AN ABSTRACT OF THE THESIS OF

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This study examines the utilization of health care by Korean American women in Pierce County, Washington. Pierce County, with its large population of Asian Americans, offers a variety of health care options, everything from biomedicine to acupuncture and herbal remedies. Regarding the multitude of options available, I asked the question "What is used and why?" I look at how each of the following influences a person's health care choice: acculturation, culture, language and financial barriers, and personal preference. I conducted open-ended interviews with Korean American women to answer my questions. From these interviews I learned that it is not an all or nothing choice. Many Korean-American women choose to employ complementary and alternative medicine (CAM), traditional Korean medicine used alone or in conjunction with Western medicine in the case of acute illness. I make recommendations on what can be beneficial to both health care providers and Korean American women in achieving better health care.

Factors Influencing the Use of Complementary and Alternative Medicine by Korean American Women

by
Jennifer M. Skidmore

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Jennifer M. Skidmore, Author

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INTRODUCTION

Examining the variety of medical systems preferred in ethnic communities and their utilization has become vital given the increase in ethnic diversity in the United States. Availability, accessibility, and effectiveness of care are all important when trying to provide health care in ethnic communities. We must take into consideration not only how these factors influence the use of Western medicine but traditional medicines as well.

This study examines the utilization of health care by Korean American women in Pierce County, Washington, focusing on the use of complementary and alternative medicines. "[A]wareness of their use of traditional medicine, often in combination with Western medicine, is an increasingly salient issue for health care professionals" (Kim et al. 2002). By studying the health care choices made by Korean American women I hope to contribute to the knowledge base on ethnicity and health care.

The Setting

Washington State has a large population of Asian Americans, with most settling in the Puget Sound area. I chose to conduct my research in Pierce County, Washington because of the sizable Asian American communities in Federal Way and Lakewood. I focused on Lakewood and the surrounding areas because Lakewood's population is 8.9% Asian American. The City of Lakewood contains a Korean

Business District, comprised mostly of Korean owned businesses including many health care providers: biomedical doctors (both Korean and American), dentists, acupuncturists, naturopaths, and herbalists.

The Korean community in the Lakewood area is large due to the presence of two military bases in the area: Fort Lewis Army Post and McChord Air Force Base. Many of the soldiers stationed at the bases are married to Korean women. Over time, many retired and settled here permanently and "have often sponsored the subsequent chain immigration of other family members" (Yuh, 2002).

Health Care Utilization Research

This study seeks to add to the knowledge of health care and the issues of ethnicity by studying an Asian American community. Currently, most of the work on ethnicity and health care focuses on African American, Hispanic, and Native American communities or transitional refugee communities. To broaden the scope of interest I chose to study an established Korean American community.

The Researcher

This study is not only an academic endeavor but also a personal journey. I have always been interested in Korean culture; raised by a Korean mother, I experienced it as a part of my daily life. Growing up in the United States in an interracial home I not only saw the blending of two cultures, I participated in it. Often times I could not give a reasonable account of why things were done a certain way in my home; I just knew that it was tradition.

The idea of "why" and my interest in health care led me to my research idea. I wanted to know what influences Korean American women's health care choices, the role that culture and traditional beliefs play in decision-making, and the influence of the dominant culture on ideas about health.

Purpose of the Study

The main questions of this study are: What medical systems are Korean American women utilizing? What are the reasons behind Korean American women's choices of medical systems? Is it ethnomedical beliefs, acculturation? To what degree to Korean American women use traditional medicine? Why? Research has led to these working hypotheses: ethnomedical beliefs influence choices of medical systems; choices may be influenced by the degree of acculturation; and no single system is chosen but rather medical pluralism exists, whereby the women rank the different systems and use them according to need.

LITERATURE REVIEW

History of Korean Immigration

The first wave of Koreans, under the protectorate of Japan, began immigrating to Hawai'i and Mexico as laborers in 1902.

> The Hawaiian Sugar Planters' Association sent a labor recruiter to Korea in 1902, and with the help of American missionaries shipped more than 7,000 Koreans to work on Hawai'i's plantations. About 1,000 left for henequen plantations in Mexico" (Okihiro, 2001).

Little by little, Koreans began leaving the plantations for the United States, settling mainly in California. In 1905, Japan ended Korean labor migration on charges of abuse on Mexican plantations (Okihiro, 2001).

"The United States restricted migration from Korea, a colony of Japan, in a move related to U.S. exclusion of Japanese immigrants beginning with the 1907 Gentlemen's Agreement" (Okihiro, 2001). The Japanese government stopped issuing passports to Koreans laborers wanting to emigrate to the U.S. (Okihiro, 2001). Between 1910 and 1924, only Korean wives and 'picture brides' were allowed to immigrate to the United States (Cao & Novas, 1996). The Immigration Act of 1924, which limited the number of immigrants to 150,000 annually with no more than two percent of each nationality, stopped all Korean immigration until after World War II.

The second wave of Korean immigrants, 1951-1964, came after the Korean War. During the Korean War, many American service men married Korean women and brought them to the U.S. (Okihiro, 2001; Cao & Novas, 1996). "These 'war brides' were the first Koreans allowed legally into the United States after 1924" (Cao

& Novas, 1996). Between 1950 and 1990, "nearly 100,000 Korean women immigrated to the United States as the wives of American soldiers" and hundreds more continue to marry American soldiers every year (Yuh, 2002). As these women settled in the U.S., they began sponsoring family members under the family reunification provision of immigration law. "It is estimated that military brides are responsible (directly and indirectly) for bringing 40 to 50 percent of all Korean immigrants since 1965" (Yuh, 2002).

The Hart-Celler Act of 1965 triggered the third wave of Korean immigration (Okihiro, 2001; Cao & Novas, 1996).

> The Hart-Celler Act essentially eliminated the National Origins Quota System. It provided instead for the annual admission of 120,000 immigrants from the Western Hemisphere and 170,000 immigrants from the Eastern Hemisphere, with 20,000 slots per Eastern Hemisphere country. Immediate family members – specifically spouses, children, and parents of American citizens – were exempt from the quota system. Preferential treatment was also given to Eastern Hemisphere professionals, laborers whose skills were in demand, and refugees (Cao & Novas, 1996).

With the relaxing of immigration laws and the economic devastation of the Korean War, Korean immigration grew by unexpected leaps and bounds. Because of the Hart-Celler Act, the face of Korean immigration changed from manual laborers to skilled laborers and professionals: doctors, engineers, accountants, and businessmen. The majority settled in California and New York, others near (military brides and family) military bases (Okihiro, 2001; Yuh, 2002). In these settlements, Korean American business enclaves grew, attracting more Korean immigrants (Okihiro, 2001).

Acculturation

Acculturation is "the process of change in knowledge, attitudes, cultural beliefs, values, and practices that occurs when the individual is exposed to a new cultural environment" (Marino et al, 2000). This process does not happen at the same rate or extent for all immigrant communities or individuals. *Acculturation of Values and Behavior: A Study of Vietnamese* (Marino et al, 2000) emphasizes the two dimensions of acculturation: behavioral and psychological. Behavioral acculturation is "related to cultural learning and the adoption of the most observable, external aspects of the dominant culture including language, social skills, and the ability to fit in or negotiate the new sociocultural reality" (Marino et al, 2000). Psychological acculturation is more complex. It is the internalizing of ideologies, norms, and beliefs of the new culture. Behavior does not reflect psychological acculturation. If someone is fluent in a language, it does not mean they have adopted the belief system of that culture. Similarly, someone who has internalized the belief system of his or her adopted culture may not fluently speak the language.

When looking at utilization of health care this internalization is important. In a study on perceptions of health and use of ambulatory care by elderly Koreans (Pourat et al, 2000) it was found that acculturated individuals were more likely to use biomedical care. "If the person was in the United States for more than 15 years or was born in the United States, they would have 1.6 more office visits than those immigrants who have been in the United States for 15 years or less" (Pourat et al, 2000).

There are three possible outcomes to the process of acculturation that may affect type of health care used: assimilation, resistance to assimilation and biculturalism.

> Assimilation occurs when an individual adopts the cultural values, attitudes, and behaviors of the (new) host culture while rejecting his or her parent culture (Chang & Meyers, 1997).

Rejection of parent culture seems to be an extreme reaction to the adoption of new cultural values. Usually the parent culture would take a backseat to the new values.

> Resistance occurs when the individual resists the host culture and maintains the cultural values, attitudes, and behaviors of the parent culture, and biculturalism occurs when the individual is able to adopt values, attitudes, and beliefs from both cultures (Chang & Meyers, 1997).

With assimilation comes acceptance and consistent use of Western medicine. Resistance to assimilation allows for behavioral acculturation but not psychological acculturation; in such case, traditional methods of healing would be sought in preference to Western medicine. Biculturalism allows for integrated use of health care, moving back and forth between two healing systems depending on factors such as ailment, accessibility, and economics.

Korean Medicine

"In A.D. 561, traditional Chinese medicine was introduced to Korea, where it blended with Korean folk medicine to create Hanbang, traditional Korean medicine" (Cao & Novas, 1996). Similar to Chinese medicine, Hanbang is based on holism, with "health seen as a state of environmental, social, and physical harmony" (Kim et al, 2002). "There are four common treatment methods in a hanbang clinic, *ch'im*

(acupuncture), *hanyak* (traditional herbal medicine), *d'um* (moxibustion), and *buhwang* (cupping) (Kim et al, 2002). They may be combined or used alone.

