contributing to their knowledge. Women also acknowledge the past, both their own and past traditions that have been passed on to them, as an important source of their vision. The substance of women's vision concerns the specific messages they reveal as having influenced their vision of life and self and menopause.

Education

Vision is best informed through multiple learning opportunities that relate to all the senses and encompass the holistic nature of this experience. The pluralism of women's vision honours the gifts of science and medicine as well as the tradition of their ancestors. They inform their vision through investigation on their own, and by talking to friends and family members. They search for information that is balanced in terms of medicine and tradition; they also search for knowledge that accommodates their enhanced capacity for understanding.

Just started reading a lot and started asking questions.

Looking at things and being educated I guess, yeah. Understanding maybe both ways of looking at it.

It is clear that a lack of health information diminishes women's vision in the sense that they are not always certain about what avenues to pursue for healing and health. According to these women, there has been much in the way of "talk" but little in the way of useful information, about actual health issues associated with peri-menopausal change.

But it would be really nice, it really, really would be nice to have a place where like a woman can go and get answers, just to talk to somebody you know where you feel comfortable and ask these questions, but .. I mean they don't have any such thing do they?

Cancer risk. There's so much talk and they really don't have the correct information. . . you know really know what it does to them you know.

As a source of information, which might enhance women's vision, doctors tend to fall short of the mark. Consequently, women often search for information through media such as the internet because they perceive that doctors know little about menopause, beyond symptoms and details about HRT. Moreover, women are often made to feel as though their views are not respected and that this experience does not totally belong to them. These women insist that they need an opportunity to learn as much as they can, so they will feel completely informed. Yet, doctors seldom encourage women to pursue alternative forms of healing, nor do they often take time to listen or demonstrate respect

for women's capacity to inform themselves. Thus, women often feel discouraged from attempting to gain greater insight and may forgo further discussion with their doctor.

I find the doctors don't really want to talk to you. .. you go in there and you ask a question about this and that and whatever, they just really, they're not there to talk to you, to inform you, you know and you ask and they're almost insulted 'cause quite often I'll go to the computer and I'll say, well this is what I read in the computer; man he gets a little annoyed. I wouldn't believe everything I read on the computer, but it just kind of . . . I wouldn't believe everything that I read so ... it's discouraging - like you don't feel like trying to get informed you know.

You can get information from the computer too, like if you're looking for information about a drug or something, you can get it from the computer, easier than from your doctor. Sometimes when you get that kind of information you kind of like to just talk to him about it you know. . . but it's almost like he's insulted that you have some other information you know.

Ultimately, women seem to learn best from one another, in the context of their home communities, with women who share their life experiences. Through sharing these experiences, women's vision broadens and clears; they are better able to view their own experience in the context of other's experience. This communality represents a critical component of a positive and well-balanced vision. This finding will be applied to recommendations in Chapter six.

Elder Lessons

Lessons learned from elders are an important source of women's menopausal vision. In part, grandmothers shape a vision of life that settles more deeply into women's spirit as they journey toward that stage in their own lives. Beyond the practical lessons related to life, elders instill values, which become the fabric of community, family and individual life.

My grandmother raised me . . . and she told me all about stuff and if it wasn't for her I wouldn't know anything... plus she taught me how to read, she told me about life, how life is growth you know but she never said this is the male and this is the female. . .

Vision includes memories of elders, of grandfathers and grandmothers; of quiet, dignified people who earned the respect of others, not through loud, boastful means, but through the quality of their character and deeds. Women begin to understand that they have the ability to make that vision a reality in their own lives; that the respect they show toward others get reflected back to them. With delight, they discover that, in many ways, they are now perceived in the same light that distinguished their grandparents. This is a very pleasant vision, one that fuses the past with the present.

Like I even remember my grandparents, like you think of the old Indians, I think of granddad and I see this quiet, dignified man who didn't demand respect but had it from everybody and I think that's the same, you look at that, you say o.k. can I become that same type of a person who's not going to be out there demanding for people to respect me but because of the way that I carry myself, have it. And I think that . . . some of us are seeing that and some of us are getting the respect and we're feeling respect towards others and I think that's just part of it, I don't know.

But it's true, as you get older you learn from your life experiences, you reach a certain age you don't panic as much as you did when you were younger.

Reflections on learning from grandparents provide yet another connection to elders, which enhances women's perception of mid-life, as a time of strength and wisdom as well as increased capacity to generate knowledge and the desire to share that knowledge with others. These positive expressions of aging create a positive vision, so that women's expectations become positive.

I think because we respect our grandmothers. . . 'cause I remember always going to grandmas. . . that was you know and I don't know if they have that, 'cause I don't know 'cause I'm not White, I don't know how they interact with their grandparents. That's the way I saw grandma. Yeah, and you learned a lot from them you know . . . And you wanted to be with them. . .

Vision is also informed by the stories of elders, who remember a life more difficult than the one contemporary women experience. Elders talk about work and responsibilities that left little time to ponder the physical or emotional discomforts of menopausal change. In many ways, women honour those who have gone before them by

acknowledging their burden and recognizing the relative comfort with which they are traversing the change. One senses immeasurable pride in women's reminiscence of mothers and grandmothers, who toiled to keep families happy and communities healthy.

I remember my grandmother saying that she couldn't see all the worry and stuff about it because she said when she went through it she didn't have time to think about it, she said she went through the hot flashes, she went through, she said she didn't remember going through the emotional thing because she said she was so busy working and providing for her family at the time that she said she couldn't basically remember it, she remembers going through it but she couldn't understand why people were so emotional about going through it because she said she just. . . had the hot flashes and that was it. . . just like that so. . . she was just too busy to think about it.

And elders have so much wisdom, knowledge of life and I look up to the elders and that. . . that's the beauty of it, of growing old, babies, a new born baby just being born, the Creator has brought in a new life for the baby it's more closer to the Creator, little child and an elder is old, so closer to the Creator too because that time is coming close elders are going to leave us in body but in spirit will always be with us, and will be in the spirit world you know. That's how I look at it the beauty in growing old. Our bodies change, everything changes. . .

Among many First Nations people, lessons are taught through stories, into which metaphors for life are intricately woven. One such story, shared by an elder woman in this study, involved a basket maker, performing a task that combines skill, patience and time. Circular and interwoven, the basket takes shape through a combination of the physical elements of nature, gently coaxed into something more beautiful, which seems to take on a life of its own. Sometimes the weaver plans the design and remains true to the form of that arrangement. At other times, the weaver achieves such harmony with the basket that its shape emerges in concert with the interplay of the elements, of earth and spirit and caring. The process requires the weaver's undivided attention and the outcome is often "fine art." This story provides a metaphor for women's change and the message is as beautifully and carefully woven as the basket. The journey begins with elements of the earth, of human creation and female fertility, both gifts of nature. The journey takes shape over time, involving creativity and patience. The design may be planned or it may emerge through a relaxed interplay, which combines the plasticity of women's physical experience with emotional and spiritual elements of change.

When I started a basket, I'm just thinking about that bottom, and finally I start to shape it, lots of times people ask me if I have a sample, or pictures I say "no", or what kind of basket you know how I go to trim it and I say "I don't know"... it's just the way I am, start it, then start to shape it and finally I look at this and I don't have a mould or anything, I just do it with my hands. . . and I don't know how it's going to look when I start it but as I go along and I said, "I'm going to do this", that's how I. . .and I don't think anything, just thinking of this, I get so involved doing it. It's the same thing when I do. . .when I make those Christmas corsages, I don't even watch t.v. or radio or anything I get so involved doing this, how I go, put this or this. . .it's good for your mind, you know. . .You have to do something, you just can't think about that. . .when is that menopause going to hit me. . .

Attention to the natural ebb and flow of change, and to the delicate balance required to achieve this "fine art", reveals experienced faces and female lives that tell beautiful stories. Mind, body and spirit achieve harmony in the careful interplay of the weaving; the process and the product are one, each dependant on the other for symmetry, balance and beauty. The product is both beautiful and practical; a happy woman in good health, content in the life she has woven.

Past

Past experiences, particularly those related to menarche, menstruation, childbirth and hysterectomy inform women's mid-life vision. Depending on their individual perspective and personality, experiences in the past might cause them to view change as either a blessing or a curse. For women who have suffered debilitating menstrual pain or excessive bleeding, menopause is often viewed as a welcome relief. Similarly, among women who bore many children, especially late into their forties, menopause is often viewed positively. This is particularly true for women who began their families before the introduction of female contraceptives and still others, who may not have practiced birth control out of deference to their Catholic faith.

I used to be terribly sore I couldn't walk... when I had my period I couldn't walk at all. . . I was paining so bad and it would go down my leg you know, up my back and then I'd be throwing up, I couldn't stand the sight of food, you know . . and it would last for god almost a week, off and on, off and on, through the day.

That stopped. . .that's why I say this is not a problem. No I never experienced nothing. And I got seventeen children. I started when I was fourteen.

For many women, issues related to reproductive change have always been shrouded in mystery and silence. Although the values of parents and grandparents are respected, lack of information about menarche, when unanticipated and unexplained bleeding were experienced as traumatic, often leaves vestiges of pain, which linger in women's memory, and may become part of their current experience. Pain, confusion and a sense of loneliness in menarche infuses women's perception. They often relate stories of being a little girl who desperately wanted to understand what was happening to her body, who becomes a woman filled with uncertainty about changes, which seem beyond her control or consent.

My grandmother wouldn't even tell me about your periods. . . I never knew. "Go see your grandfather" - she says, my grandmother told me that and I was bleeding, that's what my grandfather says. . . "why are you telling me all this" (laughter) I said, "she sent me to you" and I was running back and forth .. they were old fashion. Two years after that I was pregnant.

Mom was like that, she wouldn't tell us anything. . . I remember one time, [sister] was, she was only a teenager, she was running along and I told mom that [sister's] got Kleenex in her panties – she got right mad, I didn't know what to tell her.

Negative Talk

Women "hear people talk" – not so much about menopause in general, but about physical and emotional responses to change. Women hear about hot flashes, weight gain, mental health problems, lack of sex drive, vaginal dryness, painful intercourse, accelerated aging, infidelity (on the part of women as well as their partners), sadness, loss of emotional control, loss of memory, and sleep problems – the list is endless.

That's one thing they told me, other women would say, well you're going to get fat now. . .

*I never experienced menopause. Maybe I just didn't know. ..I might have...
..because like she said her friend was crying one time. . . I used to have bad spells*

one time. ...sometimes I cried for. . .but I don't know what reason for. . .but I don't do that anymore.

I wasn't really worried about menopause still I started feeling - o.k. I started missing periods, after that and I was kind of. . . I used to hear about this menopause and I was hearing these things..., I asked around a couple of women, old women and they tell me you'll know when you reach menopause, like you'll be mad at your family, you'll be crying and you'll be in stress and you'll be like loss of memory they told me and it was scaring me.

Although most women understand that much of the “talk” is tied to lack of accurate information about menopause, they can do little but match the elements of their experience to the only information they have. Without balanced information, how can they be expected to attribute anything but negative experiences to the change – about which they tend to hear only negative information, couched within the vernacular of suffering?

I came to the Nurse and I asked her, I told her explain to me what menopause is 'cause I'm hearing these things and they're [other women] scaring me.

I didn't know anything. . . it's hard when you don't understand. . .like some of these. . .that I don't understand, you know even in your body, inside, I don't understand like that part, like . . . it's really hard. . .

'Cause when I came home and my oldest says mom what's going to happen to you, PMS - I don't know. .. really I didn't know. . . just wait day by day and you know.

They [women] don't have the information.

This “talk” is often compared with the medical treatment women receive as a result of the “symptoms” of menopause. The conclusions they draw are formed from what appears to be anecdotal evidence that supports the medical rhetoric. Within this framework, what seems to be missing is context and representativeness. One frightening or dramatic experience can overshadow the bland, rather uneventful experiences of the majority. The distressed minority remains the focus of attention, both in the everyday talk of women or the treatment they receive.

My older sister, she went through hell, it almost gave her a breakdown...I was waiting for this menopause - waiting to put me away,

Some women I know - they feel depressed when they go in for medication and they don't know what's wrong, what's going on with their body, they don't know. They don't know how to handle the feelings.

Actually it was another band member....said about all the stuff she was going through, they were this far from putting her into the Nova Scotia Hospital, said she was crazy.

Balance

The women who partnered in this study conceptualize health as involving physical, emotional, social and spiritual constituents. Women recognize that good health can only be achieved when all of these elements are balanced. Through this conceptualization, they reveal an appreciation for the myriad dimensions of human existence, which engage in bi-directional influence of women's mid-life change. The findings also reveal women's understanding - that describing the event of menopause is not sufficient to explain mid-life health.

And that their experiences are beyond just a physical, what happens to them physically when they go through things like that.

Spiritually, physically and mentally balanced I guess is a good way you know and you know when you're out of focus you know and you have to kind of pedal yourself right back into try to be rational I guess.

Yes. . .I think starting earlier too you know, I don't think we realize the importance of that when you're younger. I think for myself, now I know my lifestyle is.. .like if I'm eating healthy and exercising, then I feel better emotionally too right, so it helps you emotionally and physically and you're better able to cope with changes - you have to get out and do something instead of just moping about it. Your attitude helps.

Traditional ceremonies are premised on the notion of balancing physical, mental and spiritual elements of human experience. For those women who practice traditional healing, these ceremonies may become particularly meaningful at mid-life. Most recognize that medical intervention alone will not fully address every health concern. Even those who don't practice traditional healing appreciate the holistic and interrelated

concept of health. In fact, all of the women appreciate and report that optimal emotional health is unlikely without good physical health and vice versa, for both depend on health behaviours that respect the body, mind and spirit.

Now, I feel that my body is out of balance, 'cause my iron is a little low so it's catching up on me so I'm going to have a little rest, a little rest time, take a break on one of my jobs for a couple of weeks, take time for me, for my body to rest. I find ceremonies, traditional ceremonies, talking circles, sweat lodges, they help me for body, mind, spirit.

Not so much just the physical stuff but also that there really is a wide variety of experiences. . .

The notion of balance also relates to women's connection to the natural flow of the world around them and an acceptance of this natural order. Finding balance often means being peaceful about events that occur naturally. They intuitively understand the similarity in all natural processes of reproductive and hormonal change and take comfort in the knowledge that this process is a natural one that they share with their mothers, grandmothers and great grandmothers.

And so people think that that balance is easier to find as you get older, it is easier to find that place where you're o.k. with all of those things.

It took me a while to adjust to that but it's fun, it's good, I have some time for me and it's almost like a new beginning.

What's the word for that - there's a word for it. . . that's our life, that's part of life, that change and just don't get angry or mad, just go with the flow, yeah just go with it and keep yourself busy and try to do positive things. . . there's a word for that I just don't know what it is.

Some of the women who participated in this study have shunned medical intervention throughout most of their reproductive lives. Several women talked about experiencing or hearing stories about women having children at home, with only a midwife and other women in attendance. They reveal their understanding of how the body cares for itself and will discover its own balance, if left to do so. "Why change what nature intended?" is the question that emerges repeatedly in their tacit response to questions about menopause.

All these years - my aunt, my mother, they never go through this. Even I though I had five children, I had all of them at home, I never go for six weeks check up or what they do now after they have a baby, so what the hell I'm not going back.

...and yet you know perhaps it's something that your body needs so you have to look for it in something else.

Same as going to have babies. . . it's a natural process.

Many of the women have decided to wait for their bodies to discover a new balance and to accommodate for the experiences brought on by this change of life. They appreciate the freedom of this experience and so, achieve balance through their perspective. However, while they believe this experience to be a natural process of change, they also accept the possibility of intervention, in one dimension or another, as a strategy for restoring balance or facilitating women's journey through change.

But if you think you need hormones, go for it, but if you think you can go without it, good for you – 'cause the estrogen is trying to cut down in your body; why add to it you know, make it last longer that's what happens.

You wait 'til your blood releases whatever you need. Yeah, yeah. . .natural hormones. . . they're in there somewhere.

A balanced perspective is one of the most notable elements of these women's experience. Pluralism plays a role in this balanced perspective, as women are able to view experiences from many, sometimes divergent, perspectives. In the traditional pluralism of their ancestors, First Nations women value multiple avenues of healing. The capacity to conceptualize, experience and address this process from a multi-dimensional perspective is particularly notable among these women, who receive relatively little information about it.

I guess it was just acceptance right you know . . . it's just one more thing that you dealt with. Yeah, just one more part of life. Yeah.

I would say like it's more acceptance, you know it's just something you know a stage of life and got to go with the flow and that's how it's been for me.

Perhaps it is this relative lack of information, which has given them such clarity of vision. Maybe they have not been so misled, as have many Euro-Canadian women, into believing this process to represent a disease state. In fact, upon reflection, I recall subsequent conversations with some of the women, in which I remarked on the medicalization of menopause. The notion of defining this process of change as a disease surprised many of them. This in no way suggests that they have not received tacit medicalized messages from the media or from doctors. Yet, while this disease model has become part of their construction of menopause, their skepticism of the medical system, forged through generations of mistreatment and neglect, perhaps makes them more critical consumers of medical information than non-Aboriginal women in Canada.

The Gifts of Menopause

Achieving balance necessitates recognizing the opportunities as well as the challenges of peri-menopausal change. The challenges, and there are many, will be explored throughout the pages of this text. However, I would also like to share women's thoughts about the gifts of menopause, which emerged around themes of freedom, discovery and wisdom.

Menopause is seen by some women as a catalyst for change – a renewal of spirit – of a zest for life – a life more centered on them – as a woman and as a human being. Many find themselves with renewed enthusiasm for activities they have not pursued since their youth. Women discover that they still have an interest in activities they once enjoyed, before the responsibilities of a home, and work and family captured most of their time and attention. Many women see it as a time to relax, when worries over work and children diminish; a time when those for whom they have cared in the past will care for them. Women are generally more relaxed about the future than they were in their youth – they live each day to the fullest because they have learned the wisdom of taking life slowly – of savoring small delights and not waiting for future pleasures that may not materialize. Most reveal this as a time when they are better able to let go of worry and become more open to new beginnings.

I'm 50 and I feel good . . . I feel great. . .and I'm active in every which way. . .and I just love it.

I look forward to being able to relax and no worries. . .no responsibility with kids.

I know a lot of women that did a lot of things that they should have did a long time ago and have gotten stronger when they got to menopause. . .they got stronger enough to push themselves to do something you know. . .and it took only that to help them over. . .

Many women viewed freedom from monthly bleeding as one of the physical benefits of menopause. Those who wish to, may now participate in ceremonies, from which they were once restricted during their menstrual cycles. Women's enhanced comfort with themselves also represents a gift of menopause, which is viewed as a milestone toward increased power and wisdom as elders. Finally, mid-life change is viewed as a gift of time – time to slow down – time to think about one's own needs, one's own health and happiness. Time becomes women's ally, rather than something to feel pressured by or battle against, as they might have done in their youth.

I didn't give a toot about it, you know I'm not going to have my period, that was the only thing I was worried about, no more pads 'cause I laugh at the girls that go "I got to go buy pads", I don't buy them anymore.

I think the sweats helped me. Yeah 'cause they get rid of the toxins like once a week or twice a week, however often we go in there, you get rid of all the toxins in your body and you feel great, 'til they start building up again. You haven't sweat for a month or so, you really feel it. You don't feel good at all because you're building up all the stuff in your . . . it gets rid of it.

It's [menopause] handy though for ceremonies when women are on their monthly cycle you can't participate in the sweat lodges and you can't touch the sacred items, the sacred bundles, yeah especially the men's, it will weaken them - sometimes the men will just drop, you know when there's a woman around and there's a ceremony .

We've gone through that cycle and it's no big deal, in fact it's kind of more "hey good you're one of the tough ones, you can sweat all the time. . .you can pray all the time, you don't have to take a week off every month".

You become more comfortable with yourself, the way you are at the time. . .you're not so worried about. . . Yeah. . .accept yourself.

Physical Balance

Women's discussion of physical balance involved concepts such as their general mid-life health, disease and death as well as issues specific to peri-menopausal change, with particular emphasis on hot flashes and hysterectomies.

Health

The women who partnered in this research claimed that health is one of the most important considerations during mid-life. It seems as though peri-menopausal changes prompt women to think about their physical health more often than they might have when their bodies were younger and stronger. As they become increasingly concerned with their health, women begin to search for information that will help them prevent disease and maintain health.

I think about my health more.

Women try to learn more about their health as they get older – especially their physical health. Staying healthy becomes more important.

It's a good time of your life to be here you know and to have health, to be able to work and I still say keep busy. Yeah, I find my health is important to me. . .like . . . I have diabetes and that's harder to eat right, more vegetables and less fat and exercise.

And like physiological changes. . . it's not necessarily going to help you work them all out in your head. . . I mean you can have all the positive attitude in the world but you know you're going through all that stuff and it's going to affect you regardless of whether you're meditating every day or not.

Well, I would say I wouldn't mind not having arthritis or migraines and a lump in my breast. . . I don't go through menopause anymore. . . I went through that when I was younger. . . basically, I need help. I wish I had better health.

Health conditions occurring at mid-life may coincide with the experience of menopause. It is not surprising therefore, to discover that women may associate menopause with illness and declining health. This perspective is supported by medical information, which emphasizes the impact of hormonal change on women's physical and emotional health.

It is yeah, the bones. . .and you know what I think too is the food situation, that's what is causing the bones to deteriorate so fast. . .because my god, just think you know even a child, a new baby you can break the bone and it will heal up just like nothing because it's like rubber you know, but an elderly person when you bend that bone, that's it, it's gone you know. . .and all the bubbles in there right, those are the ones that break down.

All the illnesses started coming and this was done, then the diabetes came. . .I was a mess - arthritis I had stomach problems, throat problems, it's still going. . .I don't think the menopause is done yet.

Yeah, your health also changes because you get . . .your stomach gets sensitive to other foods that you normally eat and then you know you start realizing "gee I used to eat that but I can't anymore you know".

Disease

Cultural nuances notwithstanding, menopause is viewed as a sign of old age. Like the experience of menopause, female aging may be perceived and experienced on a number of levels and women report experiencing "getting old" within physical, psychological, spiritual and social dimensions. Yet, physical aging, and its corresponding reduction in overall health is likely of more concern for First Nations women, than middle-class, Euro-Canadian women. Marginalized health systems and disadvantaged socioeconomic conditions contribute to the relatively poor health of First Nations women, so that old age typically brings significant risk of chronic degenerative disease, experienced within a health care system that is inadequately funded and delivered.

It will then, come as no surprise that, when asked, a group of First Nations, mid-life women report a significantly large number of health conditions. I have chosen to report those conditions because they provide context to the findings. However, I will elaborate on them no further than did the women.

In no particular order, the conditions reported by participants include: fibromialgia, migraines, diabetes, arthritis, breast cancer, high blood pressure, kidney disease, amputation resulting from complications of diabetes, "blood problems", and asthma. In particular, osteoporosis, with ensuing fractured bones as well as the

debilitation and pain caused by chronic, degenerative conditions such as diabetes and arthritis, are concerns expressed by many of the women. Finally, the high rates of hysterectomy among these First Nations women (approximately two-thirds of the sample) create concerns about estrogen causing cancers.

I know I was put on progesterone at one point and I was worried about taking that but they told me it's the estrogen that they found that was causing the cancers.

Cancer risk. There's so much talk and they really don't have the correct information. . . you know really know what it does to them you know.

You hear about diabetes. . . and diabetes is a major hit arthritis. .. Lately, women having their breast removed. .. yeah that's scary. . .

At the risk of repeating myself, the most remarkable aspect of these women's attitude is a calm acceptance of life. Aging, deteriorating health and the turbulence of peri-menopausal change are taken in stride. This is not to say that women are not troubled by these experiences, rather they are exceedingly candid about their discomfort, and actively pursue strategies, which may help alleviate unnecessary suffering. Yet, it is the composure with which they accept these changes, as a natural consequence of life, which is most remarkable.

Death

The circle of physical life ends in death, which is viewed by these women as a natural process of human existence. Menopause represents a milestone on a journey that will ultimately end in death but this phase of the journey, or the destination for that matter, is not a source of fear for most. Women seem to accept the concept of death with the same intellectual and emotional balance they accept most other natural processes of life.

Do you think we have this outlook because death is natural to us? . . . just like when a child is born that's natural, we all know we're going to die. . . and when someone dies in the community you know it's sad but it's natural and we don't hide our children from it.

Women talk about a natural and balanced flow of life – from birth, through change, to death – it is acknowledged and seldom hidden in First Nation communities. In particular, children are not shielded from death, so they tend to grow up without fearing it. While the passing of a loved one is mourned, usually by the entire community, death is seen as a natural consequence of life, which creates balance in our physical existence. We are born into the physical world and we pass out of it when our time arrives. Those we love miss us but it is accepted as something over which we do not and should not wield control. This perspective is very different than that of western society, which fears death and often attempts to hide it. This cultural difference has important implications for women during menopause, as it is an unmistakable harbinger of old age.

And we have to go through that process. . . Yeah, because you'll see little children running around [at funerals] like, two, three year old, they're all in there looking around and that's part of life. Yeah, they touch and everything - it's [death] no big deal for them. Celebrate the life, it's a celebration. It's another phase. . .that you have to go.

Change

Women described a number of experiences that they perceive as being part of their peri-menopausal transition, thereby demonstrating their knowledge of the physical components of this experience. One of the most common changes are those related to women's menstrual cycles. The diversity, with which this process plays out for most women, is similar to the experience of these First Nations women. The women talked about these changes in surprisingly neutral terms.

But it's not the same for everybody.

When I had menopause, it started up with heavy periods and real heavy and slowly, they just kind of died off and I didn't take anything... I don't know if I had hot flashes or not, but I did have running to the bathroom problems.

But after I didn't have my period for a long time, sometimes I used to go to the bathroom and check my panties, just you know. . .to see that for so many ...you feel there's something and then you check it and there's nothing; a phantom period - so that's one of the things that happened to me, I just thought I'd relate it to you.

But like a year before when I was 50 sometimes - two a month, when I had my periods just regularly, stopped then another month. Sometimes three months – finally it stopped, never took anything, didn't take anything. It's not the same. ..for all people.

Yeah, I used to go long cycles too ...gradually my period was ending, I'd have them maybe twice a month or sometimes I had them longer for two weeks and then as time went by, I would skip a couple of months and start again and it would be three months and then. . .but gradually it disappeared.

Yeah, because you can feel the change. . .you can feel the changing. .. each time, each year and it does, it's so drastic sometimes you know.

I used to have them like the last few months, well almost a year of bad PMS ones and then your periods are starting to dwindle too. .. I've been like that for the last five years, they've been longer and at some point I don't have a period at all like for a couple of months and then back to normal again.

Some women report no discernible changes in their menstrual cycle until it abruptly stops. Likewise, some report no mood swings, no hot flashes, and no memory disturbances. The experiences reported by other women include: changes in personality, eating habits, interpersonal tolerance and health; hot flashes, weight gain, mood swings, heart palpitations, hot or cold sweats, changes in libido, vaginal dryness and/or painful intercourse, sleep disturbances, irregular periods, dizziness, depression, fatigue, memory loss, incontinence, and reduced energy. The gradation and variation in reported experiences is best viewed on many continua, related to the frequency, duration and intensity of these experiences.

... it started out lately, I'll go a couple of days and then I'll have a light sleep, don't sleep well like I used to but I don't know if you need it when you get older. I don't know,' cause I always could sleep in, eight, 10 o'clock in the morning, I can't do that now I'm awake at five. . .

More wrinkles. Being tired easily. Your bones are aching all the time.

Some mood swings but not like really bad mood swings, it was just that I had noticed a change and a lot of the heart palpitations.

Oh god, I go through dizziness...like I say every three or four months I have night sweats and then during the day I literally have to take gravol because I can't stand it, during the day I take a gravol cause I'm just like. . and I can't bend down.

I'm shortminded, I forget, simple things - I forget you know. . Does it worry you? No, cause life goes on. That's what I think about life.

Short memory too. . .like you know. I put something there and the next thing I want to find it, I notice that my memory was. . I couldn't remember where I put things. . .

She [sister] decided to fry a couple of eggs, so she got out a pan and the stove and gee where's my eggs, she lost her eggs . . . so anyway she went hunting for those eggs, she found them in the drawer.

I forget sometimes, I get so scared. . . I have a fridge and a microwave like that, so my husband says "what's the ice cream doing in the microwave?" I put it in the wrong place!

It's still going to affect you. You can have hot flashes and you can have sleepless nights, you're going to have all that stuff...my grandchildren some of them make fun of me they say oh you're getting a hot flash, you know they kind of make a joke of it, cause now you're just a little bit different, you get forgetful and your eyesight isn't that good now.

I know a lady with menopause - it was awful – she didn't want anything to do with her husband or anything. Yeah I've heard that too. I've seen it happen. . .

I don't but, this woman also said about the vaginal dryness was the worst part of her menopause that she went through. . .and she tried all the creams and lotions and stuff and nothing worked. .. and she said it was downright painful.

Alright get over that time, you know grow up and take life for what it is. Things change, you're not going to be sexually active for all your life and you have to be comfortable with that, and that's not the important thing.

Participants observed that most women want to look attractive during midlife and for some women, mid-life changes such as gray hair, wrinkles and weight gain are perceived as unwelcome. While perhaps not as much a focus of attention for First Nations women, body image did emerge as one of the factors which influence women's vision of themselves during mid-life. In particular, weight control seems to become more important to some women after natural menopause or hysterectomy. Although they observed that First Nations women may not be as self conscious about the "signs" of

aging, they did acknowledge that weight gain can create feelings that range from discomfort to depression. In general, women recognize the importance of feeling good about the way they look and of pursuing sensible activities (exercise, proper diet, hair and skin care) that enhance self-esteem and well being. It is interesting to note however, that body image also emerged as an issue of physical fragility and declining health, which was associated with women's ability to fulfil work responsibilities.

As far as the aging stuff goes I think that it bothers women more than what it does men to age and the same way like when you get gray hair I mean I'm constantly dying my hair already. . .I've done it for years. . .

Yeah, but there's a lot of women too that think they lose their attractiveness, they think they lose everything, they're really down on themselves because . . .they're at that age where you know maybe everybody will know right. ..oh she's going through the change or whatever so they poke fun at her . . .she's going to stay away, she can't enjoy herself you know. . .made to feel down.

Keep active. . .keep active. . . I find when you sit home and you start doing nothing that's when you age faster like . . .

Some women try to get out for walks to keep in shape and healthy.

Hot Flashes

The diversity with which women experience hot flashes provides the most dramatic example of the plasticity of this peri-menopausal phenomenon. In general, women report experiences that range from no hot flashes at all to those, which are very mild to quite extreme. Even among those women who report hot flashes, they troubled a few for years but most for only a few months. For some women, the frequency and duration of hot flashes were minor, while others experienced prolonged episodes on a regular basis. Some women only experienced them during the day, while others only experienced them during the night. Some women sweat, while others do not. Among those women who were bothered by hot flashes, some recall the feeling as intense heat or as accompanied by what they described as a panic attack or as a "rush"; others felt short of breath, or "cooked", or dizzy, or just plain hot; some want to be alone, while others just feel nuisanced by the whole experience. A few experienced disturbed sleep, or a lighter sleep or the tendency to wake early and not get back to sleep.

I don't know although like I say all that bothered me was the hot flashes. . . oh well we're all going to get older so. . .

When I was feeling the hot flashes and lack of sleep, I wouldn't sleep through the night, I would wake up and I was tired all the time. .

My periods are irregular, I have night sweats; when I go to sleep, I have my blankets on, the middle of the night there goes the blankets cause I'm sweating and then evening time too, my son goes around turning the furnace on, I go back there and turn it off, but right now during the day I'm cold.

I'm still having hot flashes, it's ten years later. . .Wow. . so everyone of us is different. Yeah. I think mine was like for ten years, but it was like every four months maybe, every six months, I'd wake up with the hot flashes and night sweats . . . Was all this through the night? I never had them during the day. That was good. But I was up all night. . .you know.

Oh really, no I never had them during the day. Mine started when I had my tubes tied, I had them tied when my son was young and right away my period stopped and then right away I had hot flashes for about three months, every five minutes and then that was it. No problem.

I've been getting little hot flashes and I just ignored them, just keep busy and sometimes I don't notice, I don't notice it cause I'm busy.

The most plausible conclusion that can be drawn from these experiences is that diversity appears to be the norm. Like puberty, women's experience of hormonal change is unpredictable, individualized and subjective. Any suggestion of universality can only be broached in terms of potentials – women may experience any number of the potential expressions of hormonal change – one the other hand - they may not. For those who do, the experiences will likely vary as widely as any other hormone-related experience (i.e. puberty, menarche, menstruation, pregnancy, childbirth, post-partum). For instance, while we often discuss the process of birth in generalities (i.e. contractions, effacement, delivery), no two women will experience exactly the same labor – nor, for that matter, do most women experience the same labor and delivery twice. Suffice to say that women generally experience something during the peri-menopausal transition – but not always something that is particularly noteworthy or especially troublesome.

Hysterectomy

A surprising number of women in this study reported having undergone hysterectomy. Whether they represent increased use of this procedure among First Nations women or whether this large number is an artifact of the recruitment process, only future research will discern. These women do however, provide valuable insight into the experience of reproductive and hormonal change. The two most common experiences of these women include sudden hot flashes and weight gain. However, it is difficult to know whether weight gain is an outcome of hysterectomy or a product of dietary changes that might be related to coping with the diagnosis of uterine disease and subsequent surgical intervention. These women did report that they were told prior to their surgery that they would gain weight – and so, the power of suggestion might also serve to explain their weight gain. Women reported drastic reduction in physical activity after hysterectomy, providing yet another potential explanation. They were also told that they would lose their sex drive after surgery and, lo and behold – some did! This presumption of diminished sex drive seems to be pervasive.

I just lost it. . I don't have no sex drive at all. After I had the hysterectomy I found a big change.

