



# Health and Health Care of Japanese American Older Adults

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Course Director and Editor in Chief: **VJ Periyakoil, MD** Stanford University School of Medicine

✉ [periyakoil@stanford.edu](mailto:periyakoil@stanford.edu) ☎ 650-493-5000 x66209 <http://geriatrics.stanford.edu>

Authors: **Nancy Hikoyeda, DrPH, MPH** Stanford Geriatric Education Center

**Marianne KG Tanabe, MD** VA Pacific Islands Health Care Systems



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## DESCRIPTION

This module reviews the demographics, history, health risks, traditional health views, and end-of-life issues of Japanese American elders. Thoughts to consider in assessment and treatment are also discussed.

### Course Director and Editor in Chief of the Ethnogeriatrics Curriculum and Training

**VJ Periyakoil, MD**

Stanford University School of Medicine

### Authors

**Nancy Hikoyeda, DrPH, MPH**

Ethnogeriatric Specialist,

Stanford Geriatric Education Center

**Marianne KG Tanabe, MD**

VA Pacific Islands Health Care Systems

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## MODULE CHARACTERISTICS



**Time to Complete:** 1 hr, 20 mins



**Intended Audience:** Doctors, Nurses, Social Workers, Psychologists, Chaplains, Pharmacists, OT, PT, MT, MFT and all other clinicians caring for older adults.



**Peer-Reviewed:** Yes

## LEARNING OBJECTIVES

After completion of this module, learners will be able to perform the following in relation to Japanese American elderly:



1. Describe briefly the history of Japanese immigration to the US.
2. Describe why an understanding of the degree of acculturation of the Japanese elder and his or her family is important.
3. Identify a cultural belief that may have an impact on long-term care placement decisions in a traditional Japanese-American family.
4. Discuss the impact of Buddhism and other religious beliefs on end of life care.
5. Discuss three general communication approaches to consider when working with a Japanese-American elder.

## INTRODUCTION AND OVERVIEW

### Demographics

In the 2005 American Community Survey by the US Census Bureau,

For more information on demographics, see [www.census.gov](http://www.census.gov)



- 1,204,205 residents of the US, 0.4% of the total US population, identified their “race” as Japanese alone or in combination.
- Of these, 192,256 or 16% were 65 years of age or older, and 71% of these residents were born in the United States.

In the 2000 census, **California, Hawaii, Washington, and New York had the largest populations of Japanese Americans.**

With respect to language, 63.6% spoke English only, and 36.4% spoke a language(s) other than English.

The 2000 census also revealed that

- 20% of those over 65 were foreign-born;
- 5.6% lived in poverty;
- 11.3% had less than nine years of education while 15.2% had a bachelor’s degree;
- 19% considered themselves linguistically isolated.

It is noteworthy that there is considerable diversity within the Japanese American population. Differences may be based on such factors as generation, geography (Hawaii vs. mainland residents), education, income, and degree of acculturation and assimilation.

### Terminology

Early immigration to the United States from Japan occurred in the late 1800s to early 1900s although the earliest immigrants arrived in the 1860s. Due to the importance of intergenerational relationships, each generation is identified by a distinct Japanese term, please see the Table below:

Japanese Generational Terms	
Japanese Term	Description
1. <i>Issei</i>	Refers to the first generation early pioneers who were born in Japan
2. <i>Nisei</i>	Are their first generation offspring born in the U.S
3. <i>Sansei</i>	Are the children of the Nisei
4. <i>Yonsei</i>	Are the fourth generation children of the Sansei and are the fifth generation
5. <i>Kibei</i>	Refers to Japanese Americans who were born in the US, sent to Japan for their education and then returned to the US
6. <i>Shin Issei</i>	Refers to the newcomers, primarily Japanese businessmen and their families, including their parents

It should be noted that for any given individual, the generational terms are not related to age. A Japanese American elder could be of any generation, and currently most are Nisei and Sansei. A more recent contemporary term, Nikkei, has been used to refer to Japanese Americans as a whole.