Acupuncture encourages the body to heal by inserting needles into very precise points (AAMA, 2003; Helms, 1999). Acupuncture can help not only in pain control but also with digestive disorders, neurological and muscular disorders and respiratory disorders (Helms, 1999). The classic explanation is that:

> channels of energy run in regular patterns through the body and over its surface. These energy channels, called meridians, are rivers flowing through the body to irrigate and nourish the tissues. An obstruction in the movement of these energy rivers is like a dam that backs up in others. The meridians can be influenced by needling the acupuncture points; the acupuncture needles unblock the obstructions at the dams, and reestablish the regular flow of the meridians (AAMA 2003).

The scientific explanation is that by needling the acupuncture points the nervous system is stimulated (AAMA, 2003; Helms, 1999). This stimulation releases chemicals in the body that will "either change the experience of pain, or they will trigger the release of other chemicals and hormones which influence the body's own internal regulatory system" (AAMA, 2003).

Hanyak, traditional herbal medicine, is practiced both in the home and in clinic settings. It is a combination of Chinese herbal medicine and Korean folk medicine. Medicinal herbs were traditionally gathered as needed by herbal doctors and lay people to use in the home setting. Currently, "Korean herbal shops stock everything from chrysanthemum petals, snake wine, and dried tortoise to deer antlers, dried reptiles, and insects" (Cao & Novas, 1996). Remedies are made by brewing together herbs to make teas and curative soups.

"Moxibustion is a traditional Chinese medicine technique that involves the burning of mugwort, a small, spongy herb, to facilitate healing" (Acupuncture Today, 2005) by strengthening the blood and stimulating the flow of energy. It is commonly used to increase "blood circulation to the pelvic area and uterus and stimulates menstruation" (Acupuncture Today, 2005).

There are two types of moxibustion, direct and indirect, each with two subtypes. Direct moxibustion includes both non-scarring and scarring. In both a "cone-shaped amount of moxa is placed on top of an acupuncture point and burned" (Acupuncture Today, 2005). With scarring moxibustion, the moxa is left on the point until it burns out, resulting in blisters and scarring. In non-scarring moxibustion, the moxa is removed before it burns the skin.

"Indirect moxibustion is currently the more popular form of care because there is a much lower risk of pain or burning" (Acupuncture Today, 2005). One form of indirect moxibustion consists of a lit moxa stick being held close to the treatment area until the area turns red. Another involves the use of acupuncture needles. "A needle is inserted into an acupoint and retained. The tip of the needle is then wrapped in moxa and ignited, generating heat to the point and the surrounding area" (Acupuncture Today, 2005).

Like acupuncture and moxibustion, cupping is performed along the different energy meridians. It helps to "stimulate the flow of blood, balances and realigns the flow of qi [energy], breaks up obstructions, and creates an avenue for toxins to be drawn out of the body" (Acupuncture Today, 2005). Cupping can be used to alleviate

headaches, respiratory conditions, arthritis, gastrointestinal disorders, and pain (Acupuncture Today, 2005).

Cupping was originally performed using hollowed out animal horns for cups, but today glass cups are preferred. There are three methods of cupping: dry, air and wet. In dry cupping "glass cups are warmed using a cotton ball or other flammable substance, which is soaked in alcohol, lit, then placed inside the cup" (Acupuncture Today, 2005). This removes all the oxygen, creating a vacuum. The cup is then placed upside-down on the patient, drawing the skin into the glass. Air cupping does not require the heating of the cup; instead, a suction pump is attached to the cup to create a vacuum.

> In "wet" cupping, the skin is punctured before treatment. When the cup is applied and the skin is drawn up, a small amount of blood may flow from the puncture site, which is believed to help remove harmful substances and toxins from the body (Acupuncture Today, 2005).

Although Hanbang has existed for thousands of years in Korea, it has not always had mainstream status and support. In the 1800s, Western medicine was introduced in Korea, becoming firmly established with the Japanese occupation.

> Although Hanbang was suppressed during the Japanese occupation of Korea in 1910-1945, it survived this period and was revived after the Korean War with strong government support. After the occupation and a period of political struggle, Hanbang practitioners (called hanuisa) finally obtained the equivalent licensure of medical doctors and are referred to as 'Oriental Medical Doctors' (OMDs) (Yarnell & Abascal, 2004).

Shamanism

"A shaman is a person who mediates the relation between the natural world and an animated supernatural world (spirits) for the purpose of gaining some control over or knowledge of natural events" (Brown, 1997). Although shamanism is representative of religion, it plays a role in health and healing. "In ancient times illness was thought to be due to something entering the body, and recovery meant ridding oneself of this contamination" (Korean Embassy, 2000). Shamans were called in to perform exorcisms to drive away the evil spirits.

Archeological evidence traces Shamanism in Korea back to the Bronze Age, and "a written account of shamanistic practices...suggests its presence in Korea's formative times" (Fenkl, 1986). Over time and with the introduction of other religions, shamanism became a smaller part of Korea's national religious identity. However, it garnered popularity at the village level, in more traditional settings (Brown, 1997).

> Korean shamans were traditionally both men and women.
>
> There is much unresolved debate about the nature of early Shamanism in Korea, i.e., whether the tradition was at first male-dominated or egalitarian; but whatever the original tradition, it is currently dominated by women and has been for centuries (Fenkl, 1986).

These shaman are called *mudang* or *mansin* (ten thousand spirits) and are "roughly divided into two types: possessed, or charismatic shamans and hereditary shamans" (Sun, 2000). Possessed or charismatic shamans

> called *Naerim Mudang*, are typically found in the northern half of the Korean peninsula.[Traditionally women] After suffering from *sinbyong,* an illness which is generally interpreted as a sign of shamanistic calling, a potential *Naerim Mudang* apprentices herself to an established shaman from whom she acquires the knowledge and

> skill appropriate to her new occupation. The two women establish a 'spirit mother'-'spirit daughter' relationship, the spirit mother later conducting the initiation rite which transforms her apprentice in to a full-fledged shaman (Sun, 2000).

Naerim Mudang become possessed, enter trance like states during rites, and may cause the same for their clients. *Naerim Mudang* perform rites and exorcisms using spirit guides, they "are not self-ordained but intermediaries and mediums of a higher spiritual authority" (Fenkl, 1986).

Hereditary shamans, "*Tangol Mudang*, are found in the southern half of the Korean peninsula" (Sun, 2000) and are more likely to be male than *Naerim Mudang*. *Tangol Mudang* do not come to being through possession sickness but rather come from a shaman's family. Unlike *Naerim Mudang, Tangol Mudang* do not undergo trances or become possessed during rites, but may cause clients to undergo a trance.

Tangol Mudang and *Naerim Mudang* perform many types of *Kut*, exorcising ceremonies. Their services may be enlisted for any number of things including "gods blessings good fortune, the birth of a male child, good harvest," (Korean Embassy, 2000) driving away evil spirits, or avoiding or ridding oneself of bad health etc.

> To cure the sick, the shaman [makes] offering of food and wine, and sometimes even sacrifices of animals, symbolizing the ill person. In return for the offerings, the shaman would request the spirits to leave the body and home of the sick person and never return. Making the entreaty, the shaman would sing, dance, and pray (Korean Embassy, 2000).

If this did not work, the approach becomes more aggressive with the use of weapons, knives and sticks, and music.

Other forms of spiritual healing came from the use of fortunetellers. "Through divination, it was believed they could determine the causes of sickness and advise appropriate treatment" (Korean Embassy, 2000).

Complementary and Alternative Medicine

Complementary and alternative medicine (CAM) "is a group of diverse medical and health care systems, practices, and products that are not presently considered part of conventional medicine" (NCCAM, 2002). Complementary and alternative are "not synonymous: the more common term, 'alternative,' connotes the use of such medicine instead of Western medicine; the term 'complementary' has been growing in prominence to emphasize that such treatments can be used in addition to, and to balance the shortcomings of, mainstream medicine" (Spiegel et al, 1998). The National Center for Complementary and Alternative Medicine (NCCAM), a federal agency for scientific research on CAM, identifies five major types of CAM: alternative medical systems, mind-body interventions, biologically based therapies, manipulative and body-based methods and energy therapies. Alternative systems are built upon complete systems of theory and practice for example homeopathic medicine and traditional Chinese medicine. Mind-body medicine uses techniques to "enhance the mind's capacity to affect bodily function and symptoms" (NCCAM, 2002) such as prayer and support groups. Biologically based therapies use natural substances like vitamins and herbs. Manipulative and body based methods manipulate parts of the body, chiropractic care and massage would fit into this category. Energy therapies use

energy fields and are divided into two types: biofield and bielectromagnetic-based therapies.

CAM is more holistic approach to medicine, treating the patient as a whole being, mind and body rather than symptoms or ailments (MFMER, 2004). CAM is slowly becoming mainstream as it gains credibility within the medical community and society at large (AAPM&R, 2005).

> The use of complementary and alternative medicine (CAM) is growing nationally. In 1990, Americans spent nearly $14 billion on some 427 million visits to holistic practitioners (the bulk of which was paid out of pocket). By 1997, those figures jumped to $21 billion on an estimated 629 million visits, an approximate 46% increase in total expenditures and visits for alternative therapies (AAPM&R, 2005).

Some contributing factors to this growth of CAM use are "marketing forces, availability of information on the Internet, the desire of patients to be actively involved with medical decision making, and dissatisfaction with conventional (western) medicine" (Barnes et al, 2004).