My friend she went for a hysterectomy too. . . [she asked] "you dry up yet –no – me either." It's ridiculous. O.k. guys explain that to me. . I don't know cause it never happened to me. It's men that come up with all this.

Yeah, hot flashes, Weight control. . .after you've had, like I had an hysterectomy and then from there I went right into menopause and actually the only thing, the hot flashes was the only thing that affected me, but I find it's harder after that to control your weight.

And I gained a lot of weight. After you went off the pill or. . . No, when I had the hysterectomy.

Having the total hysterectomy between like a couple of months apart, you know but other than the sweats you know everything that they talk about it's menopause. .I didn't have any of that until after I had that total hysterectomy.

When I had my surgery I woke up wow no more periods you know, because I had a horrible time, I almost lost my life over that, I hemorrhaged. . .so that was a bad

year but after like two years after the surgery, and oh my god I went through. . . I would cry.

One can only speculate about whether women's emotions are a product of sudden hormonal change or whether they were rooted in the changes wrought by this experience to women's self concept – to their sexuality, femininity, fertility, or wholeness as a person. They report receiving little or no information and that what little they did receive, was written and/or presented in such a way as to alienate or confuse them. Most of the women conceptualize their experience as “not normal” and felt unsure about where they fit in discussions of menopause. It seems that hysterectomized women tend to be excluded or to be separated from “normal” menopausal women – thus further fragmenting the experiences of this group.

Well when I went for my hysterectomy, the doctor - all she told me was you've got to go for a hysterectomy and blah, blah,blah and here's a pamphlet you've got to read and this is menopause thing. . .what? You know. . .right away when I was heading out to the O.R. and she gives me all this stuff, this is my doctor that's going to open me up in 5 minutes and that was it and she said and you have to take these pills for the rest of your life.

Cause nobody talks about it. . you know if you don't talk about it, like you said you don't know. . .I went for my hysterectomy, I was going through menopause and all that, and they just show you like a pamphlet and you read it, you know why don't you tell me what's going to happen to me?

Emotional Balance

In discussions of emotional balance health, women focused most on the connection between emotional health and their interaction with others. This theme emerged as one in which balance became increasingly important. Negative and positive feelings converge in women's most intimate relationships. Balance is achieved through women's acceptance of the potential for emotional extremes, which become emphasized for some during peri-menopausal change. Women traverse the change in strength and fear, in sadness and joy, in loneliness and in blissful connection to those they hold dear. Balance is sought and found in the tension created by these emotional extremes and life is lived fully in the acceptance of emotional diversity.

Range

The expression of women's mid-life emotions ranged from inconsolable crying to uncontrollable rage. Despite these emotional extremes, most women report that they were less dramatic than anticipated, particularly in relation to feelings of anger. However, a few women did reveal experiencing feelings of intense anger, which they describe as overwhelming and uncontrollable.

Oh yeah, I've . . . like your . . . you're touchy or whatever, like if your family didn't do something oh my god you know how dare you not do this and you know. . . oh all I've done for you and you know. . . During that time, I used to cry. . . constantly . . . and then when that happened during that time.

I was mad, yeah. Just get mad for no reason. Or you want to cry or something but you don't know what it is. Mood swings. Yeah, behaviour. So like crying or mad or what kind of.

I do a lot of things at home you know. . . but once I get to that point you know I know I'm going to blow up. You know before you blow up something's coming. And it's overwhelming. Like a panic attack.

Some women described mood swings as mild, yet most of them recognized that even mild emotional changes might be difficult. Women often described themselves as becoming more tender, particularly in relation to their feelings; they stress the interrelatedness of these experiences and how they may overwhelm women. Some women also report feeling anxious during this period of change and describe the sensation as “jittery” or as “having nerves”. Some women reported caring less what people think of them. They perceive this enhanced sense of self as being tied to emotions and while women remain committed to their families, they tend to focus more attention on their own health – including their emotional health.

Maybe we don't care so much about what people think. Yeah, because you know at that time too you're going through something. . . please just leave me alone until I calm down or whatever right but it don't happen so, you're going to get bitchy. .

Afraid of rejection. . . I don't know, whatever's in front of them - if it's family, spouse, kids, youth, it could be anything.

Having the blues and the kids come around and opens up the world that's how I feel.

Depression was not entirely uncommon among this group of mid-life women. They described depression as feeling down or as emotionally exhausted. Situational depressive mood was often linked to family responsibilities, to unresolved pain, and for a small number of women, to lost youth and fertility.

Some women I know they feel depressed when they go in for medication and they don't know what's wrong, what's going on with their body, they don't know. They don't know how to handle the feelings. They just have to love themselves, that's how I look at it.

Women were aware that peri-menopausal anxiety can be exacerbated by situational contexts, which create additional stress for women who are already experiencing some degree of emotional exhaustion from the ambient stress of hormonal change. Women also described feeling overly sensitive about issues that might not have bothered them as much when they were young. In particular, traumatic experiences may contribute to an emotional milieu that creates additional barriers to women achieving emotional balance during mid-life change.

They used to say at one time that the woman has gone crazy . . you know. .and then institutionalized all of the women.

Post-traumatic stress. . . and it just snowballed from there you know. . .they need you know a professional, they need doctors who are aware and who are sensitive.

It is important to note that the post-menopausal women in these groups claim that the emotional lability of peri-menopausal change is transient and often followed by a well-earned sense of calm.

That seldom happens to me but I used to get mad. . .I'm mellowing now. Past the madness. Yeah I'm past it.

I find that I'm more calm, I am now than I was like 30 years ago or whatever. I'm more calm, you know like my kids. . .their personality has changed too.

No, and your own emotions, you don't really have those highs you know, that anger and all that . . . everything just kind of subsides and you're kind of going along.

Fear

Fear emerged as one of the emotions women experience during peri-menopause. Sometimes women describe the fear as ambient – without a source they can name. It can become pervasive however, and begin to colour other experiences, even positive ones. In many cases, fear is born of uncertainty about what to expect during this transition.

And some women enter it really afraid, really afraid like they're heard the horror stories. Yeah, and that's what scares them.

I heard horror stories.

I know a lot of the stuff people. . . it was scary what you heard, sometimes I heard stuff that people were crazy. . . Running around on their husbands, take off with young men.

This fear is often an old one – born in their adolescence, when changes occurring within their bodies, but outside their control, left many women ill equipped to respond to similar changes during peri-menopause. Without balanced information, women are left in darkness and silence – a frightening place to be sure.

They should tell you; even with periods, I remember when I had my period, that was a long time ago the first time and mom went somewhere, she was selling baskets and I heard you know. . . that's what I thought so I didn't go, I didn't urinate all day, I thought this was how it's supposed to come out and she came home about 10 o'clock at night and I didn't go to the bathroom all day and I had gone to sleep the night before that, see I thought that was part of it you know you get so stupid, you're going to pee the blood you know, they'll just tell you that.

But I think it's better that they know a lot more now than we used to because me no one knew what was happening to me, figuring I had cancer when I had my first period like you know. [another woman responds] - That's nothing, I thought I was going to have a baby every month! When I found out how babies were made from some kid at school and I ran home and said to mom, "you did that five times?" - yeah only five!

Dramatic emotional experiences can lead women to fear that this transition will change their relationships or harm the people they love. Most women perceive themselves as nurturers and the idea that they might lose control along with their capacity to nurture their families, can be a devastating one to contemplate.

But I was scared, like I was scared, like I wouldn't remember like getting mad at my boy cause he means the world to me and my husband. .. like I don't want to lose control like in the house. Like it's kind of scary and I heard these things, like you wouldn't be aware. ..

Without a clear understanding of what to realistically expect, women are left to wonder, or to dread, all manner of possibilities. The darkness of the unknown is a breeding ground for fear – that debilitating feeling robs women of their strength and of their natural intuition. Fear diminishes women's ability to care for themselves and for their families, which can be devastating to their self-concept.

Sometimes fear, just the fear of the unknown can be. ..make it more difficult, you might have some little thing happen and because you're already afraid. It's scary - really scary.

Loss

A few of the women in this study revealed feelings of loss during perimenopausal change. These women often exist in a bi-cultural state that is infused with western values of youth and beauty, so they may perceive a sense of loss during mid-life. They are often not prepared for the physical changes brought on by age.

Yeah, but there's a lot of women too that think they lose their attractiveness, they think they lose everything, they're really down on themselves because . . .

I wasn't really worried about menopause 'till I started feeling...I started missing periods...

Although admittedly relieved of the monthly burden, one woman expressed some sense of loss around her period. She talked about the regularity that, after so many years, was more difficult to let go of than she imagined. Although she was the only woman to

share this, it occurred to me that other women might experience this feeling. A few women also revealed some nostalgia about motherhood.

I was pretty near crying day and night... I like to have a baby. I told him, gee I was crying and crying. ..then years went by, 15 years before I got over it.

When I went through menopause I had my first grandchild and all of a sudden I wanted to be a mother. . . for months.

But after I didn't have my period for a long time, sometimes I used to go to the bathroom and check my panties, just you know. . .to see that for so many years - but you feel there's something and then you check it and there's nothing; a phantom period so that's one of the things that happened to me, I just thought I'd relate it to you.

Blood is tied to something very personal and very powerful; it belongs to each woman and to a time in her life that is full of promise and potential. The rhythmic cycle of her life becomes such an integral part of her that its loss may be mourned in ways in which she is unaware. This “phantom” cannot be experienced without some feeling – slightly different for everyone and more or less meaningful for each woman, it is nonetheless very much part of her experience of change.

Stress

The everyday tension and demands of women’s lives creates additional stress during peri-menopausal change. If women do not receive adequate support during those times of increased stress, they are more likely to feel unappreciated by grown children or partners. Families often don’t understand what appears to be unreasonable and unfounded stressful reactions and attribute them to menopause. Women often cannot make sense of these feelings either.

Yeah, more involved as they get older - you're more involved and busy. Do you feel that you're more stressed? Oh yeah, definitely. That's how I feel. Yeah, I feel like that.

You know you come home and after working all day and maybe the dishes are still piled in the sink, oh and they say you're never happy anymore. . .and I'm like how can you be. . .and the laundry, you cleaned up all the house and laundry is all

done, and when you come home it's a mess and boy how can you be happy. . .you know. [another woman says] Hey, I'm in the same boat, same thing - housekeeper.

What was once perceived as unquestioned responsibility, now becomes interpreted as unrealistic expectations. There are a number of possible explanations, the first of which relates to women's maturity and evolving self-concept. Many are no longer content with the double workday of their mothers and grandmothers or of their own youth. A new self-concept shifts their gaze so that they view their own efforts more realistically and they begin to expect more of those for whom they have provided care over the years. An alternative explanation involves women becoming less bound by social norms, which effectively silence young women from voicing resentment, which tends to build over many years, during which they toil for their families and communities. Age frees women from the expectation that they will bear things in silence and they feel freer to voice their discontent over inequitable responsibilities.

Strength

Like other groups of women, this group viewed strength, particularly emotional strength as a resource. Nurturing that personal resource is critical, especially at a time when women may perceive their physical strength is diminished. Psychological or emotional strength figures prominently in women's journey through peri-menopausal change. That is not to say that strength has not always been with them or that it has not been the cornerstone of First Nations women's lives beyond the oldest memory. But that strength becomes less diffuse - more concentrated during women's mid-life. Women discover – or should I say re-discover (because every little girl feels this but somehow, loses it on her journey through womanhood), their capacity to make great change in their own lives and the lives of others, to free themselves, to renew themselves, and to push themselves and others.

[Interviewer asks] Do you think that work, that women working has any influence on their experiences. Do you think that might influence it? [One participant says] I think it makes them stronger. [Another woman says] Yeah, exactly. . it helps take your mind off it. Makes your mind stronger because they've got nothing else to fall back on.

Female strength is valued in most Aboriginal cultures. For women who practice the traditional spirituality of the Mi'kmaq people, menopause is viewed as a sign of strength, unlike the expectations for many Euro-Canadian women, who have traditionally been seen as the weaker sex (even though this label is fallacious in the extreme). Before the intrusion of European culture, First Nations women worked side-by-side with their male partners during times when egalitarianism was the norm. To be a woman is to be strong. This mantle of strength is born with pride and with some measure of ambivalence, for it is accompanied by inequitable responsibilities, for self, family and community. The expectation is often that exceptional responsibilities will be shouldered without comment or complaint, and without thanks or appreciation to the benefit of others, despite the detriment to women.

And I think that's the message that we got when we were growing up, that being a woman you have to be strong, you know and it's almost kind of can be a little bit of a detriment when it comes to a relationship with a man because you kind of. . I grew up thinking. . . You take over. . . Yeah. . . thinking that men are weak you know.

Mothers and grandmothers teach the value of female strength, their words and their actions guide daughters and granddaughters to value strength and stoicism. Past generations of women displayed physical strength through endless hours of work and emotional strength in the quiet, undemanding assumption of whatever burden had to be born. Acceptance emerges once again as a fundamental truth of First Nations women's existence. "We do what must be done", reveals an understanding of a world that is grounded in reality, rather than idealism. Women recognize the ways in which this edict has changed and the ways it has remained unchanged. Modern life has brought with it a measure of freedom from many of the burdens their mothers bore, yet the manner in which these women shoulder their own responsibilities, mirrors the same quiet dignity as their mothers, grandmothers and great grandmothers before them.

But my mother was like a real strong person and she . . . well no you just have to work through it, just go to work you'll be alright because they used to go walk.

My mother walked to town, swept floors all day, walked back with groceries because she didn't want to spend the extra on a taxicab, and she went, whether she was sick, whether she was having her menopause, it was just something that she had to do.

Our mothers - they did a lot, they did a lot more. . I know my mother did a lot . . .cooking, walking.

' Cause they never complained. . I bet your mom never complained about menopause. Well she did complain about it but she didn't understand it . . .

They didn't dwell on their sickness too much, they didn't have time - they just had to work.

Several theories emerge to explain this sustained edict of female strength. The first relates to cultural values of stoicism. The next relates to cultural norms around complaining or drawing attention to oneself. The third relates to weakness - historically, the challenges faced by Aboriginal peoples left little room for error. Everyone, women included, had to contribute to their family and community. Complaints did not contribute and were thus discouraged. Acceptance of what must be done in order to adapt to changes and attend to the daily rigors of life was expected. The fourth relates to the third but deals specifically with the harsh realities of colonialism and the ensuing encroachment on Aboriginal lands and intrusion into Aboriginal lives, which created difficult realities that could not – until recently, be changed – so, had to be borne. “That which does not kill us makes us stronger” – “that which cannot be changed, must be accepted” – both may be aptly applied to the cultural imperatives of the Mi’kmaq people, upon which women address the change of life. Strength, which is always present, must be harnessed during times of challenge. Taught the harsh reality of an Aboriginal existence early in life, mothers and grandmothers attempted to instill the same determination and tenacity in their children, so that they might draw on that strength during the harsh reality of residential school, the hardships brought on by a colonial government and the blood born, historic trauma of attempted ethnocide.

When physical strength is waning, whether from chronic health conditions that plague First Nations women or from the slow onset of old age, with its consequent aches and pains, women draw strength from their ancestors. Ever practical, they find ways to

complete the tasks they assign themselves; they listen to their bodies and discover a different rhythm, a slower pace in order to do all that has been set out for them to do.

Now I feel that my body is out of balance, cause my iron is a little low so it's catching up on me so I'm going to have a little rest, a little rest time, take a break on one of my jobs for a couple of weeks, take time for me, for my body to rest. I find ceremonies, traditional ceremonies, talking circles, sweat lodges, they help me for body, mind, spirit.

I don't think you have the energy to do as much. Physically I think you. . . I for myself, I don't have the strength or the energy to do. . . well I do things differently, I used to be able to do a chunk of stuff like this period of time, now I can only do it this time then I rest and I do it, you know I have to divide it differently.

True strength lies in understanding ones own nature; in recognizing the delicate balance between staying the course through challenging times and draining oneself of precious emotional resources, which are needed by everyone. Acceptance is an element of women's strength, but it is the practicality with which they wield it, that best reflects their wisdom. Others recognize this strength, in the explicit ways they are sought after to act as family and community supports, and in the tacit deference shown by those for whom they care.

Social Balance

Within the broad theme of balance, the concept of social relationships emerged as one of particular relevance for the women who participated in this study. Through discussions of mid-life balance, women identified the sources of their most significant social relationships as well as the most meaningful dimensions of those relationships. Although each dimension exerts a distinct impact on women's subjective experience, they are conceptualized as an interconnected network, within which collective influence is experienced.

The interrelationship of concepts, which influence First Nations women's mid-life experience, create a challenge in deciding where elements fit best in a discussion. The context and quality of relationships is an essential element in women's discussion of mid-life health. Balancing those relationships is an integral part of their lives. Although the concept of social interaction is explored in the section about relationships, I have decided

to also discuss findings, which relate specifically to how and why women balance relationships as part of the process they undertake to find balance during the mid-life transition. Yet, the strength of this determinant of women's experience is such that it merits a more in-depth analysis and discussion, which will be included later in the text.

When asked about what is most important to them, almost every woman reported family as foremost in their thoughts. Yet, as discussed earlier, during this stage of life, some women feel a need to be alone, a feeling that they might never have experienced before. Women worry about how their behaviour will impact the health and well being of their family. Women experience a somewhat disturbing tension between increased value of relationships, at a time when hormonal change may make it more difficult for them to cope with the stress inherent in human interactions.

All this big stuff, it's nothing big, it's all simple, everything is not important, all that's important is how you interrelate with others you know - without really hurting another person intentionally, you know we all hurt somebody unintentionally at times, but that's what's important.

Yeah it becomes more intense. . . more intense like you want to be by yourself you know and then when you're by yourself you don't want to be all alone.

Most of the women in this study reported some mid-life change in the way they interact with others. However, these changes were as diverse as the women themselves. For instance, those who were deferential during their youth may become more outspoken, while those who were irreverent in their youth, may become more concerned about offending others. These feelings may reflect an inter-relational manifestation of hormonal change but they may also result from changing social role expectations for aging women. Some women may attempt to balance changes in family structure and dynamics, while others may suffer role confusion, related to care giving and care receipt, in their attempt to navigate the changes occurring in their social relationships.

The way we were brought up, no matter what that person is doing - you respect them, and you know that's hard to do but then when you're at this age and somebody is rude, not being respectful, you've got to let it go, you know that's them, it's not towards you, let it go, they go through that - you could be happy

and to get picked on you know, release some of the anger and go out maybe and do other things.

I was more outspoken when I was younger, I'm being more careful now about hurting people's feelings as you get older. Now, I'm the opposite; when I was younger see I wouldn't, I wouldn't say anything but now I'll speak my mind if I don't agree with something, you'll know I don't agree.

As being bitchy. . .you know , maybe we don't care so much about what people think. Yeah, because you know at that time too you're going through something – “please just leave me alone until I calm down” or whatever right but it don't happen so, you're going to get bitchy. . .

A few of the women perceived that a loss of attractiveness, vitality and sexual capacity affected their social relationships. In attempting to hold on to the vestiges of youth, women may experience more difficulty making the transition to mid-life and eventual old age. Unfortunately, despite the acceptance of age in Aboriginal cultures, First Nations women are not immune to the same messages that Euro-Canadian women receive about the value of youth and its tenuous link to beauty. Bi-cultural forces may create additional tension for women who, while accepting Aboriginal values of deference and respect for elders, are also susceptible to social pressure to conform to western standards of beauty. Depending on the degree to which they adopt these social values, women may experience similar difficulties with the notion of aging and with menopause as a symbol of female age. While I am pleased to report that this problem does not seem to exist for most of the women who talked to me, I don't want to discount the issue for those who do experience difficulties related to this very significant issue.

Some get really upset about it. . . I have a friend that's turning 40 and I'm telling you she was in a real crisis because she was going to be turning 40. And I think actually a lot of it is because I value age. . . It depends on how you age. I mean if you're turning 40 or 45 or whatever - well yeah then everything is going to come down on to you but if you don't feel your age I think that has a lot to do with it; it's how you age.

As far as the aging stuff goes I think that it bothers women more than what it does men to age and the same way like when you get gray hair I mean I'm constantly dying my hair already. . . I've done it for years. . . but it doesn't really. . . bother me and as far as getting old I really don't think about it. . . But more women dye their hair than what men do right?

During mid-life, women report enjoying the company of their family and appreciate these distractions from discomfort associated with hormonal change. However, the care giving role is so firmly entrenched in their social position that women often overtax themselves before they realize that an imbalance exists. This can lead them to seek time alone, to regroup and relax. This issue seems to be more common among women who are experiencing peri-menopausal hormonal fluctuations, rather than women who are post-menopausal and have achieved some degree of hormonal and social equilibrium.

But sometimes it could be an overload. . . That's the thing. . . And they just don't fully realize it, they just. . . caring overtakes everything else.

Strong mother-daughter relationships emerged as an important element of many women's experience of change. Women who had children early and now have grown daughters, often relate to them as close friends. This aspect of indigenous cultures, including African-American Black cultures, some immigrant groups as well as some rural groups, differs somewhat from the majority Euro-Canadian culture, in which children are often expected to leave home in their late teens or early twenties, and move some distance from their parents. First Nations people tend to stay connected to their home community and, by and large, remain in very close contact with their parents. While there are obviously exceptions to this rule, in general, First Nations women can look forward to the support, and sometimes the responsibility, of their children throughout their elder years.

As women get older, they can become a friend to their children – they also remain close to your nieces and nephews.

Oh god no. I have one, she wants to move but I like her being home so I can do things for her cause she's not feeling good. We are happy being together you know. What are we going to talk about today. I think that's a sign of the times too, kids are moving in, they leave and they come back again, like they don't get settled outside like we did . . . by the time we were 30 we were all settled outside.

Intimate involvement in children's lives is not always viewed positively. For some women, the anticipated years of relative calm and relaxation do not materialize as they expected. Close relationships also present a double-edged sword, in which intimacy has a price and is subject to "fall out", which may result from difficulties related to individual personalities, conflicting expectations, and family dynamics.

To me my relationship with my family is very important but the way I see the relationships is different than what they see, how they see it and I've had to learn that and you know it looks different from their point of view so I've had to make kind of an adjustment in my own head as to what that relationship should be like and you adjust and you take what you can get and you just concentrate on yourself you know, that's what I've had to do.

Many of these mid-life women reported becoming more invested in the quality of their relationships and the role those relationships play in achieving balance. For some, self-reflection and a broader life perspective enhanced their capacity to engage with others in less confrontational ways. They also reflect on an increased capacity to forgive and to appreciate the role they might have played in problematic relationships.

I think as I get older, one time I wouldn't forgive, you stay in that corner and I'll stay in mine. . . go about my business and stay on your side of the fence. . . as you get older. . . as I got older it's easier to forgive, I think we can look back, we have that experience and we can look back and you reach a certain part in your life and you say well I wasn't perfect after all you know and I made mistakes, and you learn from those mistakes.

Women's social networks also expand during mid-life, whether from their reduced care giving for young children, retirement from work or from the increased value they place on relationships. Women who might not have interacted in the past, may find that they share more in common.

I think that's good as opposed to having one tiny little friend that you hang on to. We don't cling to one person, there's a mixture and I don't know if it's because we're Native - I don't know but I see that. I think maybe when you're younger you have this one special person but that changes as you get older.

Yeah and not only that, you see what other people can offer you know, it isn't just this one person that has everything that you need like maybe comfort, one will do a little better than the next one or you're more open to some people but. . . You see the value in front of us.

Comfort and commiseration become critical components of coping, particularly in relation to sharing experiences with women who have common backgrounds. Women talked specifically about the benefits of living on reserve and the subsequent opportunities for support and sharing with other women. They celebrate this distinction of their culture and the opportunities for growth that come from access to a wide and supportive network of kin, extended kin, and lifelong friends.

I think that's the beauty of being in the community - all these places that you can tap into you know and you're always connecting with someone, doing something. And I think as a result of that because the way we (Native women) are, that we intermingle a lot with each other. . that's a good learning experience also to grow.

Women's relationship with their own mother seems to become notably highlighted during mid-life. They no longer relate to their mother as young women, and begin to appreciate the contribution (beneficial and the not-so-beneficial) she has made to their lives. Some women re-establish a relationship with their mother after many years of tension, while others seek a connection that time and circumstances have restricted. Still others enjoy the same close, loving relationship with their mother that they have had since their youth. This mother-daughter relationship will be discussed in greater detail later in the text, as it merits a separate discussion.

When I was younger I couldn't stand my mother, I mean we didn't even get along, we didn't even so much as talk. . let alone try to get along in the same room, now I'm with mom I would say almost 24 hours a day and I really value my mother now and I think that all changed when I was around 40 probably when I was going through the change of life . I didn't realize I was a woman and then I look at her and say you know this is Mom, and she isn't going to be here forever so I'm going to be there as much as I can, as often as I can, cause I don't know how long she'll be here, you know it may be ten years, may be five, may be twenty but I'm going to be there and just enjoy what she has to offer.

Ironically, some degree of disengagement also represents an important element in achieving social balance during women's mid-life experience. The changing circumstances of growing families and the ensuing changes in women's roles necessitates a re-balancing of these relationships. This is particularly true for women's relationships with grown children. Although women want to remain a support, they do not want to become so involved in their children's lives that mid-life physical and emotional stress is exacerbated. Sometimes women are required to refocus their attention away from the minutia of family life and to develop a greater sense of self, a transition that is not easy for everyone, particularly for those who maintain a value system that may be somewhat different than that of their children.

When you have several children living away, the phone calls, some of the stress you know and I'm able to hang the phone up, have a good conversation at the end we're kind of laughing you know and the other person is. I can let go and hang up and not worry, I can go to sleep afterwards - try not to give too much advice you know, cause I never liked advice when I was their age maybe too much of it, unless I asked for it. So I'm able to let go, I guess that's the word. . .and they have their future and I wouldn't want to influence how come to settle their whatever, their problems.

Women often acquire an enhanced appreciation for their contribution to relationships and this new self-concept defines them in a new light. Increased self-respect and value also creates a greater awareness of the ways in which interactions affect their overall health and their experience of menopausal change. Heightened awareness brings them into closer contact with feelings that might have been ignored during years when family and work and others demanded their attention. Acceptance emerges in women's discussion of balancing their response to relationships that are disrespectful or destructive. Through acceptance, emotional balance becomes linked to achieving interpersonal balance.

I've become important since I've gotten older. I'm more focused on me and my needs because I don't have anyone else to focus on, I'm kind of forced into focusing on myself and it took me a while to adjust to that but it's fun, it's good, I have some time for me and it's almost like a new beginning.

I guess it all depends on where you are in your life, how you deal with it so I can see where it can be depressing because you know if you find yourself alone and you are in menopause right you know you might not have too many positives to face right so I think until you can reach acceptance, you can move on then just accept it as another stage in life.

The values instilled during childhood become emphasized during women's mid-life relationships. Although these values have always been an integral part of women's lives, respect, forgiveness and acceptance become highlighted during the reflective years of mid-life. The value of friendships and support as well as the give-and-take of relationships is keenly important and women achieve an enlightened perspective by way of those relationships. Women experience peace through their attention on living in the moment, rather than worrying about what tomorrow might bring. These women are also better able to accept the ebb and flow of hormonal change.

Gender

Gender balance is generally evident in the way women talk about men's journey through mid-life and, while specific experiences may differ, they believe that men and women both experience important changes during this time of life. However, women do reveal some feelings of imbalance relative to gender through their acknowledgement that aging is likely to affect women more than men. This is not surprising when we consider that the oppression of First Nations people has created multiple jeopardy for women, that is likely felt more acutely during the reflective years of mid-life. Aboriginal traditions of gender equality and egalitarianism have been eroded by years of social and political pressure by Euro-Canadian society.

Balancing gender roles often requires women to accommodate social pressure on First Nations men to adopt a stereotypically, powerful male role, while it is openly acknowledged that women are the center of family life and the glue that holds communities together. Women feel the pressure of having to remain strong so that male partners and children will not become distressed. While men may have a number of outlets to express themselves, women do not always have the same opportunities because their emotional health often provides a template for the entire family. Women sense the

inequity of these social responsibilities, yet in true fashion, accept this as a part of life, over which they have little control.

Men do go through. . . They do go through a stage but it's not nearly as drastic as a woman. . . change a life, to have a fling. . .they blame it on the change of life. . . Honest to god.

Sometimes men go through a hard time at that time cause women are distressed and they are showing a weakness the whole family kind of buckles, yeah they kinda come down to and get kinda depressed. But they won't admit that they go through that, men wouldn't admit that, oh yeah, what are you trying to say. They're not allowed to. . . No, they have to be Macho Yeah, they're the hard, cold, quiet type. Yeah, yeah, Until they get home. Watch out eh!

Don't try to show it[stress] to your family but you show it to each other when we call each other up and say hey I've got to come and talk to you.

Family responsibilities emerge as a stressor for mid-life women, thus a supportive partner, not only provides practical and emotional support, but also reduces women's overall stress by reducing her workload. The support these women receive allows them the time and attention they require for self care during periods of physical and/or emotional discomfort. Some women talked about how their husband takes the children out so that they can have some quiet time alone. Others have partners who take care of the children so they can get out to visit with friends, or calm themselves down and regain their composure after a stressful event.

Oh yeah, if they don't get along. . . If you're with somebody that's supportive. . . it's better.

Well mine anyway he was great about it. Like supportive, yeah, and if I . . .he knew when something was wrong with me, he would just leave and he'd take everybody with him or you know, and I'd be there with a big smile on my face. . I got rid of them! That's the way he felt, if he knew there was something wrong and I was bitching around you know, he'd leave and he'd take the kids with him.

According to these women, a supportive partner plays a key role in enhancing a woman's experience of menopausal change. In particular, men who take the time to learn

what they can about this process and to accommodate the physical and emotional expression of change can alleviate much of the external stress women experience.

I'd just turn on the fan or put it near my bed if I was too hot, take my husband out, like I wanted to be alone.

My husband and I have herbal tea - we drink in the evening, he's got high blood pressure and so we drink the green tea at night or the sleepy time and we just sip on that, that's our hot drink for the night.

Women who are raising sons while going through the change sometimes take the opportunity to teach these young men about the reproductive changes women experience and encourage them to be gentle and compassionate with women. This connection and teaching, particularly between mothers and sons is another Aboriginal practice that stands as an example for western culture. Strong family connections encourage empathy in boys and a greater likelihood that they will grow into men who are equally empathetic and supportive with their life partner.

And my son - and some girls get crabby or mean, and it's well you just let them go with the flow. Be patient with them. . . yeah be patient with women and respect them.

Sexuality

According to these women, balancing sexual relationships can become challenging for women during a time when hormonal fluctuations may create transient changes in sexual desire and function. Vaginal dryness may lead to painful intercourse, after which women may become less likely to initiate sex and less responsive to initiation by their partner.

I just lost it. . I don't have no sex drive at all

I know a lady with menopause - it was awful – she didn't want anything to do with her husband or anything. Yeah I've heard that too. I've seen it happen. . .

I was kind of like - ah I can take it or leave it and now I'm like. . . . After I had the hysterectomy I found a big change.

I lost it years ago. But they say it comes back when you're in your sixties. . . I'm waiting for it to get better.

Most of the women in this study have heard stories about the “dried up old women” they will become and some may even buy into that misinformed perspective. Unfortunately, this may become a self-fulfilling prophecy, as women’s experiences may appear to support the misinformation they receive.

Sometimes you hear people say you're old and you're dry you can't even have sex you know all that - you're all dried up.

I know something else. . . that you think of, that you're supposed to think of. . . I don't but, this woman also said about the vaginal dryness was the worst part of her menopause that she went through. . . and she tried all the creams and lotions and stuff and nothing worked. . and she said it was downright painful.

You know you can't have sex cause you'll dry up. . . What's that – what's wrong with us? My friend she went for a hysterectomy. . . you dry up yet – no – me either.

Yeah all dried up and nothing but an old lady.

Several women reported that they continue to enjoy a satisfying sex life well beyond menopause. For these women, mid-life change represents a time of sexual freedom. They report a general sense of sexual well being – a certain calmness they did not possess as young women. They are now past a time in their lives when contraception – or in the case of some women – uncontrolled reproduction influenced their sexual freedom. These women have discovered the balance between their new hormone levels and the freedom of not having to concern themselves with contraception or the relative lack of privacy that comes with a houseful of young children. Enhanced self concept may also be related to the relatively high degree of sexual satisfaction that these post-menopausal women seem to achieve.

It's good nowsex is better, you don't have to worry about getting pregnant.

There was an old lady and I was asking her about menopause and I asked her about her experience and she said that was the best time of my life, she said sex was never as good as it was then!

Yeah I like my teepee, hell yeah girl I like my teepee, didn't we all. . .(laughter)

And then it's the individual choice really in everything you do. . .what are the advantages of it is knowing that you can't have children anymore you know and you will be enjoying your sex more so hey, give me more you know. . .

And it relieves a lot of stress and anxiety and all this stuff and sex too. There's one lady who says this is better than sex. . .I'm so relaxed.

Balancing all aspects of intimate relationships, including the role sex plays in those relationships, is reflected in women's arrangement of sex in the context of their lives. Many women achieve a new comfort about sex because they have achieved acceptance that their sex life, much like their life in general, may change. "Going with the flow" emerges once again, as an important element of coping with mid-life transitions.

Spiritual Balance

Spirituality emerged as an important determinant of women's overall health, which becomes increasingly emphasized during the peri-menopausal transition. Faith, in whatever form it takes, seems to sustain women through this sometimes-difficult transition. For many women, spirituality has always been a foundational component of life and provides the value system upon which they conduct themselves and raise their children.

Spirituality and the church –becomes very important ...but not everyone feels comfortable going to the church in their own community. When you get older – you go back to the religion that you were raised on. Some women feel it's very important to keep their kids in religion – it helps them.

I'm grateful I do have a lot of faith given to me by you know our people and that helps.