**(INTRODUCTION AND OVERVIEW CONT'D)**

Japanese Americans are the most acculturated and assimilated of the Asian subgroups due to their length of time in the US and the decline in immigration rates from Japan. Japanese Americans also have the highest socioeconomic status among other Asian ethnic groups as well as the smallest average household (McCracken et al., 2007). The out-marriage rate now exceeds 50% (Kitano, 1993).

**Historical Experiences of the Cohort**

The reasons for immigration to the United States from Japan in the late 1800s and early 1900s were varied but occurred during Japan's transition to a modern economy with its accompanying upheaval. Most of the Japanese immigrated for work and economic opportunities.

The Hawaiian sugar industry boom brought many Japanese to Hawaii and in 1910; Hawaii had four times as many Japanese as the US mainland. Between 1882 and 1908, 150,000 Japanese moved to Hawaii and about 30,000 to California. On the mainland, economic opportunities were primarily found in domestic and unskilled labor employment such as in the logging industry, mining, or railroads. During this time, the Issei started families and by 1930, native-born Japanese Americans (Nisei) exceeded those born in Japan by 80%. Many worked as contract laborers and as the opportunity arose, the Japanese Americans acquired land or established businesses.

Mainland Japanese Americans, in particular due to their minority status, encountered institutional racism and discrimination. This prejudice came in many forms such as the Naturalization Act which denied citizenship to Asians (1870-1952); segregated schools (San Francisco, 1906); antimiscegenation laws which forbid intermarriage; the Gentlemen's Agreement which limited immigration of Japanese laborers (1908); and the California Alien Land Law which prohibited non-citizens from owning land (1913). In 1942 during World War II, Executive Order No. 9066 ordered the internment of 120,000 Japanese Americans on the US West Coast into inland relocation camps, which had

For more information on historical experiences influencing Japanese American elders, see **Appendix A— Significant Dates and Periods in Immigration and History**.

a devastating effect on families and their economic circumstances. Businesses built over a lifetime and personal possessions had to be sold or liquidated within a few days resulting in substantial monetary losses. However, in spite of these great setbacks, many Nisei later advanced economically by pursuing an education and careers in white-collar professions.

A second wave of immigration occurred after World War II when Japanese-born wives of US servicemen entered the United States (sometimes referred to as “war brides”). It is estimated that over 30,000 Japanese women were in this cohort, however, very little is known about them.

**Language**

Japanese is a complex language with inherent honorifics conferring degrees of politeness used to address others of different social status or hierarchical relationships.

The written Japanese language uses three scripts:

- *kanji*
- *katakana*
- *hiragana*

Although the spoken Japanese language is different from the Chinese language, between the fourth and fifth century, the Japanese borrowed written Chinese characters or *kanji* and further adapted them for their use. The spoken Japanese language is syllabic.

Just as in the United States, regional accents exist as well as some dialects. The Okinawan native dialect, for example, is incomprehensible to mainstream Japanese, and within the immigrant Japanese community, immigrants from the island of Okinawa often faced discrimination from immigrants from mainland Japan.

## (INTRODUCTION AND OVERVIEW CONT'D)

Of occasional utility with respect to the Japanese language is that some Korean and Chinese elders speak the language fluently secondary to their acquisition during the time of Japanese governance of areas such as Korea, Taiwan and parts of China pre-World War II.

Among the younger generations of Japanese Americans, use or knowledge of the Japanese language is rare.

## Religion

In traditional Japan, two primary religions—Shintoism and Buddhism, and one code of ethics—Confucianism—have influenced the Japanese way of life and view of the world.

### Shintoism

Shintoism is the indigenous religion of Japan based on the appreciation of nature and the belief in “kami” or spirit gods existing in nature—mountains, trees, rocks, etc. It emphasizes cleanliness and purity.

### Buddhism

Buddhism, which began in India, was introduced to Japan by way of Korea in 500 to 600 AD. Prince Shotoku of Japan converted to Buddhism in the 7th century and Buddhism subsequently flourished.