So, who are these Americans using CAM? "How many Americans? What therapies are they using? For what health problems and concerns?" (NCCAM, 2004). In 2004, the National Center for Health Statistics (NCHS) with the National Center for Complementary and Alternative Medicine (NCCAM) published the answers to these questions in *Complementary and Alternative Medicine Use Among Adults: United States, 2002.*

Rates of CAM use are high among those dissatisfied with western medicine; "this dissatisfaction may be related to the inability of conventional medicine to

adequately treat many chronic diseases and their symptoms such as debilitating pain" (Barnes et al, 2004) and those with life threatening illnesses (cancer, HIV).

> Overall, in 2002, about 62% of U.S. adults used some form of Cam in the past 12 months. Subgroup differences were noted in the use of CAM: women were more likely than men to use CAM; black adults were more likely than white or Asian adults to use CAM when megavitamin therapy and prayer specifically for health reasons were included in the definition; persons with higher educational attainment were more likely than persons with lower educational attainment levels to use CAM; and those who had be hospitalized in the past year were more likely than those who had not been in the hospital in the past year to use CAM (Barnes et al, 2004).

The systems of CAM available in the U.S. are derived from traditional medicines from immigrants' countries of origins: Ayurveda and Chinese Medicine (Barnes et al, 2004). According to the NHIS the 10 CAM therapies most commonly used in terms of percentage of U.S. adults were:

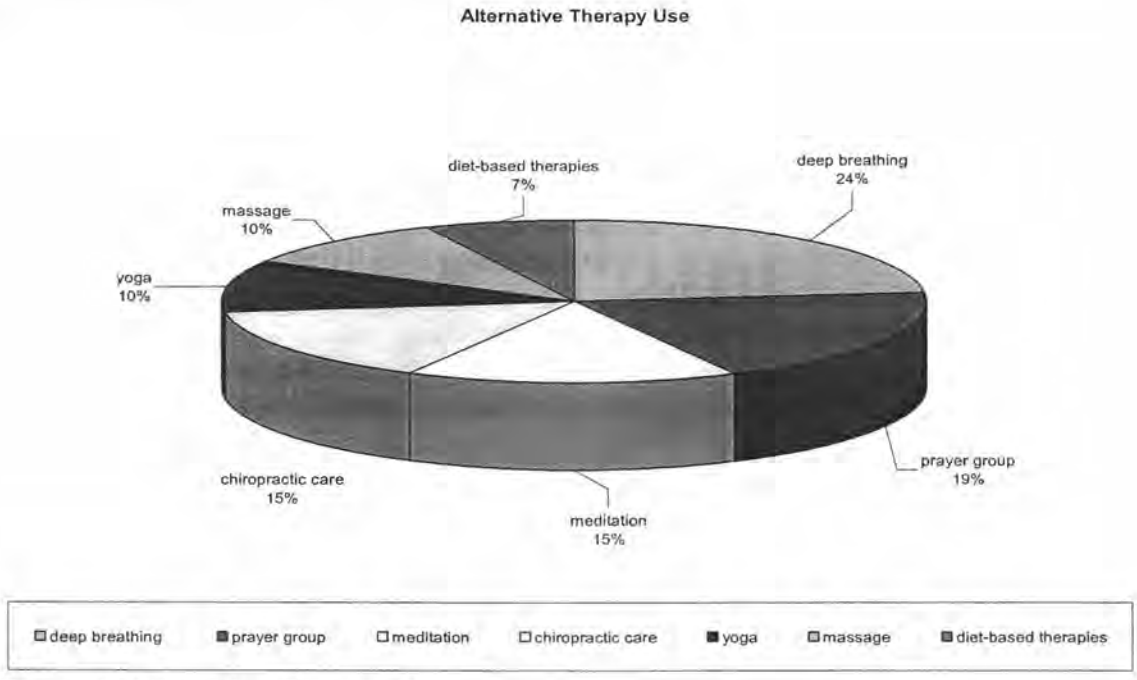

Figure 1. Alternative Therapy Use

These therapies were "most often used to treat back pain or problems, head or chest colds, neck pain or problems, joint pain or stiffness, and anxiety or depression" (Barnes et al, 2004). The majority of CAM users used CAM not as an alternative to western medicine but as a complement (Barnes et al, 2004).

METHODS

Throughout my research the central questions have been "What type of health care do Korean American women seek and why?" In order to answer these questions I have conducted research on complementary and alternative medicine, availability of Western medicine, and possible barriers to health care. Data collection was done by interviewing Korean American women about the type of health care they utilize. I used ethnographic and qualitative content analysis (Bernard, 2002) to assist in data analysis and to identify general themes in informant interviews.

The Sample Population

This study's sample population consisted of Korean American women living in Pierce County, Washington, specifically the Fort Lewis, Lakewood, Spanaway area. Informants were selected from this geographic area because of the large Korean American population and their easy access to complementary and alternative medicines. Pierce County has a few enclaves of Korean Americans; one of the largest being in Lakewood, which has its own Korean business district.

Originally, informants were to be recruited through social service agencies and community groups, a standard method of research (Yuh, 1999). I visited local Korean American churches and contacted the Korean Women's Association (KWA) with the intention of enlisting their help. However, I decided on a more personal approach, finding informants by word of mouth and through personal connections. This decision was made after reading Ji-Yeon Yuh's work; she discussed issues of bias stemming

from informants chosen through social service agencies. I felt that if I went through a church or the KWA I would eliminate some of the randomness; I would only be introduced to women with health issues or those involved in traditional medical systems.

The twelve informants are Korean American women between the ages of 40 and 65, living in Pierce County, Washington. All are United States citizens, long time residents, and moderate English speakers. They are widows of, divorced from, or currently married to military men. Six of the informants are married to Caucasian men, three to Hispanic men, one to a Korean man and two were married to African American men. All have immigrated to the United States within the last 30 years, though not consistently living in the United States due to husbands' military commitment.

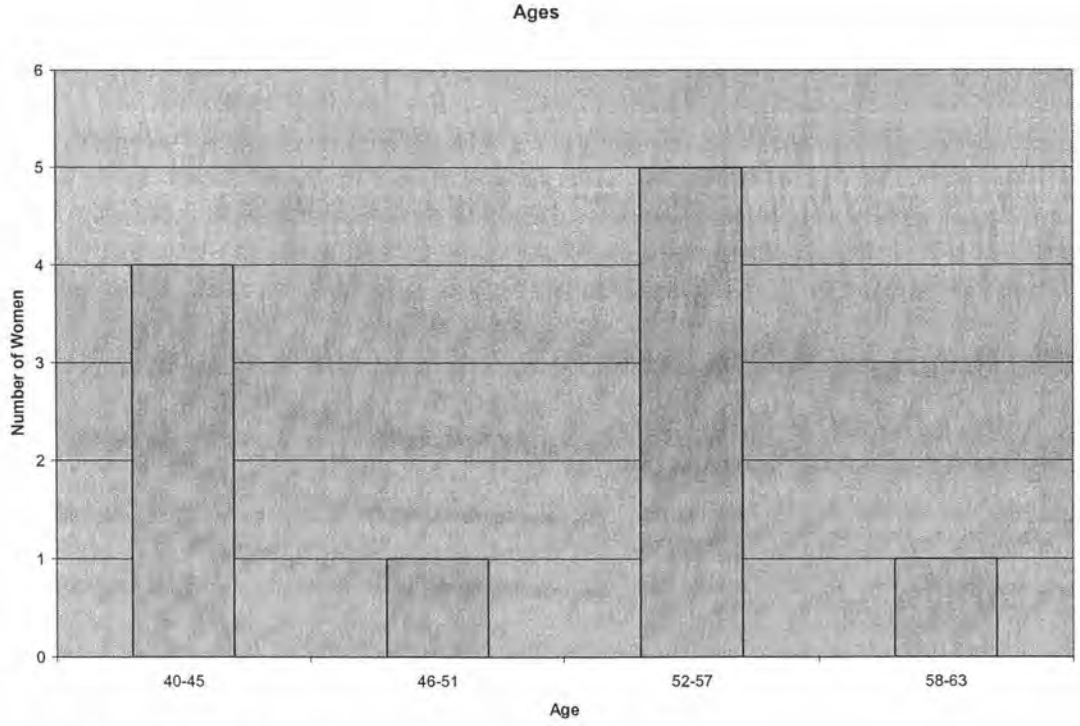

Figure 2. Informant Ages

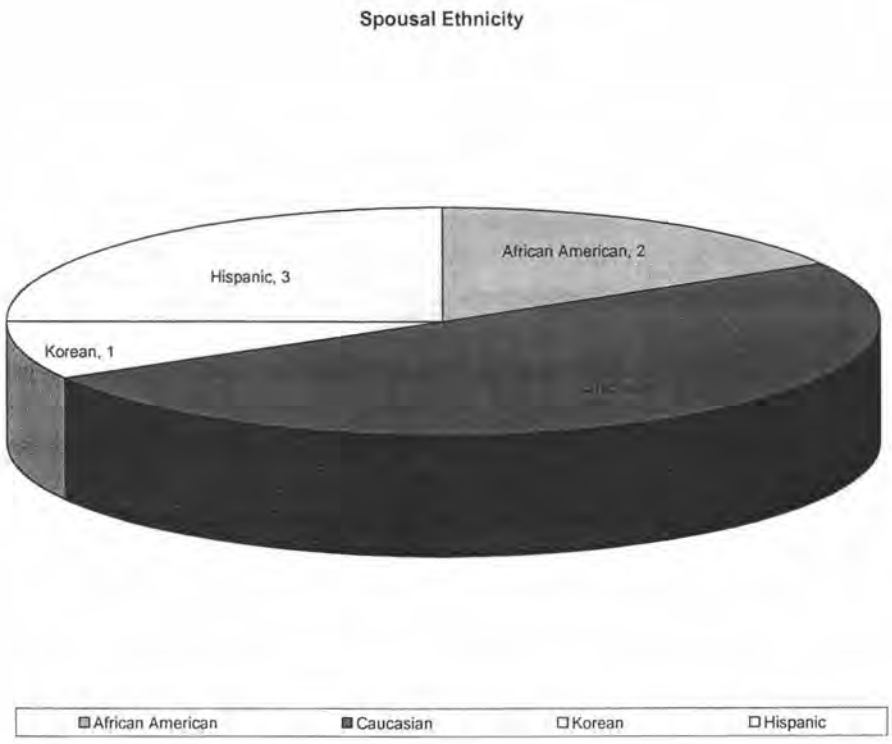

Figure 3. Spousal Ethnicity

Everyone had insurance, most often through the United States military, eliminating a barrier to access to Western medicine. All the informants had similar histories; raised in rural or small town settings. Most had no or little access to Western medicine as children.