So - I'm happy with myself today. . .contented with myself, whatever the Creator has in store for me, I'm ready for it, ready or not, I'm ready for what there is out there for me. I don't plan for tomorrow, I make my plans just for today, tomorrow's not here yet. I thank the Creator for each day and for what I have, I have my son and I have a home, I always have food on the table and my family, I have my friends and I have you.

The enlightenment and clarity, which emerges during mid-life, prompts many women to re-discover their spirituality. Some women practice Euro-Canadian religious traditions, while others practice traditional ceremonies such as the sweat lodge, pow wow and traditional prayer, all of which contribute to their spiritual strength and help them connect more deeply with themselves and others.

Oh yeah, definitely, I don't go to church anymore. ..there's nothing wrong with church, I have no problem with church and I will go to church when it's important to people that I care for but no, I pray traditionally now, I do sweats and other things. But that's just my choice. But that's important. . .trying to live it daily.

Some women turn to spirituality to keep from worrying about things ? Native spirituality and rituals is important.

I find ceremonies, traditional ceremonies, talking circles, sweat lodges, they help me for body, mind, spirit.

The re-emergence of Aboriginal spirituality was reflected in the perspectives and practices of several women. Beyond their involvement in traditional ceremonies, they also reveal traditional metaphysical beliefs about a connection between the natural world, human existence and multiple domains of spirituality. Women express particular pride in the spirituality of First Nations people and the way it benefits them in general as well as in specific ways relative to the peri-menopausal transition.

And elders have so much wisdom, knowledge of life and I look up to the elders and that's the beauty of it, of growing old, babies, a new born baby just being born, the Creator has brought in a new life for the baby it's more closer to the Creator, little child and an elder is old, so closer to the Creator too because that time is coming close elders are going to leave us in body but in spirit will always be with us, and will be in the spirit world you know. That's how I look at it the beauty in growing old. Our bodies change, everything changes. ..yeah, that's how I feel.

Yeah, it always comes back. That circle - always coming back.

For those who practice Aboriginal spirituality, the emphasis seems to be on connecting with emotional or spiritual stress and releasing it through the body. This

ideology works especially well during the peri-menopausal transition, when emotional and physical experiences respond well to traditional healing. For instance, heat and sweating, often pathologized in Euro-Canadian culture, are emphasized as an avenue of healing and spiritual growth.

It depends on how much stress you're carrying right, some people just sit there and they don't even sweat a drop. When I first started, it didn't bother me at all, but now when I sweat, it really hurts; if I'm praying for people who are sick or people who are having a hard time and. pouf I'm right out, I can't handle it. it's really, really hard, so the more you do it, the harder it gets really. Cause you're praying.

According to some, post-menopausal women, who are no longer restricted from participating because of menses, are valued for their ability to sweat. The release of sweat, through heat, in combination with enlightenment and contemplation, is of spiritual significance. Beyond a natural process of reproductive change, the peri-menopausal transition, with its corresponding inner heat and external sweat, as well as introspection and reflection, may be viewed as a form of spiritual catharsis.

We've gone through that cycle and it's no big deal, in fact it's kind of more hey good you're one of the tough ones, you can sweat all the time. . .you can pray all the time, you don't have to take a week off every month.

And a lot of Native cultures at that time [menstruation] you don't have to sweat – it's a cleansing. . . . But there's a lot of misconception about that, non-Native people don't understand.

You know when I heard this was a healing thing [this talking circle], and I thought my god - I don't know why I never even thought about whatever was going on [menopause].

Balance Strategies

Women were not asked a specific question about what strategies they employed to achieve balance during peri-menopause. However, during discussion of their experiences, they frequently talked about the ways in which they coped with the specific challenges that hormonal change presented as well as strategies they employed to promote their general health.

I was not surprised that these discussions evolved naturally. After getting to know these women a little better, I became increasingly aware of their conscientiousness about their own health and the well being of their families. Those qualities are combined with traditional values of pragmatism and a “do what has to be done” attitude. This is not surprising when we consider all that First Nations women do for themselves, their families, their communities, and their nations, particularly in the field of health. This work is done in the context of poor funding, contentious relations with the federal government, apathy on the part of the provincial government and disadvantaged social conditions, resulting from historic and current transgressions on the part of those governments.

Women demonstrate their personal autonomy and collective innovation through seeking out and engaging in activities, which they determine are best for them. The impetus lies in cultural understandings of the link between mind, body and spirit, in which women employ a variety of strategies to achieve balance in their physical and emotional health. The diversity of strategies pursued by women reveals the holistic way in which they conceptualize their health in general and this process of change in particular. Balance is achieved through hormonal, herbal, spiritual, physical and psychological strategies. In general, they pursue strategies that minimize the deleterious affects of situations over which they have little control. Women also engage the help of those closest to them to either reduce the intensity of hormonal change, to reduce external stress or to treat the outcome of either.

Maturity seems to enhance women’s capacity to be successful in the pursuit of balance. Specifically, during mid-life, women develop the capacity to first conceptualize balance and then to pursue strategies that create movement toward it. This is particularly true regarding emotional balance, perhaps because hormonal changes, which often create physical imbalance, are most effectively addressed through mental strategies.

Physical Activity

Physical activity, whether through work or leisure, is seen as a way of maintaining the stamina women require to traverse the physical and emotional challenges they face during mid-life and menopausal change. Women talked about the benefits of exercise for their cardiovascular and skeletal health as well as how it helps them feel energetic and keeps them from feeling depressed.

Yes. . I think starting earlier too you know, I don't think we realize the importance of that when you're younger. I think for myself, now I know my lifestyle is.. .like if I'm eating healthy and exercising, then I feel better emotionally too right, so I you know it helps you emotionally and physically and you're better able to cope with changes you have to get out and do something instead of just moping about it. Your attitude helps.

I'm just thinking even just of myself now and the winter gets me down right but I have a choice, I can sit there and feel sorry for myself or I can put on my jacket and go for a walk up the road and I'll feel better if I get out there and walk up the road right. So, I think it's going to help you face things, other problems in life.. .I mean I know not necessarily menopause is a problem but it's just a hurdle right.

Aside from describing specific activities, which include mostly walking, going to the gym or exercising at home, women talked about benefits that extend beyond general fitness and disease prevention, to include the promotion of emotional and spiritual health. They also report that staying active means staying young, not so much in an aesthetic sense most common in western culture, but in terms of youthful vigor, strength and joyfulness.

Keep active. . .keep active. ..I find when you sit home and you start doing nothing that's when you age faster like . . .we go out. ..

And walking is really, I mean it's good for your bones, for your heart, it's good for everything. . .and the food, I know just even when I was growing up we never had like - we had like apples or raisins that was like our treat. .everything else was like raw like vegetables, not even a whole lot of meat. . .no nearly as much. . .

Staying Busy

In general, women believed that keeping busy represents one of the most effective strategies for achieving balance during hormonal change. Staying busy is seen as a positive strategy for maintaining balance of mind, body, and spirit. Some of the strategies women employed to stay busy include: sewing, basket weaving, making crafts, baking, playing cards, telling stories, knitting, reading, fund raising, community projects/volunteering, and paid work. Staying busy and being useful emerged as an important way for women to not only promote their own health, but also as a way to stay connected to family and community and to contribute their unique gifts, thereby enhancing their feelings of self worth. This type of action-based strategy is also tied to the collectivity of First Nations people, and the value of combining ones own benefit with benefit for others.

I started to do something, I do the sewing because I was very good at sewing so I do a lot of sewing, make quilts out of old clothes, and make grandchildren you know pajamas or whatever. I do that for about four or five years, then I get so tired. I started basket weaving and I said this year I'm not going to buy anything and run our own Christmas - Christmas present for somebody, I said I'm going to make baskets and I'm going to give everybody a basket.

When I make those Christmas corsages, I don't even watch t.v. or radio or anything I get so involved doing this, how I go, put this or this. . .it's good for your mind, you know. You have to do something, you just can't think about that...when is that menopause going to hit me.

I think when you're, especially when you're getting older. . .a person should prepare . . .that's one thing I could advise somebody, that the men are worse than women. . .like when you retire you should do something to occupy your mind and your body and. . . get busy, not to just lay down and sleep or . . . sit doing nothing.

Social Activity

Engaging in activities with others was seen as an important strategy to regaining or maintaining balance during peri-menopausal change. Women recognize that this process of change may contribute to depressed mood and believe in the healing of others, particularly family members and other loved ones. Social activities can keep women's minds occupied and ward off feelings of loneliness. In particular, some women report

that having grandchildren with them helps to dispel feelings of loneliness or depression. Whether these activities simply take women's minds off their problems or provide a social outlet, the company of others was viewed as a source of healing.

There's a lot of people that are turning into vegetables at home all winter long, sitting there staring at the t.v...

Women need to stay occupied. They need to feel useful.

I love having the grandchildren around. Oh the grandchildren are no problem. . . Having the blues and the kids come around and opens up the world that's how I feel. I love my grandkids I don't see my grandkids, they're not allowed over. I see my grandchildren and I make a big meal . . . It's great when they're around. . . yeah. Makes them feel good. And when the grandkids come, yeah you kind of go back to that and that kind of fills you up with a familiar feeling that you had before and kind of brings you back to when you were younger

Psychological Strategies

These mid-life women described a number of psychological strategies they used to cope with peri-menopausal change. These strategies are believed to strengthen women's resolve and boost their spirit during times of particular difficulty. The most common psychological strategies involve a shift in perspective. A balanced perspective is viewed as an effective coping strategy. Indeed, a positive outlook is viewed as one of the most powerful strategies, influencing women's ability to engage other strategies effectively.

Stoicism.

I am somewhat reluctant to discuss findings related to stoicism because I am concerned about perpetuating a stereotypic view of the "strong Native woman". This stereotype is based on a misunderstanding about the nature of stoicism, which is often conceptualized within a biologically deterministic framework. Rather than a genetic attribute of individuals or groups, stoicism is a characteristic, which may be nurtured and developed in order to accommodate difficult circumstances.

Notwithstanding these misinterpretations of meaning, as a researcher who is committed to revealing this experience, as it was shared with me, I feel obliged to reveal

the emergence of stoicism in women's discussion of change. I think it is important to note that many women from marginalized and relatively disadvantaged groups learn the value of stoicism as a means of coping with harsh social and economic circumstances. It is not my place to suggest whether First Nations women are more or less stoic than other women. I will however, as faithfully as I am able, report what I have heard and leave further interpretation to those who understand the meaning for First Nations women better than I do.

Women seem to practice stoicism not only to cope with their own discomfort but also to protect their families from the negative "trickle" effects of their experience. First Nations women, like most women, are often the center of family life – this fact is widely acknowledged. Despite inequities in social, political and economic power, women's role and responsibility in stabilizing families is rarely questioned. Women recognize that this time of change may be especially difficult because of the pivotal role they play in families and their position as emotional compass for family life. This responsibility however, creates tremendous pressure on women to "hold it together", not only for their own sake, but for the sake of their family and through extended kinship networks, their community.

I don't think. . .we weren't allowed to complain, we had to be so stoic – that's important - you just weren't allowed to complain, it was taboo, so you learned to keep things, accept things....something that was accepted. That's how you were brought up, it's hard to change, you have to retrain your system.

Many women reflected on the stoicism of their mothers around menopausal change, particularly in relation to difficult physical and/or emotional experiences and claimed that this psychological strategy is one that they tend to emulate. The quiet stoicism of mothers and grand mothers provides a role model for women, who are seeking a template upon which to evaluate and model this process of change. Long days of work and countless years of child bearing, shouldered with silent dignity become the yardstick against which women judge their own "performance".

Once when I was sick and I missed a class, they reprimanded me, I thought I was doing the right thing, then they said don't complain. I didn't know you know, I

thought you weren't allowed to complain, cause my mother didn't believe in some medicines - I don't know what we thought you know.

I remember my grandmother saying that she couldn't see all the worry and stuff about it because she said when she went through it she didn't have time to think about it, she said she went through the hot flashes, she said she didn't remember going through the emotional thing because she said she was so busy working and providing for her family at the time that she said she couldn't basically remember it, she remembers going through it but she couldn't understand why people were so emotional about going through it because she said she just. . had the hot flashes and that was it. . just like that so. . . she was just too busy to think about it.

They didn't dwell on their sickness too much, they didn't have time - they just had to work.

Contrary to intuition however, in many ways, the life of contemporary First Nations women may be more stressful than the lives of their mothers and grandmothers. Granted, women do not have to work as hard and they now have access to contraception, which allows them to control the number and timing of children. Yet, bi-cultural forces and the added stress of rapid political change, essentially wedges contemporary First Nations women into a very tight psychosocial space – with little wiggle room for peri-menopausal change.

These women may enter peri-menopause in a state of adrenal exhaustion (overuse of the adrenal gland to cope with stress), caused by multiple and persistent personal, family and community responsibilities. Women who were raised with the value of stoicism believe that even if they are suffering, they should not complain because others and themselves might perceive it as a sign of weakness. Life is difficult, it is accepted and one is expected to make the best of every situation. Weakness does not benefit anyone and, in a culture rooted in communal life and shared experience, no one can afford to shirk their responsibilities just because they are uncomfortable.

Yeah. . .keep everything to yourself and if you did complain, nobody would listen to you anyway, just walk away and if you fell down, nobody was going to come up to you and say oh where does it hurt?, you're supposed to get up and go. . . walk on. Yeah. . .don't complain you know. Any complaint was a sign of weakness. You have to be tough.

Women who conform to this ideal, enter peri-menopause without complaining much about it. Their coping strategies tend to be those which will not so much ease discomfort as those that will minimize the impact of their discomfort on others. Among these women, support is rarely sought and I fear that many suffer alone needlessly.

Healing

Health behaviours involve value systems, which encourage behaviours that either promote or place at risk the multiple dimensions of human health. Women's discussions of healing include philosophical, psychological, spiritual and social forms of healing as well as physical practices specific to peri-menopause. Most women recognize natural forms of healing as important ways to achieving balance. In general, women listen closely to their bodies and use natural, lifestyle strategies to support health. Value for the give-and-take of natural cycles is reflected in the approach women take to allowing negativity to escape, while leaving room for positive feelings and experiences. Healing is often a shared experience, where women learn from one another and support each woman's efforts to heal.

The pluralistic dimension of Aboriginal healing is evident in women's acceptance of diverse avenues, which are pursued by women who, not only encounter different issues during peri-menopausal change, but who also feel more comfortable and familiar with certain healing practices over others. Acceptance emerges as an integral fibre in the thread of women's discussion of balance. Women discover balance between that which is lost and that which is gained. To accept one's life – its ebb and flow – its challenges and its celebrations and to find peace in times of trial - is to achieve balance.

I think it's a part of life you know, you've got to accept it regardless where you are, what you are.

So you view it positively, you have to make the best of it. It's going to come.

I guess it was just acceptance right you know...it's just one more thing that you dealt with. Yeah, just one more part of life.

I would say like it's more acceptance, you know, it's just something you know – a stage of life and got to go with the flow and that's how it's been for me.

Women recognize that the social conditions and subsequent health problems experienced by First Nations people, impact women's experience of mid-life health and that healing must also address those domains in order to be effective. To a lesser extent, women talked about changing their diets, particularly adding food and vitamins that are known to benefit health and/or have estrogenic properties (e.g. soy products). Very few women took medication other than HRT to maintain balance and only one woman revealed that she occasionally smoked to relieve the stress brought on by hormonal change.

A lot of us people are kind of stuck on a treadmill of drugs and alcohol, and escapism, and so they're losing some of that value system but then I think there's a little spark of it there somewhere but I find a lot of the people who are used to just remembering back.

So I just take my vitamins now, vitamin B, vitamin D.

I try to eat all this stuff, I go to Sobeys and get the muscles and the smelt and all that stuff.

I'm watching what I eat but a little bit of weight, not much. . . I walk. I'm going to need to take time to exercise because usually working all day.

According to some of the women, in the past, menstruation was seen as a form of healing, in which the body cleansed itself. Cleansing occurs on a metaphysical level, in which the concentrated power of female reproductive capacity is renewed through a monthly cycle. It was generally believed that the healing practice of sweating was not required for women during their menses because their body is providing its own form of spiritual healing through a similar process of excretion. The menstrual cycle represents a renewal of women's power to create and nurture life. The shedding of menstrual blood is a form of metaphysical restoration, represented in this cyclical process of physical and spiritual renewal. It is the concentration of this power, in the form of menstrual blood, which led to the exclusion of women in ceremonies where it was believed that they would draw power from others, particularly men, who are not imbued with this blood-given gift. This concept of cleansing was misinterpreted by Europeans to mean that

menstrual blood was unclean and a misconception that led to widespread misunderstandings that can still be seen in textbooks.

So there's still that. . around the menstruation, cause I know traditionally that. . . Oh they're not allowedand it's not because it's dirty, no. No, that's a misconception. Too strong, they're too strong at the time.

It's handy though for ceremonies when women are on their monthly cycle you can't participate in the sweat lodges and you can't touch the sacred items, the sacred bundles, yeah especially the men's, it will weaken them sometimes the men will just drop, you know when there's a woman around and there's a ceremony.

Traditional healing is available, and in varying degrees practiced, by several of the women. The extent to which they pursue traditional healing was often a function of the degree of cultural accommodation within their community, but often depended on individual women's own distinct cultural identity. Those who do not ascribe to traditional healing practices, however, sometimes pursue it when western medicine fails to provide the healing they seek.

I find ceremonies, traditional ceremonies, talking circles, sweat lodges, they help me for body, mind, spirit.

Where there's Indians, there's all kinds of medicine around them. Not everywhere, but there's places that you can pick it there – here - around here.

But some people don't come unless that's the last resort, lots of times it's the last resort. . . Western medicine isn't working and then they'll come and ask for prayers, but it's there, the option is there for people at all times, but most people don't come unless it's. . . they've tried all the Western medicine and then they'll come to the traditional and I find sometimes it works and sometimes it doesn't, you know it depends on the person. Yeah, you have options, there are other options.

In many ways, women see peri-menopause as a time of healing, in which they have the time and inclination to review aspects of their lives that were left unattended during the busy years of youth. Increased attention to physical health can also be conceptualized as a form of healing in the sense that women attend more closely to behaviour and environmental determinants that effect their health and well being.

Disease prevention and health promotion behaviours become important and women become active agents of change and healing from past experiences that might have been detrimental to their health.

You get to the point where you want to cry, well my God do it you know. . do it, it's just a form of healing you've got to get rid of it. . . you know in order to bring in good stuff, that's what I would say anyway . . .cause I know it works for me .

You know when I heard this was a healing thing [menopause], and I thought my god, I don't know why I never even thought about whatever was going on.

Herbal Medicine

A combination of adherence to traditional healing practices as well as recent evidence about the deleterious effects of HRT, has led many First Nations women to seek out Aboriginal and Euro-Canadian herbal preparations to address peri-menopausal change and to improve overall health. Herbal remedies typically work with, rather than against, the body and are more bioavailable and bioacceptable. Herbal medicine is sometimes used to relieve anxiety and stress – making it an ideal choice for peri-menopausal women. Herbal teas were especially popular as a sleep aid or for calming jittery nerves. Some women described herbal medicine that will improve your sex life – comments such as this were met with much friendly teasing and laughter.

You should take some herbal tea before you go to bed. Chamomile tea that's more relaxing and more soothing . . . But I'm going definitely...I'm going to look into those products. . .

I've been drinking herbal tea, that helps, yeah that helps and trying to keep myself busy so I'll get tired. . .she knows that I'm always on the go. . .but I enjoy it.

And it relieves a lot of stress and anxiety and all this stuff and sex too. There's one lady who says this is better than sex. . .I'm so relaxed.[laughter]

Many women see the use of Aboriginal medicine, provided by the earth, and untouched by pharmaceutical entrepreneurs, as a means of restoring balance in a natural way. The oldest woman (83), who was very knowledgeable about traditional healing, used teas made from rose hips or punch berries extensively. She advised that punch

berries, brewed into a light tea, help to thin the blood. This medicine is very old and was used extensively by the Mi'kmaq people in the not-so-distant past.

You should take rose hips - that's the name of this tea, oh it's good, I got some at home but I very seldom take it.

You're a strong believer in herbal medicine. . . . and no diabetes, I brewed this medicine all the time, now I don't even have a stitch of it, nobody picks it for me - punch berries leaves. All the time my husband and I, we drink it, every, every month I brew about a gallon.

When you're forty, your blood is getting thicker and thicker, he says that's why people have, when they are getting old then, the blood got stuck and that's why they have a stroke, a heart attack but he says this medicine, you brew it and you take that and that medicine cleans your blood and it thins your blood.

And nobody; them days nobody ever had high blood pressure and I think you know it cleans your blood.

The increased rates of chronic illness experienced by First Nations women means that they have to be cautious about taking herbal remedies and ensure that they don't contraindicate or negatively effect prescription medication they may be taking. This is especially important for women who are experiencing hot flashes but also for those taking anti-coagulant medication for heart disease. According to these women, physicians know surprisingly little about herbal medicine and traditional healers typically don't divulge the contents of their healing preparations. Consequently, women are not always aware of the effects on platelet recruitment from herbs like don quay. After each session, I provided women with information about herbal remedies from sources I used for this project but also encouraged them to check with their pharmacist before taking any herbal medicine.

Even if you talk to your doctor about that Native medicine too. . . like if you talk to him about Native medicine he says I'll give you something before you get your Native medicine, I'll give you something.

Women want to know more about herbal remedies. Native women need more information that they can access and understand. Women don't know which information is accurate. Women want to know about herbal remedies and prescription drugs – interactions.

According to one woman, there are “Indian medicines” that help women go through menopausal change. However, it is almost impossible to find out what these medicines are because most healers will not share their secrets. This is due, in part, to years when Aboriginal medicine and other healing practices were outlawed in North America. Healers had to practice “underground”, away from the prying eyes of Indian agents and reserve doctors. This is also a way to protect Aboriginal medicine from Euro-Canadians who might try to exploit this knowledge, stripping it of its spiritual context and extracting the biopharmaceutical elements.

Cause it helps get rid of all the toxins. . I know with one of the ladies who is going through menopause now, she had somebody making her Indian medicine to help her go through it. . .well they're doing. . she's taking Indian medicine, to help her get through it faster . . .

And anybody who gives it to you isn't going to tell you what it is - if you're like, he's not going to tell you what it is. . .because of the chances of people exploiting it, testing it. . . He'll listen to you – why you want to be doctored. Why he wants _____ what are your symptoms, why do you want it and how long did you have it and something like that, then he'll do up some kind of herbal medicine.

In true pluralistic fashion, women combine the use of herbal medicine with other physical, psychological and spiritual healing practices. Although many prefer Aboriginal medicine that incorporates the important spiritual component of health, they also embrace the Aboriginal medicines of other cultures such as Asia and Africa.

Hormone Replacement Therapy

Standing in stark contrast to women’s holistic approach to health, is their use of HRT, which is prescribed and monitored within a rigid biomedical model. Once again, we see women’s pluralistic attitudes toward employing diverse forms of healing in order to maintain or restore balance. In like manner, acknowledgement of HRT as a viable option for women who feel they need it, is balanced by a healthy skepticism of the system that produces and profits from its use.

Some women can get through it on their own without medication and that's fine and there's other women they may need something to get them through it. . .

It's different for everybody, the reason why they wanted to take us off the estrogen they told me, like they told me that the longer you take it, it could cause like cancer and all that. . heart, stroke. . .and all that.

And I don't think they can cure it like not to have menopause, like before you had to take some kind of pill, then you wouldn't have this menopause, they don't have anything like that. . . That's what we're taking, that's what they are taking us off. The pills so you wouldn't know you were having menopause.

The reasons cited by women for taking HRT are similar to those found in the literature, including relief of hot flashes, night sweats and/or sleep disturbances, joint pain as well as issues related to hysterectomy. Some of the women were also advised by their doctor to take HRT because they were thought to be at risk for osteoporosis.

When did these pills come out? I know I tried a needle once. . . and a patch there. . I don't even know why I got on them or how I got on them. . . I don't remember how it started, I don't even remember menopause- I'm intact. I don't even know how it started or why. About 25 years ago. . . When I was about 40 or so - I don't even know how I started, I couldn't have asked for them, I didn't know what they were.

I had my partial hysterectomy they just took my uterus out, and then later on they put me on that pill but I never had hot flashes or the mood swings.

I don't know if I had hot flashes or not, but I did have running to the bathroom problems and a year or so later that I began to take hormone replacement therapy and or maybe later, now most of the time when I take it I feel better.

I remember going to my doctor and you know what was going on with me, maybe I need estrogen and then I read earlier that when I asked him you know. . that's what I needed - so he said yes and I said besides I think some of these pills cause cancer, and he said yes it does you know, but they have the estrogen and the progesterone, you take one for estrogen and the other one is supposed to counteract cancer.

One disturbing trend, which emerged in discussions of HRT, concerns the lack of information most women receive about the mechanisms or risks of HRT. Without adequate information, many women did not comply fully with prescribed regimens; in many cases, they simply stopped taking HRT without informing their doctor. Women cite

a number of physical, emotional and social reasons for non-compliance, including continued or increased hot flashes, break-through bleeding, breast tenderness, water retention, weight gain, depression and irritability. Fear of the cancer risks associated with HRT and distrust of the system that produces, promotes and profits from its sale, also emerged as underlying reasons for women's non-compliance.

Well I did that, like after I had the hysterectomy and I got hot flashes I was on a low dose for a while then gradually I took myself off them and I find now I don't get hot flashes anymore, but I know that some people they don't want to go on hormonal replacement therapy because. . .Cancer risk. There's so much talk and they really don't have the correct information. . . you know really know what it does to them you know.

When I started noticing gaining so much weight, I secretly went and got off of them without the doctor's approval, see I had them like one, two, five and I looked like a balloon, just like that, Michelin tire and I got more depressed because I'm always self conscious about my weight and I said that's it, I said I'm going to do this on my own and I did. After a while I stopped using those bloody things I felt better. I got more depressed being on them. So I just didn't take any more, I didn't wean myself off. . .I just didn't bother with them.

I just went cold turkey off that Premarin, like I said nothing happened to me and we were on the same pill, one pill and she turned into a mad cow (laughing!!) and nothing happened to me. She got the mad cow disease – laughter.

Like once I got off the pill, whatever was happening to me then doesn't happen to me now. Why? That's weird. When I was on those pills, I'd get this hot flash, I'd get this wake up thing in the middle of the night and get moody but since when I went off them, nothing happens, no moodiness, nothing. No hot flashes – no sweats.

So I took this pill. Holy shit, talk about someone more negative than what I usually am...my daughter said mama, you are a super bitch and then my son....took the pills and garbage.

Unfortunately, withdrawal of HRT may result in the onset of hot flashes and other uncomfortable experiences. A relative lack of comprehensible information or support also left women feeling as if they were not in control of this experience or in the restoration of balance in their lives.

I'd been on the pills for so long, I was normal until I stopped taking them. Now I'm not normal. . . it's the other way around. But that's because my system was used to it.

Like now I don't like what they're doing at the doctor's here, taking all this estrogen away from these ladies. ...me, I know I've got mine back but like the others, the others are at home right now with these sweats, these mood swings, these sleepless nights, what about them out there? That's my concern.

Women's skepticism of the health care system does not always include their local physician, whom many know very well and in whom they place a great deal of trust. For years, these physicians have been prescribing HRT in good faith, yet under some misconceptions about its relative risks and benefits. It is important to note that, while each group of women represent diverse experiences, the women in each group typically live in the same community and most see the same physician. Therefore, the attitudes and behaviours of those doctors influence the experience of almost all of the women in that community.

Medicine can be harmful. Women should do lots of research before they take anything. Women can get hooked on HRT/other drugs but if your sick – you want relief.

And I never liked pills. And my boyfriend was sitting there, you have to take those pills for the rest of your life or something is going to happen. . nothing's going to happen, you know, I'm not going to croak or anything, you know, but the way she said it you know and it scared him.

It's a low dose that I take and my doctor, I check with him like every time I have to get the pills, he says it's o.k. so I trust him and I just keep on taking it.

Most doctors do not offer alternatives to HRT and many downplay the risks. Consequently, women do not feel as though they receive much help from their doctor in the form of information or support around alternatives to HRT. Women recognize the disparity of information about the health of men and women. This is particularly true for First Nations people, who are typically aggregated into gender neutral groups for the purpose of examining health issues. According to these women, the aging of men is more

accurately understood and, thus women do not always value male doctors as a credible source of information about menopause.

Oh o.k., but he [doctor] said in some women yes it does cause cancer. I said, why would you want to give this to women you know and he said because in some women it does help so. . .I said well I don't think I want to go that route but I need to know ways of how I could help myself you know go through this, so. . .and he said well exercise, there's not too much we can do about it you know, unless give you a pill you know. . .I didn't want to go on the pills.

Yes. . . them giving us something and then you hear 15, 20 years later after they've been pumping that drug in our body and then they're telling us now you stop that thing cause there's danger of cancer and all this bad stuff about that pill. And before, before you even started they said if you don't take it, then chances are your bones will be all brittle and. .. you'll get heart disease.

No information, justthey are good for you – no discussion. Take it and shut up. ...

Relationships

Relationships emerged as an important theme in women's discussion of mid-life and peri-menopausal change. In fact, most topics related to change involved some relational elements, whether in terms of influence, context or outcome. The context and substance of relationships form the foundation upon which women understand and experience life in general and their health and change in particular. Context refers to the network of relationships in which their lives are embedded, while substance refers to the psychosocial constituents of those relationships, which shape women's perception and experience of mid-life health and peri-menopausal change. Substance also refers to the specific dimensions of women's relationships, which emerged as most meaningful during mid-life and peri-menopausal change.

The Context of Relationships

Community

Within each community, the groups of women who participated in this study often grew up together, having shared many of the same joys and sorrows. I observed the familiarity and comfort with which they interact as closely resembling the characteristics

of family relationships. This expansive network of supports often provides women with a “soft place to fall”, should they experience difficulties during mid-life change. The emotional and affirmational support they often receive from mothers, sisters, daughters, nieces and life-long friends, may create a buffer against loneliness. However, like most close relationships, interactions are not always positive and relationships are not always supportive.

I think that's the beauty of being in the community all these places that you can tap into you know and you're always connecting with someone, doing something And I think as a result of that because the way we (First Nations women) are that we intermingle a lot with each other. . that's a good learning experience also to grow . .

Older people living on-reserve are well cared for by the community – someone will call to see if you need anything. There is a lot of support for elders in the community. Older women have known each other most of their lives and can turn to one another for support and for sharing.

Many of the older women have known each other most of their lives and can turn to one another for support and for talking.

Women explained that the development of close ties emerges from relationships, which are nurtured throughout childhood, under the tutelage and care of their elders. Family and “like family” ties, fostered through many decades of close contact and shared experience, continue to be strengthened through the middle years of marriage and children, until women arrive at mid-life - hand-in-hand - with a large number of people, spanning many generations, who know them intimately and love them unconditionally.

Family ties are one. . . As you get older yeah, like gatherings with family or whatever, become more important to you. . . . You enjoy it more.

Hopefully you have more respect as you get older. I think if you're learning properly from other community members

They were quick to point out however, that it is overly idealistic to assume that relationships never involve difficult circumstances and sometimes, bad feelings. Like any long-term, close relationship, betrayals and lingering hurt may diminish the benefit

women draw from their social interactions. Yet, in general, the benefits tend to outweigh the disadvantages, particularly in a culture that places such value on collectivity over individuality.

But there are people that make you feel more comfortable and you don't have to worry about what they say and what they think. . . if you have to worry about that you're under pressure all the time, my god you'd be scared to walk right up you know.

All this big stuff, it's nothing big, it's all simple, everything is not important, all that's important is how you interrelate with others you know without really hurting another person intentionally, you know we all hurt somebody unintentionally at times, but that's what's important.

According to these women, elders in general, and “grandmothers” in particular, are considered a valuable resource in First Nation communities. Grandmothers represent role models of behaviour and teachers of Aboriginal culture and history, passing traditions and stories from one generation to the next. During this life phase, women often have more time to organize and execute community projects particularly those aimed at improving educational and social opportunities for youth. This contribution to the community in general and to the youth in particular is considered invaluable. It is not surprising therefore, to discover that the majority of women in this study do not fear old age as a time of loneliness, or idleness, or both.

And I think that's the difference we see - non-Native society seems to think if you become too old to take care of, you just put them in a nursing home. I see a lot of that, you don't see too many Native people being put in the nursing homes and there are a few mind you, maybe when they get to be 100 and are peeing on the floor.

The women explained that community members’ specific attention to the needs of elders reflects a principal of many Aboriginal cultures, which has existed since time immemorial. This community support may act to counter some of the fears women have about the physical limitations of old age. The subsequent expectation of women is that they will journey toward old age in relative safety and comfort. However, not every community has the resources to ensure that elders have the social and recreational

opportunities they need. Unfortunately, this situation often leaves elder women and their families without adequate physical and social support.

The community is close knit and so are the women. Women feel more respected as they get older/ become elders. Seniors are taken care of by the community. The band office has counselors for seniors. Home care workers come into seniors' homes to help out. Community makes you feel special.

...there's no activities for them [elders] you know if they had a place just even to talk you know. . .that's a great socialization, just even talking, play cards and . . you know your mind gets worked up when you're playing cards. . .tell stories or knit.

The inter-generational quality of Aboriginal experience is emphasized in community support across the life span, from the birth of a child to the death of an elder. This commitment also involves many generations, from very young children to very aged elders. Even in death, most women have the comfort of knowing that they will not be alone. Consequently, when women do experience loneliness during mid-life, it is especially painful because their cultural values reject separation of individuals from their families or communities. Thankfully, these feelings are uncommon and many of the women in this study expressed sympathy for Euro-Canadian women, whom they perceive as greatly disadvantaged by the lack of value or respect attached to old age in that culture. They also perceive the individualism of Euro-Canadian culture as detrimental to mid-life women's experience.