Japanese Buddhism emphasizes the interdependence of all living things and an acceptance of all aspects of life including suffering and the cycle of birth and death.

During the Japanese immigration to the US, most of the Japanese practiced both religions to some degree. Thus birth and marriage rites were Shinto rituals and end of life beliefs and funerals were often Buddhist, yielding the saying that a Japanese is born Shinto but dies Buddhist.

### Confucianism

Confucianism was also important in influencing the Japanese culture and way of life. Confucianism is really a code of ethics with origins in China placing importance on family values and social order. Thus, inherent in the family is the importance of taking care of one’s parents, or filial piety. In Japan today, about 1% of the population is Christian. Overall, Japanese-American elders are diverse with respect to religious preferences. They may be followers of Christian, Buddhist, or other religious traditions.

## PATTERNS OF HEALTH RISK

The Honolulu Heart Program studies began in 1965 with a cohort of 8006 Japanese American men and continue to this day. Much of what we know about the health and aging of Japanese American men is based on the several hundred publications that have come out of these studies.

The Seattle Kame Project, an eleven year prospective cohort study on aging, cognition, and dementia in Japanese American older men and women in Seattle and King County, Washington, started in 1991, has also been instrumental in increasing the scope of knowledge about Japanese American elders.

Studies, in general, have tended to group Japanese Americans with other Asian Americans thereby rendering it difficult to draw conclusions specific to the Japanese Americans.

### Cardiovascular Disease and Stroke

Japanese Americans have been found to have much lower risks for cardiovascular diseases than their white American counterparts. The traditional Japanese diet is rich in fish and soy both of which have been found to decrease risks for cardiovascular diseases (Yamori et al., 2006). With increasing adaptation to the Western diet, which includes high meat and less roughage, however, there appears to be an increase in coronary artery disease.

A higher body mass index is also a risk factor for coronary heart disease. In the INTERLIPID study, a collaborative study of Japanese American men and women in Hawaii and their ethnic counterparts in Japan, a higher body mass index was noted in the Japanese American which raises the consideration of a more sedentary lifestyle for those living in the United States (Ueshima et al., 2003). Additionally, natural lifestyle caloric restriction, as opposed to overeating, may have played a role in the subgroup of Japanese American men of the Honolulu Heart Program who were examined for all-cause mortality and caloric

restriction. Caloric restriction was associated with reduced risk for all-cause mortality up to the point of 50% of the group mean, after which caloric restriction was associated with a detrimental risk (Wilcox et al., 2004).

CHD incidence and prevalence was compared in the Hispanic and NHW populations of San Luis Valley in rural, southern Colorado (Rewers, Shetterly, Hoag, Baxter, Marshall, & Hamman, 1993). This is a unique sub-group of Hispanics, calling themselves Spanish-Americans, that are descendants of 25,000 Spaniards banished from Spain during the Spanish Inquisition (late 1500s and early 1600s) to look for gold in northern New Mexico and southern Colorado.

The Honolulu Heart Study cohort was found to have a lower risk for strokes than men in Japan. The incidence of strokes also declined during the first two decades since the inception of the studies. This was felt to be possibly related to a decline in blood pressure and smoking. However, there is a higher risk of hemorrhagic stroke among Japanese American men compared to Caucasian men. One theory is that this may be related to the lower fibrinogen levels (Iso et al., 1989). In a more recent study of Asian American ethnic subgroups, Japanese Americans had a high risk of hemorrhagic strokes (Klatsky et al., 2005).

### Cancer

Currently, there is no national unified cancer database for incidence, mortality, and risk factors for Japanese Americans as most previous data were combined with that of other Asian Americans and Pacific Islanders. Present information is derived from published studies, the California Cancer Registry, and the Surveillance, Epidemiology, and End Results (SEER) program among others. With the adaptation to Western diets and a trend to be overweight as elucidated by the California Health Interview Survey, a telephone survey of health risk behaviors, colorectal cancer in Japanese Americans appears to be increasing.