Data Collection

Qualitative interviews were employed in data collection "to understand the world from the subjects' point of view, to unfold the meaning of peoples' experiences" (Sewell, 1997). "An interview, rather than a paper and pencil survey, is selected when interpersonal contact is important and when opportunities for follow up of interesting comments are desired" (Frechtling & Sharp, 1997). There are other

advantages to qualitative interviewing: subjects are able to describe what is important them in their own words and interviewers can ensure that questions are being interpreted correctly. This type of interviewing allowed me to follow up on answers that provoked more questions and to backtrack over questions I did not feel were fully answered.

I obtained informants through networking in the Korean -American community. The informants were unknown to me and often referred me to others. The interviews were scheduled in places of their choosing, often their own homes, to allow them to feel comfortable opening up to me about private matters. All interviews were conducted in person; I wanted to be able to connect with the women. Most of the interviews were not recorded, since the women preferred note taking to recording. The interviews lasted from one to three hours; I conducted only one formal interview per person. However, I made two follow-up phone calls to verify some information.

The interview process began with the informant signing a consent form, obtaining an alias and filling out a Subject Profile Questionnaire (Appendix A). I then conducted in depth interviews. "In depth interviews are characterized by extensive probing and open-ended questions" (Frechtling & Sharp, 1997). I prepared an interview guide (Appendix B), a list of topics and questions that I wanted to cover. The guide was useful in that it provided enough structure to assure that I addressed all important topics but allowed my informants to expand on what they felt were important topics.

Data Analysis

Data analysis is the process whereby all the data collected is compiled and examined.

> The most appropriate method of analysis for any given study will depend on the purpose of evaluation and the nature of the material, as well as the time and resources available for this part of the process. Some methods attempt to be more objective, while others depend more heavily on subjective judgments and insights of the researcher. (Sewell, 1997).

Once the interviews were conducted, "[q]ualitative content analysis and comparison of interview data were used to answer the research questions" (Ma, 1999). The interviews, a minimum of an hour long, "produced a large volume of material which [had to] be condensed [and] categorized" (Sewell, 1997) before they were of any use. Content analysis consists of transcribing and compiling data from each interview. I reviewed and coded by key words or phrases my interview data. The second phase was to bring together all the interviews and code them, pulling out repetitive ideas and words to learn what informants felt were most important. The coded interviews were "analyzed for emerging themes, trends, and patterns in the responses" (Ma, 1999).

Limiting Factors

The sample size was purposely small. I chose to interview only twelve women because my goal was to develop a qualitative, not quantitative study. The small number of informants allowed me to conduct in-depth interviews.

There were very few problems in conducting the interviews. I first feared, along with many of the informants, that language would be an obstacle. In reality, it

was not. Many of the women thought that their English would not be good enough to convey their thoughts. I tried to ease their concerns by telling them that my mother is Korean, that I understood some of the language, and that if necessary we could conduct some of the interview in Korean. It never came to that; I found that their English language skills were very good once the initial hesitancy wore off. There was occasional code switching (English to Korean) but nothing that was unfamiliar to me.

I worried about the informants opening up to me about something as private as health care. I tried to make them as comfortable as possible, allowing them to pick settings and times. For the most part, they always answered the first few questions quickly and succinctly. I had to draw out longer answers in the beginning, whether this was due to subject matter or not understanding what I wanted is unknown. I found that if I told stories of my childhood and personal experiences with traditional Korean medicine, the women's answers were more expansive.

CASE STUDIES

Mrs. T

Mrs. T was the second interview I conducted; I met her through her husband. He was an acquaintance who had heard about my research and thought his wife might be interested in participating. I provided him with information on my study and what type of questions I might ask. He took the information home. A few days later, he told me that his wife was interested and gave me their phone number. I called her and set up an interview in their new home.

The morning of the interview, I traveled to Mrs. T's home on the outskirts of Parkland, Washington close to Mount Rainier. She opened the front door as I got out of my car. It was a large single story home in a new subdivision. The foyer was lovely; following Korean tradition, I left my shoes there. Raised in a Korean-American home, I knew enough to wear nice socks.

I followed Mrs. T into her kitchen/family room; on the walls were pictures of her daughter and Korean calligraphy. She invited me to sit at the kitchen island. She went to turn off her television where she had been watching a Korean drama.

We made small talk about the new house; they had it custom built. "We didn't want an upstairs. Going up and down hurts my husband's knees." She offered a tour of the house; I accepted thinking that it would break the ice and make her more comfortable.

The home was decorated in an interesting mix of Korean and American décor. There were Korean figurines mixed in with ones collected in Europe, Asian style

planters and Korean wall hangings. We went outside to look at the landscaping. In the backyard, she had planted a small garden along the fence line. It contained mostly Korean vegetables: mixed lettuces (red leaf, green leaf), *boo choo* (chives), garlic, peppers, and a few tomatoes.

Back inside she offered me something to drink; I accepted a glass of ice water. We made ourselves comfortable at the kitchen island and began with the paperwork. After I explained the scope of the research, she signed the consent form, and I helped her fill out the Subject Profile Questionnaire (Appendix A).

Mrs. T, 44 years old, was born in Kwangju, South Korea. She was raised in a rural community, attending school only through junior high school. She met her American husband while he was stationed at a military base in South Korea. They have one child, a married daughter in her early 20s. Mrs. T is currently unemployed, but has worked in the past as a clerk in a convenience store and as a factory worker. Her husband retired from the Army more than ten years ago and currently works in a contract position at Fort Lewis. Since Mrs. T's husband is retired from the Army, they have Tricare, which is insurance provided by the military. They are able to receive emergency care and make doctors' visits at Madigan Army Medical Center, Fort Lewis

Mrs. T first came to the United States in 1981, but soon traveled back to South Korea, returning in 1986 when they were stationed at Fort Lewis. As her husband neared retirement they bought a house in the area. "I like it here; there are so many Korean people. I have everything I need: grocery stores, restaurants, video stores, and

church. My friends are here; a lot of them I know from other places or from when we lived on post."

After the questions on her history, we began to talk about health. I started out asking about her childhood, health care beliefs, and the types of medicine she used. I had to explain what I meant by health care beliefs, ideas about what made you ill and how to deal with those situations and the difference between traditional and western care. She said she had been raised with traditional beliefs. Her family used home remedies, OMDs and visited herbalists when ill.

Interviewer: "What type of home medicine did you use?"

Mrs. T: "We use homemade soup when sick. Sometimes tea. Ginseng is important."

Interviewer: "Did you go to doctors?"

Mrs. T: "Sometimes if it was bad, really sick, or hurt."

Interviewer: "Why only then?"

Mrs. T: "Too far and expensive. Better to take care of yourself if you can."

I asked her if she remembered any major illnesses from her childhood, or treatments that she thought were interesting. Nothing occurred to her, "I was never sick, only sometimes with cold." I asked if she knew about shamans, fortunes, and *mudangs*. She had no first hand experience.

I then started asking about how she views health care now and what she uses. "I see doctors when I have to, but if it's something small I make things at home. When I have cold or flu, I make tea and eat soups. But when my stomach hurts or I

have allergy problems I go to the doctor. If something happens, like I cut myself or break something I would go to emergency room" (Mrs. T).

Interviewer: "You have allergies?"

Mrs. T: "Sometimes bad; I'm allergic to bees. Are you allergic?"

Interviewer: "I have hay fever and am allergic to grass and kiwis."

Mrs. T: "I got stung by a bee one time; it was bad. It itched and I couldn't breathe."

Interviewer: "What happened?"

Mrs. T: "We went to the hospital, I had to get a shot and make appointment for allergy test. You have one?"

I nodded my head no.

Mrs. T: "They stick you with needles to test. I'm allergic to bees, dust, and pollen."

I then asked about acupuncture and herbs.

Interviewer: "Have you ever used acupuncture?"

Mrs. T: "Yes, I use it for my hands and when I got Bell's palsy; my face didn't move, like stroke."

Interviewer: "Why did you need it for your hands?"

Mrs. T: "I used to work sewing factory; my hands hurt. I went to the doctor, arthritis. They gave me medicine but it still hurts; sometimes I can't hold anything."