Grandmother

The role of grandmother is intimately associated with these women's experience of mid-life. Aside from the benefits of this social position, individual women place great importance on their relationship with grandchildren, who are universally cherished. The experiences of these women highlight important differences in the role of grandmothers within Euro-Canadian and Aboriginal cultures. In Euro-Canadian culture, grandmothers often play a somewhat peripheral role in the lives of their grandchildren. Geography, responsibilities, and cultural norms tend to distance women, first from their children and then from their grandchildren (Hirsch, Mickus, & Boerger, 2002). There are many

exceptions to this generalization, but they tend to be just that - exceptions rather than the rule. For First Nations women, the role of grandmother involves both an extension of the mother role as well as the integration of cultural and spiritual teacher. Most grandmothers are intimately involved in the lives of their grandchildren, many of whom live in homes that span generations. In many cases, interaction with their grandchildren, takes precedence over women's social and work activities. In general, involvement with the lives of their grandchildren contributes to a positive mid-life experience.

I think because we respect our grandmothers. . .cause I remember always going to grandma's. . and I don't know if they have that, cause I don't know cause I'm not White, I don't know how they interact with their grandparents. that's the way I saw grandma. Yeah, and you learned a lot from them you know . . . And you wanted to be with them. . .

That [aging] doesn't bother me. . . no. . .it doesn't bother me as long as I know there's my kids growing up and my grandchildren growing up. . .

Many of the women reminisced about the relationship with their own grandmother as a time of love and learning. It is not surprising, therefore, that they enter mid-life with expectations and experiences of those same interactions with their own grandchildren.

My grandmother raised me . . .and she told me all about stuff and if it wasn't for her I wouldn't know... she told me about life, how life is growth.

And elders have so much wisdom, knowledge of life and I look up to the elders and that. . that's the beauty of it.

Youth

The role of grandmother and elder is especially meaningful in women's relationship with youth, which they recognize as playing an important role in the future of First Nation cultures. Through their discussions, women reveal a strong sense of optimism for the next generation of women, who will know more and suffer less than their mothers or grandmothers. Women's efforts are directed toward creating opportunities for youth that were not available to them during the era of residential schools and overt ethno-cultural discrimination.

Parents are more open now, kids know everything under the sun. They know more than us.

If it could be different for our children. . . they will make more of a big deal about it – they will be more vocal about it. Yeah, I think you're right.

Women feel generally optimistic about the young women who will follow their path through mid-life and peri-menopausal change. They recognize the important role they play in serving as role models for that transition and the value of their knowledge and experience in informing the perspective of young women, who, like them, will need this knowledge in order to traverse this journey of change.

I've been noticing moreso like the younger people that are just beginning to experience menopause that are talking about it, and they have the symptoms and I told them what's happening you know.

Women talked about the important changes, which have occurred over their generation - a time when new ways of thinking were not always encouraged. During those tumultuous times, First Nations traditions were in danger of annihilation and elders struggled to sustain Mi'kmaq language and culture. Yet, socio-economic pressure has forced many First Nations to adopt a more bi-cultural approach. It is into this environment, the next generation of First Nations women will traverse peri-menopausal change.

I think my generation started, but your generation you start to be freer and what they used to call (Mi'kmaq word) how would you describe (Mi'kmaq word)? "Thick head", they know how to listen. . . you're that generation you know when you came up with a new way of thinking.

Today kids are more open. They learn more in school today too, like years ago and your parents never talked to you about things years ago like that.

Mother

Like most women, the relationship these women had with their mother determined to a great degree, how they view themselves and perceive their role in the family, community and nation. Among other Indigenous cultures, First Nations people

are especially noted for fostering close relationships between mothers and daughters. Mutual respect and lifelong involvement in one another's life characterizes these relationships. The respect women have for their mother was evident in almost every discussion of this study.

Yeah. . .my mother was going through mood swings...just try to be patient with her - you get frustrated but still help with whatever she needed you know.

Observing the peri-menopausal experience of her mother was often the only source of information available to mid-life First Nations women. Women's expectations are often formed during these periods of observation, which also represent a model for their response to mid-life change. For many women, the picture is one of silent stoicism. The tacit message women receive is that they must endure whatever discomfort they may be experiencing in relative silence.

I used to wonder why my mother said I'm dizzy as a bat and I never knew why. . .now I know. . . I felt as dizzy as a bat, yeah it's awful.

No one talks about menopause so women don't know anything about it. No one talked to their mother about it.

When I came to my mother for advice you know well she says when you went through menopause she says did you have hot flashes. .. oh god no she said I refused to. .. but she would. . .she was so steady . . .

Well I think a lot of people didn't talk about it, so they kind of look at it hey, my mother made it through that stage and never talked about it. . .

This relationship women have with their mother is also as dynamic as any other and generally changes over time, as women reach their own maturity during mid-life. The role their mother plays in women's gender development becomes more salient and valued as they reach this stage of life. This connection to the life of one's mother also has important implications for the meaning women attach to their gender roles.

My mother never talked about it. Even when I was younger and she never said anything that you were menstruating, you will be you know all these things. .. it's the same things I did to my daughters, I didn't tell them anything.

My three daughters are in their 30s so I mean you know like they'll ask me you know, whereas I wouldn't have called and asking my mother, you know if she was going through it or anything you know so I think that's the difference.

Women look to their mothers to provide a template for their own experience. Many believe that their peri-menopausal experience will be similar to that of their mother, as well as to that of other female relatives. Unfortunately, some of these women witnessed the difficulty with which their mother traversed peri-menopausal change. It is little wonder therefore, that they might experience some trepidation about traversing this experience.

The person we should ask is our own mothers cause . . .we tend to go through the same cycle as your mother does.

Every woman's cycle is different though. Mostly though you take after your mom. My mom had a hard time. But some of your aunts though you know, we all have the same blood, the same genes.

My mom had it rough, sometimes I think she still has it like you know. . .

Maybe because growing up I didn't have a dad like you know and I know my mom had a really hard time.

It is important to note that 20-30 years ago, the lives of First Nations women were appreciably more difficult than those of contemporary First Nations women. Traditional values of stoicism as well as inadequate social and health programs meant that First Nations women entered mid-life facing poor health and an even poorer health system. Moreover, prior to the 1990s, doctors knew relatively little about menopause and what they did know was tainted by the dual forces of Euro-Canadian anaphobia (aversion to older women) and the medicalization of First Nations health. Women who sought medical assistance during difficult periods of peri-menopausal change, were often misdiagnosed with anxiety disorders, depression or mental illness. Others were promptly

prescribed dangerously high levels of untested synthetic hormones that presented much in the way of risk and little in the way of real help.

Doctors

I feel some trepidation about discussing the findings related to women's relationships with their physicians. I fear it will offend as many physicians as it will congratulate. It is important to note that some of the women who participated in this study reported positive, respectful, trusting relationships with their physician. Yet, many did not; therefore I must present these findings as they were expressed to me.

I have a good doctor you know, I can go see him, tell him and maybe cry. . you know if I need to. . . and sometimes I ask him for something, he says you don't need it, you're strong enough and he won't put me on a tranquilizer or something then I'd get hooked on it, but like you were saying some doctors they so very easily put people on tranquilizers and then they get hooked on it.

First Nations people have experienced a long and somewhat tempestuous relationship with the Euro-Canadian medical system. It is important to acknowledge this relatively unsettling historic context within which First Nations health care has evolved as well as a relative lack of First Nation physicians. Consequently, health care continues to be delivered by Euro-Canadian physicians that, despite positive interactions with First Nation clients, remain within a position of relative power as well as one that might view health from a very different perspective. Some reserves employ a physician who has practiced in that community for many years, often serving entire families; delivering several generations of children, while providing medical services to their parents and grandparents. In this way, physicians become an important, albeit somewhat peripheral, part of the community. However, it is impractical to examine the physician/patient relationships of First Nations women outside the political, socioeconomic, and biomedical frame within which they occur.

The general shortage of on-reserve physicians, relative to the health care needs of First Nations people also means that physicians do not always have time to provide women with the information they require in order to make informed decisions about their health. Moreover, many women reveal a preference for female doctors, with whom they

feel more comfortable sharing “delicate” issues such as sexuality and emotional health. This is especially relevant for mid-life women, many of whom feel uncomfortable discussing the changes they are experiencing during peri-menopause with a male doctor. They believe that a female is better able to understand and empathize with their experiences. According to many women, despite physician’s knowledge of the biomedical elements of reproductive physiology, only another woman really understands the totality in this transition of women’s lives.

Most of them [doctors] are men. . they don't want to talk about it. They don't know. . .They sign your prescription here, take that and you'll be all better. You don't open up to a man doctor, no. You tell a woman different things. That's why I went to [health nurse] cause I wasn't comfortable talking to a doctor, he doesn't know.

More and more of my friends were seeking out women doctors, they're a lot more comfortable. . .you know going to women doctors. . . They found them a little more understanding . . .some were able to relate to some of the problem, they were having.

We have a really good doctor here and we had a woman doctor.

There's a lot of women that would prefer a woman doctor.

I was astounded by the healing potential of the group discussions employed in this study. One elder woman claimed that she had learned more about her body in one afternoon of talking to other women, than she had learned in her 80+ years of life. How is it possible that a woman, who admittedly suffered from many health problems, which required prolonged medical attention, was given so little information about her body? It seems as if women have been effectively silenced by physicians who speak the language of medicine fluently but with little clarification. It is not surprising therefore, to hear that they feel as though their voices are not heard and their beliefs and opinions are not valued.

I feel like he's saying oh this old lady is coming in you know. . I can't be bothered with her sort of thing but maybe it's just my feeling but that's how I kind of feel you know.

Ironically, women's silence is generally construed as acquiescence, when in fact, it is likely nothing more than polite resignation. Many Aboriginal cultural norms discourage blatant disagreement so that women will not always dispute their physician's opinion or advice. This pattern of medical subordination is frequently experienced by Euro-Canadian women as well, however, the potential for harm is especially significant for First Nations women who might experience limited access to alternative medical support, through geographic, economic and/or cultural barriers.

I went once and why. .. I don't know maybe I just uncomfortable. Uncomfortable. . that's why. Because I thought that - all these years like my aunt, my mother, they never go through this. Even I though I had lots of children, I had all of them at home, I never go for six weeks check up or what they do now after they have a baby, so what the hell I'm not going back.

Many of the women in this study felt that physicians' knowledge of menopause was somewhat limited to the physiology of reproductive change and more specifically to the form and function of HRT. Rather than recognizing mid-life changes as a natural process, women felt as though physicians pathologized their experience by submitting them to unnecessary tests, unsafe exogenous hormones and unnecessary gynecological surgeries.

Doctor's don't really know much about menopause – just about HRT.

But the doctor scared me, what should have been a normal process...kept on saying "something's wrong, you're too young" and kept sending me for ultrasounds and blood tests, and D and Cs, all the whole year .. when I went in there [doctor] looked so disappointed, and said "nothing's wrong." (Laughter) It was the change of life.

Most of these women saw the use and/or encouragement of herbal remedies as an indicator of good medical care. In their opinion, physicians who promote herbs display a more holistic approach to health as well as respect for the traditional healing practices of First Nations people, all of which instilled trust and comfort. Yet, with the exception of one community, most women's physician did not appear particularly supportive of herbal remedies and most did not encourage women to pursue alternatives to HRT.

We have a really good doctor here and we had a woman doctor and her husband and her used this herbal medicine and they're very good.

Even if you talk to your doctor about that Native medicine too. . .like if you talk to him about Native medicine he says I'll give you something before you get your Native medicine, I'll give you something.

Women also recognize that physicians are in a position of power relative to mid-life women's state of health while accessing medical care. Rather than looking beyond the physical manifestation of women's dis-ease, physicians tend to focus on treating experiences with pills meant to subdue, repress or mask 'symptoms', which might simply be the expression, rather than the root of women's distress.

My personal feeling about doctors from what I hear is too often that they seem to be too willing to mask the problem rather than dealing with the problem. Like I'm hearing so often about prescriptions being prescribed that maybe might not be altogether necessary you know. . . and people are left with not dealing with the disease itself right. ..like o.k. the disease is "dis-ease", so you find a way to get to the root of the problem rather than giving medication. . . that's my personal. .

Those women, who reveal inequities in their relationship with medical professions, often feel disempowered to critically discuss the use of HRT or its associated discomforts with their physician. In fact, some of the women revealed that their physician became annoyed or insulted when they pursued other avenues of information and approached him or her with questions and concerns about the risks of HRT. The consequence of these unpleasant interactions is women's silent non-compliance. Though, rather than gradually weaning off HRT with natural supplements or bioidentical hormones, women often stop "cold turkey", thereby increasing the likelihood of sudden withdrawal symptoms, which are typically worse than those which prompted them to seek relief in the first place.

I find the doctors don't really want to talk to you. . . you go in there and you ask a question about this and that and whatever, they just really, they're not there to talk to you, to inform you, you know and you ask and they're almost insulted cause quite often I'll go to the computer and I'll say well this is what I read in the

computer, man he gets a little annoyed. I wouldn't believe everything I read on the computer, but it just kind of . . . I wouldn't believe everything that I read so . . . it's discouraging like you don't feel like trying to get informed you know.

You can get information from the computer too, like if you're looking for information about a drug or something, you can get it from the computer, easier than from your doctor. Sometimes when you get that kind of information you kind of like to just talk to him about it you know. . . but it's almost like he's insulted that you have some other information you know.

My doctor he doesn't like second hand information you know. I went to him one day and I said oh my sister was telling me about this diabetic drug and he said oh never mind what your sister is telling you. . . you're doing well on this pill, you're doing well on this pill and you stay on it.

Some women expressed concerns about the overzealous prescribing practices of physicians. Rather than working in collaboration with other health professions to care for the whole person, women describe an approach to health care that more closely resembles a grocery store check out. Women receive a polite hello, a quick scan, and a concluding assessment – handled, bagged and sent on their way – slightly beleaguered but relieved to have it over with.

But I think with going to the doctors now you get an appointment and you have to wait a week or two before you can even get to see your physician so . . . and I think they're so swamped with so many patients coming in that they don't feel like they have the time to talk to that person so I think that's part of it too.

A doctor sees you when you're, everything is down, you know, but you know a couple of days you're feeling better, your immune system is up so I think they're prescribing the wrong kind of medicine at the wrong time you know and now they give you blood work and blood work is supposed to tell everything it doesn't - who knows. I think you decide for yourself. I'd like for the doctor to say go home and come back in a week, then we'll see. I like to hear that, instead of you know here.

The doctor gave me sleeping pills. What's his name gave me sleeping pills.

Based on the stories of some participants, it appears that in the past, women were often placed on HRT without any information at all. In fact, women as young as 40, with fully functioning reproductive organs, were placed on high doses of HRT, where they

remained until well into their sixties; after which time, they must suffer, without the resiliency of youth, withdrawal from these powerful hormones, to which their bodies have now become accustomed.

I had a family tragedy at that time and I was feeling bad - I didn't feel good. I work in a public place and the doctor must have just decided [to put me on HRT]. ... Yeah . . . cause I didn't know what it was.

But Dr. _____ he put me on HRT I took those stupid pills...put me on them about five years after I was finished cause he did an exam and saw that I was full menopause.

HRT is going on more lately, seems to be. I've been on the HRT for a long time.

Many of the women who have undergone hysterectomy seem especially disillusioned by their interaction with health care professionals. According to some of these women, they received relatively little information about their particular problem or the procedure required to improve their health. They also report a lack of information about the potential consequences and risks of the procedure or the hormone regimen that was to become a permanent fixture in their lives. Some women perceive this as an assumption on the part of health professions that First Nations women do not wish to receive or cannot understand information about this aspect of their health.

But then again, how can you know the doctors they're sitting there and telling her o.k. this is what you have, without doing a number of tests on her.

No. . .none of that [information]. . .they just give you the damn paper like that. . .

I went for my hysterectomy, I was going through menopause and all that, and they just show you like a pamphlet and you read it, you know why don't you tell me what's going to happen to me?

Well when I went for my hysterectomy..., the doctor told me, you've got to go for a hysterectomy and blah, blah, blah and here's a pamphlet you've got to read and this is menopause thing. . .what? You know. . .right away when I was heading out to the O.R. and she gives me all this stuff, this is my doctor that's going to open me up in 5 minutes and that was it and she said and you have to take these pills for the rest of your life.

This information is particularly important, given the relative lack of health staff that have access to all but the most generic information about menopause. Much of the available information takes the form of written material that it is not always useful to First Nations women. Moreover, little attention is paid to women's existing knowledge of their bodies or to their level of literacy.

The pamphlets and stuff. . .? Yeah that would help. . . like you said she wouldn't be able to read it. .

Some women simply refuse to visit a physician and so, remain outside this medical loop – or noose - depending on your perspective. Although these women are likely spared potentially disempowering interactions, they also run the risk of late diagnosis for conditions such as diabetes and hypertension as well as cervical and breast cancers.

I don't go to doctors too much, I don't like going to doctors, but when my prescription runs out I have to go.

Women revealed a number of barriers to accessing traditional resources for maintaining their mid-life health. In particular, economic barriers may constrain women's ability to access comprehensive menopause information (e.g. books) as well as herbal and plant based products and preparations. For instance, soy products and other phytoestrogenic foods as well as supplements, which are becoming a popular alternative to HRT in the relief of hot flashes (Elkind-Hirsch, 2001), tend to be expensive, and therefore outside the reach of women on modest incomes, particularly elder women. The Non-Insured Health Benefits Program does not cover products outside pharmaceuticals and/or products of a medical nature (Assembly of First Nations, 1999). Hence, women are left with few options outside synthetic hormone therapy. Similarly, geographic isolation, stigma, and/or a lack of community resources may create barriers to programs such as yoga, exercise and meditation, which represent natural alternatives to HRT.

I was spending a fortune trying to get them [soy based foods] you know, but I could have got money from the band cause the doctor you know wrote a letter, but

I didn't take it, I was too embarrassed. . . I really was embarrassed to take that letter there, I'd rather pay for my own.

The Substance of Relationships

The substance of women's relationships emerged as an important theme in their overall mid-life experience. Beyond the context of relationships, women talked about how their social roles and responsibilities influence and are influenced by their mid-life experience. Specifically, women discussed the nature of other care, particularly in terms of the mother role and the concept of empty nest. They also talked about the concepts of personal autonomy and about the role that support, respect and laughter play in their mid-life experience.

Other Care

The women in this study described mid-life transformation as a dynamic process, which occurs within the complexity of their social relationships. Burgeoning perceptions of 'self' emerge gradually and often compete with well-established and well-supported obligation to and responsibility for others. Within most Aboriginal cultures, relationships are built upon the value of collective conscience and women, in particular, are expected to put the needs of others before their own. For women with children and grandchildren, this gender role expectation is especially significant. In true pluralistic fashion, many women believe that this perspective is co-constructed by women's reproductive hormones, as well as by their own cultural values and Euro-Canadian societal gender norms.

Until mid-life, most women claim that they remained narrowly focused on the needs and concerns of others over themselves. However, peri-menopause seems to represent a time of multi-dimensional change, often involving the direction of women's gaze. While other care remains an important dimension of women's relationships, it becomes balanced with growing self-care. These women talked about an enhanced sense of self – of self-concept, self-esteem, and self-love. Yet, this new gaze is often unfamiliar and, for the most part, unwelcome to those who may not perceive its direct benefit.

My family is important, my friends. I think of me first cause if I don't take care of me, I can't help anybody else.

So my health is important to me and if I'm not healthy and I'm not any use to myself or to my family and I thank god you know that I have come this far and maintained this much health at the age I'm at now.

Some women were not comfortable with this change of gaze and stayed primarily “other” focused – likely into old age. Yet, they acknowledge that there is no right or wrong way to proceed and every woman must choose a path that suits her best. In both cases, women encounter obstacles – from themselves as well as others. For women who choose to navigate the crosscurrent of a shifting perspective from other to self, feelings of guilt and sadness may be mixed with a sense of injustice and rebellion. Family and friends, who do not always understand the origin of this transition may feel rejected.

And I think that's the message that we got when we were growing up, that being a woman you have to be strong, you know and it almost kind of can be a little bit of a detriment when it comes to a relationship with a man because you kind of. .. I grew up thinking, You take over. Yeah, thinking that men are weak you know.

The crabby mood or a bad mood, I'm not going to take it out on somebody else just because if I'm feeling bad why should I take it out on somebody else?

The most unfortunate outcome of this process is that women themselves often don't understand it and the ensuing miscommunication may create tension in family relationships. This is particularly true for intimate relationships, the emotional balance of which women may have been solely responsible. The mid-life transition seems to alter some women's perspective about the relative costs and benefits of her social roles and responsibilities and some women demand change or simply leave.

I am moving out... that's it, I don't care what you do with the place after that. . honest to god, I'm getting out.

If I'm not comfortable with myself or with this situation between you and I o.k. I ain't giving it and I don't care you know, my needs or whatever.

Well you know mine has come back home. . . I don't have that problem. I can't get rid of him. I'm the same way, I can't get rid of them... they move in and I think, they're never going to move out.

You got to explain why you act the way you act. . . cause you've got mood swings - cause you don't know. . . he's really good, he's a good supporter and he knows when not to talk and when to listen.

Most women view the expression of anger, particularly toward children, as an unwelcome consequence of peri-menopausal change. Irritability and outbursts are a particularly disturbing reality for women who are sensitive to hormonal change; a reality that has important implications for their self-concept as well as the quality of their relationships. In general, women fear these outbursts, and are perplexed as to the origin of their feelings. The expression of anger toward others is so unacceptable to some women that they devise management strategies, many involving self-care. These resourceful women tend to be those who access emotional and spiritual support more often than others.

I'm hearing these things and they're scaring me like at home I'm usually not mad at my husband or my kids and I don't want to be, like I don't want to be mad at them, I want to be ready, like I want to know what it feels like to have menopause and I told my husband once I'm hearing these things and I told him if I get mad at you and if I start to get mad at the kids, just lock me up in the basement til I stop.

That's what I tell my daughters too. . if I go too far or if I just lose it, but they knew now this is what's going to happen to me but most of the time I just leave. You know I think I've got to talk to my kids about this because I haven't talked to them about menopause because I didn't know about it. . . You better learn some more before you talk to them. . .

My personality starting to snap at the girls, I was being a bitch. . .and my god my daughter said mama you are a super bitch and they took the pills and garbage.

Even the possibility of these outbursts can be devastating to women who have not yet completed the process and do not have access to supportive networks of women who have had similar experiences and understand them in context. Without an opportunity to explore changes and discuss new feelings with family and friends, women are often left feeling alone and out-of-control.

Mother Role

The majority of women who participated in this study reflected on their role as a mother and the meaning that role has played in their mid-life experience. It seems to be the most important relationship in their lives, and the one, which brings them the most joy and the most pain. Although they perceive the mother role as life-long, they also explained the diversity of that role over the course of own their lives and the lives of their children. During this time of life, women reflect on the changes in relationships with their children and with their own mothers. Like most mothers, they have tried to do better for their children than their own parents were able to do for them.

The inequitable division of household labor is no less common among First Nations women. The literature has clearly demonstrated this trend, which seems to cross ethno-cultural boundaries to influence the lives of all women. However, the extended cohabitation of First Nations families has implications for women, who might experience this inequitable workload for longer periods of time. They might also be more likely to experience it during the peri-menopausal years, when hormonal change may create greater sensitivity to external stress, particularly that which is perceived as inequitable.

You know, you come home and after working all day or on the road for two or three days, you come home and maybe the dishes are still piled in the sink, oh and they say you're never happy anymore. . .and I'm like how can you be. . .and the laundry, you cleaned up all the house and laundry is all done, and when you come home it's a mess. [another woman says] Hey, I'm in the same boat, same thing. . housekeeper.

Despite differences in the tasks they perform within the mother role, women did not perceive any real change in that dimension of their identity during mid-life. Women did however, describe this phase of life as one in which they spend considerable time reflecting on the role they have played in the lives of their children. The maturity and insight of mid-life contributes to a somewhat surprisingly enthusiastic assessment of their mothering. During our discussions, many of the women candidly reflected on their strengths as well as their shortcomings.

I find I'm easier on my children now than I was when I was younger, I had them marching around like tin soldiers. ..and I was very protective, and that wasn't good either, you may as well be neglectful because I was . . . I controlled them you know and now one of them I had problems with, I'm paying.

I found I was more lenient with my kids when they were younger and I shouldn't, like to me I should have been stricter and now that they're you know. I find that now I'm trying to do that but it's not working cause I mean they're grown men you know and then all of a sudden oh well they look at you well you can't tell me what to do.

Some of the women had one set of children during their late teens and/or early twenties, and another child or children during their late 30s or early 40s. They explained that the mothering responsibilities for younger and older children require different capacities, knowledge and supports. These women are often performing “double duty” with respect to the care of children and the added responsibility of this dual role, not to mention the emotional toll it takes on women, which may create stress that negatively affects their menopausal experience. However, the close relationship and support women often receive from their children, particularly from older children who help with younger ones, also nurtures and supports them, thus representing a benefit that women with no children at home do not experience.

There are women 45 or 50 who are having children. They're having children much longer than ... My aunt had a son when she was about 49. ... To be honest with you - forget that! I'm finished.

Empty nest often depends on how many kids you have – women sometimes have kids late in life so they still have young ones when they go through menopause. Many times, children don't move far from the reserve so women see their children and grandchildren.

When you have children and/or work, you don't have any time for yourself. Many women still have kids (children or grandchildren) in the home so they are kept busy – still cooking, cleaning, child care.

When I was going through it, I felt like I was going alone but I shared it with my kids, you know my girls, cause they're the ones that were telling me. . . or whatever you know what I mean. .

I had a lot of support from the kids too you know, they made fun every now and then, having the hot flashes. ..I got a lot of support that way.

Women recognize a number of differences between the relationship they have with their daughters, and the one they had with their own mother. Mother/daughter communication seems to be more open among contemporary First Nations women, who have incorporated new parenting practices, while maintaining the cultural values that benefit those relationships.

Some of the women talked openly with their daughters about sex, menstruation and pregnancy, but these women seem to be the exception, rather than the rule. It is not a matter of being closer to their daughters, so much as it is that they feel more comfortable with their knowledge of the subject and do not fear expressing a negative attitude. Although the other women talk more openly than their mothers did, they are still reluctant to talk about issues related to sexuality and reproductive change. In most cases, this stems from a lack of information about those particular processes but sometimes, it seems to originate from a sense of protectiveness women feel toward their daughters. Some women are reluctant to talk about it because they might express the sadness that is so much a part of women's lives. They desire more for their daughters and so, in the hope that they will not negatively colour their perspective, they remain silent on the subject, and hope their daughter's experience will be better than their own.

My mother never talked about it. Even when I was younger and she never said anything that you were menstruating, you will be you know all these things. .. it's the same things I did to my daughters, I didn't tell them anything.

I told my eldest girl about it and my youngest I didn't want to tell her, she's my baby and I didn't want to tell her, my daughters told her. . I don't want to start crying and bawling my head off telling her. Yeah, same in my family. But my second oldest was. . . I started when they were eight years old, my girls, and I explained to her. . . what could happen. .. because you can't just you know get mad at them

You know I think I've got to talk to my kids about this because I haven't talked to them about menopause because I didn't know about it. . . You better learn some more before you talk to them.

My daughters...they'll ask me you know, whereas I wouldn't have called and asking my mother, you know if she was going through it or anything you know so I think that's the difference.

Empty Nest

The concept of 'empty nest' appears to differ in a number of ways for First Nations women. It begins with women's reproductive experiences, particularly the age at which they have children (especially their last child) and the subsequent ages of those children when women traverse menopausal change. This temporal component of women's reproductive experience influences whether an empty nest exists at all as well as the degree to which it occurs and the subsequent impact on women's lives.

Despite some variation related to social class and recent changes in post-secondary educational activities, the "empty nest syndrome" persists as a model for understanding women's mid-life experience (Borland, 1982). However, the assumption that children and grandchildren will live some distance away during women's mid-life transition did not apply to most of these First Nations women. Child pursuing post-secondary education, unmarried daughters and their children, living at home, or grown children who have come back, means that women often experience peri-menopausal change with a very full nest. Several women talked about providing care for adult children living at home, younger children born later in life as well as grandchildren. This proximity means that, during mid-life, First Nations women generally put more time and energy into their families. The abeyance of an "empty nest" translates into women's relative peace and freedom when children do move away. Although some of the older women expressed nostalgic feelings of mothering infants and small children, this wistful sentiment was quickly qualified with practical comments about time and energy – and their current lack of both.

I didn't mind having. . . now I wouldn't mind having them [grandchildren] all the time. . I wouldn't like to have children of my own at this age is what I'm trying to say.

Empty nest often depends on how many kids you have – women sometimes have kids late in life so they still have young ones when they go through menopause?

Many times, children don't move far from the reserve so women see their children and grandchildren.

Well you know mine has come back home. . . I don't have that problem [empty nest]. I can't get rid of him... I'm the same way, I can't get rid of them... they move in and I think ...they're never going to move out.

Although some women commented on the “empty nest”, this concept did not emerge as a theme across groups. In fact, most women’s experience was contrary to this presumably well- established dimension of mid-life. Nevertheless, some women did express feelings of loneliness, and its implicitly consequent depression, which they conceptualized as empty nest syndrome.

Also too I think it could be you know recognizing that your arriving at another stage in your life, you know it wasn't long before that you kind of had to face the empty nest syndrome and then . . I guess it all depends on where you are in your life, how you deal with it so I can see where it can be depressing.

That's what we're used to doing, you know and when the kids grow up and they're gone – you don't have to do that anymore and then when we have the opportunity when the grandkids come, yeah you kind of go back to that and that kind of fills you up with a familiar feeling that you had before and kind of brings you back to when you were younger.

Women who have children in their mid and late forties, may experience hormonal changes related to pregnancy, post-partum, lactation and peri-menopause during mid-life. Women will likely not distinguish between these experiences - in fact - researchers cannot be sure how pregnancy interacts with the menopausal transition because the Euro-Canadian subjects of menopause research are not having children at this time of life. It is safe to say, however, that the presence of a newborn baby, who will not reach maturity until his or her mother is well past menopause, substantially diminishes the likelihood of “empty nest syndrome”.

For women having children in their thirties, the nest also stays relatively full of young children well past menopause. Aside from prolonging this experience, these mothers are often kept very busy with responsibilities of childcare, which could either

exacerbate the experience of hormonal change or keep her too preoccupied to focus much attention on the changes she is experiencing.

The role of grandmother among First Nations women may also provide a buffer against the emotional impact of an empty nest. Elder women contribute substantially to the care of their grandchildren, adult children with disabilities as well as other children in their kinship networks. This extension of childcare provides women with many of the benefits – in addition to the consequences - of those responsibilities.

I don't care as long as I'm healthy and I can walk and I can run and play with the grand kids and you know cause I'm with them every day nine to five and I have fun with them and you know and I have three more up here and I spend time with them.

Many women baby-sit their grandchildren.

Autonomy and Support

Within this study, autonomy was conceptualized as an important element of women's life experience, particularly in their mid-life relationships. In this case however, autonomy is not conceived, as it might be in Euro-Canadian culture, as individual control, so much as it is an extension of cultural norms around respect for others' independence of thought and behaviour. In fact, this cultural value is so deeply ingrained in many elders that, out of respect for everyone's right to believe and say what they wish, some people will not disagree with others, even if they believe what they say to be false (Paul, 2000).

Women reveal the value of autonomy in their acknowledgment of the right of every woman to subjectively perceive the benefits and drawbacks of menopausal change. The notion of staying true to what feels right for the individual also emerged as a component as women's autonomy. Everyone's experience was accepted and validated as a meaningful expression of her individuality and no one's healing practice was received with disapproval or scorn. According to these women, to claim that menopause is definitively this or that, may demonstrate disrespect toward a woman who is not experiencing the same benefit or challenge. This belief provides some clues about why

advice giving around menopause is so uncommon among First Nations women – as this type of opinion sharing or advice may be considered inappropriate and/or disrespectful.

And then it's the individual choice really in everything you do.

But I think. ...it's up to the individual if you prefer, what you prefer does you good.

I think you decide for yourself.

But it's not the same for everybody. You can control it.

Seldom, if ever, did I hear women giving advice during our talks. While they asked me questions and expected answers, I noted that, within the discussions, advice was rarely explicit and the wording of responses was couched in diplomacy. I was grateful that my personal inclination to respond diplomatically and to offer advice only when it is requested prepared me for our talks.

The unpredictability of hormonal change, and its expression in physical and emotional domains, may influence women's sense of autonomy. For instance, heavy, unexpected bleeding, hot flashes or panic attacks may confine women to their homes, where they feel better able to cope with these experiences. Although they may be motivated to pursue physical and recreational activities that promote health and prevent illness, many older women are restricted by weather, lack of transportation or physical impairments.

The weather keeps older people inside, which can be frustrating.

Getting exercise is important but even if there is a gym in the community, the weather often stops older people from going because they are afraid to fall.

Like it's kind of scary and I heard these things, like you wouldn't be aware. . if you go somewheres and you lose a lot of blood and that scared me cause I'm already like have this blood problem so I'm scared.

For many women, this diminished physical autonomy has implications for their mid-life health. Lack of physical autonomy is perceived among these women, as a barrier to social interactions that represent an important source of support. Fiercely self-

reliant however, these determined women rarely succumb to the psychological or emotional discomforts of physical limitations. Fortunately, many women also report enhanced autonomy as they move beyond the relative instability of peri-menopausal change.

Spiritually, physically and mentally balanced I guess is a good way you know and you know when you're out of focus you know and you have to kind of pedal yourself right back into try to be rational I guess.

I have to be independent with myself, I have . . I can't depend on anybody, I got to depend on myself.

I'm free to do what I want to do you know, so that's how I feel.

Well you've only got yourself to depend on. That's good.

Autonomy around decision-making seems to be of particular relevance to First Nations women. Despite direct instruction from physicians regarding hormone replacement regimens, without adequate information to support those external decisions, women will, and often do, decide for themselves whether they will comply. This was discussed in greater detail in the section related to HRT and women's relationship with health professionals.