### (PATTERNS OF HEALTH RISK CONT'D)

The 2000 to 2002 California Cancer Registry data showed the incidence of colorectal cancer to be higher than that of other Asian ethnic groups and non Hispanic Whites. The colorectal cancer mortality in Japanese American men was also noted to be higher than that of other Asian ethnic groups and non Hispanic Whites. With the exception of fecal occult blood testing, colorectal cancer screening patterns in the Japanese Americans were similar to that of non Hispanic Whites (McCracken et al., 2007).

Japanese Americans also have a high incidence of stomach cancer. In the California Cancer Registry data of 2000 to 2002, the incidence was higher than non Hispanic Whites, Filipinos and Chinese. The consumption of nitrite/nitrate rich and salty foods such as cured meats is thought to increase the risk for this cancer. One Hawaii study of Japanese Americans found an inverse association between fresh fruits and raw vegetable consumption and the risk of stomach cancer. However, no significant relationship was found between stomach cancer incidence and intake of processed meats. (Galantis et al., 1998)

The incidence of breast cancer in the California Cancer Registry of 2000 to 2002 was lower than that of non Hispanic Whites but was higher than that of other Asian ethnic groups. Acculturation and Western lifestyle risks such as late childbearing, fewer children, and hormonal use, which are breast cancer risks, are thought to have influenced the high incidence of breast cancer in the Japanese Americans. One study using the National Health Interview Survey found that the percentage of Japanese American women who never had a mammogram and who never had a Papanicolaou (Pap) screening test did not differ much from that of White women (Kagawa-Singer et al., 2000). Of interest, uterine cancer incidence but not cervical cancer was also high in Japanese Americans compared to other Asian ethnic groups (Kwong et al., 2005; Kagawa-Singer et al., 2000).

The incidence of prostate cancer for Japanese Americans was second highest next to Filipino Americans when

compared with other Asian ethnic groups but lower compared to non Hispanic Whites (McCracken, 2007). The incidence of prostate cancer in Japan compared to that of Japanese Americans in the United States is low. Studies into dietary influences are ongoing (Marks et al., 2008; Masumori et al., 2008).

### Diabetes

One disease that has a higher prevalence among Japanese Americans than their counterparts in either Japan or Whites in the US is Type II Diabetes. In the Seattle studies, 20% of Nisei men between 45 and 74 were found to have diabetes, half of which were not diagnosed, and 56% had abnormal glucose tolerance. Those rates were over twice as high as comparable samples of men in the US population in general (Fujimoto et al., 1987). Those with diabetes were found to consume more fat and animal protein than their non-diabetic Nisei counterparts, although both groups consumed the same amount of calories.

A study of Japanese Americans in King County, Washington reported that those with normal fasting blood sugars but impaired glucose tolerance or diabetic glucose tolerance had cardiovascular risk factors that were worse than those with normal glucose tolerance (Liao et al., 2001). It has been proposed that the Japanese may be genetically predisposed for a weaker insulin secretion response to a glucose load thus rendering them at increased risk for diabetes with a westernized diet low in fish and soy products (Nakanishi et al., 2004).

### Dementia

With the general longevity of Japanese Americans, the prevalence of dementia, both diagnosed and undiagnosed, appear to be increasing with age and assimilation. Among some Japanese, there may be a reluctance to report alterations in mental status or acknowledge changes in behavior.

In one Honolulu-Asia Aging Study (HAAS), the prevalence of vascular dementia among Japanese-



**(PATTERNS OF HEALTH RISK CONT'D)**

American men appeared to be higher than that of White men. The prevalence of Alzheimer's disease, however, was the same except when compared to their counterparts in Japan, in which case residing in Japan conferred a lower prevalence (White et al., 1996). Among Japanese American men in Hawaii, age 71 and older, the prevalence of Alzheimer's disease was 5.4% and 4.2% for vascular dementia (Yeo et al., 2006). For the population of Japanese Americans age 65+ in King County, Washington, the prevalence was 4.46% for Alzheimer's and 1.85% for vascular dementia (Yeo et al., 2006).