Interviewer: "Why did you decided to try acupuncture? Did you use it in Korea?"

Mrs. T: "No, I never did. I use it now because my hands hurt. My friend told me that it would make the pain go away. I went with her, it worked. I go whenever the pain comes. After that, I go for other things, my stomach sometimes. You ever use?"

Interviewer: "No, I've never been to an acupuncturist. The needles scare me."

Mrs. T: "It doesn't hurt. It feels good. All the hurt is gone and I can use my hands. You go to the doctor and he gives you pills, sometimes they don't work so good and you hurt. When your bones or muscle hurt not much you can do."

Interviewer: "What about the Bell's palsy? How did it help?"

Mrs. T: "My face couldn't move; the medicine didn't help. The acupuncture worked."

Interviewer: "When did this happen?"

Mrs. T: "Last year at Easter, after church, we went to IHOP for lunch. I feel something different couldn't move my face. We went to the emergency room; first, they thought it was allergy and gave me medicine. At 4:00, it felt funny again. The doctors give me more medicine and tell me it's Bell's palsy. I don't know what that is. They explained but I was still worried. What if I stay that way?"

Interviewer: "Why did you go to the acupuncturist?"

Mrs. T: "I wasn't getting better; I don't think the medicine works. I started to worry so I went to [acupuncturist] to see if he can do something. I asked anything you can do to help; I didn't know if it would work but I have to try."

After two trips to the acupuncturist, her symptoms were gone.

We started talking about family; I asked how her husband felt about traditional medicine, whether he participated, and if so to what extent.

Mrs. T: "[Husband] doesn't like the teas; he'll eat soup but not for medicine just dinner. So if he's sick we will have a Korean dinner; it's healthy."

Interviewer: "How does he feel about you making and using teas?"

Mrs. T: "If I am sick I drink tea; he doesn't care as long as I get better. When I don't feel better and complain, he asks if I think some other way is better. Medicine [is] medicine; you have to find something that works."

Interviewer: "Does your daughter drink the teas or use acupuncture?"

Mrs. T: "Not acupuncture. She doesn't like the tea but when she is sick she says, 'Mommy make me some tea'."

I began asking about factors that influenced her. Is cost an issue in deciding between traditional and biomedicine? "No, we have insurance, I don't really think about that. If someone needs hospital you go." In regards to the acupuncture, she said that the out of pocket money was reasonable, especially when it meant relief from pain. Was it hard for her to find the things she needed for her home remedies? "No, there are lots of Korean stores. Most things I use you use as food, and Korean stores like to sell medicine things. Other things you can get from Chinese medicine stores; sometimes they can be expensive."

At this point, we were wrapping up the interview. I collected my items and thanked her for her participation. She said it was interesting to talk about things she does not normally think about.

Mrs. R

Mrs. T introduced me to Mrs. R; they attend church together. Once I contacted Mrs. R, and set up an interview time, her husband provided me with directions to their home. They live in a modest home in Parkland, Washington.

When I rang the door bell, I was greeted by Mr. R. After introductions and removing my shoes I followed Mr. R into the living room, where Mrs. R was watching Korean television. The Rs had recently subscribed to Korean cable channels; previously Mrs. R rented Korean videos and watched Korean news on-line.

The Rs provided me with a quick tour of their home. Like other Korean-American homes I had been in, there was a mix of Korean and American décor. Korean wall hangings, vases, and pictures of the couple in Korea were displayed. We left Mr. R in his office and returned to the living room. Mrs. R offered me something to drink and a plate of fruit Asian pear and apple slices. Once settled on the couch, television still on, we began filling out consent forms and the subject profile.

Mrs. R, 44 years old, was born in small city, 30 minutes south of Busan, South Korea. She was raised in a Christian household. After finishing high school, Mrs. R moved to find work. In the 1980s she met and married her husband; they have no children.

Mr. R is of Hispanic descent. He was born in New Jersey and spent his childhood in Puerto Rico and New Jersey. He joined the military and eventually was stationed in South Korea where he met Mrs. R.

Mrs. R's first trip to the United States was in 1990. They traveled with the military for a few more years before being stationed in Fort Lewis, Washington. Mr. R retired from the Army and is working in a contract position on Fort Lewis. Currently, he is applying for contract positions in South Korea, Mr. R said "I love Korea; I've spent a lot of time there. [Mrs. R] would like to be near her family." Mrs. R has spent the majority of her life sewing; she works as a factory seamstress.

Mrs. R is insured through Tricare, health care insurance provided by the military. However, unlike Mrs. T, Mrs. R does not seek health care services at Madigan Army Medical Center, Fort Lewis; she is assigned to a civilian health care

group. She is able access emergency treatment at Madigan and may be referred to Madigan specialists by her primary care physician.

After all the profile questions we began to talk about health. I began by asking about her health care in Korea. As with other informants I had to explain what I meant by health care beliefs and the difference between traditional and western care.

Mrs. R: "Oh, we used traditional medicine, *hanyak,* but we went to the doctor when it was serious."

Interviewer: "What type of traditional medicine?"

Mrs. R.: "Plants, special drinks, soups, things you make at home."

Interviewer: "What kinds of plants and drinks?"

Mrs. R: "Plants like ginger and ginseng; they are good for you, herbs or roots you collect. I don't know all the names but there is lot. Oh and garlic is good; you eat that all the time in food. Fresh is better."

Interviewer: "And drinks?"

Mrs. R: "You can make tea with the ginseng or ginger. For cold sick you boil ginseng with orange skin and add honey. Just green tea is good. Plus to stay healthy you can drink rice water [sweetened fermented rice]."

Interviewer: "What about letting out bad blood?"

Mrs. R: "Bad Blood?"

Interviewer: "Whenever I had a stomach ache my mom would tie string on my finger and poke it with a needle."

Mrs. R: "Ahh, I know. If you have stomach problems or heartburn too, it can help."

Interviewer: "How does it work?"

Mrs. R: "Like you said, tie string around finger we use thumb and poke where fingernail starts. Blood comes out, and then you feel better. No blood you have to try again."

Interviewer: "Why does that work? What does it do?"

Mrs. R: "I'm not sure. I think it lets the bad out."

Mrs. R was unsure as to why this worked. So I made a note to ask other informants and moved on to questions about supernatural influences on health.

Interviewer: "Did you or your family ever use a shaman, *mansin* when someone was sick."

Mrs. R: "No, my family is Christian. We don't believe in that."

Interviewer: "Do you know how they work?"

Mrs. R: "Yes, it is old part of Korea. Some people think that when you get sick [it's] because of *kwisin* [ghosts] then you ask *mansin* for help."

Interviewer: "Was it common, used a lot?"

Mrs. R: "When I was a little girl my friend she [was] hurt. Her family called *mansin* they danced around her, very scary, my mother come get me."

I then asked about current health care use. She cited a preference for traditional home remedies for minor illnesses.

Interviewer: "Do you use western or traditional medicine now?"

Mrs. R: "Both. I like to use traditional but sometimes you have to go to the doctor."

Interviewer: "How do you decide which to use?"

Mrs. R: "When I'm sick if just something small…a cold, I make ginseng tea or eat hot soup. Like Americans who eat chicken noodle. If I don't know what is wrong or hurt too much I make a doctor appointment."

Interviewer: "Does you husband influence which you use? Makes you feel one is better or more important than the other?"

Mrs. R: "No. He doesn't say anything about my medicine. He worries if I don't get better, then maybe he says 'make an appointment'."

Interviewer: "Does he use Korean medicine?"

Mrs. R: "Not by his self [sic]. My husband don't like Korean medicine, but sometimes when he's sick, I make tea and tell him to drink it."

Interviewer: "Does he?"

Mrs. T: "Yes, he knows it will help."

Mr. R must have sensed we were talking about him, because at this point he entered the living room. The interview essentially ended there. I thanked them for their hospitality, put my shoes on and left.

Mrs. U

I had met Mrs. U before my research began. Once it was underway I thought she would make a good informant and approached her. She heartily agreed, intrigued by the idea of being a research subject. "You think I have interesting things to tell; maybe I do."

I arranged to interview Mrs. U in her own home in Lakewood. I arrived a little early; she was already steeping the brown rice and green tea. The dining room table held a fruit plate: Asian pears, apple, and persimmon slices. We ate fruit and chatted for a few minutes.

The dining room opened into the living room, and I could see that it was decorated in the same mix of Korean and American decor as other Korean homes I had visited. On the fireplace mantel were pictures of her children in Korean dresses, on the walls pictures of each family member when they were young, and a family

portrait. Next to the television were stacks of video tapes with Korean labels, and propped next to the wall a small black lacquered table.

I helped Mrs. U fill out the subject profile questionnaire, "Ask me the question; you write for me." I inferred from this statement that she did not feel comfortable with her English reading and writing skills.

Mrs. U, 52 years old, was born in Busan, South Korea. She spent much of her childhood in Busan and the surrounding countryside. She lived with her mother, older brother, and three sisters. Mrs. U dropped out of school around the 8th grade when she started working odd jobs and taking care of her younger sister. The family eventually moved to Daegu. From there Mrs. U went to Dong Du Chon where she met Mr. U at a friend's home. Mr. U at that time was stationed in South Korea. They later married and had 2 daughters. During the first 13 years of their marriage they traveled between military bases in the United States and abroad. They came to Fort Lewis, Washington in 1987 and decided to settle permanently in Lakewood, Washington. Mr. U retired from the Army about 13 years ago, and holds a contract position on Fort Lewis.