The concept of support is closely linked to women's relationships during mid-life. Most of these women discussed the benefit of having people in their lives, who acknowledge their experience and provide various types of support. These support systems represent extensive networks of people, spanning generations, including youth, other women, community members, health professional, elders, healers, and family, from whom mid-life women can solicit help when they need it. Yet, although partners, children and friends are generally compassionate and gentle with women in the peri-menopausal transition, they know little about the process, so are perhaps unable to provide some of the direct support women require.

I know. .it helps, it helps a lot. . .but then for something like that you know something personal you want to be alone with someone that you can open up too

and that's what's bothering our younger women today. . . they're so down and. . I think it's the style of life that you're living, you make it your own.

Older people living on-reserve are well cared for by the community – someone will call to see if you need anything. There is a lot of support for elders in the community. Older women have known each other most of their lives and can turn to each other.

I think that's the beauty of being in the community all these places that you can tap into you know and you're always connecting with someone, doing something And I think as a result of that because the way we (First Nations women) are that we intermingle a lot with each other. . that's a good learning experience also to grow .

Yeah and not only that you see, you see what other people can offer you know, it isn't just this one person that has everything that you need like maybe comfort, one will do a little better than the next one or you're more open to some people but. . . You see the value in front of us. . .

And [health nurse] is great. She is our health nurse here; she was great. I mean she'll talk to you and she'll make you visualize, and make you see like you know it's not the end of the world but this is what's happening, like you know.

Aloneness and Loneliness

Women reported feelings that range from intense loneliness to an overwhelming desire to be left alone. Some women talked about feeling lonely and speculated that these feelings can lead mid-life women to feel unloved by their families, unappreciated by their community and undervalued by their culture. Yet, they also seem to understand this experience from a distant perspective, which allows them to introspect about it and separate the emotion from reality.

Women who are alone have more problems

I got a friend that's non-Native and she was talking to me a little about it, like she'd say there'll be a time when you don't want your husband around, like you just want to be alone and I was feeling these things. I don't know if I would have had them if she didn't tell me about it.

Yeah it becomes more intense. . .more intense like you want to be by yourself you know and then when you're by yourself you don't want to be all alone. Then you get the crazy crying jags you know. . .you're all alone, nobody cares, nobody

wants me, nobody cares. I'm going to eat worms or something you know. But you do, you go through very emotional times.

I was somewhat perplexed to discover that so many women desire more time alone during the change of life. This is particularly relevant for First Nations women, whose culture emphasizes inter-connectedness. However, according to Northrup (2002), longing for time alone is one of the most common themes in women's discussion of menopausal change. Turning inward and becoming reflective as well as recognizing inequity is also something many women talked about. This desire to be alone may stem from women's need to adjust, emotionally and physically, to the changes they are experiencing.

Being alone in a literal sense and feeling alone in your experience of peri-menopausal change emerged as the most profoundly negative determinant of this transition. Whether women had experienced these feelings or whether they could simply reflect on them as determinants of peri-menopausal change, they generally agreed that being alone in this experience compounds the physical, emotional and social difficulty women might encounter. The relative fragility of some women's emotions, combined with changes in their relationships (whether from a newfound sense of entitlement or the dynamics of growing families) may create feelings of loneliness and alienation, which might actually precipitate problems such as depression.

You're all alone, nobody cares, nobody wants me, nobody cares. I'm going to eat worms or something you know. But you do, you go through very emotional times.

Sometimes it's lonely so I like to have friends around me, my family around me, so like people that I can talk to...

Women who are alone have more problems.

Women spoke about loneliness both literally and figuratively, often making a clear distinction between being alone and feeling lonely. Indeed, many are happy to have some quiet time to themselves, without the constant hustle and bustle of adult children or grandchildren. However, for women who do not have a lot of children and thus, find themselves alone, particularly when they are relatively young, loneliness may exacerbate

existing fears about impending old age and the potential ensuing alienation. Some women talked about being alone or “in the house” too much of the time, which can lead to boredom that in turn, might encourage them to focus too much attention on their problems. Most preferred to get out and work or participate in volunteer activities in the community.

Well, like I couldn't get a job for a long time and like my son is old enough, he's out with his friends and everything so I was alone and I didn't like it my husband was busy, I really didn't like it when I finished cleaning, I cleaned the house and everything and then I sat down, I wanted to do something.

I didn't have a job and I had the hysterectomy and I didn't work, it was just closing in, closing in, closing in you know.

But I'm not comfortable like staying in the house all the time.

Figuratively, participants talked about the potential loneliness of this experience for women in general. A lack of information, combined with historic silence around this issue, keeps women in a state of isolation with respect to sharing with others. Many women find it difficult to intimately share this experience, occurring within the context of family and community life, with other women. Therefore, they must confine their discussion to the boundaries of a physician's office, where further attempts are made to confine it even further to the boundaries of women's bodies, never permitting it to spill over into her interactions with others. Women's reliance on interactions with doctors seems to perpetuate their feelings of isolation. Hence, despite the extended networks of people typically involved in First Nations women's lives, this process of psychosocial isolation can promote feelings of loneliness.

Being alone is not something to which most First Nations women are accustomed. Many of the women in this study were raised in large, extended families and left home only when marriage, children or work warranted the move. In most cases, First Nations children are not encouraged to leave home with the same enthusiasm found in Euro-Canadian culture, so as discussed earlier, women are often well into or past menopause when they experience an “empty nest”.

Respect

Unfortunately, the hectic years of raising a family and working don't allow much time for women to seek the respect they deserve. Though during the relative quiet of middle years, the enhanced dignity with which women carry themselves commands, rather than demands, the respect of those around them.

It's hard to ask for respect you know when you're busy with a family and teenagers, you know. .. what you were brought up, no matter what that person is doing you respect them, and you know that's hard to do but then when you're at this age and somebody is rude, not being respectful, you've got to let it go, you know that's them, it's not towards you.

Despite occasional references to feeling disrespected, most women talked about the deference paid to elders in First Nations communities. It is easy to see why elders are respected, if one sits quietly and listens to the wisdom and clarity with which these women view the world. The generosity of spirit and loving acceptance expressed by these older women provides an excellent role model for respectful behaviour. The positive role model they represent creates a more positive attitude in general and a positive attitude toward elders in particular.

The community is close knit and so are the women. Women feel more respected as they get older/ become elders. Seniors are taken care of by the community. The band office has counselors for seniors. Home care workers come into seniors' homes to help out.

I think you get more respect. I mean when you're in town people will open doors for you and all this stuff because you're older. . .they see the white hair...and when people see you smiling, you have a pleasant look on your face, you know help you with - open the doors.

Some of the women believe that the degree to which elders are afforded respect has changed since the time of their youth. There seems to be some variation in the perception and experience of women with respect to this topic. This difference may be related to differences in community cultures and the degree to which traditional ceremonies, language and philosophies are promoted and practiced.

I find that young people today, whether you're a man or a woman, younger people today don't have the respect for older people that we had when we was growing up. . we were taught to respect your elders. ..when we were growing . .and I find the culture today is different. It sure is - drastically different. We used to get a gosh darn good whooping.

I even remember my grandparents, like you think of the old Indians, I think of granddad and I see this quiet, dignified man who didn't demand respect but had it from everybody and I think that's the same, you look at that, you say o.k. can I become that same type of a person who's not going to be out there demanding for people to respect me but because of the way that I carry myself have it. And I think that . . .some of us are seeing that and some of us are getting the respect and we're feeling respect towards others and I think that's just part of it, I don't know.

Inter-generational disruption may reflect the legacy of residential school experiences, which separated elders from children, leaving little opportunity for building close relationships. Moreover, the custom of inter-generational households has declined somewhat during the past 30 years, with a resultant decline in sustained contact and learning between elders and children. Likewise, youth are being acculturated through the media, which aside from the Aboriginal Peoples Television Network, does not portray the traditions of First Nations people. Rather, Euro-Canadian media promotes the segregation of youth and elders, often depicting youth culture as the antithesis of adult culture.

Laughing at Life

Joking and teasing are an integral part of communication in many First Nations cultures, particularly around sensitive issues. Many of the women in this study used jokes as a vehicle for sharing information about menopause in a more palatable and appropriate way. The value of this communication strategy lies in its capacity to allow women to express their feelings and to highlight this issue in a context where it might otherwise be unfavorably received. In fact, many women report that jokes about menopause are the only context in which they have ever heard it mentioned.

I've never discussed it with anyone. I hear lots of women talking about it, they just make jokes and stuff like we do. . . I can't see that. . why there would be a lot of difference. . .

But some people joke on it. . .

Sometimes women joke about it.

Maybe more joking. .yeah.

At the end of our book, we should have all these jokes.

Joking might be conceptualized as a strategy for coping, which is linked to the concept of acceptance. Discovering the playful and positive elements of a situation or experience, and sharing it with others, represents a cultural norm, which has created resiliency in First Nations people during difficult experiences of colonial intrusion and attempted assimilation. Although joking provides an outlet for many women, those experiencing significant difficulty or heightened emotional sensitivity at peri-menopause, may perceive it as embarrassing or disrespectful. For the most part, however, these women viewed joking in a positive light and perceived it as a sign of support and acknowledgment of their experience.

The grandchildren some of them make fun of me they say oh you're getting a hot flash, you know they kind of make a joke of it.

I said I had a lot of support from the kids too you know, they made fun every now and then, having the hot flashes. . I got a lot of support that way

The following statement provides an excellent example of the good-natured teasing women talk about.

I just went cold turkey on that Premarin, like I said nothing happened to me and we were on the same pill, one pill and she turned into a mad cow [laughter] and nothing happened to me. She got the mad cow disease. [laughter]

Summary

In-depth analysis of the findings of this research revealed a number of sub-themes, which coalesced to create the structure, upon which the main themes of vision, balance and relationships were constructed. Within the discussion of each sub-theme, I have attempted to illustrate the subjective and diverse nature of women's perception and experience of mid-life health and peri-menopausal change. I believe this process

represents a critical feature of any exploratory study, which seeks to reveal both the breadth and depth of human experience.

In this chapter, my intent has been to delve as deeply as I am realistically able, into the collective experience of these particular women. In the following chapter, I hope to expand that discussion beyond the boundary of these women's lives and consider how the findings might compare, contrast, support or contradict the findings of other research. I have also contemplated the degree to which these findings might contribute to the way we conceptualize peri-menopausal change in general. Finally, I have suggested ways in which First Nations women might contribute to a discussion of cultural context in the menopause discourse.

CHAPTER FIVE: DISCUSSION

A credible portrait is typically one, which provides both depth and breadth; a rendering that is complex as well as comprehensive. Ideally, my presentation of the research findings presented some of the depth of women's experience. It follows that my discussion should extend beyond the boundaries of these particular women's lives, to encompass other constructions, which might facilitate our understanding of these findings. The conceptual framework upon which findings were depicted has proven useful as a rough template for this discussion, yet I have also built on related concepts, which are relevant to First Nations women's mid-life health. My interpretation of the findings also represents a blend of feminism, phenomenology, critical social theory and Aboriginal philosophies.

In this discussion, I have attempted to reveal that which is comparable to the experiences of many Euro-Canadian women as well as that which seems remarkable about First Nations women's mid-life and peri-menopausal experience. The foundation of my discussion is the engagement of both western and Aboriginal bodies of knowledge and thought. I hope that, whether through good fortune or careful attention, I have imparted insights that will be both palatable and useful to Aboriginal and non-Aboriginal people.

Vision

First Nations women's vision of peri-menopausal change differs substantially from the vision, which is purported within biomedical literature to be widely accepted by women. Indeed, the vision of menopause presented in these findings differs as much from that portrayed in biomedical literature as it corresponds with that expressed in feminist literature. This circumstance is likely a product of the similarities and differences in the paradigms and methodologies that shaped those disciplines of research. According to the women who partnered in this research, First Nations women know little about menopause and based on my observations, this statement is generally true. Yet, what they do not appreciate and what becomes apparent in their discourse, is that First Nations women understand a great deal about the "change of life;" about a life transition researchers are just beginning to conceptualize in its entirety.

The women describe a vision that goes beyond holism, to encompass both the breadth and the depth of this phenomenon. Vision of self blends with vision of perimenopausal change to create a broad perspective, one that captures both the essence and the association of self; one that encompasses the horizon in all directions, and one that involves all of the senses, upon which experience is constructed, and all domains of life upon which it has influence.

Women's vision of menopause is revealed within a variety of contexts and through a multi-dimensional lens, which is fashioned by values of the past and present, by embodied experiences of aging and reproductive change, by learning and spiritual growth, and by relationships and self-discovery. Women's vision is inclusive in terms of temporal boundaries and social determinants, as well as relationships and experiences. Embedded within this vision, women's expectations of menopausal change become linked to cultural values and social norms, through which explicit and tacit messages are conveyed.

The multi-dimensional concept of vision represents a critical element of women's experience. Vision encompasses the horizon of women's lived experience; the life, which provides context to her experience, the flesh and blood of menopausal change, as well as the relationship she has with herself and with others. All of these elements are involved either directly or peripherally in shaping the lens, which creates a filter for her vision.

Women's vision of menopause often becomes the template upon which they apply their current experience. This template is often forged by expectations and theoretical understandings, which women bring to the experience, but also those, which emerge as a result of living that experience and forming alternative ways of understanding it. Expectations are formed through past experience, personal beliefs and self-vision. They are also linked to the silence women experience around their own reproductive processes as well as those of their mother and grandmother.

The women who partnered in this research are critically reflective about this process of change. The social, economic and political context of their lives and the lives of their ancestors positions them to contribute to a vision of menopause, which acknowledges that life is difficult and that pain and loss are a part of life, which cannot

and should not be denied. According to Busch, Barth-Olofsson, Rosenhagen, & Collins (2003), this realistic appraisal of a transitional phase of life reflects mature personal and interpersonal development.

Context

It is entirely likely that the experiences of this generation of mid-life, First Nations women present a very new picture of change. Although the timing and duration of menopause among First Nations women does not appear to have changed much over the past one hundred years, the extent to which this transition impacts women's lives has been altered by socio-economic and political contexts (Currier, 1891; Hallowell & Irving, 1991; Shimony, 1961; VanStone, 1963). The circumstances of their lives are not only vastly different than those of more advantaged groups of Euro-Canadian women, but also than those of their own mothers and grandmothers, who would not have experienced the additional pressure of bi-cultural forces impacting their peri-menopausal experience. By that, I mean that they are the first generation of women old enough to remember the overt subjugation of past generations but young enough to have participated in the resurgence of Aboriginal cultures and the movement toward self-determination and self-government. This process of change-within-change makes this group unique. Although cultural identity is typically described as the experience of a particular group of people (Barrios & Egan, 2002), First Nations women have been triply engaged - in the re-emergence of their cultural identity, within the context of cultural accommodation that is specific to women, during the turbulent years of their own peri-menopausal change.

Acculturation tends to be conceptualized as a linear process, in which minority cultures are assimilated entirely into the dominant culture, from one extreme to another (Barrios & Egan, 2002). Yet recently, theorists have suggested that cultural identity, particularly that of First Nations people, may represent a more fluid process, in which adaptation to Euro-Canadian environments is used as a means of facilitating health and well being (Barrios & Egan). During the past 500 years of colonization, First Nations women have struggled to forge an identity that conforms to some extent with Euro-Canadian values, yet also maintains their core identity as First Nations women. Their interaction with the federal health care system represents one instance in which cultural

accommodation and adaptation is required in order to promote their own health as well as the health of their families and communities (Barrios & Egan).

The past twenty years has witnessed a renewal of Indigenous identity, in which First Nations women have played a major role, through various activities intended to resist assimilation and to promote self-determination. Many First Nations women construct their identity from traditional definitions of self, which are based on the role of nurturers and guardians of culture. From this social position, they have been instrumental in revitalizing language, art, ceremonies and healing as well as community programs and services that promote health and well being (Gongaware, 2003). Women achieve this through a myriad of intra-personal, inter-personal and social activities, including their utilization of female networks as well as their connection to the traditional role of caregiver to family and community in addition to caretaker of culture and tradition. This multi-dimensional self creates a filter for women's lived experience (Gongaware).

Unfortunately, this vision is in jeopardy of being distorted by external forces that seek control of women and of First Nations people. As a consequence, women's vision becomes permeated with tension between observing traditional ways of knowing and accommodating western ideas and practices. Loss and degradation, emphasized in the western biomedical model of menopause, are juxtaposed against a traditional model, which emphasizes strength and connection.

Stoicism and personal autonomy, valued within many Aboriginal cultures, is set against the paternalism of a federal health care system, which limits First Nations peoples' capacity to care for themselves. The value of female strength and elder wisdom are set against powerful western messages about the value of youth and the frailty of women. Finally, the natural acceptance of change, so integral to Mi'kmaq culture, struggles against the medicalization of this natural process. Within this bi-cultural struggle, First Nations women must forge a vision of themselves that accommodates change, while maintaining balance.

Many Aboriginal women are growing old in a world that requires their vigilance in protecting the values of their own culture, yet one that demands their accommodation of western ways. This burden is added to existing responsibilities to family, community and nation. Is it not surprising, that women have little time left for self-care or to pursue

information about menopause that is not made amenable to them in the first place. It is therefore, little wonder that women enter this process with some measure of trepidation. In fact, it may be surprising to some (likely to those who have not met these women and seen their strength first-hand), that so many have traversed this process with such relative balance.

Temporality

In the lexicon of many First Nations languages, change refers to a time, not a thing (Leavitt, 1995). Accordingly, temporality represents an important construct in the circular model of women's mid-life experience. Within this construct, women's experience of peri-menopausal change is conceptualized as involving the distant and recent past, the present, and the future, all of which are intimately connected. The temporal quality of women's mid-life transition is also played out in their social relationships, which span several generations and include multiple and reciprocal dimensions of care and challenge. This perspective is common among many Aboriginal peoples, whose life philosophy embraces the past as a vital source of information and a template upon which current experience is understood (Buck & Gottlieb, 1991). However, this construct is rarely employed in biomedical models of health, which tend to "slice" events out of the temporal reference or focus on the relative timing of particular events, rather than temporal influence.

History provides First Nations women with a rather unique understanding of the constituents of mid-life experience. Within a temporal construct, women's experience of peri-menopausal change involves many generations, which provide the root upon which their current life experience becomes grafted. In addition to the experiences of their ancestors, a woman's own past experience forms an integral component of her overall experience. Personal past blends with that of ancestors to create a broad and insightful vision. Past social, economic and political contexts are embedded in women's memories and understanding of how their experience has been shaped. In particular, poverty, family structures, cultural norms and Euro-Canadian involvement in the lives of First Nations people, form a template upon which women's current perceptions are shaped. Women understand their own experience as an extension of the experiences of their mother and grandmothers, who traversed peri-menopause in the context of economic

disadvantage, social marginalization as well as attempted assimilation and ethnocide. In addition to viewing this historical domain of influence as a source of cultural pain, women are strengthened by the tenacity of their forbearers and draw on past wisdom to inform their own vision.

Women's personal history settles next to that of their ancestors, to provide additional structure for understanding their current experience. The respect and deference given to elders in the past provides a buffer against the anaphobic attitudes of Euro-Canadian culture, and its influence in the lives of First Nations people. Women's perception of mid-life change is saturated with memory, with past experiences that have shaped who they are and how they perceive their current experience, particularly those related to menarche, childbirth and menses, which contribute to the foundation upon which understanding of peri-menopause is formed. Yet, it is not only the substance of those experiences, but the context within which they occurred, which forms the basis of women's understanding.

Women's past experiences might also create a personal environment of strengths and sensitivities, a kind of biochemical (e.g. adrenal function) and psychosocial (experiential) memory that prepares them to undergo this change of life. Past also forms an emotional and psychological foundation for understanding who they are and what role they play in their family, their community and their society. Perceptions of love, esteem, trust and commitment set the stage for positive attitudes and social experiences. Conversely, alienation, separation and discrimination may create an emotional milieu, which is more vulnerable to fear, confusion, self-doubt and loneliness.

The circle moves as it should when old women pass their wisdom and experience on to the next generation, thereby inhabiting the experience of their daughters and granddaughters. This responsibility to reconstruct their experience into a form that is beneficial to future generations ultimately shapes women's own experience of change. This inter-generational temporality creates a bi-directional force, which extends backward and forward through many generations of female experience.

Self Vision

Peri-menopausal change may be viewed as a transformative period in women's lives, in terms of the ways in which it alters their vision of themselves. It is expressed through the way women talk about this life stage, as extending beyond the confines of hot flesh and brittle bone (Busch et al., 2003). This view also accommodates the holistic perspective, which characterizes many Aboriginal world-views.

During peri-menopausal change, women engage in a process of re-balancing their vision to suit the rhythm of this new state of life, with new opportunities and new directions. Internal to this process is an examination of women's relationships and the management of their social roles as well as the healing of old wounds and the discovery of a new identity, ideally, one that provides an opportunity for creativity and self-expression.

Self-vision refers to women's evolving sense of themselves, encompassing self-identity, self esteem, self worth and self-care. Self-vision is the nucleus of lived experience, which continues to be modified throughout life, in tandem with that experience. Therefore, at a personal level, self-vision is a mutable construct, changing its colour and texture over the course of women's lives. These women provided a glimpse of their vision through a candid and open discussion of how the circumstances of life shape them. Their willingness to share this experience opens the door to a new way of understanding the process of peri-menopausal change.

Self Reflection

Anthropologist, Margaret Mead once claimed that the energy resulting from menopausal change represents a powerful, creative force in women (Margaret Mead, in Lock 1993). Northrup (2002) further asserts that peri-menopause is a life transforming process; one she refers to as "the reclaiming of self". Busch et al. (2003) also suggest that the peri-menopausal transition provides opportunities for women to reflect on personal and interpersonal issues, thereby serving as a catalyst for psychosocial development. Despite these distinctions, which have been bestowed on this process and on the women who traverse it, as recently as 1969, American physicians still claimed that menopause marked the end of a woman's service and value as a human being (Crowley, 1994).

In order to set the stage for a well-balanced menopausal experience, it seems that women must begin by recognizing the “no-nonsense mental clarity of peri-menopause,” rather than accepting a misogynistic portrayal of their devalued state. In many ways, women become their own healers in this process of mid-life self-reflection. Specifically, the changes women experience, both in thought process and in focus, can help them perceive more clearly, that which they previously could not or would not see. Women have reached an age of maturity, which allows them to address issues that might have been beyond their intra-personal reach as younger women. It is as if their body has been patiently waiting until the time was right and they were prepared to recognize and attempt to resolve many personal and inter-personal issues (Northrup, 2002).

The findings of this research resemble those offered by Buck & Gottlieb (1991), in which a group of Mohawk women revealed that midlife represents a time of shifting priorities and personal fulfillment as well as one focused on relationships and reflection of the past and future. The findings of both studies support the inclusion of an intra-personal component to the models we use to understand the peri-menopausal transition. This concept goes beyond emotional or psychological domains, to include the evolving relationships women have with themselves, with the young women they were, the mid-life woman they have become and the old woman into which they may yet evolve. The relative value placed on aging in Aboriginal cultures as well as the emphasis placed on elder wisdom, provide additional opportunities for First Nations women to become reflective during peri-menopausal change. This introspection, which serves as a catalyst for personal growth, is also valued and encouraged in traditional Mi'kmaq culture (Paul, 2000).

It is critically important however, to recognize that peri-menopausal change presents an *opportunity* for self-reflection, not a pre-requisite. Neither should we assume that self-reflection is a necessity for every peri-menopausal women. Some women may not perceive the challenges of peri-menopausal change as an impetus for personal growth. Personal characteristics as well as contextual factors may inhibit women's capacity to engage in a lengthy and complicated process of introspection (Busch et al., 2003). Moreover, regardless of circumstances, the degree to which women pursue this introspection remains a personal decision, which is only modified by cultural contexts.

It is difficult to separate women's vision of others from their vision of themselves, as the two are intimately connected. An in-depth discussion of the role relationships play in women's mid-life experience follows later in this text. Nevertheless, it bears mentioning at this point that, like most women, First Nations women construct experience within a model of self-in relation. According to Jean Baker Miller's (1976) self-in-relation theory, women define themselves by the relationships that are most meaningful to them. However, although this theory might serve as a framework for understanding the relational dimension of women's self-vision, it lacks the cultural significance of Aboriginal frameworks, which support gender neutral connectedness between all members of a family and community.

This relational framework also precludes a discussion of the particular role elder women play in the lives of younger women. First Nations women's self-in-relation goes beyond the traditional role of caregiver, to one of mentor and teacher. The women who partnered in this research are part of a larger group of First Nations women, who view themselves at the forefront of a movement to educate younger First Nations women about the opportunities and challenges of transitions like that of peri-menopause. This inter-generational process is one, which follows the tradition of First Nations people, where young and old come together for sharing and learning. Women view their lives in general and this experience in particular as interwoven into a temporal circle; their role is now one of teacher; their responsibility is to the next generation of women, who need their wisdom and experience to help them cross this transition feeling strong and connected.

Menopause Vision

Since Jones and Jones (1981) first argued against Wilson's (1963) characterization of mid-life women as "unstable [and] estrogen-starved," many researchers have been suggesting that menopause might actually represent a "gift of nature", intended to protect women's aging bodies from the rigors and dangers of pregnancy (Bell, 1987). Within the larger circle of human existence, these women talked about a sense of renewal during mid-life. Although they acknowledge this stage of physical life as one that connotes declining health and increasing fragility, in a metaphysical sense, the process is viewed as one of rebirth. They are born again to

themselves; they feel a sense of spiritual awakening that they might not have experienced since childhood.

The findings of this study support the development of a framework, which includes multiple dimensions of peri-menopausal change. Women's vision of menopausal change is filtered through these multi-dimensional contexts and subsequent constructions, which become the template upon which they discern and define their experiences (Green et al., 2002). These overlapping spheres of understanding allow for simultaneous degrees of experience – both comfortable and uncomfortable.

Expectations

Expectations might be viewed as women's first experience of peri-menopause. Societal attitudes toward women in general and older women in particular form the basis upon which menopause is constructed (Chornesky, 1998). Women's expectations of menopause may influence their subjective experience of the changes that occur during this transition. Consequently, an analysis of menopausal change, must acknowledge the effect those constructions have on women's experience (Busch et al., 2003).

For most women, expectations are linked to the direct and tacit messages they received from a variety of sources. Women's vision is sometimes clouded with misinformation and fear. First Nations women also receive conflicting social values, implicit in messages about menopause, which may create additional tension in their experience of change. Holistic, cultural models of health are framed against the rigid biomedical model of western systems, within which health information and care is often provided.

Mid-life, First Nations women's fear of disease is well founded. Likewise, given the degree to which their reproductive health has been detrimentally medicalized, trepidation about the physical and emotional consequences of hormonal change, and subsequent medical intervention, present legitimate cause for concern. Without enough information about what is occurring in their bodies, women may feel out of balance – with no acceptable explanation, beyond those provided by the most dramatic experiences, as told to them by other women.

Lay Theories and Tensions

Some researchers suggest that “lay theorizing” provides a more culturally contextual understanding of health related experiences such as menopause (Green et al., 2002). Women’s lay theories of menopause include explicit construction of a diverse and subjective experience. Creating a vision of mid-life change involves developing one’s own theories, which are based on much more than the conversations we have or the books we read. Each woman’s distinct vision of mid-life change typically begins with a picture of her mother or her grandmother. Upon her perception of this experience, she forms certain expectations about her own change and about what she should and should not do in response to that change. This process reflects a human predilection for contemplation of multiple possibilities, based on observation of those who we believe to be similar to us in some respect (Roberts & Caspi, 2003).

It is likely that most women’s mother did not experience the same expression of change for many reasons, one of which is that their experience was neither so closely scrutinized, nor so tightly controlled. Nevertheless, this connection to and tacit instruction by older women represents an important constituent of women’s vision. Women’s learning through observation and through the talk of other women is rooted in an oral tradition. Additionally, comparison of self-in-relation to others’ experience is rooted in the process of modeling as a learning strategy.

Silence

Despite the current discussion of menopause presented in this study, we are left with the question of what lies beyond women’s silence about reproductive processes related to blood. At best, silence casts more shadow than light on this experience. A number of conflicting explanations may be considered in an exploration of women’s silence. One is tied to the cultural ravages of a residential school system that taught young First Nations women to feel shame about the strength and beauty of their bodies and about their capacity to reproduce. Residential schools created a legacy of silence for First Nations women, particularly around issues of sexuality. Puritanical, patriarchal values were strictly enforced in the context of cultural, familial and gender restructuring. One can be silenced when one believes that your words will fall on uncaring ears. One

can also feel silenced when, once spoken, those words are met with disapproval. This was the experience of First Nations women, for whom sexuality and reproduction became taboo in a culture that once revered women's ability to conceive life.

It is likely that, until the early 1900s, Mi'kmaq women still spoke their native language at home, the place where such things as menopause might have been discussed (if they were discussed at all). The rigid, Victorian values, upon which residential school curricula were based, would likely not have provided a name for this intimately female process. Thus, First Nations women would be left with little or nothing in the way of explanation for many of the experiences of menopausal change.

Language creates reality and the language of western colonizers has changed the menopausal reality of Mi'kmaq women, for whom a word for menopause did not exist prior to the imposition of English. Without a word to define this process, it simply might not have existed within women's frame of reference. Consequently, their focus would remain on the process of aging and the consequent changes in women's role within families and communities.

Silence might also be viewed as a sanctuary; as women's attempt to protect their daughters, for as long as possible, from the hard realities of womanhood – a few more happy months or years at play – before the time when gender and sexuality and/or motherhood overtake their vision. This silence however, ultimately resists the natural flow of child to woman.

A final, perhaps more palatable explanation for some, is rooted in traditional beliefs about the sacred power of menstrual blood. As well, women's silence might reflect cultural norms around discussing private things in a public way or drawing attention to oneself, so as to appear self-centered or overly self concerned (Paul, 2000). Finally, women's silence might connote peaceful acquiescence or resolute stoicism, both which can be viewed as a form of acceptance – of quietly submitting to the natural ebb and flow of life – without making “much ado about nothing”.

Medicalization

The medicalization of menopause has created a very disquieting situation for women in general but for First Nations women in particular. Until very recently, western culture associated menopause with loss of status and most women responded with efforts

to alter the aging process through any number of technologies and preparations (Chornesky, 1998). We have painted a dismal picture of menopause as a disease process of female age and in response, flooded women's bodies with synthetic hormones, which we now understand to be more harmful than previously predicted. Upon reflection and some credible research findings, we now advocate withdrawing the very drugs we once claimed were essential to mid and later life health. However innocent, this mendaciousness was particularly harmful to First Nations women who, I suspect, have been over-prescribed HRT through the Non-Insured Health Benefits program, which provides free prescription drugs to all status First Nations people (Assembly of First Nations, 1999).

Until recently, the process of medicalization created a distorted reality, upon which women formed their expectations and judged their personal experiences. Fortunately, women are beginning to create a new reality through their own discourse. According to Northrup (2002), women engage in a process of de-medicalization when they begin to discuss menopause as a natural process of change, along a continuum of life changes. In particular, toward the end of the peri-menopausal transition, women seem to become more reflective about the process as well as more positive about the stage of life within which it occurs. In addition to this resistance to medicalization, First Nations women have also engaged in a process of cultural resistance in their attempts to de-medicalize menopause, through discourse that is based on a more holistic model of health.

Comparing Experiences with Other Women

Comparisons of First Nations and other women's experiences depend, to a great extent, on the dimensions of menopause upon which we choose to focus. Given the relative socio-economic advantage of many Euro-Canadian women, they tend to enter peri-menopause in better health and with more resources to maintain their health than First Nations women. The epidemiological literature is clear about the relatively poor health of First Nations women and these qualitative findings lend support to those statistics. Chronic disease was reported by many of the participants and what also becomes clear is that, while their strategies reflect an appreciation for and commitment to

promoting better health, social conditions often restrict their options (Royal Commission on Aboriginal People, 1993).

When compared to Euro-Canadian women in the same age and socio-economic groups, midlife First Nations women experience higher rates of obesity and are therefore at higher risk of cardiovascular disease (Glanz, Croyle, Chollette, & Pinn, 2003). It is important to note that this difference does not appear to exist between Black and First Nations women but, like a great deal of health research, statistics for Euro-Canadians are presented as the gold standard, against which all other groups are measured. This epidemiological reality notwithstanding, the natural weight gain and/or redistribution occurring at menopause may also enhance women's consciousness about maintaining a healthy weight. These findings suggest that First Nations women are exposed to the same societal influences that shape Euro-Canadian women's body image and self-perception. However, First Nations cultural norms provide a more relaxed standard against which women define beauty thus, First Nations women seem to enjoy a higher degree of body satisfaction than many Euro-Canadian women.

It is not surprising, given what we know about the detrimental effect Euro-Canadian culture has had on First Nations people, that First Nations women experience higher rates of poor health and disease than many groups of Euro-Canadian women. Some have suggested that the health of First Nations people is more highly medicalized and tightly controlled within the current system of health care (Kelm, 1998; Young, 1984). It is therefore, conceivable that First Nations women's experience of menopause has been medicalized to a degree not experienced by most Euro-Canadian women. In fact, the imposition of a medical model on First Nations women's experience is well documented in the literature (Dion Stout, 1999; Kelm; Waldram et al., 1995) and likely applies equally to their menopausal experience.

Peri-menopausal change corresponds with many other life experiences including social marginalization, which may negatively influence women's perception of change (Berg & Lipson, 1999). Disparities in socio-economic status and health resources between many First Nations and Euro-Canadian women, create differential experiences, many which are inappropriately attributed to menopause. When physical health is used as the basis of comparison, most Euro-Canadian women appear to have a better

experience. If, however, we use another lens, one which seems to be preferred by many of the participants of this study, cultural norms around realistic standards of beauty, social inclusion and the presence of cohesive traditions lend support for the relatively positive experience of First Nations women.