Several HAAS studies have examined relationships between such factors such as diabetes, hypertension, cigarette smoking, body weight, serum cholesterol, social engagement, physical activity and function, midlife dietary intake of antioxidants, and midlife

C-reactive protein among many others with dementia (Curb et al., 1999; Pelia et al., 2006; Tyas et al., 2003; Stewart et al., 2005; Stearet et al., 2007; Saczynski et al., 2006; Taaffe et al., 2008; Laurin et al., 2004; Laurin et al., 2008). The Kame Project of Seattle, Washington has also examined factors such as alcohol and consumption of fruit and vegetable juices with cognitive changes (Bond et al., 2005; Dai et al., 2006).

**Survival**

Older Japanese Americans are, in general, long lived. A study using data from the Honolulu Heart Program/ Honolulu Asia-Aging Study showed that of the 5820 Japanese men that met inclusion criteria for the study, 42% survived to 85 years or older (Wilcox et al., 2007). Whether or not general longevity continues with future generations will be of interest.

## CULTURALLY APPROPRIATE GERIATRIC CARE: FUND OF KNOWLEDGE

### Traditional Health Beliefs

#### Kampo

Traditional Japanese remedies referred to as Kampo may be sought or used in conjunction with ongoing medical treatment. Kampo uses herbal medicine, which originated in traditional Chinese medicine around the 7th century. The herbs used are generally in powdered or granular form.

#### Moxibustion

In addition to herbs, moxibustion might also be utilized. In moxibustion, dried mugwort is burned on specialized points of the skin to stimulate life energy and blood flow. **It should be noted that the resultant bruising may be mistaken for elder abuse.**

#### Shiatsu

Shiatsu is a form of hands on message therapy concentrating on pressure points on the body. Shiatsu aims to redirect or reestablish energy flow in the body to restore balance.

#### Acupuncture

Acupuncture is another form of health practice that may be sought by Japanese American elders. Tiny needles are inserted into various parts of the body to rid the body of toxins and relieve pain.

Many Japanese American elders may combine traditional and Western therapies and treatments, making it necessary to ask a patient what they might already be doing for their medical conditions.

## CULTURALLY APPROPRIATE GERIATRIC CARE: ASSESSMENT

### Important Cultural Issues

Confucianism was an important influence on early Japanese culture and way of life. Confucianism, which originated in China, provided a code of ethics that emphasized the importance of family and social order. The following Japanese terms reflect the Meiji era values of traditional Japan.

#### Filial Piety

The Japanese concept of filial piety (*oyakoko*) stems from Confucianism. Confucian philosophy arrived in Japan in the seventh century and has been passed from generation to generation. In Confucianism, filial piety was extremely important. Children were expected to obey and respect their parents, bring honor to their family by being successful in life, and support and care for their parents in old age.

“...as the Confucian influence of filial piety fades with increasing cultural integration and assimilation, trends in nursing home statistics are expected to change.”

Additionally, for many Japanese immigrants, “*kodomo no tame ni*” or “for the sake of the children” became the motto by which parents made sacrifices in order to provide a better standard of life for their children. Thus, parents may expect, and children should feel obligated to support and care for their parents. For example, even though adult children may find it difficult to provide adequate care for their parents, guilt results if parents are placed in an institutional long-term care facility.

#### IMPORTANT TERMS

**Haji**—shame

**Hazukashii**—embarrassed

**Kodomo no tame ni**—for the sake of the children

In the past, Japanese Americans were less likely to place their elders in nursing homes when compared to their non-Asian American counterparts. However, as the Confucian influence of filial piety fades with increasing cultural integration and assimilation, trends in nursing home statistics are expected to change.