Mrs. U is no longer working. She spent most of her life working as a laborer, in factories and hotels. "I'm too tired to work; the diabetes made me sick. Anyways, my girls are all grown up; I can stay home." Mrs. U worked mainly to earn money for college tuitions and the extras the family wanted.

After all the profile questions were answered, I asked about forms of health care from her childhood.

Interviewer: "What types of medicine did you use as a child?"

Mrs. U: "Home medicine."

Interviewer: "No doctors?"

Mrs. U: "No money, you can't go to the hospital. Growing time was very poor, no money for doctors."

Interviewer: "What type of medicine did you use at home?"

Mrs. U: "All kinds."

Interviewer: "Plants?"

Mrs. U: "Mountain roots, plants. All different kinds, you picked yourself or go to....they sell here now the same way."

Interviewer: "How did you use them?"

Mrs. U: "Make teas, you cook and drink. If you have cut, you smash [the root] and put on top."

Interviewer: "What else?"

Mrs. U: "I don't know, hard to think of everything?"

Interviewer: "How about finger pokes or shamans...um...*mansin*?"

Mrs. U: "Oh, those kinds. If you eat and something gets stuck [pats her chest], then poking with needle is best medicine. Stomach problems good too."

Interviewer: "How does that work?"

Mrs. U: "Massage arm; tie string around the finger; sometimes you do more than one and poke. Wait for blood. When blood dark, almost black it's good."

Interviewer: "Why does that work?"

Mrs. U: "You know, peoples hands [shows me her palms] they have places that make things better...different spots [squeezes between the thumb and index finger] you push and things happen...you dong [defecate]."

She begins to laugh at her own joke. She seems to be associating the poking with acupressure or acupuncture. I decided to pursue another line of questioning.

Interviewer: "And *mansin*?"

Mrs. U: "Oh, fortunes. I don't remember using. I sometimes followed big people when they go to see. I just watch what going on."

Interviewer: "Do you believe in fortunes?"

Mrs. U: "Ohhhh, maybe 30%. I don't know it works. Maybe more for people to feel better in the mind. They believe so they get better."

Interviewer: "So you think it's more about believing? [Mrs. U nods] Anything else you remember about medicine in your childhood."

Mrs. U: "No, oh wait. When I was little, I think 7 years old, I was very sick. We don't know what was wrong...mmmm...something like chicken pox. My mother took me to the mountain to Buddha temple."

Interviewer: "What happened there?"

Mrs. U: "They gave me a new name. My name was bad."

Interviewer: "Bad?"

Mrs. U: "In Korean they check words, what they mean; sometimes they are not good."

Interviewer: "They can just give you a new name?"

Mrs. U: "They pray and find me a good name, one with a better future. They also said the in my future I can't live in Korea. [laughs] I get married and come here."

Interviewer: "What name do you use now?"

Mrs. U: "Buddha name."

Interviewer: "That's legal?"

Mrs. U: "Yeah. After the [Korean] war lots of paper missing so when we moved to city we needed papers. I make new papers with new name."

Interviewer: "How long were you at the temple?"

Mrs. U: "Long time, one year. My mom left me there. She come back couple times a month with rice and food for us. I wanted to go home; I cry and beg. She used to sneak…tell me to go nap or get something…I come back she's gone."

Interviewer: "It took you that long to get better? What did you do?"

Mrs. U: "Every morning I get up and go to the statues. Leave water and candles."

Interviewer: "Did you pray?"

Mrs. U: "Not that much; I was little. I played in the mountains. Fun except miss my family."

Interviewer: "What kind of medicine do you use now?"

Mrs. U: "Half, half. I use own medicine, 50% believe. Doctors for surgery or diabetes."

Interviewer: "What do you use at home? How'd you learn it?"

Mrs. U: "I make tea, ginseng and tangerine for colds. Ginger is good too. Sometimes I make soup, *kongnamul* [bean sprout]. I make spicy use jalapenos, open the nose, lets you breath and helps push out the cold. I learned by watching people, my mom and other people. Also, you ask."

Interviewer: "Have you ever used acupuncture, needles?"

Mrs. U: "No, I never get it. Scared it'll hurt. People don't even like shots, but a whole bunch a needles [shudders]. Plus not that sick."

Interviewer: "You mentioned diabetes, how long ago did you find out and how?"

Mrs. U: "I was tired all the time, nothing helped so I went to the hospital. The doctor say I have diabetes, I don't believe him."

Interviewer: "How do you take care of it?"

Mrs. U: "Medicine. First pills, then insulin, now pills. I tried different food but it didn't help."

I began asking about her family's influence on her health care decisions and participation.

Interviewer: "How does your family feel about Korean medicine?"

Mrs. U: "They ok with it. My husband and daughters always drink the tea when I make it. I know they don't like the taste but they do it. When girls were little it was harder. I have to watch, now if they sick at home they ask for it; if not here I tell them how to make for themselves."

Interviewer: "Do you think your husband would like it better if you used more Western medicine?"

Mrs. U: "No, he knows when important I go to the doctor. Because my diabetes I have appointments every year. I see eye doctor, woman doctor [gynecologist], and mammogram. My diabetes doctor every couple of months."

Interviewer: "How do you feel about those visits?"

Mrs. U: "They are important, but not comfortable. Nobody likes doctor visit."

Interviewer: "Do you go alone?"

Mrs. U: "No. Mostly I go with my husband or daughter. When no one can go I go by myself. Sometimes it's hard to understand."

Interviewer: "Have you ever gone to a Korean doctor?"

Mrs. U: "No. I go to Madigan. I think about sometimes but too much trouble."

We began wrapping up the interview. I went over a few questions I had about her answers. I found Mrs. U to be an interesting interview, very willing to share stories.

Mrs. E

A mutual acquaintance introduced me to Mrs. E. I explained my project to her and asked if she was interested in participating. She hesitated, and then said that she would first like to discuss it with her husband. I told her that would be fine and gave her my business card. That evening I received a phone call from her husband. Once I explained the research, he said that it would be up to Mrs. E. She agreed to an interview.

I met with Mrs. E at her home in Lakewood. It was lovely with an Asian garden in the back including a Koi pond. Once again, I followed the Korean tradition of removing my shoes before entering the home. She led me into the living room, where I met her husband. Mr. E was a retired Army officer currently working for Edward Jones, a financial advising company. Mrs. E worked on Fort Lewis as bagger at the commissary.

Mrs. E, 47, was born in Chong Yun, South Korea and grew up in a rural community. She left school after the 9th grade and eventually married a U.S. Army officer stationed in Korea. She came to the United States in 1976 but moved in and out of the country with her husbands work. They were stationed on Fort Lewis in the 1980s and returned when Mr. E was near retirement. They have two grown sons, both in the military.

The interview started with the consent form and subject profile, Mr. E left the room at this point. I began by asking the history questions.

Interviewer: "Where did you grow up? In the city or country?"

Mrs. E: "I was a country girl. Still country."

Interviewer: "What type of health care beliefs were you raised with? Traditional – like use of herbs, shamans, acupuncture, or more western doctors?"

Mrs. E: "More traditional, we took care of ourselves or within the village. No doctors."

Interviewer: "What type of medicine did you use?"

Mrs. E: "Not medicine but herbs, teas and stuff for fevers, colds and stuff. If I had a stomach ache, my mom would stick our fingers with a needle, three or four times. No doctors, not until I was 15. It was summer and I had pneumonia. We had to go the hospital in the city; they gave me an IV."

Interviewer: "What do you use now?"

Mrs. E: "I go to the doctor when I need to."

Interviewer: "Any home remedies, acupuncture?"

Mrs. E: "No home remedies; I don't like needles."

Interviewer: "Why don't you use traditional Korean medicine?"

Mrs. E: "I don't know Korean medicine; I didn't learn about it. I'm not a doctor; how would I know what works."

Interviewer: "You didn't learn when you were young?"

Mrs. E: "No, my mom, aunts, and *Halmoni* [grandmother] took care of me when I was sick. I know things like tea, and plants are good but not which ones or how to make things. I remember the medicine not where it came from. I don't trust them. Some older ladies use all kinds; too many... don't even know what works. They say I'm too American; I say I'm going to the hospital."

Interviewer: "So you don't use them and wouldn't consider using traditional remedies?"

Mrs. E: "Only in a life death situation, maybe if I were in the woods or something." (Laughs)

I did not ask about factors that influenced choice; it seemed clear to me that cost and availability were not issues. She did not see that there was a choice to be made; when you are ill you seek treatment from a doctor.

RESULTS

Culture largely influences health care choices because culture determines the ethnomedical beliefs that one holds. The Korean- American women interviewed in this study held ethnomedical beliefs derived from their socialization as children. The amount of influence of early socialization over choosing health care systems was determined by other contributing factors: acculturation, and barriers of culture, language, trust, and economics.

Health Care History: Beliefs and Utilization

Most of the informants were raised with similar traditional Korean health care beliefs. They had all used homeopathy, herbs, and other natural remedies at home as children. Mrs. R, Mrs. D, Mrs. H, Mrs. E, and Mrs. U all recounted stories of drawing out bad blood, especially for stomach ailments and heartburn. The process involves only a needle and thread. "You massage the arm then wrap string around your finger and poke by the tip or fingernail, just a little bit to let some blood out," explained Mrs. S. The desired result from the sticking is a dark bead of blood. No one was sure how and why it worked. When asked about the remedies used during their childhood, they often could not remember the reasoning behind it, just that it was done and often worked.