Like many researchers, Busch et al. (2003) suggest that women can be divided into bi-polar attitudinal groups, based on the ways in which they describe their menopausal experience as well as the emphasis they place on experiences they associate with aging. According to these researchers, optimistic women feel an enhanced sense of freedom and autonomy as well as maturity and calmness during peri-menopause. They generally perceive this stage of life as a “milestone, a possible beginning of a new life phase, associated with new expectations and priorities, as well as an opportunity for reflection” (p.186). The European women who were labeled optimistic in the Busch et al study also engaged in evaluation of the past and consideration of the future – something the First Nations women in the present study discussed extensively. Both groups of women also report a new inner strength, self-confidence and assertiveness as well as improvement in overall well being and in the quality of their social relationships (Busch et al.).

Busch et al. (2003) also suggest that the association of menopause with negative mood indicates a pessimistic attitude, and women use this period as an excuse for expressing negative emotions. Pessimistic women reported mood changes such as depression, irritability, mood swings, fatigue and sadness. Aging was viewed by this group as a time when women lost their physical attractiveness and many did not see any positive outcomes, only negative ones like weight gain, gray hair and wrinkles. The findings of this study do not support Busch’s proposition. In fact, this interpretation reflects an assumption that all women use the same cultural and psychological reference to inform their understanding of menopause. In particular, they suggest that women who hold an optimistic attitude are those who relate aging with positive outcomes. In contrast, while First Nations women generally view aging as a positive outcome and menopause as a natural life stage, they are just as likely to link the experience of menopausal change with a number of discomforting or disconcerting physical and emotional changes, all within a framework of acceptance and optimism. Lock (1993) also challenged this

assumption that non-Western women experience only positive outcomes from peri-menopausal changes because they tend to enjoy increased social status at mid-life.

According to Kittell et al. (1998), core concepts of control and concealment emerge in a process-oriented description, which focuses on women's perception, interpretation and response to peri-menopausal change. The embarrassment experienced by these Euro-Canadian women resulted in attempts to control and conceal menopausal changes. Within a culture that emphasizes discipline, these women felt out of control. These findings contrast those of the current study, which highlight the maintenance of balance, rather than of gaining control over natural peri-menopausal processes of change.

Menopausal Balance

Readers may be somewhat surprised that a dissertation about menopause spends relatively little time discussing the physical changes women report. To so do, I am afraid, would repeat the mistakes of the past. A more insightful question might be "Why have almost 50 women, who have never discussed this experience in an open forum before, chosen to speak so little about the physical changes they experience during this transition?" I must admit to having a hand in this, as it has become increasingly clear that researchers often find that which we seek. I sought to understand this process beyond its physical manifestation, and so I asked, and not surprisingly, was told about those dimensions of change. Personal biases notwithstanding, women were afforded many opportunities to talk about physical experiences. What follows is an attempt to extrapolate these findings within a broader context.

The Biochemical Process of Change

It is clear that hormone levels, brain chemistry and life situations combine to create a biopsychosocial milieu in which women experience physical changes during mid-life. The findings of this study support others, which suggest that women who seem particularly sensitive to hormonal changes, are more susceptible to menopausal changes than other women (Schmidt, Nieman, Dancceau, Adams, & Rubinow, 1998). This disparate sensitivity provides one possible explanation for the variation in "symptoms" expressed by women from similar social backgrounds. It appears that, among these

women, difficulties during puberty, menstruation, pre-menstruation and post-partum might predict difficulties in peri-menopause (Larsson & Hallman, 1997; Novaes & Almeda, 1999).

Decades of research has determined that hormone receptors in the hypothalamus, amygdala and hippocampus organize and control memory, desire and anger (Northrup, 2002). Clinicians now suggest that peri-menopausal changes may interact with these brain centres to recruit and facilitate women's capacity to recall situations that may have been left unattended during reproductive years. According to Northrup, under the influence of hormonal change, this re-circuiting of neural pathways creates new focus and self-awareness among mid-life women.

Some of the women in this study, who were prescribed HRT, report an exacerbation of 'symptoms', which may have resulted from excessive estrogen rather than estrogen deficiency. Contrary to popular rhetoric, and according to well-respected experts in the field of menopause, the first stage of peri-menopause appears to involve a decrease in progesterone levels, which create a relative excess of estrogen (Lee, 1994; Love, 2003; Northrup, 2002). These changes are likely related to levels of follicle stimulating hormone (FSH) and lutenizing hormone (LH), which become erratic during the peri-menopausal transition. These fluctuations are thought to occur because, while a larger number of follicles are recruited during each cycle, ovulation does not always occur. Consequently, progesterone levels decline, while estrogen levels begin to fluctuate and rise (Northrup).

The relationship between elevated estrogen and hot flashes is also confirmed by studies, which demonstrate that hot flashes are not confined to menopause or to women. Love (2003) reports that hot flashes may also occur as a result of estrogen-medication used by men to treat prostate or breast cancer or by those who have undergone removal of the testicles.

As women move closer to menopause, follicle stimulating hormone (FSH) and lutenizing hormone (LH) levels become more balanced at a new, higher level, which then remains relatively constant after menopause. According to Northrup (2002), these elevated post-menopausal levels of FSH and LH indicate a dual function of these hormones not completely understood by researchers or clinicians. These elevated levels

also occur during the pre-ovulatory phase of the menstrual cycle, a phase characterized by improved mood and vitality for many women. Perhaps these hormones play some role in the feelings of serenity and renewed vitality experienced by the post-menopausal women in this study. Steiner, Dunn & Born suggests that “the higher incidence of depression in women is primarily seen from puberty on and is less marked in the years after menopause, with the exception of an additional peri-menopausal blip” (2003, pg. 67). According to many Aboriginal concepts of health, the body is constantly searching for ways to balance itself. Perhaps, when age withholds one thing (e.g. physical strength), it bestows another (emotional and spiritual strength).

Transitional Changes

The findings of this and myriad other studies contradict a fragmented and isolated definition of women’s mid-life experience. Researchers have discovered that physical and psychosomatic changes tend to occur much earlier than previously recognized, lending credibility to the suggestion that these changes may not be entirely the result of declining hormone levels (Freeman, Crisso, Belin, Sammel, Garcia-Espana & Hallander, 2001). As an example, Randolph & Sowers (1999) report that approximately 80% of women experience changes well before menopause. In another study, which included 2,700 women, participants reported transitional changes 2-8 years prior to menopause (McKinlay, 1992). The women in this study reported biopsychosocial changes, which occurred several years before and after the cessation of menses.

According to the World Health Organization (WHO), the “menopausal syndrome” includes: hot flushes (flashes), night sweats, menstrual irregularities, vaginal dryness, depression, tension, heart palpitations, headaches, insomnia, lack of energy, dizziness, and difficulty concentrating (WHO Scientific Group, 1996). More recently however, researchers have argued against this universal menopausal syndrome and suggest that women’s experience is saturated with individual and cultural determinants. As far back as the early 1980s, researchers such as Bungay, Vessey, & McPherson (1980), claimed that, with the exception of hot flashes and vaginal dryness, middle aged men reported as many, if not more, of the “symptoms” associated with menopause, than women (Love, 2003).

Since then, countless studies have demonstrated that the diversity of women's experience refutes a peri-menopausal syndrome. Moreover, despite the WHO's persistent pathologization of this experience, women's discourse does not emphasize physical discomfort as the primary issue of mid-life. Rather, balance in all elements of life and health is recognized as a fundamental determinant of women's experience.

The findings of this and similar studies demonstrate how multiple domains of influence interact to construct women's mid-life experience. Yet, we continue to assert menopause as the origin of that experience. An example may be found in research asserting that, weight gain and changes in body composition, relative to lean and adipose tissue, which tend to occur during the peri-menopausal transition, are uniformly associated with hormonal changes. The consensus appears to be however, that age, rather than menopause, is responsible for changes in weight and the redistribution of fat (Avis & Crawford, 2001a). There is also some evidence of a relationship between migraine headaches and hormones, with estrogen playing a role in the dilation of blood vessels and progesterone constricting them. Nevertheless, researchers have not reached a distinct understanding of the mechanism by which this association is formed (Love, 2003). Incontinence provides another example of an experience that may be related to thinning of the urethra, caused by diminished estrogen, yet might also result from stress caused by multiple pregnancies and childbirth (Love).

The women in this study provide additional evidence, if any were required, that this experience transcends the body, to encompass many dimensions of life as well as elements situated within those dimensions. Some of the women did not recall experiencing any physical or emotional changes beyond the cessation of their periods, which either dwindled off or stopped abruptly. That is not to say that these women were not introspective about mid-life – for the opposite is true. In fact, these women exemplify this process as one, which is experienced on more than a physical level. Yet, physical and emotional discomfort can sometimes become emphasized. That which takes up most of our gaze becomes that to which we most closely attend. Perhaps it is only when our gaze is diverted or, if we are fortunate enough not to experience any physical or emotional discomfort, that we might contemplate the many other dimensions of our experience.

Hot Flashes

Researchers have argued convincingly in favour of a link between vasomotor lability and hypothalamic activity. Several researchers also suggest that vasomotor disturbances do not arise so much from relative levels of estrogen in the blood, as from fluctuations in estrogen levels (Lee, 1994; Love, 2003). According to this theory, the hypothalamus, which is situated next to the thermo-regulator center of the brain, temporarily malfunctions during peri-menopause, causing the brain to assume that a core body temperature of 98.6 is too high. To oppose this false increase, the hypothalamus sends out messages to increase heart rate, to send blood to the surface (in a rush!) and/or to sweat, all in an effort to cool a body that is not really hot (Love). Ironically, the result of this counterfeit response is an increase in skin temperature as much as 6° Celsius (Elkind-Hirsch, 2001).

In a number of North American and European studies, women have reported sensing a loss of control during the peri-menopausal transition, particularly in relation to hot flashes (Avis, & Crawford, 2001b; Ballard et al., 2001; Bell, 1987; Busch et al., 2003; Dickson, 1990). In particular, a perceived loss of bodily control seems to take precedence during this time of life, to become a filter for women's entire experience. Though a few women in this study perceived some loss of control associated with hot flashes, the majority of women did not emphasize this response. Several explanations for this difference in perspective likely exist. However, I would suggest that, while autonomy is a meaningful component of First Nations women's concept of health, they have also been required to accommodate several hundred years of occupation and colonialization (Ballard et al., 2001). Thus, although perceived as the right of every human being, control is rarely assumed. These divergent perspectives, relative to the issue of control, may reveal a 'white privilege' in Euro-Canadian women's perceived entitlement to control. While First Nations women contest disembodiment and challenge attempts to control their lives, they also accept what cannot be changed and find ways to cope, using whatever resources are available to them.

Unfortunately, the loss of cultural tradition may contribute to women's perception of lost autonomy. For example, use of the menstrual hut, traditional menarchal teachings

and the role of elder women in ceremonies afforded women greater understanding of their bodies and the autonomous power they possess. In traditional practice, women defined these processes for themselves, and determined the most appropriate response to corresponding changes.

Sexual Changes

The sexual changes reported by the women in this study are similar in content to other mid-life women (Avis et al. 1993). Their perceptions of sexuality are similarly based on social norms regarding gender roles as well as cultural expectations (Greer, 1992). Unfortunately, these women are also similar in their misperceptions about female sexuality during mid and later life.

The vaginal dryness reported by some of the women in this study does not represent a universal experience of peri-menopausal women. In fact, research indicates that only 20-45% of women report this experience, while many are not bothered by it and most still enjoy their sex life (Hunter, Battersby, & Whitehead, 1986, New England Research Institute, 1991). The hormonal component of sexual function, which may be reflected in vaginal dryness, appears to be transient so that adequate vaginal lubrication may resume when hormones become balanced at post-menopausal levels.

As women age, loss of tissue elasticity, atrophy and dryness does make the vagina more delicate and vulnerable to injury during penetrative intercourse. Surgical menopause, specifically oophorectomy (removal of the ovaries) may create additional problems with vaginal dryness as ovaries produce testosterone and estrone, both important in sexual function. According to Northrup (2002), fibroid tumors, diagnosed in almost 40% of peri-menopausal women, may require hysterectomy, thus affecting the sexual function of many North American women. Among some peri-menopausal women, adrenal exhaustion may further reduce testosterone levels, which might decrease libido and reduce sexual arousal (Love, 2003; Northrup). Though the findings of this study represent the experiences of a small number of women (42), they appear to support the preceding hypotheses.

Although hormones are seen to play a role in women's (and men's) sexual functioning, there has been no direct correlation between women's sexual interest and

their hormone levels. In a study of 1,120 women and 500 men, responses to a questionnaire that did not mention menopause indicate that men and women both experience equal difficulties with vaginal intercourse as they age (Love, 2003). Blood supply exerts considerable influence on vaginal lubrication. Engorgement of erectile tissue is required for firm erections as well as abundant vaginal lubrication. Several researchers have discovered a link between cardiovascular function and vaginal dryness and erectile difficulties, both of which diminishes with age (Hyde et al., 2004; Love; Northrup, 2002). In truth, diminished heterosexual activity among older couples is typically associated with men's difficulties in achieving and maintaining an erection (Love).

We need to be equally cautious about forewarning the challenges as well as extolling the benefits of hormonal change on women's sexuality. While we do not want to create a false sense of deficiency, neither do we want to create unrealistic expectations. We do not want healthy, vibrant mid-life women to feel as though sexuality is no longer an important part of their lives. Yet, we also do not want women who may not be as sexually inclined in their later years, to feel as if they are sexually dysfunctional. We must be particularly mindful of the social messages all women receive about the link between their sexuality and their social value. From puberty onward, the message is clear – without sexual appeal and appetite, female life cannot be fulfilling. Thankfully, most of the First Nations women in this study do not buy into this self-defeating myth.

Health Changes

It has been well established in the literature that immune function and susceptibility to infection are influenced by psychosocial determinants such as social support, belongingness and independence (CIAR, 1991; Northrup, 2002; Weaver, 1998). Feelings of powerlessness and barriers to expression of those feelings may exacerbate vulnerability to and reduce survival rates for many chronic conditions and disease processes (CIAR; Northrup). These psychosocial determinants of health also interact with hormonal change, to influence women's experience of mid-life health.

In general, the health concerns of this group of First Nations women are similar to those of other North American women, who report concerns related to osteoporosis and

cancer as well as neurological and cardiovascular disease (Hsieh, Novielli, Diamond & Cheruva, 2001). Yet, the health determinants of First Nations women present unique challenges to understanding their experience of peri-menopausal change. On the one hand, we know a great deal about the relatively poor health of First Nations women, relative to most Euro-Canadian women. The literature teems with increased rates of chronic diseases like arthritis, diabetes, hypertension and heart disease as well as increased death rates from cancer of the breast and cervix. What tends to be missing from most analyses is a discussion of the historic trauma and external stress, related to the disadvantaged social, political and economic position of First Nations women, which places them at increased risk of chronic disease (Dion Stout & Kipling, 1998). On the other hand, First Nations women's health is influenced by a unique combination of social determinants, which may balance their susceptibility to illness and disease. Psychosocial buffers, conferred through cultural belonging and the social support of First Nations families and communities, may offset socio-political and economic stressors.

Balancing Emotional Health

Before I begin my discussion of First Nations women's emotional health during peri-menopause, I think it is important to state my position clearly. I consider it senseless to deny something simply because we find the implication unpalatable. In the case of mood changes during peri-menopause, rather than questioning the overwhelming evidence that *some* women do experience mood changes during periods of hormonal change, we should be challenging those who use this to devalue older women. Few dispute the role testosterone plays in men's emotional health; indeed, it has been widely documented across species (Hyde et al., 2004). Yet, we do not use evidence of physical and sexual aggression, which is linked to this primarily male hormone, to devalue men's opinions or actions (although I must confess that my mother often did). In many ways, male aggression is socially condoned and even promoted (Hyde et al.).

Female hormones however, present a very different picture. Rather than accepting the role of biology and physiology in female experience, in many cases, we have attempted to re-construct a female who is devoid of any connection to her body or

its natural processes. I fear that our attempt to counter the deleterious implications of biological determinism crosses a line and becomes just as singular in its reasoning.

Like her male counterpart, the human female is a creature of nature, who is blessed with psychosocial capacities far superior to her animal sisters. However, to understand her fully, we must accept the influence that nature has on her experience. Otherwise, we become myopic in our vision and cease to see her; rather, we see an agenda into which she must be appropriately diminished in order to fit.

Having shared my personal position, I must emphasize that the connection between health and emotion is well documented in the literature (Northrup, 2002). Indeed, it should come as no surprise that hormones and mid-life mood are interrelated, when we consider the multiple roles played by the hypothalamus in binding and coordinating estrogen, progesterone and androgens as well as epinephrine, dopamine and serotonin, which regulate mood (Northrup). Moreover, the thymus, lymph nodes and bone marrow are innervated by the autonomic nervous system, which also processes emotions, hormones and neuro-chemicals. During peri-menopause, this delicate balance of constituents may become susceptible to external stress, at a time when women are most vulnerable to illnesses like diabetes, hypertension and arthritis (Northrup).

At this point, it is important to note that several women in this study report no emotional changes during the peri-menopausal transition. These findings correspond with a study of 13,000 peri-menopausal women from Norway, Canada and Massachusetts, which also reported little increase in psychological problems (Kaufert, Gilbert, & Tate, 1992). Findings such as these support a flexible model of menopause, which accounts for the diversity of women's experience, without attempting to establish some point of excellence upon a particular physical or psychological gradient.

While we continue to debate the role hormones play in women's emotional health at mid-life, we must also consider a number of possible explanations. We typically assume that fluctuating hormones act as a trigger for women's feelings of depression or anxiety. This argument places emphasis on hormone levels as the origin of women's emotions, rather than on the circumstances and events of her life. Based on the findings of this study, I would suggest that it is not so much a question of women becoming upset by situations that would not typically upset them, so much as an exacerbation of those

feelings. So, rather than feeling mildly irritated by grown children leaving a pile of dishes in a kitchen that was clean when she left for work in the morning, a peri-menopausal woman may feel unappreciated and undervalued by her family. A fight with her partner, which would ordinarily upset her, might devastate her during times when hormonal fluctuations increase her emotional sensitivity (Love, 2003). These mood changes often parallel those experienced by women during puberty as well as during pre-menstrual and post-partum periods. However, many women, including some of the women in this study, report that the intense anger of peri-menopause represents a unique experience of hormonal change (Northrup, 2002).

During the past 40 years, several researchers have attempted to discover the determinants of women's peri-menopausal psychosocial health. Matthews, Wing, Kuller, Meilahan, Kelsey, Costello, & Caggiula (1990) discovered that peri-menopausal women's emotional health might be associated with personal characteristics and self-esteem. They suggest that these constituents may influence the way women perceive changes. In addition to causing psychological discomfort such as anxiety, depression and stress, personal characteristics could influence women's perception of their capacity to cope with related changes (Chornesky, 1998).

Despite the prominence of psychological constituents in women's experience, many researchers contend that psychological vulnerability is exacerbated by adversity during the peri-menopausal transition (Busch et al., 2003). In particular, qualitative researchers have discovered that negative emotional experiences must be examined in the context of women's lives (Greene, 1984; Winterich & Umberson, 1999; Winterich, 2003). In 1980, Greene and Cook discovered that social stress creates greater psychological problems than the peri-menopausal transition. In the case of First Nations women, these contexts include economic disadvantage, discrimination, social marginalization, as well as past trauma in residential school, intense political structuring, and cultural struggle. Trauma must also be conceptualized as both specific to individuals as well as cumulative for First Nations women, sometimes leading to posttraumatic stress disorder and other psychological distress (Miller & Chuchryk, 1996; Walters & Simoni, 2002).

Stress is a well-documented risk factor for many diseases (CIAR, 1991). According to Northrup (2002), persistent elevation of the hormone DEA, in response to chronic stress, may deplete the adrenal gland. Women whose lives have been stressful or who suffer from chronic illness may enter peri-menopause in a state of adrenal exhaustion. Moreover, chronic elevation of epinephrine, resulting from historic trauma, disadvantaged social and economic conditions as well as social issues such as addiction and abuse, can leave women with little energy when hormonal shifts occur. The high cortisol levels required to counteract elevated adrenaline levels caused by stress, are additionally deleterious to women's health (Northrup). Unresolved emotional stress can exacerbate the effects of hormonal change by making the effect on temporal lobe and limbic areas more pronounced, thus activating anxiety and emotional lability (Ballard et al., 2001).

We can safely speculate that due to historic trauma as well as socioeconomic and political disadvantage, the lives of many mid-life, First Nations women are generally more stressful than those of most Euro-Canadian women. Consequently, we can assume that more First Nations women enter peri-menopause in conditions of poor health and adrenal fatigue. We might also consider that the high levels of cortisol, required to balance the effects of persistent stress, deleteriously affect their mid-life health. All of these suppositions might lead us to determine that the peri-menopausal experiences of First Nations women are negatively influenced by the historical, social, economic, and political context of their lives (Ballard et al., 2001; Walters & Simoni, 2002). In particular, socio-political intrusion into every dimension of life might result in ambient stress that affects all dimensions of health, particularly during the more vulnerable years of peri-menopausal change.

These findings lend support for the notion that the mid-life health of First Nations women cannot be examined within a narrow frame of genetics and biology or even one of culture and lifestyle. We must account for sociodemographic determinants, which may situate First Nations women in a more vulnerable psychosocial position as they enter mid-life. For instance, mid-life stress, combined with unresolved grief, may exacerbate psychological and physiological changes experienced during the peri-menopausal transition. Acknowledging these vulnerabilities, while recognizing the strength of First

Nations women, reflects a holistic perspective, which will ultimately paint a more accurate portrait of First Nations women's reality (Walters & Simoni, 2002).

At this point, I would like to share a somewhat disconcerting idea. It has occurred to me during the course of this research and my analysis of women's words, that in addition to representing freedom from the restrictions of monthly cycles, menopause might represent freedom from 'socio-hormonal restrictions' as well. A number of feminist writers have suggested that estrogen functions to pacify women in some respects (Northrup, 2002; Greer, 1992). Socio-biologists would likely agree with this supposition, pointing out the evolutionary utility of a docile female, who is imbued with the hormonal capacity for patience and nurturing. Perhaps the psychosocial changes, manifest during peri-menopausal change, are simply the effects of a release from this hormonal pacification. Yet once freed, women emerge in the same world that knew and loved them silent and subservient; young women who stayed the course and "toed" the line. They are now released upon an unsuspecting world – inadequately prepared for the dual force of hormonal change and maturity or for the women experiencing that sweet release and the wisdom to understand its meaning. In the clear light of age, women might see much too clearly, for anyone's comfort, how the disadvantages of life have shaped them and the price they have paid.

Barriers and Buffers

Barriers.

In general, information from the dominant, Euro-Canadian culture emphasizes the aesthetic conditions of women's mid-life (e.g. changes in body shape, wrinkles, gray hair) and links them to health behaviours such as diet, exercise, and hormone supplements (Green et al., 2002). This social prejudice, sometimes referred to as anophobia (fear of old women), has been identified as the genesis of women's negative perception of aging in general and menopause in particular. Certainly, there is little evidence that most Euro-Canadian women perceive many positive outcomes in general health or social status with menopause (Kittell et al, 1998). While this barrier appears to be less prevalent among First Nations women, it is nonetheless reflected in their mid-life experience. Although it is irresponsible to ignore the harmful psychosocial effects of

pessimistic social messages, it is likewise disrespectful to diminish mid-life women's concerns about physical appearance. In our enthusiastic vilification of societal expectations, we often lose sight of individual women and their self-concept. While we do not want to recommend that women conform to some fallacious, youth-oriented image, we must acknowledge the outcome of social expectations on women's experience and self-concept (Busch et al., 2003).

Social rules, within social settings, influence women's perception, interpretation and response to mid-life experience. Within Euro-Canadian society, the rhetoric of menopause has led to unrealistic expectations about the self-regulation of perimenopausal changes, including physical and emotional experiences that are beyond women's control (Kittell et al., 1998). As an example, the concept of concealment is rooted in Western beliefs about the impurity of menstrual blood. Although our discourse has changed considerably over the past three decades, women continue to receive less-than-subtle messages that the "observable indicators of hormonal changes are embarrassing, socially inappropriate, and possibly threatening to one's credibility" (Kittell et al., p.27).

This 'negative talk' - or persistent focus on troublesome changes associated with perimenopause - creates a distorted template for women's experience as well as a barrier to unquestioned subjectivity. I would suggest that the "negative talk", reported by most of the women in this study, may be attributed to a number of situations and circumstances, perhaps an element of truth exists in each. The first relates to a human propensity for drama. A story is infinitely more interesting when it involves some agitation, an element of the unknown, somewhat forbidden, with just a snippet of human suffering. It follows that those stories, which involve women's suffering through the perils of an experience that is relatively unknown and until recently, implicitly taboo, will be the most memorable. Women might also recall and recount those stories in the most vivid detail, much as we might a frightening and suspenseful movie.

The second hypothesis involves human fear as a motivator of attention. We will likely attend more carefully and remember in distinct detail, information about that which we know less and fear more. A single story about a dangerous encounter with a shark will likely have greater impact on our summer experience, than countless stories of

people paddling about in the surf. Likewise, stories of uncontrolled and frightening perimenopausal change may be similarly recalled over a non-eventful transition.

The final explanation involves human compassion, particularly the empathy women feel toward one another. These feelings, particularly among cultural groups that emphasize collectivity, may motivate women to attend more closely to those in need of support. Nurturing is understood as an important element in the socialization of First Nations women, who develop close and lasting relationships that often span generations and move beyond kinship ties.

Individuals in relatively small communities are often exposed to the nuances of daily life in a manner, which differs substantially from those living in the isolation of discreet, urban neighborhoods or the sprawl of suburban communities. Intimate knowledge of one another's lives, combined with an edict of care, may emphasize those in need – so that their experiences become highlighted and act as a yardstick against which other women's expectations are formed and their experiences are measured. Silence, beyond the most dramatic experiences, might create ambient stress and specific apprehension about the potential for harm – all of which may profoundly influence women's experience of change.

Buffers.

One of the most notable "buffers" available to First Nations women as they traverse mid-life change is the pluralistic traditions of Aboriginal cultures. Aboriginal peoples have long embraced pluralism in their medicine, spirituality, politics and social activities (Paul, 2000; Prins, 1996). For the purpose of this study, I have defined pluralism as the philosophical and practical recognition of the capacities and deficiencies in a number of approaches to a particular phenomenon, whether that approach is one of conception or convention. The combination of physical, psychological, medical/hormonal, spiritual and social approaches, which First Nations women pursue toward health and healing, demonstrate pluralistic philosophy and practice. By way of illustration, while First Nations women actively engage in activities, such as weight-bearing exercise, as well as take vitamin supplements and hormone therapy, to prevent or treat heart disease and osteoporosis (Hsieh et al., 2001), they also pursue psychological

and spiritual avenues of health and healing. This stands in stark contrast to the dualistic notion of healing most prevalent in Euro-Canadian culture, which is especially evident in the way non-medical approaches are classified as 'alternative' – the assumption being that a medical approach is standard or 'traditional'. This is particularly true for menopause, which has become so medicalized that all non-medical approaches seem to represent a substitute for that tradition.

Aboriginal concepts of healing are based on intersecting spheres of existence – physical, emotional/psychological, spiritual and social. Holism is synonymous with the notion of balance and healing is intended to create balance in all elements of life (Kelm, 1998; Paul, 2000). This concept of holism seems to be deeply rooted in First Nations women's philosophy of mid-life. In truth, they are fortunate to be the recipients of cultural teachings, based on holism and diversity, rather than dualism and conformity. Traditional concepts of holism also act as a buffer against individualistic healing practices such as HRT, so First Nations women often pursue mid-life health in the context of family and community life.

Historic and current contentions between First Nations people and a colonial medical system provide First Nations women with a rather unique and critical view of western medicine. Many women are learning about the medicalization of health, through critical social theory and feminist research (Bell, 1987; Greer, 1992). First Nations women have long been aware of the deleterious impact of this system and its corresponding practices, which tends to fragment human experience, in an effort to classify, diagnose and treat a wide range of unnatural and natural health experiences.

First Nations people have a long history of medicalized health (Kelm, 1998; Dion Stout, 1999). Consequently, although they are not always successful, they have developed strategies of active and passive resistance (Ballard et al., 2001). It bears repeating that this resistance is under girded by an awareness of the detrimental effects and broad social implications of adherence to western medicine. Active resistance to further encroachment in First Nations lives, is demonstrated through the resurgence of traditional healing practices, while passive resistance is displayed through First Nations women's non-compliance to synthetic hormone regimens.

Women embrace cultural buffers such as identity pride, spirituality and traditional health practices as a means of moderating historical trauma and current life stressors (Walters & Simoni, 2002). Engagement in specific activities that enhance identity pride likely strengthens women's ability to cope with physical or psychosocial difficulties. Similarly, spirituality represents an important source of physical and psychosocial coping. Finally, experiential and exploratory findings reveal that traditional, naturalistic healing practices and preparations may have intrinsic advantages connected to positive health outcomes (Walters & Simoni)

First Nations women's preference for natural approaches is obvious in the positive way they discuss herbal remedies. These findings reflect those presented by Shimony (1961), who described Iroquois women's use of herbal preparations to ease potential discomforts associated with menopausal change. In addition to presenting fewer risks than pharmaceuticals like HRT, women understand the significance of practicing the healing traditions of their own culture. This practice represents a small but significant component of a larger movement among First Nations people, away from the medicalization of their health by western systems.

This process is also reflected in the language women use to describe mid-life healing. By way of illustration, most women did not use the term remedy, which connotes the treatment of symptoms. Indeed, 'treating the symptoms' of menopause with herbal remedies does not necessarily mean we are approaching peri-menopausal change from a holistic or spiritual perspective. It might simply mean that we have chosen a natural 'cure' over a synthetic one. Instead, some of these women use the term medicine, which alludes to healing beyond the physical body. Medicine is used in a way, which corresponds with philosophical understandings of human existence as well as holistic concepts of human health. Aboriginal herbal medicine is rooted in nature and its healing symbolizes the interconnection between human existence and the natural world. The spiritual component of herbal medicine also reveals a belief system in which physical and spiritual domains intersect.

The psychosocial buffer of stoicism seems to be an integral part of most Aboriginal cultures across North America. Perhaps this attribute originated during times when the physical demands of nomadic life required the development of a strong

constitution and calm in the face of physical or emotional suffering. This quality was no doubt called upon during colonialization, from encroachment onto Aboriginal lands, to intrusion into Aboriginal bodies, through assimilationist health and social policies. In the face of epidemic disease, forced relocation, discriminatory registration policies and harsh living conditions imposed by colonial invaders, women were required to harness this psychosocial resource in order to maintain balance in their families and communities. More recently, First Nations women had to cope with having their children taken from their homes and kept in residential schools, the very schools that some women spent much of their own childhood. In these schools, physical, emotional and sexual abuses were compounded by aggressive, systemic and racist attempts to strip Aboriginal culture from First Nations minds, bodies and spirits (Knockwood, 1991).

Stoicism is closely tied to the concept of acceptance in that these women seem to accept the reality of their mid-life circumstances – not necessarily the way they would like it to be, or the way it should be, but the way it is. It is this strength in the face of difficulty, which has seen First Nations women through many social, political and economic hardships, over which they had little control. This characteristic, born of adversity, is an important quality of resilient people, who are often able to overcome obstacles that might emotionally cripple others (Hewlett, 1998; Hobfall, Bansal, Schurg, Young, Pierce, Hobfall & Johnson, 2002). This stoicism also provides a buffer for First Nations women who may experience increased vulnerability to ambient stress, caused by sociopolitical disadvantage. It is likely a component of women's capacity to find balance, despite the persistence of social, economic and political barriers.

HRT– Buffer or Barrier?

Almost all of the women in this study have taken HRT at some time during mid-life. According to recent research, only 45% of non-Aboriginal women have tried HRT, most for relief from menopausal 'symptoms' as well as the prevention or treatment of heart disease and osteoporosis. Women who undergo hysterectomy typically experience a three-fold increase in HRT use, while those who undergo oophorectomy experience a two-fold increase (Finley, Gregg, Solomon, & Gay, 2001). The seemingly extensive use of HRT among First Nations women may be an artifact of research sampling however,

groups were often recruited through snowball techniques and not just from health centres, thereby reducing the likelihood of a purely clinical population. A larger study of First Nations women is required to accurately determine the similarities and differences in HRT use. Nevertheless, there are some unsettling implications related to this finding, which concern the relatively high rates of diabetes and hypertension in First Nations women, conditions that might preclude the use of HRT, if not at the very least, encourage cautious prescribing practices (Northrup, 2002).

At a fundamental level, the disease model, upon which the development and use of HRT is predicated, turns counter to naturalistic philosophy and practice, prevalent in Aboriginal healing. According to Dr. Joel Hargrove, the Medical Director of the Menopause Centre at Vanderbilt University, "Premarin is a natural hormone if your native food is hay" (Northrup, 2002, p. 137). Others like Lee (1996) have suggested that HRT essentially numbs women to the changes occurring in their bodies. Lee further offers that the use of HRT may actually hinder women's natural capacity to adapt to hormonal changes occurring during the peri-menopausal transition. Yet, it appears that a proportionately large number of First Nations women are prescribed HRT at the first sign of hormonal change and sometimes prior to any evidence of peri-menopausal status. I would hazard that the undertone of this practice is reminiscent of the paternalism of past medical practice among First Nations people.

Ironically, historic misdeeds have created a measure of distrust of the medical system, thereby protecting First Nations women from the somewhat rose colored filter, through which many Euro-Canadian women view medicine in general and doctors in particular. These First Nations women tend to demonstrate autonomy in decisions about HRT and the use of alternative healing practices, which are becoming more available to them through the re-emergence of traditional healing after years of government suppression.