When asked about supernatural beliefs, cures involving shamans and monks, five of the informants had no personal knowledge. Mrs. R explained that she knew of shamans and their role in healing but had no first hand knowledge because she is a

Christian. However, she once had a friend who was healed, "I was a little girl and my friend she hurt [and] they danced around her, very scary, my mother come get me." Mrs. U on the other hand had sought help from Buddhist monks as a child. She had been very ill when her mother took her into the mountains to a temple; she lived among the monks for a while. When she returned home healthy, she had been renamed because her name was wrong and attracted illness.

Often it was not traditional health care beliefs that limited their use of Western medicine but rather barriers to access. Two barriers that stood out in the interviews were cost and availability. For informants who lived in rural settings access to biomedicine was limited. Mrs. T stated that there were no nearby hospitals or clinics. Unless it was an extreme emergency people never visited a doctor, either a western doctor or an Oriental Medical Doctor (OMD). Mrs. E had no contact with biomedical doctors until the age of 15 when she developed pneumonia.

Current Health Care Use

Currently, all informants have access to both Western medicine and alternative medicine. However, what is utilized varies from person to person. All confirm using Western medicine, and eleven out of twelve employs alternative medicine. Mrs. E. is the only one who relies solely on biomedicine. When asked about CAM she stated that she does not use them because she does not know what works and does not trust them. She would employ them "only in a life death situation, maybe if I were in the woods or something." This sharply contrasts with her childhood where home remedies made from herbs were used.

Eleven out of twelve informants preferred CAM, stating that given a choice between CAM and biomedicine they would choose CAM. Although CAM is preferred, western medicine is often employed out of convenience and lack of knowledge in the traditional healing arts. Mrs. J said, "I don't like to go to the hospital, but I have to if I can't fix myself." With the exception of acupuncturists, the women rarely visited Oriental medical doctors (OMDs). Much of the CAM used was done at home; treatments were rarely sought in clinic settings. Eleven of the twelve informants professed some knowledge of alternative home treatments for common ailments used at home, but nothing for serious health issues. Mrs. E stated that even though she grew up using alternative medicine she never learned the basics, and therefore never uses traditional therapies. "My Mom, aunts, *Halmoni* [grandmother] took care of me when I was sick, I know things like tea and plants are good but not which ones or how to make things. I remember the medicine not where it came from" (Mrs. E).

The common home therapies mentioned were soups, special foods, and teas. Mrs. U and Mrs. R had similar remedies for a cold: a tea made by boiling mandarin orange or tangerine rinds with ginseng and served with honey. My mother is also fond of a similar brew, often using bee pollen or powdered honey and occasionally ginger for added spiciness. A pot could last days with each brewing increasing the potency.

Mrs. U used traditional bean sprout soup (bean sprouts, garlic, and green onions) as a cold remedy by adding extra jalapenos or crushed red pepper. She said the extra spiciness "opens the nose, lets you breath and helps sweat push out the cold." Others talked about seaweed soup as being good for you. Mrs. C recalled that after

two hospital stays (lumpectomy, hysterectomy) friends prepared and gave her seaweed soup. According to Mrs. C "It is easy to make and very good for you, has garlic and the seaweed is always good. You can mix with rice." The soup is easily made, using dehydrated kelp. Soak it first, then sauté it in garlic and sesame seed oil after which water is added and the whole thing boiled. Adding it to rice gives it porridge-like consistency. It is not only used for illness but also on special occasions, especially birthdays to ensure a good new year.

Food was a common remedy and preventative measure for informants. Soups were eaten when ill "like Americans who eat chicken noodle" (Mrs. R). Fresh vegetables and herbs were a part of every meal to maintain health. Garlic was the most talked about; it not only helped in overcoming illness but also was used in illness prevention. "Garlic is good; you eat that all the time in food. Fresh is better" (Mrs. R). Informants see Korean food as healthy because of its lean meats and fresh vegetables. The food is less processed than Western food, and is often made from scratch in the home.

Acupuncture stood out as a popular pain relief treatment. Three out of twelve use it consistently; one occasionally seeks treatment for joint pain; and four have used it in the past for specific ailments. The acupuncturists were all Korean American practioners with clinics in the Korean Business District of Lakewood.

Mrs. T sees an acupuncturist frequently for joint pain and most recently for treatment of Bell's palsy. I asked if she had used acupuncture in Korea, because she had not mentioned it during our discussions of childhood health; she replied, "No, I never did. I use it now because my hands hurt." A few years ago, a friend had

recommended acupuncture to relieve joint pain in her hands. She said that the relief was so great that she was hooked on the treatments, "It feels really good. All the hurt is gone and I can use my hands." Mrs. T feels there is nothing biomedicine can do for joint pain and muscle aches, other than to prescribe medication, "You go to the doctor and he gives you pills, sometimes they don't work so good and you hurt." Her recent bout of Bell's palsy cemented the effectiveness of acupuncture as a medical treatment. First Mrs. T went to Madigan Army Hospital at Fort Lewis seeking treatment; she was given medication that did nothing to alleviate her symptoms. She decided to seek help from her acupuncturist, "I asked anything you can do to help. I didn't know if it would work but I have to try." After two trips to the acupuncturist, her symptoms were gone.

Ms. V. echoed this testimony for treatment of Bell's palsy with acupuncture. She, too, went to a hospital seeking treatment with no satisfactory outcome. However, unlike Mrs. T, Ms. V did not know about acupuncture and waited a month before seeking treatment on the advice of a friend. Mrs. V said, "I waited too long, I didn't know what to do. I meet a friend at the Asian market. She told me that her friend had the same problem and went to acupuncture. I had to try something."

When asked about possible influences on their choice of health care, all replied that type of illness was one influence. Mrs. K said that unless it was a major illness or an emergency she preferred to take care of it herself with herbs, soups, teas, etc. Informants with major health issues such as cancer (Mrs. C) or chronic illnesses like diabetes (Mrs. D) all sought biomedical help first. However, they did supplement it with CAM.

The role of CAM depended on the perceived effectiveness or effects of both the biomedical treatment and traditional medicine. CAM was often used at home, as an added measure to alleviate side affects of the biomedical treatment or to alleviate the need for treatment all together. Mrs. C, a breast cancer survivor, used teas to treat nausea associated with chemotherapy. Friends and family often brought over their own home remedies to ease her pain and help her regain strength. Mrs. D, a diabetic for 20 years, often tries new herbal remedies in hopes of finding a cure for her diabetes. "I drink teas and eat foods that help clean the blood. Garlic is really good for you, especially fresh."

Family influences were minimal; spouses did not unduly influence their choices. Rather, Mrs. T stated that her husband often told her to seek out CAM if she was not satisfied with biomedical treatments. "When I don't feel better and complain, he asks if I think some other way is better" (Mrs. T). Mrs. K said she prefers to treat illnesses at home first; her husband urges her to see a doctor only if the treatments do not seem to be working. "I go when nothing works and I have been sick too long" (Mrs. K).

Most spouses participated in CAM only minimally, often using home remedies at the urging of their wives. "My husband don't like Korean medicine but sometimes when he's sick I make tea and tell him to drink," explained Mrs. R. Mrs. S's husband had suffered from colon cancer; she often fed him herbal teas and concoctions from the local Chinese pharmacy to ease his symptoms and pain.

Informants with children stated that their children did not like herbal remedies but often used them at their mothers' behest. Mrs. U and Mrs. H both brew teas for

ailing children, regardless of their children's preference. Mrs. H's philosophy is "I make it; they drink it. It's good for them. They stop complaining when they feel better." Mrs. T explained that her daughter laughed at her herbal concoctions but when battling a major cold would come to her saying, "Mommy make me some tea." Mrs. U's daughters are adults now and use home remedies taught to them by their mother. The consensus was that it is harder to get children to drink the teas, most complaining about the taste. The teas are often harsh in flavor especially with added spiciness. The lingering taste of ginger after the initial sweetness of honey can be rather odd. The soups and porridges are more likely to be eaten and enjoyed purely as food, not medicine.

Friends did not influence the use of traditional medicine over biomedicine, but rather allowed for the use of both. Friends form a sharing network of information on traditional remedies. Informants who used CAM on a regular basis would learn about different remedies from friends either in passing or by direct questioning. If what they were using was not effective or if they were unsure about what to use they could always ask others. Often the women would relate their troubles to someone and be given alternatives to their healing methods. Ms. V, who had Bells palsy, told a friend that the biomedical treatments were ineffective. Her friend replied that she knew someone with the same condition who went to an acupuncturist and was helped, propelling Mrs. V to seek similar treatment.

DISCUSSION OF THEMES

As I analyzed the data, I began to recognize themes within each interview and among the twelve interviews. In this section, I identify the themes that emerged: *Acculturation, Barriers, and Medical Pluralism.* I also discuss related issues that give rise to the themes.

Acculturation

As I interviewed different women, I began to notice the different levels of acculturation. Most of the women interviewed had good language skills, although many expressed doubt at being able to get their ideas across to me in English. However, by the end of the interview, when the comfort level had increased, there were no troubles in communicating. It was not until I read the interviews again that I realized these women, with the exception of one, embodied the idea of biculturalism. They had accepted the American way of life, ideas, and behaviors without sacrificing their own cultural identity.

Mrs. E was the only one who differed. She is the best assimilated, in that she still uses the Korean language and certain cultural behaviors; however, she has embraced American ideologies, especially in the area of medicine. When asked about using traditional medicine Mrs. E stated, "I don't trust them. Some older ladies use all kinds; too many...don't know what works. They say I'm too American, I say I'm going to the hospital." Mrs. E chooses not to use traditional medicine, even though she had been raised with those beliefs. This lent support to my hypothesis that

acculturation affects choice of health care; acculturation leads to use of Western medicine. However, it is opposite of a study done in the Greater New York Metropolitan area, where 143 Korean Americans were surveyed on their use of CAM (Kim & Chan, 2004). This research found that acculturated subjects preferred alternative medicine, in support of a 1990 study by Jung Kim Miller, which also found that the most educated, and acculturated Korean Americans were more likely to use Korean health practitioners, OMDs, than less acculturated subjects (Kim & Chan, 2004). This differs from my sample who use traditional Korean medicine as CAM but not OMDs or any of the other CAM therapies being used in mainstream America i.e. prayer, massage, etc. The most acculturated informant, Mrs. E, did not participate in CAM. The other eleven informants, who were less acculturated, preferred CAM. Mrs. E thought herself to be American, both psychologically and behaviorally acculturated. I found that although she was behaviorally acculturated and testified adamantly to her "Americanness," she was not psychologically acculturated. Mrs. E speaks Korean, prefers Korean foods, decorates her home with Korean items, watches Korean television, and socializes mainly with other Korean Americans, lending credence to the idea that her claims to be American it is only through behavior and not ideology.

The more I read on CAM use, especially within ethnic communities, the more it seemed likely that a higher level of acculturation increased the use of alternative medicine. I had to rethink my ideas on acculturation. My sample, though acculturated behaviorally, was not psychologically. "When relating acculturation to health and other social issues, this psychological dimension has been of critical importance"

(Marino et al, 2000). This lack of psychological acculturation is evident in their fear of Western medicine.

Barriers

The traditional barriers to biomedical health care, economics and accessibility, were not issues in this study. All the women were insured and had access to Western medicine. The only time finances were mentioned was during my interview with Mrs. J. She had visited a Korean-American biomedical doctor. When asked about the experience, she said it was not worth the money. She had gone expecting the visit to be easier than seeing an American doctor but said that she did not feel that it was any better.

A major barrier expressed by ten informants was language, although that did not deter them from seeking biomedical treatment. The women worried that the American biomedical doctors did not understand them, and were certain that they did not understand all of what the doctors said. Only two of those women made office visits alone; the other eight always went with their husband or children. As an adult, I attend many doctors' appointments with my mother when my father is unavailable. My role during these appointments varies; most often, I just sit and listen. I relay details to my father, or explain hard to grasp concepts to my mother, most often after the visit. I try not to interfere in the actual appointment, preferring to be an observer, only stepping in when a communication problem arises.

Only one of the women, Mrs. J, sought out a Korean medical doctor because of the issue of language. She felt that the visit was not worth paying out of pocket, and

returned to her insurance-covered health care provider. Mrs. J said, "I thought it would be better, more comfortable. Not really, maybe doctor visits are always uncomfortable. I didn't like to spend the extra money when it's not different."

Distrust was a greater barrier to utilization of Western medicine. The women, except Mrs. E, were all wary of both the biomedical system and care providers. Whether it was due to lack of access in Korea or a belief in traditional medicine over biomedicine the outcome was the same - little or no contact with Western medicine. This lack of contact often manifested itself in distrust of doctors. The women were not likely to go to the hospital for anything other than acute illnesses or emergencies.

There are also barriers to traditional medicine, the greatest being lack of knowledge. Although, eleven of the informants preferred CAM, especially for minor ailments and injuries, it was not guaranteed that they would know what traditional medicine to use in all cases. None sought out OMDs, other than acupuncturists, and went to local markets in search of ingredients for traditional Korean remedies.

Medical Pluralism

"The typical pattern of use of available health care resources for immigrant populations in the United States is pluralistic, incorporating a variety of traditional healing resources as well as biomedical" (Ell & Castenada, 1998). I observed that to be true among my informants. Thus, the hypothesis of an either/or scenario did not come to fruition. Eleven informants felt obligated to neither medical system. Most of the women preferred traditional medicine, resorting to Western medicine only in cases of acute illnesses and emergencies. This preference was reflected in lack of

preventative care. The women were unwilling to see a biomedical doctor unless absolutely necessary, with fear as a motivating factor. Mrs. D never made regular visits to a doctor until her diagnosis of diabetes; even then, she only went for her required yearly exams. As she grew older, she became more fearful of her disease, "I'm worried I lose my eyes, what happens when I can't see? Who going to drive me, how can I work?" She now faithfully visits her "eye doctor" every year, along with her primary care provider. Similarly, Mrs. C was not fond of doctors and often skipped her yearly gynecological exams until she began experiencing abnormal bleeding and pain during menstruation. After a diagnosis of fibroids, "I was so scared, I thought it was cancer. But doctors say no, just fibroids," Mrs. C underwent a partial hysterectomy. After this scare, she kept all of her yearly appointments including mammograms. Her breast cancer was later detected in a mammogram.

These women embody the CAM ideology, in that alternative medicines are employed instead of or simultaneously with Western medicine to fit the needs of the patient (NCCAM 2002, & Kim, 2004). They are taking from both medical systems to create one that is unique to them and their needs.

CONCLUSION

In this study, I have tried to answer the questions, "What type of health care options do Korean American women use and why?" I have described the options available, traditional care and Western, and the factors that influence their choices. I have also looked into the complementary use of alternative medicine.

This research contributes to the discipline of medical anthropology by adding to the knowledge base. It provides information on Korean American women's ethnomedical beliefs that influence the health care decision-making process and barriers to health care. The present study is unique in that it looks at an established ethnic community where accessibility to alternative medicines is not limited.

Summary

While reviewing the data, and the themes that it produced, I realized that choosing a health care option is not an all or nothing decision. Many Korean American women choose to employ complementary and alternative medicines. Often the choice depends on the ailment and the perceived effectiveness of the medical therapy. Barriers such as ethnomedical beliefs do exist but are not the overriding factors I once thought them to be. They influence the choice depending on the severity of the illness. Muscle aches are not life threatening and often treated with alternative medicines. Why engage in an uncomfortable trip to the doctor's office when an acupuncturist can relieve the same ache? For serious ailments biomedicine is the choice, although that does not mean a complementary medicine is not used in

conjunction with the biomedical treatment. I realized that ethnomedical beliefs heavily influenced the trust placed in biomedicine for minor ailments and prevention but not necessarily for acute illnesses.

Recommendations

I recommend that clinics and hospitals provide a more holistic approach in their treatments. CAM deals with the human being as a whole, tending not only to the symptoms of ailments but looking for both the physical and emotional causes. "Several types of CAM programs are being developed by health systems and medical centers throughout the country" (Spiegel et al, 1998). A possible way to accomplish this is through integrative medicine clinics, the combining of "mainstream medical therapies and CAM therapies for which there is some high quality scientific evidence of safety and effectiveness" (NCCAM, 2004). "Physicians, usually in primary care, incorporate complementary practices and practicians into a single setting or related settings" (Spiegel et al, 1998).A clinic where complementary medicine is practiced is more likely to draw in people who are reluctant to seek out biomedicine.

Removing cultural barriers is an obvious solution to lack of utilization of biomedical health care, however not an easy task. Intermediaries are helpful but raise the issue of privacy and comfort; having another person, family, or stranger, involved in a doctor's visit can be embarrassing, but should not be a deterrent. Hiring more Korean-American biomedical doctors would alleviate many of the barriers, if they are fluent in the Korean language and culturally aware; often second or third generation Korean-Americans are not well versed in either Korean language or culture. Western

doctors in Korean communities should learn more about Korean culture and CAM.

Korean-American communities should be educated in preventative care. There needs to be a community outreach program in place that would educate the family as a whole on health care. Families are a key to overcoming resistance to preventative care; they provide the incentive to maintain health and are often in a position of influence. An outreach program may not reach the whole community, but those who learn from it can education and influence others.

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APPENDICES

APPENDIX A

SUBJECT PROFILE QUESTIONNAIRE

Name (or alias):_____

Age: _____

Birthplace: _____

Length of time in the United States: _____

Marital Status: _____

Spouse's Ethnicity: _____

Number of Children: _____

Educational Level: _____

Occupation: _____

Spouse's Occupation: _____

Average Annual Household Income (circle one):

A) under $25,000
B) $25,000-$35,000
C) $35,000-$50,000
D) $50,000-$70,000
E) over $70,000

Do you have health insurance? _____

If yes, which (circle one)

A) Private health insurance
B) Employer insurance
C) Military
D) Medicare
E) Other:_____

Have you ever used (circle all that apply):

A) Western Medicine
B) Acupuncture
C) Herbs
D) Massage
E) Homeopathy
F) Naturopathy

APPENDIX B

Possible Interview Questions

History

1. Where did you grow up? Rural area? City?

2. When did you come to the states? Why?

3. Marriage?

4. Employment? Spouse?

Health

1. What type of health care beliefs were you raised with? Western medicine? Naturopathy? Supernatural?

2. What type of health care did you use? Exclusively? Multiple? Reasons?

3. What type of care do you seek now? Why?

4. What factors influence you? Cost? Availability? Illness? Symptoms? Spouse?

5. Preference?