Risks.

Among Euro-Canadian research participants, long term compliance with HRT is between 3% and 13% and the reasons women cite for non-compliance include unpleasant side effects, weight gain, breast tenderness as well as the re-initiation of menstrual bleeding (Elkind-Hirsch, 2001). However, the most notable motive for non-compliance relates to women's (including those in the current study) concern about the harmful effects of exogenous hormones on their health, particularly with respect to breast and/or endometrial cancer (Elkind-Hirsch; Finley et al., 2001). Given what we now know about the risks of HRT, as a result of research conducted by the Women's Health Initiative, the Health and Estrogen/Progestin Replacement Study and the National Cancer Institute, it appears as if women's fears are well founded (Northrup, 2002). These findings have particular relevance to First Nations women, who experience higher rates as well as risk factors for heart disease and estrogen based cancers (Dion Stout, 1999).

Research.

Research into the efficacy and safety of HRT has been mostly restricted to the experiences of Euro-Canadian women, whose health profile, lifestyle, health behaviours and socio-economic conditions differ significantly from First Nations women. In fact, what we know about menopause is generally limited to the experiences of well educated, relatively well-to-do, white women – this is a well-known and undisputed fact (Adams, 1995; Dion Stout, 1999; Formanek, 1990). In the past, the findings of HRT studies produce what has been referred to as the “healthy woman effect” because the groups of women from which the samples were drawn tended to be those who ate well, maintained a healthy weight, exercised regularly, smoked less, had lower risk of heart disease and cancer, had higher education and SES, as well as practiced prevention behaviours and complied with medication regimens (Matthews et al, 1990).

Unfortunately, this sample bias has affected the findings of research about the safety and efficacy of HRT (Finley et al, 2001). For the purpose of comparison, the findings emerging from past biased samples provide little information about the effects of HRT on First Nations women, to either benefit or harm their health (Finley et al.; Love, 2003). In fact, this sampling bias has particular relevance for many First Nations women,

whose disease profile is less-than-favourable and who experience high rates of smoking. We know that smoking increases risks associated with blood clots and stroke for women taking estrogen-based contraceptives (Love), yet no additional precautions seem to be taken to protect this group of menopausal women from these increased risks. The presumption that Euro-Canadian women's experience can be generalized to First Nations women is unfounded. In particular, generalizations based on the experience of HRT users, whose experience is significantly different than that of First Nations women, creates a blind-spot for health researchers and practitioners.

First Nations women have been denied a voice in menopause research, yet have been prescribed exogenous hormones for more than 40 years without examination of the effects HRT has on their already compromised health. High rates of use suggest over-zealous prescribing practices on the part of doctors through the Non-Insured Health Benefits (NIHB) program, which presents a double-edged sword, in the sense that, while affording First Nations women access to prescription medicine, it may also expose them to unnecessary and potentially dangerous drugs.

Access.

There is substantial evidence to suggest that physicians exercise powerful influence over women's use of HRT. While many women take HRT to relieve symptoms (70%), or to prevent osteoporosis (64%), a significant number take it because it was recommended by their physician (61%) (Finley et al., 2001). In most cases, women require fewer doctor visits once they are past their reproductive years (Love, 2003). Yet, a prescription of HRT guarantees continued visits, which generate income for many individuals, except the women themselves. Unfortunately, doctors may be additionally susceptible to subtle and not-so-subtle pressure from pharmaceutical companies that have devised sophisticated marketing campaigns and economic incentives. The bitter reality seems to be that the economics of synthetic hormone manufacturing outweigh the intuitively obvious benefits of more subtle interventions like bioidentical hormones or plant-based and herbal preparations, which cannot be patented and therefore, represent no financial benefit for pharmaceutical companies or physicians (Northrup, 2002).

Rather than working with Band governments and/or health staff to increase awareness, knowledge and access to holistic practices as well as herbal and plant-based preparations, many physicians continue to prescribe this drug, of unknown effectiveness but well documented risk. It is not my intention to offend the many fine doctors who provide excellent services to First Nations people. Nor do I mean to suggest a complete lack of doctors who promote naturalistic healing. In fact, several women claimed to be very happy with the medical care they receive. However, it is my task to view this process through a critical filter and to examine the social and political implications of the health care First Nations women receive in the context of a dominant health system.

The Context of Menopause

Cross Cultural Analysis

Several studies discussed in the previous review of literature emphasize differences in the peri-menopausal experience of women from diverse cultures. Yet, researchers have also discovered numerous similarities among women of diverse cultural backgrounds. For example, after controlling for education, health and economic status, Avis and Crawford found some combination of psychological and physiological experiences including vasomotor disturbances, dizziness, palpitations, incontinence, depression, insomnia, headache, anxiety and irritability, across five, distinct ethno-racial groups in North America (Caucasian, African-American, Chinese, Japanese, and Hispanic) (Avis & Crawford, 2001b).

Intra-cultural diversity has also been observed, to the extent that women's mid-life experiences might vary as much within ethno-cultural groups as they do between cultures (Chornesky, 1998). Within the context of North American culture, Caucasian women tend to report more psychosomatic difficulties, while African-American women report more vasomotor and physiological experiences such as hot flashes and dizziness (Avis, et al., 2001; Freeman et al., 2001;). However, a number of studies suggest that most peri-menopausal changes are consistent across women in North America. Moreover, despite cultural background, all women's experiences tend to vary over time, and no pattern across any particular group of women is discernable (Kittell et al., 1998).

In many ways, the changes reported by First Nations women in this study also reflect the experiences of many North American women. This finding comes as no surprise, as First Nations women share a similar diet, lifestyle and environment; they also share the same human biology and pursue many of the same work and leisure activities as Euro-Canadian women. It is difficult to say whether the imposition of dietary and other lifestyle changes has modified First Nations women's experience of hormonal change, as the historical record and the women themselves, are silent on the subject (Love, 2003).

Although philosophically distinct from Euro-Canadian women in many ways, First Nations women share some practical understandings of menopause with certain groups of women. As an example, Davis (1986) discovered that women from a fishing village in Newfoundland also view the profuse bleeding that sometimes occurs during peri-menopause as a type of cleansing. Other researchers have recently discovered a growing number of women who, like First Nations women, recognize this stage of life as one, which has great potential for personal, relational and spiritual development (Apter, 1995; Ballard et al., 2001).

In the past, researchers suggested that a positive perspective of aging might be associated with a relative lack of physical and psychological "symptoms" (Kaufert, 1990; Lock, 1993). This hypothesis was based on the findings of research conducted with Asian women, who view age in a more positive light and do not experience the same type or degree of peri-menopausal changes as North American women. In her 1993 book entitled, *Women's Medicine Ways*, Starck suggests that menopausal symptoms are also rare among First Nations women because menopause is viewed as a symbol of wisdom and maturity. Unfortunately, Starck's interpretation is not grounded in empirical evidence but rather, appears to be extrapolated from the experiences of Asian women and the subsequent interpretation of that experience by Euro-Canadian researchers.

The First Nations women who partnered in this research, experience physical and psychosocial discomforts similar to those experienced by many other women yet, demonstrate a positive attitude toward change in general. Consequently, the findings of this study do not support the supposition that enhanced social status during old age positively influences the physical changes women experience during peri-menopausal change. Rather, it is the meaning women attach to those experiences, as well as the

specific cultural filter through which they view the entire process of mid-life change, that distinguishes First Nations women's experience.

In some respects, First Nations women's mid-life experience resembles that of Asian women, in the sense that traditional cultural norms around aging appear to promote positive attitudes toward peri-menopausal change. Like the Thai women who participated in a similar study in 1994 (Chirawatkul & Manderson), First Nations women candidly report a wide range of physical and emotional discomforts, but also look forward to and enjoy the physical freedom from menstruation, pregnancy, and childbirth as well as the social value of old age in a culture and community that respects and cares for elders. First Nations women's experience is also similar to that of some Filipina women, who experience hot flashes and irritable mood, yet do not perceive peri-menopause as a disease process, but one involving a natural reproductive transition (i.e. a "fact of life" or "part of life"). Sikh women in British Columbia take a similarly pragmatic approach to physical experiences and also look forward to the enhanced social status of post-menopausal years (George, 1988).

Bi-cultural Issues

A few of the women who participated in this study make an overt effort to follow Aboriginal traditions and avoid the influence of Euro-Canadian culture. However, most employ a bicultural approach, which follows Aboriginal principles but also incorporates Euro-Canadian practice when it is required. These women must also accommodate dominant structures and institutions in order to fulfil their role in the family and community (Barrios & Egan, 2002).

It is generally true that to be First Nations is to live a political life. For the past five hundred years, North America has been the staging ground for a struggle between Aboriginal and Euro-Canadian cultures. This struggle, which sadly pits one culture against the other, originated with the assimilationist and racist agenda of past and to some extent, present Euro-Canadian society. This powerful cultural force, which has carved a path through Aboriginal lives, left in its wake, some degree of cultural dissonance. Certainly, for most of the women in this study, almost every aspect of life is experienced within a bi-cultural crosscurrent that must be navigated with care. On one side is the

dominant culture – its branches spreading and seeking to envelope those on the opposite shore, who are desperately holding those influences at bay, while attempting to accommodate those which have already taken root.

Many First Nations women maintain this position in North American society. They are caught in a bi-cultural cross current, the force of which exerts influence on their experiences. In some ways, they benefit from this unique position, yet in other ways, they are disadvantaged by it. On one hand, a holistic, naturalistic perspective protects women from pathologizing their own experience or fearing old age. On the other hand, a dominant biomedical system may pressure them to attend to changes too quickly and use pharmaceutical interventions too often (Love, 2003). Similarly, First Nations women are blessed with a philosophy, which informs a broader perspective of health. Yet, they are confined within a health care system that promotes the medicalization of their health. Personal autonomy struggles with paternalism, holism with fragmentation, collectivity with individuality. This is the sociopolitical milieu within which women attempt to create meaning that will beneficially inform their mid-life experience.

To pose one cultural perspective over the other is to neglect the influence both have over First Nations women's experience and the unique position they find themselves in during peri-menopausal change. This position provides a window into aspects of this experience that may not have been previously examined. We are only just beginning to understand the link between acculturation and women's peri-menopausal experience (Avis & Crawford, 2001b). Within the bi-cultural existence of most First Nations women, traditional philosophies have come in close contact with those of Western science, creating a slippery slope for First Nations women traversing mid-life change (Chornesky, 1998). Arab and Jewish women, who also experience diversity in their peri-menopausal experiences, depending on their level of acculturation, share this precarious position. Among these women, those belonging to traditional nomadic tribes, experience higher levels of psychological well being during mid-life. Yet, those caught in transitional cultures, which have lost traditional rites of passage and focus on western values of reproduction and youth, experience diminished well being at mid-life (Dantan, 1986).

Most behaviours, particularly those related to health, can be traced to a set of beliefs that provide the foundation upon which those behaviours emerge and re-emerge over time. In this case however, we have two, often conflicting belief systems – both struggling to inform women’s vision and behaviour, and both of which impact their mid-life health. Most First Nations women understand how social values influence the practice of medicine. First Nations people have lived through Indian agents, reserve doctors and residential schools, many who imposed foreign cultural values within the provision of health care (Kelm, 1998). The practice of medicine, within the structure of a dominant society, has attempted to discredit Aboriginal ways of knowing, while destabilizing Aboriginal cohesion and resistance. The primary goal was to fashion Aboriginal awareness into Euro-Canadian conformity (Gongaware, 2003).

Fragmentation, control and compliance, all elements of biomedicine, have become synonymous with First Nations experience during the past 500 years of colonial occupation in First Nations lives (Green et al., 2002). In many ways, the fragmentation of women’s reproductive processes, along with the separation of their experience from the world in which they live and the compliance required of rigid hormone regimens, parallels the general experience of First Nations people. Balance has been especially difficult for First Nations women, who attempt to accommodate western medicine as well as Aboriginal philosophies and practices.

Negotiating cultural differences in social relations and social actions requires First Nations women to balance their own cultural values with their lived experience, perhaps generating barriers in the development of self-identity (Gongaware, 2003). Ultimately, the personal resources required to achieve and sustain this balance must be drawn from an already overtaxed source. In truth, we are just beginning to understand the health consequences of this demand on the physical and psychosocial resources of First Nations women.

Relationships

What becomes increasingly evident in the findings of this study, is that the concept of balance extends beyond physical, emotional and spiritual dimensions, to include social interactions within personal, interpersonal and sociopolitical domains. Indeed, it seems that embracing the social dimension of women’s mid-life experience

begins with acknowledging the interdependence of peri-menopausal change and women's relationships.

To fully understand the bi-directional influence of peri-menopausal change and social relationships, we must explore the diverse avenues through which relationships intersect with women's mid-life experience. The findings of this research indicate that interconnected determinants create an intra and interpersonal milieu that may influence women's social health at peri-menopause. Similarly, determinants involve broad social constituents such as cultural norms and traditions, as well as diverse social contexts and social roles. Correspondingly, personal and interpersonal determinants related to constructs such as autonomy and separation, as well as issues related to family and caregiving responsibilities interact to influence women's perception and experience of mid-life health.

While several studies make reference to social relationships as a determinant of women's menopausal experience, few clarify how social contexts and social roles interact to create the psychosocial milieu within which women perceive and experience change. The albeit limited research base however, does implicate myriad determinants, which direct women's peri-menopausal perspective as well as their social roles at mid-life. One of the few studies to emphasize the role social relationships play in women's mid-life experience is Berkum's 1986 study, which revealed an important connection between women's distress during peri-menopausal change and their perception of social relationships.

Nowhere is the concept of social balance more firmly rooted than in Aboriginal cultures, in which relationships form a foundation upon which human experience is understood. Many First Nations communities are relatively small and intimately connected. Among First Nations people, identity is constructed in relation to family, community and tribal affiliation (Paul, 2000). Powerful and extended kinship ties as well as expansive and prolonged community relationships represent the canvas upon which, individuals construct myriad life experiences. It is therefore, not surprising to discover that, among First Nations women, relationships form the apex around which their mid-life experiences are formed.

Ironically, the achievement of social balance may be especially challenging for First Nations women, who must negotiate conflicting socio-political structures, within which their mid-life experiences are embedded. Traditional kinship and community relationships often create a supportive network, which influence women's self-concept and experience of health, long before peri-menopausal changes occur. Likewise, this tribal identity and community connection may provide a buffer against some of the physical and emotional challenges women experience during the peri-menopausal transition. However, First Nations women must also interact with Euro-Canadian institutions and structures, which possess the potential to either compliment traditional relationships or to compromise them.

Social Context

A discussion of peri-menopausal change among First Nations women cannot disregard the socio-environmental context of their lives, which is intimately associated with their colonized status as well as with diverse forms of discrimination. In the absence of this context, interpretation of health information may further pathologize the experiences of First Nations women (Walters & Simoni, 2002).

Although Aboriginal cultures are not homogenous, many social values exist, which may be framed in contrast to the dominant society. An example may be found in the Euro-Canadian emphasis on individual fulfillment and the acquisition of personal power through competition, which is dichotomously opposed to Aboriginal values of egalitarianism and generosity (Barrios & Egan, 2002). The findings of this study reflect these traditional values by demonstrating women's conceptualization of their own health in relation to how it benefits and affects others, particularly family members. However, these findings also reveal how social marginalization, combined with a relatively poor health profile and the unlimited consequences of hormonal change, may disadvantage the health of mid-life First Nations women.

It is clear that the shared history of First Nations people creates an expanded sense of identity, which may act as a buffer against individual difficulties. However, the historic trauma experienced almost universally by First Nations people, may also diminish the capacity with which group identity protects against experiences that

diminish women's self esteem. This is particularly relevant for First Nations women who, due to poor health and the general medicalization of menopause, experience sustained contact with the same health care system that once played a major role in the traumatization and attempted assimilation of First Nations people. Unfortunately, it appears as though contemporary First Nations women's experience has been constrained by the same biological determinism as their Euro-Canadian sisters. Furthermore, Euro-Canadian individuals and institutions are intimately involved in the lives of First Nations women, to the extent that a Euro-Canadian cultural repertoire has been imposed on and transposed with Aboriginal social norms (Gongaware, 2003).

In general, Aboriginal cultures represent a philosophical structure, which positions the life of an individual within a network of family, community and nation. Traditional norms emphasize collectivity and the fulfillment of social roles through action with these social networks. Culture also provides the psychosocial structure upon which First Nations women make sense of their mid-life identity within kinship networks and the wider community. Identity is thus embedded in the context of social relationships, which are rooted in themes of reciprocity and complementarity. Separation from one's social network, whether self imposed – for the purpose of peri-menopausal healing – or imposed by others – through external forces that disrupt kinship networks (i.e. reliance on the Euro-Canadian medical system), can be detrimental to identity and self-concept, which may ultimately be harmful to women's health and well being (Barrios & Egan, 2002; Yellow Horse Brave Heart, 2001).

In the past, large kinship networks included many households, dozens of people and several generations. Cultural values were relayed from generation to generation through these vast, tightly woven networks (Barrios & Egan, 2002). During the process of colonial imperialism, these relationships were denigrated, along with the traditional modes of constructing and maintaining them. The outcome is the recent generation of mid-life women, who experienced the debasement of their Aboriginal self-esteem and for some, "disdain for the old ways of their parents" (Gongaware, 2003). Forced cultural accommodation within educational and economic structures, often limited the interaction between old and young, effectively distancing some women from a connection to the strength and support of their families.

Kinship Networks

Whether women undergo peri-menopausal changes that are subtle or dramatic, their mid-life transition tends to correspond with changes in family dynamics relative to adult children, grandchildren, aging parents, and spouse/partner interactions. As an example, peri-menopausal change may provide a psychosocial outlet for some women's increased emotional energy, permitting them to express their feelings more freely. It seems that, during mid-life women become more attuned to imbalances in their relationships as well as more inclined to attend to perceived inequities.

The influence of family relationships, primarily the "empty nest syndrome" most common in discussions of women's mid-life experience, differs on a number of fundamental levels for First Nations women. To begin, the way family is constructed among First Nations people provides a much broader base for social roles and relationships, to which we might attach meaning to women's experience. "The large Native family networks including multiple households, can involve literally hundreds of people, who may be biologically or informally related, and span several generations – an extended kinship network through which culture and values are modeled and transmitted from generation to generation"(Barrios & Egan, 2002, p. 210). Membership in these social groups entails many roles and responsibilities for mid-life women, including caregiver and care receiver, all in the context of distinct cultural norms around autonomy, reciprocity and social status.

It is likely that this generation of First Nations women have not experienced the same degree of social pressure regarding family size as Euro-Canadian women. In fact, it is conceivable that, given the historic decimation of Aboriginal populations, First Nations women may actually experience some social pressure to have more rather than fewer children. Among First Nations people, children are universally considered a blessing and the devastation of populations during colonial conflict may have created some cultural pressure to rebuild numbers.

Several of the women in this study talked about having relatively young children – so children are more likely to be involved in the daily experience of menopausal change. The reality of large families, born over the course of women's reproductive

lives, has implications for their social relationships, particularly at mid-life. Clearly, the demands as well as the support of expansive families present unique challenges and opportunities for First Nations women.

Social Roles

In 1971, Glaser and Strauss developed the theory of status passages, which attempts to explain how experiences are viewed within the context of life stages, in which individuals undergo status change during each subsequent stage. These passages may involve both objective as well as subjective features; in the case of the mid-life passage, women undergo objective status change to that of a postmenopausal woman, accompanied by subjective changes in their self-image, relationships and social status. According to this theory, status change rarely occurs in isolation, yet certain passages, such as the peri-menopausal transition, may take priority over others occurring during the same period. It is entirely likely that this prioritization creates additional challenges for women, who must attempt to develop multiple social strategies for diverse life passages (Ballard et al., 2001).

Although these findings support the theory of status passage, they do not support others, which suggest that women who perceive a benefit from menopause, typically in the form of improved social status, also report fewer or less severe experiences. As discussed earlier, the women in this study report the same variety and degree of physical and emotional changes as other North American women yet, they seem to view the process much more favorably. Although these women are concerned about, and sometimes even fearful of, physical and emotional changes, they also look forward to this time in their lives as one that is full of freedom and promise (Love, 2003).

Grandmother

Respect for the female elder is universal among Aboriginal peoples. “The formal and informal connotation of ‘grandmother’ [or Noogumich in Mi’kmaq] (Prins, 1996) elicits reverence in virtually every Aboriginal culture in North America, [where]....grandmothers are the central characters in the daily and symbolic lives of Native women” (Barrios & Egan, 2002, p. 212-213). These revered symbols act as the

conduit through which traditions and values pass from one generation to another. Grandmothers also play a critical role in raising children, as well as teaching values through story telling, as well as crafts and healing through experiential learning (Barrios & Egan). Elders teach by living example and through stories, rather than the more didactic approach used by many Euro-Canadians. “The Ancient Grandmothers, who had walked those paths of discovering the Self before them, the ensuing generations of women were never given the answers but merely given a map, a guideline, allowing them to express their own uniqueness and to learn their own lessons in their own ways” (Sams, 1994, p. 25).

Aboriginal self-concept is typically defined by one’s position in a network of relationships that form the foundation for interpreting myriad, subjective experiences, including those of mid-life change. In this case, the role of grandmother contributes to a positive identity among First Nations women, which may supersede the pejorative identity offered by biomedicine and the dominant culture. Traditions of female strength, taught and modeled by elder women, offer positive identity with respect to both gender and ethnicity (Barrios & Egan, 2002). Mid-life is perceived as women’s transition to this esteemed social position, thus providing a buffer against the negative, anaphobic messages they often receive from Euro-Canadian society.

Elders

Mid-life presents women with two, interconnected, yet distinct elements of change relative to the notion of becoming an elder. On one hand, the provision of care to many people represents an important element of their mid-life experience. Yet, for some women, increased family support in their mid and later life also becomes part of this process of change. The reciprocal nature of caregiving within Aboriginal cultures is such that this duality exists in most social roles so as not to appear exceptional for anyone.

The social status of older people in First Nations communities and the reverence generally afforded to elders, reflects communal values, which tend to benefit women’s peri-menopausal transition. The collective care of elders is a cultural norm, which is reflected in the small number of First Nations elders placed in nursing homes. According to recent health literature, social support in general and instrumental support in particular

has been identified as a key determinant of health among older adults (Weaver, 1998). Women living in a community where they are likely to receive care in their old age by people who love and respect them, are more apt to experience reduced uncertainty about mid-life. This stands in stark contrast to the subtle neglect perceived and experienced by many Euro-Canadian women as they enter their middle years.

Caregiving for elders, which is reported as a source of stress by many Euro-Canadian women (Northrup, 2002), is perceived somewhat differently by First Nations women, who have usually lived in close proximity to, if not with, elders throughout their lives. Consequently, caring relationships with elderly relatives do not emerge suddenly during mid-life and are not therefore, perceived as a source of mid-life stress. In fact, First Nations women tend to view relationships with elders as a source of support and guidance so that the care women provide is typically not viewed as extraordinary – to the extent that they did not mention it, except when discussing its positive aspects. The unique knowledge of elders in general and of old women in particular is viewed as critical to the survival of kinship and community networks as well as the future of distinct cultures (Gongaware, 2003). The contribution made by elders to the spiritual, emotional and cultural health of communities, positions them as highly valued community and family resources.

The women who participated in this study did not indicate any degree of gender inequity with respect to the care of elders. Yet, they likely experience similar gender role expectations and consequent health implications reflected in other cultures. Nevertheless, I have been mindful not to use a pan-cultural lens (and by that, I mean Euro-centric) to examine gender role expectations, or the perception of those expectations by First Nations women.

The women's movement was promoted by and for affluent Euro-Canadian women who may experience different social and political challenges than First Nations women. In fact, female emancipation might represent an ill-conceived concept among women who have struggled alongside their men for freedom from the stranglehold of a western colonizer. Women's roles are deeply and intricately connected to their communities and to their nations. That struggle is far from over and First Nations must maintain gender cohesion if they are to achieve the goal of self-determination.

Having said my piece about the important role First Nations women play in their Nations' struggle, I will concede that they are still women – who must often contend with social inequalities related to gender. There is much room for improving relations between men and women in every culture – this is no less true for First Nations people. The social problems, which plague many First Nations communities are borne by their women and children, as has always been the case whenever societies experience social problems.

The social norms of Aboriginal cultures differ considerably from Euro-Canadian culture with respect to the concept of reciprocity. Within Aboriginal cultures, inter-generational connections and the genuine reciprocity of those relationships, create very different perceptions of elder care. Reciprocity tends to be conceptualized in more relative terms and considers each individual a vital thread in the social fabric of the community (Paul, 2000). The interconnection of generations within families and communities means that most people are assured a valued social position, whether as a cherished child or grandchild, a nurtured youth, a committed parent, guardian or relative, or a respected elder, who is sought after as a teacher, mentor and advisor. Each individual contributes something unique to the community. Elders may be particularly valued for their accumulated knowledge and understanding of history, culture and spirituality. Especially at this time in history when many communities are struggling to maintain their culture and language, it is the elders who are sought out for advice, instruction and guidance (Gongaware, 2003).

Medical Contexts

The historical significance of relationships between First Nations people and the federal health care system cannot be underestimated when attempting to understand the influence of social contexts on women's mid-life experience. According to the findings of this study, women who pursue traditional healing and/or herbal medicine seem to feel more empowered about this life experience. However, jurisdictional issues related to accessing health services outside those covered by the federal government, present barriers to First Nations women who wish to pursue alternatives to HRT and "medical treatment" during this natural process of change.

Historic relationships, in this case between First Nations women and physicians, differ substantially from those of most Euro-Canadian women, the cultural group to which most physicians belong. Interactions between physicians and First Nations women are premised on inter-cultural and inter-class inequities in social power, which may disadvantage women with respect to decisions about their mid-life health (Adams, 1995). Physicians may not be particularly sensitive to women's past life experiences, particularly those, which might predispose First Nations women to difficulties during peri-menopause. In particular, the link between adrenal function, post traumatic stress disorder, historic trauma and hormone sensitivity may place some First Nations women at increased risk of emotional and/or physical difficulties during peri-menopausal change.

Knowledge becomes part of socially constructed power when a lack of information positions First Nations women to become reliant on and in many cases acquiesce to, health care professionals who seem reluctant to share their knowledge or the power it confers. Not only are these interactions disempowering to women in a general sense, but they also promote a disease/pathology perspective in terms of the language women must use to express their peri-menopausal experience (Bell, 1987). Reliance on the medical system may leave women with few options for self help. Moreover, disempowering experiences, leading to negative attitudes, may increase the likelihood that women will avoid the health care system until they are very ill, thereby contributing to poor health profiles. When subordinated autonomy is sustained over the course of individual, family and community life, and occurs within the context of political, social and economic marginalization, the effect on self-concept, self-efficacy, self-determination and ultimately health, can be devastating.

Summary

The findings of this study make a useful contribution to the existing menopause discourse. The substance and context of First Nations women's vision of mid-life reflects many of the concepts, currently emphasized in mainstream research. Yet, these findings also provide new insights into cultural contexts, which are more distinct to First Nations women's experience. Findings related to the concept of balance, which emerged as a major theme in this research, offer unique perspectives related to how psychosocial and

physical changes are perceived, experienced and addressed. These findings challenge more dichotomous models, which have been developed to explain women's experience of the peri-menopausal transition. Finally, the intersection of peri-menopausal change and women's social relationships emerged as demonstrating particular relevance for First Nations women's mid-life experience.

CHAPTER SIX: CONCLUSIONS AND RECOMMENDATIONS

In this chapter, I have attempted to summarize my conclusions about the scholarly and practical utility of these findings. I hope this contribution offers something new to the theoretical discussion of mid-life and the peri-menopausal transition. I have based my recommendations on the insights of the research participants, as well as the disparities and distinct needs, which I have observed as a result of conducting this research and engaging in this process of analysis and interpretation. The recommendations are intended to serve the needs of First Nations women and may therefore, have limited utility for women from other cultural backgrounds. They are also intended to be a starting-off point, from which community-specific practice and future discussions will flow.

Re-Conceptualizing Mid-Life Change

Altering the direction of our literary and literal response to menopause presents a number of challenges, particularly for those of us attempting to make sense of what now appears to be a puzzle, which may actually contain the wrong pieces. The pendulum has begun to swing in a direction counter to that of a purely biomedical perspective, to one that acknowledges the social construction of women's mid-life experience. Yet, we must be cautious not to overshoot our target and become equally myopic in our vision of this multi-dimensional experience.

The most effective way of ensuring balance in our perspective and our practice is to include the voices of many women, from diverse backgrounds, in the menopause discourse. Initially, this means incorporating the perspectives of a cross-cultural group of women, in the development of a multi-dimensional model of peri-menopausal and mid-life change. Without these voices, we might continue to describe this process as one of fragmented deficiency or, in the case of recent trends, one that is devoid of physicality. Both models deny women equal opportunities to delight in and despair of this uniquely female experience.

Women's past silence around this issue presents us with something of a double-edged sword. For women who enter this experience in relative silence, knowledge is

typically gleaned through observation, print material and the occasional snippet of conversation. The heterogeneity of these sources makes it impractical to predict what each woman's vision will be – so her perception could be equally skewed in a very positive or a very negative direction. Silence, however, can also protect women from half-truths and outright lies about what this experience is and is not, about what it should or should not mean, about what they will or will not experience, and about what they should and should not do. In this respect, silence might represent a quiet place from which each woman may fashion her own unique experience, one perfectly suited to her own vision, the rhythm of her own life and the reality of her own culture.

It is important to point out that women are not victims of menopause. In fact, they are active agents in this experience; perhaps even in the process of its medicalization, by seeking the technologies that remote, biomedical knowledge defines as appropriate. Our task is not necessarily to create a new vision of mid-life change; rather we must re-focus our attention and begin to ask different questions of others and ourselves. What we see and the manner in which we see it is not always a product of happenstance. Myriad forces, some of our own making, determine the position from which we view this phenomenon. Sometimes, it is a matter of deciding for ourselves what we will see and what we will not see. Gaze, like old habits, is not easily changed once it becomes fixed in a comfortable position.

The framework for a positive mid-life experience already exists in the local knowledge of every woman, yet it has been overshadowed by powerful messages that simply don't fit our vision – so we have acquiesced when we should have rebelled. Regaining control of our vision begins with those who know us best and know what is best for us. Elder women, who have traversed this life phase, hold the key – as they always have – to embracing change and discovering balance. By actively involving elder women in theory development and knowledge generation, this critical component of the process will not be lost. De-medicalizing and re-defining this process also begins with the local knowledge of diverse women, who act as the conduit through which information is passed from one generation to the next.

At this point, I would like to offer my own modest contribution to existing theories about the menopausal transition. The additional dimensions I offer to the

theoretical literature might be useful for those who wish to pursue the topic of peri-menopausal and mid-life change from a more holistic and balanced perspective. The pluralism with which many Aboriginal traditions embrace diverse philosophies and practices contributed to the development of this discussion, which recognizes not only the myriad properties of peri-menopausal change, but also a temporal dimension, which has been previously overlooked. Finally, the concept of balance, within and between various dimensions of change, underscores the need to develop more pluralistic approaches to our research, rhetoric and response to women's mid-life experiences.

A Spherical Concept of Change

Although it is necessary to separate findings into distinct categories for the purpose of analysis, interpretation of their meaning requires the cultivation of theoretical landscapes, which should not be viewed in isolation. The findings of this study are most compatible with a spherical model, which consists of interrelated constructs. Movement through the phases of human existence occurs within this multi-dimensional sphere, so that human experience is understood within many convergent realities. This model is intended to serve as the basis for understanding multiple domains of influence, which flow together to form intellectual, physiological, philosophical, cultural and spiritual experience. Each domain exists within the context of the others and my attempt has been to understand mid-life women's physical, emotional, social and spiritual experiences within that context as well as the extent to which domains of influence hold sway over women's vision, over their achievement of balance and over the quality of their relationships. This concept of fluidity is a critical characteristic of models, which seek to explain human experience. Therefore, I ask the reader to temporarily suspend any predilection you may have toward deduction and consider a framework that does not constitute distinct component parts – merely interrelated components - like elements of water, which upon extraction, lose their relevance for those who thirst.

Rationale

Aboriginal paradigms have endured in the form of “blood memories”; in an understanding of life and the nature of reality, which is passed from one generation to

another in the blood of First Nations people. These traditional models also hold sway over women's construction of this life phase. However, holistic paradigms and cultural values that view old women as the guardians of tradition and the caregivers of family and community, struggle against the anaphobia of western culture.

Persistent and prolonged efforts to assimilate First Nations people have influenced the way First Nations women perceive and experience menopausal change. Moreover, beyond conjecture, there is an absence of theory, or narratives to inform theory, about First Nations women's mid-life insights and experiences (Green et al., 2002). These bi-cultural tensions create additional barriers for First Nations women seeking balance during the peri-menopausal transition. The deleterious implications of this tension, illuminate the need for an inclusive and fluid model, within which we can begin to construct this process, not just from a more holistic perspective, but from one that accommodates the plasticity and temporality of women's lives.

A multi-dimensional framework, while complex and time consuming to construct and utilize, provides the only avenue through which researchers can discover the countless influences of women's mid-life experience. The current focus on generalizing menopausal symptoms negates the subjectivity with which women experience, interpret and respond to change. Similarly, concentration on mid-life women's health, draws attention away from the personal, interpersonal and social contexts, within which women perceive and attend to health issues that might arise during mid-life (Kittell et al., 1998). Despite our best efforts, current notions of holism remain tied to a conceptualization of human existence, which compartmentalizes individual components into a collective frame, rather than combining fluid elements within a multi-dimensional sphere. This is the basis of problematic research; for instance, if I distill women's experience to the point at which their lives, outside my variable of choice, becomes irrelevant, might I 'discover the truth of their experience'? It is likely that I would find something, which would at that point, be unrecognizable to them. It is my hope that this conceptualization carves more deeply into women's experience, than frameworks we have attempted to construct in the past. In particular, I hope it contributes to a vision of women's experience beyond embodied reality.

Philosophical Underpinnings

Beyond new-age feminist literature, there has been little discussion about the philosophical dimension of women's mid-life change. Yet, this connection is not new to Aboriginal cultures, which have always recognized the wisdom of elders and the distinct knowledge women gain through a lifetime of healing and caring for others. This unique cultural position includes the role of grandmother, in which older women fulfill their role as conduits through which traditional knowledge and culture pass.

In many ways, women's discourse about their journey through mid-life reveals the circular model with which they conceptualize lived experiences. This circular model favors blended experiences, and contests the fragmentation of phenomena for the purpose of examining them. In particular, women describe peri-menopausal experiences within the context of an interconnecting series of life phases, situated where physical, intellectual and metaphysical domains intersect.

At first glance, there appears to be a somewhat disconcerting tension between the way women describe the change of life (natural) and the way menopause is constructed by, with and for them (medical). The concept of embodiment may be useful in understanding how complex biological, spiritual and social relationships in effect, create women's mid-life bodies (Martin, 1992). According to this conception, First Nations women's physical experiences have been historically, medically, and socially constructed. To fully understand this multi-dimensional experience, we must conceptualize those bodies within all domains of influence.

First Nations women's discourse is grounded in a philosophy, which embraces overlapping domains of experience and considers fragmentation an element of immature reasoning. I make this observation, not from the statements of one woman or a group of women, but from the collective voice of these "grandmothers". They acknowledge and accept this experience in the context of an entire life, which is lived among other lives, and exists between many generations.

According to this paradigm, human existence possesses both physical and spiritual qualities; natural life is merely a journey that is demarcated by physical existence. We begin life in a spiritual realm that transcends the physical body, and life represents a journey toward complete spiritual renewal. The journey may be swift or

slow, it may be gentle or rough, it may be interrupted by sudden gusts or may proceed relatively undisturbed, but it is inevitable once it has begun. The physical body will grow old and, through death, become more intimately connected with the natural world but the spirit is immutable and becomes more potent as we near the end of natural life. As a destination, old age is not objectionable because it provides opportunities to share gifts we have acquired throughout our journey and by virtue of our renewed spiritual strength. The stages of life are intended to serve an overall purpose, in propelling us toward this imperative.

The philosophical basis of Aboriginal experience is old – and despite hundreds of years of assimilationist pressure, has endured in the hearts of First Nations women. This expanded vision provides an additional layer of understanding to a process, which has been doomed in western culture, since its ‘discovery’ by early philosophers and later by physicians. In many ways, this group of women represents a critical link between ancient and contemporary philosophies. Their vision is essential to our understanding of how traditional beliefs and customs might inform women’s current experience of change. The specific knowledge of elder First Nations women contributes not only to a broader conceptualization of peri-menopausal change but also emphasizes the cultural diversity of this process. Culture must be recognized as an essential component of women’s peri-menopausal experience, not just as a generic determinant of health but as the foundation upon which we attach meaning to our experience of change.

Although this model seems ideal for most women, we must remain cautious about “borrowing” concepts and injecting them into a cultural framework that cannot support them. Ancient Aboriginal paradigms have been adopted, and in many ways appropriated, by Euro-Canadians during recent years of cultural maturation. Prior to this enlightenment, Euro-Canadian cultural understandings of life in general and health in particular, were premised on a Cartesian model, which espoused the fragmentation of reality as the most advantageous avenue to discovering the “truth” of human existence. Aside from the incongruity of applying constructs outside their cultural context, this appropriation represents a disrespectful approach to honoring the manner in which First Nations women understand mid-life change.

Some Native feminists point out that “New Age Native Americanism” has been embraced by Euro-American feminists, who are searching for an escape from the traditions of patriarchy and the monotheistic religious traditions of Euro-American culture (Donaldson, 1999). However, without adequate acknowledgement, “historical specificity, or contextual depth”, this cultural misappropriation mimics other ideological forms of white supremacy (Donaldson).

While appropriation demonstrates a disrespectful approach to honouring the capacities of distinct cultures, pluralism represents an approach, which acknowledges the strength of diverse perspectives and practices, without attempting to ‘swallow’ them into a dominant framework, thereby stripping them of cultural relevance. The traditions of pluralism determine that the pursuit of multiple avenues of learning and healing must honour the traditions of origin and that cross-cultural reciprocation must be based on mutually respectful consensus (Donaldson, 1999).

Balancing Multiple Dimensions of Change

Human experience is fluid and dynamic; it is subject to countless domains of influence, all of which combine to shape individual experience. Women’s experience of mid-life change is no less mutable and animate. Until recently, few have proposed a model, which emphasizes equally the pleasure and the pain of mid-life change. Yet, balance cannot be achieved, let alone conceived, without acknowledging these potentials.

Balance represents a critical component in any model, which seeks to explain women’s mid-life experience. Balance does not necessarily assume the absence of tension, rather it denotes the acceptance of bi-directionality - the influence myriad dimensions have on one another. Acknowledging the bi-directional nature of human existence is a critical first step in achieving a balanced perspective. To ignore the bi-directionality of physical, psychological, social and spiritual dimensions is to deny balance in human existence.

Balance is a fundamental axiom of pluralism, in which the notion of distress or discomfort become recognized conditions, which are not contrary to that principle. Nature is equally beautiful and brutal. Indeed, yin and yang, good and evil, hot and cold, all represent polarities characteristic in nature and human experience. Situated within

this multi-dimensional model, there also exist many continua of experience, the gradient contrasting for each.

A philosophical paradigm, which acknowledges and values the interrelatedness of the natural and “super” natural world, lends itself to the formation of attitudes and norms, which accept diverse and dynamic human experience. This perspective represents the foundation upon which many First Nations women develop acceptance, which emerges throughout their discussions of mid-life health and peri-menopausal change. This philosophy also encourages the pragmatism with which First Nations women focus on the realities of life, rather than on idealistic notions, which may create imbalance in perspective as well as practice.

Acceptance is interwoven into almost every theme of this research, thus, representing an essential fibre from which the threads of the overall design are formed. To dilute the essence of acceptance excessively is to jeopardize the integrity of this design. However, it is critical that we recognize the fibres as being spun from the historic, social and economic realities of Aboriginal life. To acknowledge the power of this constituent and reveal its role in the sophisticated design of women’s lives, is all we can do.

Aboriginal beliefs about the interconnectedness of human beings and the natural world necessitate a model, which acknowledges the physical dimension of human existence. In the colloquial words of my own mother, “we are all just shit and blood”. As a component of the natural world, human experience follows a path, which is governed by natural forces directing physical birth, growth, decline and death. The reproductive process of female life follows a similar pattern of change – from the birth of a woman during puberty, to the growth and development of any children she might bear; from the decline of her capacity to reproduce - to its eventual conclusion.

Physical existence is meaningful – it is quite literally, the stuff of life. Physical change demands attention – to expect anything less is to be deceived. Likewise, attempts to negate this dimension of peri-menopausal change represents incomplete conceptualization of this multi-dimensional experience. Rather, we must embrace this dimension as one, which provides additional substance. However, fallacious extrapolation of physical experiences from psychosocial origins creates an unrealistic and

perhaps more challenging process for women. The problem lies, not in distinguishing the potential physicality of peri-menopausal change, but in the psycho- dramatization or social traumatization of those experiences, thus creating negative meaning for mid-life women.

The psychological or emotional component of change must be similarly acknowledged in order to facilitate development of a comprehensive model. Psychological determinants such as individual temperament, memories, and perceptions are embedded in social contexts, which exert pressure on women's emotional health during the peri-menopausal transition. It is not possible to understand the psychology of mid-life outside this social frame. Indeed, the distinct theoretical frameworks used to explain psychodynamic experiences during the peri-menopausal transition are secondary to the contribution of this dimension to the over-arching model.

The contribution First Nations women make to our understanding of mid-life goes beyond an additional layer of socio-cultural experience. These women offer an expanded vision of evolving identity and self-concept. The lesson, gently shared, is the lesson of many stories. It speaks of walking your path with quiet dignity. Through their stories, women share the wisdom and strength with which they understand and experience this process, which is embedded in the cycle of their lives. The overlapping spheres of physical, emotional, spiritual and social health within a circular model that embraces a natural beginning and end of physical existence, as well as the power and promise of psychosocial potentials, provides women with a model upon which to positively experience this important life transition.

Implications for Re-conceptualizing Change

The manner in which mid-life in general and peri-menopause in particular, is conceptualized has important implications for the meaning women attach to their own experience. The promotion of a multi-dimensional and balanced framework of mid-life may encourage women to acknowledge the challenges as well as the opportunities of peri-menopausal change. Rather than obligating mid-life women to assume a particular position, we must encourage them to embrace the plurality of this phase of life as one, like all other phases of life, which presents delights as well as deprivations. Balance is a

dimension of human experience that evolves over time. It is something we must first conceptualize, then actively seek out. It is a prize not easily won and one that eludes many of us, often searching with ill-conceived assumptions about its constitution and its derivation. Once discovered, the struggle becomes one of preservation.

Embracing the psychosocial and temporal dimension of women's mid-life experience means addressing complex social issues, which require more than a simple prescription for HRT. This change in theoretical focus demands a corresponding shift in the research agenda, toward the multiplicity of women's mid-life experience, and away from univariate prediction and control. This brings me to an important point, which has become increasingly clear during the course of this research - prediction is not an option. At best, we can contemplate, maybe even speculate, what might occur during perimenopausal change. The question we should be asking ourselves is, "Why it is so important to pin-point – to the last ovum – what women's experience will be"? Regardless of the rationale, reality remains unchanged – prediction beyond the most fundamental elements of change (e.g. the cessation of menses) is neither possible nor helpful.

Research

Health Needs of First Nations Women

The historic and current medical and socio-political experiences of First Nations people have important implications for the health of First Nations women, particularly as they age. The imposition of colonial structures effectively reorganized the social and political life of many Aboriginal peoples. Euro-Canadian economic imperatives eroded Aboriginal systems of healing, as well as equitable gender roles and reciprocity. The new system created restrictions on the use of traditional lands and healing practices, as well as conditions of high unemployment. The subsistence and healing activities of women were devalued within this competitive economic structure, in which they became increasingly dependent on government medical institutions. While women have maintained their governing role in the private domain of family and community relationships, they have also become increasingly involved in the labour force, with over half being employed in education, health professions, and reserve government (Gongaware, 2003).

The dual role, extended work life and medical dependence of First Nations women has implications for their future health needs. In particular, more information is needed about the ways traditional social roles interact with First Nations women's increasing involvement within Euro-Canadian medical institutions and structures. Additionally, the health needs of mid-life women, who must negotiate bi-cultural imperatives in order to facilitate health and healing, are not well understood. Likewise, given their current position within this bi-cultural environment, and their involvement in traditional social roles as well as mainstream political and economic domains, the younger generation of First Nations women will likely confront similar as well as additional challenges in meeting their needs at mid-life.

Mid-life Transition

The familiarity of menopause creates a false illusion about the potential consequence of biomedical research on women's mid-life experience. Yet, feminists and other critics have been consistently adamant in their proposal that biomedical research is the root of medicalization; the outcome of which is the repression and alienation of mid-life women on myriad levels (Bell, 1987; Greer, 1992). Fundamentally, biomedical research creates embodied alienation, through promotion of exogenous hormones, which dull women's response to their own peri-menopausal experience. Women may become alienated from one another within a labyrinth of biomedical language, which dissuades them from sharing feelings and experiences, through which they might form meaningful connection. The rhetoric of psychological research, which describes women's feelings as inappropriate or invalid, perpetuates their emotional alienation (Greene, 1984). Dissemination strategies, which favour academic, medical and policy audiences create a general lack of awareness about this transition and the way it affects relationships, effectively alienating women from family and friends, from whom they might access support. Finally, women are alienated from themselves through a lack of women-centered, culturally appropriate research, which promotes a balanced appreciation of this profoundly important process of physical, emotional, social and spiritual change.

The point is not to dismiss or do away with meaningful research, which has utility in the lives of mid-life women. However, we require a more balanced research agenda,

one that incorporates the strengths of many disciplines as well as accommodates the corresponding limitations of each. In the end, the best we can do is provide opportunities to break the current silence, for those women who wish to talk or those who wish to simply listen. In breaking the silence, however, we must be mindful of the gravity of what we say - the filter this information creates has the potential for great harm as well as great healing.

By emphasizing balance in our creation of knowledge, we might begin to address some of the difficulties, which have evolved from past research and practice. This balance can only be achieved through equitable research funding opportunities for relatively small, qualitative studies that attempt to capture important nuances of mid-life change, the knowledge of which creates a more balanced perspective from which to develop and implement educational, instrumental and emotional supports for mid-life women.

The Silence of First Nations Women

There is a critical point to be made here. The fact that these Mi'kmaq women appear to have fared relatively well, despite the additional obstacles they face during peri-menopausal change, does not negate close examination of those obstacles. It is not enough to admire the strength and resiliency of First Nations women, while we ponder ways to improve the peri-menopausal experience of Euro-Canadian women. Their relative resiliency does not infer a lack of need. The socio-political structures, which create additional challenges for First Nations women during the peri-menopausal transition, must be explored and addressed. These mid-life women represent the guardians of their culture and the receptacles of inter-generational wisdom. Future generations of women depend on this knowledge – about what it means to be a woman, and what it means to grow old, sandwiched between two cultures that oppose one another on philosophical and practical levels, which directly impact women's mid-life experience.

Information

In the following section, in addition to describing the potential implications of the findings and possible directions of future research and practice, I have included direct quotes from the research participants, as a means of generating specific recommendations for this group of women.

As a rule, First Nations women receive medical treatment and information, which is embedded in the western medicalization of health and devaluation of older women. In addition to its potential to deleteriously impact the experience of individual women, inaccurate or inadequate information also influences the perception of those within women's immediate and extended social networks. Without comprehensive and comprehensible information, individuals within these networks lack the capacity to provide needed support for their mid-life grandmothers, mothers, wives, daughters, grand daughters, sisters, aunts, nieces, and friends.

Alright then, let's say for the white women [even though] it's no different what they went through; were they told about this menopause, the menstrual thing and all everything you know or were they much different than the Native people and the Black people? I'm asking, were they more educated, the white women than us - the Black and the Native, are we more "in the dense" because our parents did not tell us anything about like our mothers or what not? Do they know more about it, the white women?

A cursory examination of most health literature reveals extensive discussion about the need to provide women with additional information about peri-menopausal change. Although I do not dispute this recommendation in any general sense, I do however, take issue with what we are defining as information. For example, are we suggesting that women should be aware of a peri-menopausal transition? Should they understand what occurs in their bodies at this time of change? Should they be aware of the physical and psychological potential of peri-menopausal change? Should they understand the implication of those changes for their health and well being? The obvious answer to all of these questions is yes! However, does talking about one element of a particular subject constitute getting information about it? For instance, can we really categorize

discussing the “symptoms” of menopause as getting information? Information that is so limited in its scope might not be justifiably considered knowledge at all.

To clarify women’s vision, knowledge must be comprehensive and well balanced between all the elements of change. Knowledge building is a process, which is based on information that facilitates recognition of both the challenges and opportunities offered to women at this time of life. To spoon feed women endless lists of ‘symptoms’ or to mollify them with prescriptions for HRT or mood modifying drugs shows little respect for their capacity to enhance their own experience. We are not dealing with a group of women, incapable of caring for themselves. Particularly in the case of First Nations women, we are talking about a group of women who have overcome insurmountable obstacles, not only in their own lives, but also in the lives of their families, their communities and their nations. To deny them a voice in their own mid-life care is to deny them autonomy and self-determination. It is abundantly evident in the voices of these “grandmothers” that they wish to play a role in educating one another about mid-life change.

Women need to talk to each other so they will know that they are not alone in their experience.

Education seminars. . . Like we did today, maybe on a bigger scale. . or small scale too. Yeah. Discussion groups you mentioned earlier. I think it's helpful to bring in young women, like women I don't know, teens, twenties, thirties. .

Workshops. . . we need something like you're doing right now. . . . Information I guess. . . workshops. . . don't have to be like thirties. . it could be younger coming in at least they'll know. . . . If the women that come to talk to each other, then that group should be in there.

Sharing and you know. . . . Everybody says that too. .Yeah you know it's going to be helpful for support . Bring the younger women in with the older women. Yeah. . mothers and daughters. . . you're a woman and then you know whatever - go for it.

Those of us who pursue information about mid-life and peri-menopausal change are afforded an opportunity to contribute, in a modest way, to this process. Consequently, dissemination strategies must become a critical component of our research

design. Dissemination plans should resemble a 'funnel', through which information flows. Initial research findings reveal broad theoretical and academic implications as well as subsequent research applications. The momentum must continue with consideration of the utility of research findings for multiple audiences, which often represent the direct domains of influence over women's mid-life experience. Further refinement will create information appropriate and applicable within community environments, particularly organizations, which possess the capacity to further organize and disseminate relevant material to the principal audience of mid-life women.

Practice

Programs

Mid-life women's efforts to gain knowledge from multiple sources demonstrate their pluralistic approach to the peri-menopausal transition. This pluralism must become the basis upon which programs and services are developed and delivered. Specifically, the contribution of multi-disciplinary teams of researchers, health care professionals, community organizations, and mid-life women will ensure that multiple perspectives are represented in the development and implementation of self-care and support programs.

I would like for it to go everywhere so that everybody can get information, like not just women's groups, like everywhere . . . medical facilities everywhere. . . It needs to be broadcast out there, it doesn't need to be just in a small area. I didn't know nothing about it and some day it's going to hit me, oh this is menopause. . . so come on - let's go. . .

When you have large conferences like that it's fine for a certain number of people but it's not getting to the grass roots people, so you need to have smaller and many different ways.

But she [health nurse] needs more help [because she] doesn't know that much about it, she needs help in that way so she'll tell us like. . . And think it would be most helpful for it to come from community women in the community rather than like print form or television or something. .. Yeah, oh yeah. Yeah, I think it would be nice.

Workshops. Videos, Pamphlets. Information can be native and non-native. Informal gatherings are best.

As a general rule, current educational strategies tend to promote medical intervention, which does not appear congruent with women's beliefs about this natural process. In fact, negative and/or disrespectful interactions with health professionals may disincline women from seeking information that is critical to their mid-life health. Ideally, program inertia should be in the direction of capacity building, rather than perpetuation of medical dependence. The specific content and context of this process should likewise, involve the full and active participation of multiple collaborators, primary among them, the elder women who will act as a conduit through which culturally relevant knowledge will ultimately flow.

Well yeah, it would be nice if we could get together just women. . . young women and older women, this way, get together, have lunch and have just talk and talk about this. . . Different generations. . . Well that's what we have today. . . talk about what with this one has happened to her and you know so a younger woman will learn about the older women. . .

I think there should be more workshops done on menopause and I also think that when they do these workshops that like even the women that are 30, 35, 40 should get in on these workshops cause they're the ones who are just starting. They're the ones that usually don't come. We're all going through it or else we wouldn't be here you know, it's good information for the younger ones that, in a few more years are going to go through it.

Yeah, and you know too they should have something like that because the younger women that are beginning to notice the changes are beginning to . . . their emotions get mixed up, very, very emotional and it helps for them to have someone to talk to, someone outside the family you know. . . that would be nice, even if some women went you know, that's even better. . .

As far as the teenagers, the young girls, the young women, they go through PMS, they don't understand why they're feeling so grouchy or depressed before their monthly cycle, I think they need to be educated about that. So they understand what their bodies are going through. So I think more about walk-in health clinic, counselling for someone to talk to, just to walk-in and say I need to talk to you or even just to talk there and say can I come in or something.

Elder women, who have experienced this process, and can reflect on it in greater depth and from greater breadth, are those who should be informing our collective vision. Aside from informing a broader vision of peri-menopausal change, elder First Nations

women have a role to play in the re-acclamation of Aboriginal health, away from a medical system that is predicated on the assimilation of First Nations people.

Based on the findings of this research, practical, informational and affirmational support provided to mid-life women must be focused on achieving balance, rather than on effecting a cure. Acknowledgement of the duality and fluidity of peri-menopausal change is particularly important in promoting a balanced perspective. Women must be given social permission to commiserate as well as celebrate mid-life change. Yet, without a framework upon which to build a new language, they will remain mute – about a subject that holds such singular meaning to countless women. Without an opportunity to talk to others, women will continue to be unsure about what to expect, about what they are experiencing, and about how to explain those experiences, all of which greatly increases their stress at mid-life, thereby exacerbating any difficulties they may encounter.

But it would be really nice, it really, really would be nice to have a place where like a woman can go and get answers, just to talk to somebody you know where you feel comfortable and ask these questions, but .. I mean they don't have any such thing do they?

Like a women's centre. . . that's what ..

We need a centre, we need some place to go. Just to get information, somebody who will talk to you. Well, I think a female nurse - but they're so busy.

Health Professionals

Allied health care has a particularly important role to play in women's mid-life experience. We have not moved nearly so far in that direction as we should, primarily because we persist in clinging to antiquated notions of health in general and peri-menopausal change in particular. It is clear that the influence of biomedicine on women's peri-menopausal experience has not always been beneficial or even benign. In fact, most critics propose that medicine's control over this experience might have caused more harm than good (Bell, 1987; Love, 2003; Northrup, 2002). It is becoming increasingly clear that distinct differences in the manner in which problems are identified

and managed by women and by health professionals, creates discord in that relationship, whether actively or passively articulated (Green et al., 2002).

Given the relevance of peri-menopausal change in most women's lives, it is intuitively surprising that so many remain silent on the subject. It may be equally surprising that this silence is often a circumstance of choice, governed by personal sensitivities and enforced through cultural norms. Despite our recent antagonism toward traditional gender norms, which often subordinately position women, we must acknowledge that position and work from its consequent reality. Accordingly, health care professionals must be respectful of women's silence, but mindful of their need for well-balanced information as well as opportunities for pluralistic approaches to self-care and support.

Approaches aimed at informing First Nations women about the challenges and opportunities of mid-life change must account for the local knowledge of the women themselves. Health professionals, particularly those from outside First Nations communities, can enhance educational workshops by incorporating opportunities for women to share their experiences with one another. This practice not only acknowledges the subjectivity of this experience but also honours the tradition of story telling as a useful tool for learning.

Traditional Practice

Until recently, reserve communities did not have resources (beyond a doctor for some) for women seeking information about menopause. The medicalization of menopause was such that physicians tend to prescribe HRT, thereby perpetuating a disease model. However, with the recent resurgence of traditional healing, women are beginning to incorporate traditional healing/spirituality into their conception of mid-life health and menopause.

The mid-life women who participated in this study offer a wealth of knowledge, with which to inform a pluralistic and balanced approach to peri-menopausal change and mid-life health. Of particular relevance to First Nations women, are traditions and ceremonies, which provide an avenue for healing that is deeply rooted in Aboriginal customs.

Women want to know more about herbal remedies. Native women need more information that they can access and understand. Women don't know which information is accurate. Women want to know about herbal remedies and prescription drugs – interactions.

Some of the women suggested that traditional forms of healing might be particularly helpful during peri-menopause. For instance, the spiritual component and relative personal safety of a talking circle provides women with an avenue of emotional healing that might not be available to them outside the safety of the circle.

A women's retreat with women's talking circles.

Everybody could share their stories. .. oh that happens to you, that happened to you. ... Then you feel better. .

The most profound gift offered by these grandmothers is one of tolerant acceptance, the outcome of which is a well-balanced perspective and a pluralistic approach to mid-life change. With careful consideration of cultural context, the constituents of this perspective and approach might be used to inform the vision and practice of other women. In order to expand our vision of mid-life beyond the microscopic lens of biomedicine, we must embrace the principles of balance and pluralism, without denuding their cultural context. Rather than adopting the distinct traditions of diverse ethno-cultural groups, Euro-Canadian women, who might lack an adaptive cultural structure, must define their own practice, based on the principles of pluralism and balance. Through this respectful approach to honouring the customs of diverse cultures, mid-life women might even come together for mutual sharing and healing, in a forum where we all have an opportunity to contribute our unique gifts as well as our special challenges.

A Final Word

The theoretical framework, which emerged from these findings, is based on Aboriginal philosophies, which provide a more culturally appropriate and useful framework upon which to consider the interdependence and interaction of multiple health

determinants. Consequently, I have attempted to incorporate the perspectives of philosophy, mythology, sociology, psychology and medicine into the text. Ultimately, interdisciplinarity is not so much an attempt to embrace divergent philosophies, as it is a philosophical position that has its roots in many disciplines of thought.

First Nations women possess a remarkably holistic vision of this experience, which is embedded in a life that is complicated and dynamic. This vision is one of intersecting natural, spiritual and social spheres of experience and understanding. To suffer is not always to be sick; one can suffer in the context of joy as well as find peace in the context of suffering. Aboriginal philosophies allow First Nations women to harmonize these constructed polarities and truly experience this transition within a holistic framework.

One of the most important lessons I have learned from these “grandmothers” is that, despite my initial ramblings about the dangers of medicalization and the wisdom of crone philosophy, I might have missed the point completely. We have been approaching this subject from a dualistic perspective. Though we (academics) might claim to view menopause holistically, we typically end up discussing the polarity of this experience, either from a demonized medical view or an idealistic feminist one. Pluralism is about seeing the good and the bad, the ugly and the beautiful, the painful and the pleasant. This experience is saturated with life, which is never experienced or understood in polarities. Nature promotes diversity, yet it seems that we continue to deny it and make every attempt to negate it.

In the end, we can *definitively* claim that a *definitive* menopausal experience does not exist for all women. The blatant diversity of this process demands a fluid and multi-dimensional model. Not only must we re-consider how we attempt to understand this process, we must come to terms with the consequence of agendas, which have perpetuated the kind of variable-specific research and subsequent treatment practices we have witnessed over the past 50 years. In my humble estimation, these few women have breathed new life into a somewhat depleted subject. Their simple, yet sophisticated wisdom demonstrates that this is a living, breathing phenomenon of nature. Their words direct us to move beyond our current scope of understanding, which is limited to hot flesh and brittle bones – to begin to create a new vision of this ancient life passage.

Menopause, with all of its diverse, subjective and sometimes mythical changes, is purely female; it is about female bodies, female minds and female lives. It is also about who we were, who we are and who we will become. The past, present and future meld together at this time of life, when women might achieve a comfortable balance between the wisdom of years and the sensation of youth. Spirituality and emotional maturity transcend the delights and distresses of the physical body. Female wisdom becomes the template upon which women's experiences are poured – of mothers, grandmothers – of sisters and friends; each contributing to a vision that materializes over women's journey through change.

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Appendix A: Discussion Guide

Preamble

We are here today to talk about your thoughts, feelings and experiences of mid-life and menopause. At the end of the discussion, I would also like you to share your thoughts and feelings about the issues that we have discussed. This will help us to further develop the question guide so that the questions are clear, understandable and respectful. Your feedback will also help us to ensure that this study is respectful of your time, knowledge and experience.

You don't have to talk about any issues that make you feel uncomfortable and you may stop participating at any time. Once again, we are honored that you have agreed to help in this study; your input is very valuable.

1. *Preamble:* We might begin by talking about some of the things that are most important to us, as we become mid-life and older women. Please try to think about aspects of your life as an individual woman as well as member of a family, community and Nation. Also, please think about things that are physical, emotional, spiritual and social.

Question: As an Aboriginal women, what things become important to you as you get older?

2. *Preamble:* Menopause or the change of life is one of the things that most women experience as they get older. This is a time when we stop having a period and we can no longer have children. Some people see this time of change as positive and some see it as negative.

Question: What are some of the beliefs and attitudes women have about menopause?

3. *Preamble:* Many things, such as our own thoughts, feelings and actions or the thoughts, feelings and actions of others, may affect the way we feel about menopause. Sometimes they affect us in a positive way and sometimes they affect us in a negative way.

Question: How do thoughts, feelings and actions affect how you, or the women you know, feel about the change of life?

4. *Preamble:* There are many situations that affect our experience of health and illness. They may be related to family life, culture, where we live or access to resources. These things may also affect how we experience our change of life.

Question: What situations do you believe might affect women's experience of the change.

Appendix B: Information Letter

Date

Hello - and thank you for considering participation in the “Grandmothers’ Voices: Mi’kmaq Women and the Menopause” study. The purpose of this study, which is being conducted as part of a Doctoral thesis at Dalhousie University, is to gather information about Mi’kmaq women's experience of mid-life health and menopause (the change of life) as well as their perception of what things might effect those experiences. I will be working with a woman from your community, who may also guide a discussion in which you will join other women in talking about mid-life health and menopause. The discussion will last between one and two hours and will take place in your home community at a location that is suitable for all participants. You may participate in this study if you are a Mi’kmaq woman, who is experiencing or has experienced menopause.

Your participation in this study intends no harm or discomfort to you: the questions are mainly focussed on your thoughts, feelings, and experiences of mid-life health and menopause. You may or may not benefit from sharing your wisdom and experience at the time of your participation. However, your input will contribute to our knowledge about menopause among Mi’kmaq women and may benefit other First Nation women who are looking for information about menopause. Each woman who participates in this study will receive a gift of \$25.00. Refreshments will also be provided and, if you require reimbursement for travel costs to and from the meeting, it will be provided. However, due to budget constraints, a limit of \$10.00 per person for travel will be necessary.

When discussing sensitive topics, some participants might need personal support, which may be provided by the other members of the group. In addition, women may also have questions about menopause or need information about community resources. I will attend each of the discussions and provide whatever information you may require (in print and verbal form) immediately following each session or as soon as I can obtain that information. We will also have a list of community resources available to women who may require counseling or other services as a result of their participation in this study.

The facilitator and I will tape record the discussion and later, the information will be recorded in writing. This written transcript of the discussion will not include your real name, nor will any report or publication reveal your identity or that of your home community. Although the facilitators and I will keep your participation in this study confidential, we cannot guarantee that the other women in your group will keep your identity or comments private. Therefore, we ask that everyone who participates in a discussion respect the privacy of others in the group.

Before the discussion, the facilitator will ask you to sign a consent form or voice your consent to participate in the study and to be audio-taped. However, your participation in this study is voluntary and you may withdraw at any time. Also, if you do agree to

participate, you may choose not to discuss any issues that make you feel uncomfortable. The tapes and written transcript will be kept in a locked cabinet throughout the study. The tapes will be destroyed one year after the study has concluded and the transcripts will be destroyed five years after the study is complete. A copy of the transcript (with all names and places deleted) may also be stored in a secure location at the Community Health Centre, where it will be treated as confidential health information. You may look at your transcript as well as our summary of your discussion at any time.

The information gathered during this study may be used in a thesis presentation, journal publications, newsletters, workshops, and future research projects. We will also be providing a full report of the research findings to your community (Chief, Band Manager, Health Director/CHR/CHN, and facilitator) as well as to the Confederacy of Mainland Mi'kmaq (CMM) and the Union of Nova Scotia Indians (UNSI). Also, we hope to use the findings of this study to develop brochures and workshops about menopause for all Mi'kmaq women as well as other First Nation women. I hope that together, all of the women involved in this study can help educators, health professionals and other First Nation women better understand menopause from a First Nation perspective.

If you have any questions or concerns, please feel free to call me at home (902) 423-3852 or at work (902) 494-6620. I would be happy to meet with you or to discuss any questions or comments you have over the phone. Please be assured that I will keep you informed about any new information that might affect your decision to participate in this study and you will be contacted in the unlikely event that this study is terminated.

Many thanks,

Charlotte Loppie

Appendix C: Consent Form

You have been asked to participate in a study entitled “Grandmothers’ Voices: Mi’kmaq Women and the Menopause,” the purpose of which is to gather information about Mi’kmaq women’s experience of mid-life health and menopause. Charlotte Loppie, a graduate student in Interdisciplinary Studies at Dalhousie University, is conducting this research as part of a doctoral thesis.

You will be asked to participate in a group discussion about your thoughts, feelings, and experiences of mid-life health and menopause. This discussion will be tape-recorded but one year after the study is complete, the tapes will be destroyed. You have the right to read the written transcript and summary of your group discussion. You may also refuse to answer any questions or to end your participation at any time without repercussions. Neither your real name nor the name of your home community will be used in any report or publication and information about this study will be reported in such a way that you and your community cannot be identified.

I have read/heard the introduction letter of the “Grandmother’s Voices” study. I have been given the opportunity to discuss this study and my questions have been answered to my satisfaction. I hereby consent to take part in this study and to be audio-taped.

Participant's Signature

Date

Signature of Person Obtaining Consent

Date

<p>In the event that you have any difficulties with, or wish to voice concern about, any aspect of your participation in this study, you may contact Human /Research Ethics/Integrity Co-ordinator at Dalhousie University’s Office of Human Research Ethics and Integrity for assistance. Phone: (902) 494-1462.</p>

APPENDIX D: PARTNERSHIP AGREEMENT
between
(Name of the First Nation Community) and Charlotte Loppie

RE: Grandmothers' Voices: Mi'kmaq Women and the Menopause

The purpose of this Partnership Agreement is to define the research relationship between the _____ and Charlotte Loppie, Dalhousie University. Within the context of this relationship, both parties agree to the following conditions:

- _____ will be identified as a partner in this study as well as any further health related research efforts, which require use of _____ Community data.
- Prior to formal release of the research report, the findings will be presented to the _____ as well as interested community members. Community interpretations of the findings will be respected and will be incorporated into the final report.
- A copy of the transcripts for the _____ group will become the property of the _____. This information will be treated as confidential health information and will be stored in a secure location in the Community Health Centre.
- Facilitators and participants of the "Grandmothers' Voices" study will have access to the transcripts of their own group.
- Participants will be informed that a copy of their data will be stored at the _____.
- The _____ data will not be used for any other purpose without written consent by the _____ partners, including the facilitators and participants.
- Chief and Council or a designate has granted approval for this study.

Name and Title

Date

Charlotte Loppie
Dalhousie University

Date