Japanese community organizations in three West Coast cities (Seattle, Sacramento, and Los Angeles) have built Japanese-specific long-term care facilities (assisted living and/or skilled nursing homes), although non-Japanese are also welcome. In Seattle, a study of over 1100 independent older Japanese Americans explored their preference for use of nursing homes. A little over half said they would use a nursing home if they had dementia, but that percentage was reduced by 60% if the Japanese nursing home, Keiro, was not available (McCormick, et al., 1995).

#### Mental Illnesses

There is a general stigma associated with mental illnesses among Asian Americans in general. Thus, Japanese American patients or their families may not seek psychiatric care or psychological counseling. In traditional Japanese society, individual family members are taught to avoid bringing shame (*haji*) or embarrassment (*hazukashii*) upon the family name. For example, during the time of arranged marriages, having a family member with mental illness could easily have deterred the marriage.

**(ASSESSMENT CONT'D)****Home Care Etiquette**

For healthcare professionals conducting home visits, it would be important to be respectful, polite, and courteous and to gain the trust of the Japanese American client.

**Examples of Respectful Behavior**

**Entering a Home.** It may be necessary to remove the shoes at the door prior to entering the home.

**Offering of Food.** In some very traditional Japanese households, if food is offered in gratitude for services and chopsticks are placed on the table, **it would be important to be aware of two faux pas:**

1. To not allow chopsticks anchored in food to stick straight up into the air when not holding them. This practice is associated with funerary customs in Japan, and traditional families will find it offensive.
2. The other practice is to not pass food from chopstick to chopstick as this practice is also associated with funerary customs in Japan.

If a questionable situation occurs, it is appropriate to ask the client/patient what the correct or most comfortable behavior/action should be.

**Eliciting the Patient's Perspective****Level of Acculturation**

The initial approach with respect to assessment of the Japanese Americans should include an understanding of the degree to which the elder and his or her family still maintain traditional Japanese values, views and beliefs, i.e., their degree of acculturation.

There is a marked variability in the level of acculturation in the Japanese-American community. Depending on the number of generations removed from the original immigrants and the degree to which the traditional values have been maintained in the family, the elder and his or her family may be more "Americanized",

“Among Asian Americans, the proportion of United States-born Japanese American elders is highest among Japanese Americans.”

having adopted the Western culture and outlook on life.

Values such as individualism, autonomy, and frankness in expression of thoughts may then become the norm, whereas these values would have not been readily observed in traditional families where group or family honor precedes individualism and autonomy. As in many immigrant families, many individuals of the third generation do not speak the native language of their grandparents and are culturally quite Westernized.

Among Asian Americans, the proportion of United States born Japanese American elders is highest among Japanese Americans. Of note, however, is that there may also be different levels of acculturation within the same generation of a family. For example, an adult child may marry a native Japanese person who holds onto traditional values and customs, an acculturated Japanese American, or someone outside the ethnic group.

**General Approach**

Courtesy, respect, and thoughtfulness are particularly valued in the Japanese culture and these would be appreciated during an assessment.

It would be preferable, and more respectful, to call an elder by his or her last name with the appropriate suffix, rather than to call the elder by his or her first name.

A traditional Japanese elder may not volunteer information, and thus respectful inquiry might be helpful to elicit pertinent clinical information.

Some traditional Japanese elders may feel that pain should be endured because stoicism is highly valued. They must *gaman* or bear it and not complain. This may

### (ASSESSMENT CONT'D)

be rooted to some extent in Buddhism that teaches that life is full of suffering. Hardship and suffering may also be considered to build character.

In family meetings with a Japanese family, keep in mind the level of acculturation of different family members. More traditional family members might find open disagreements of care plans and goals unsettling. They may find this akin to bringing shame on the family name or losing “face” especially as this may reveal discord in the family. Traditional Japanese family members most likely will not voice their opinions, if they disagree.

If the more acculturated family members speak out and the more traditional family members do not say much, there is a chance that the meeting, might appear to have gone well in the eyes of the casual observer, when in actuality, it has not.

An empathetic, blameless, problem solving approach, especially in counseling situations, would work better than a direct, blunt approach, as the traditional Japanese, in general, are indirect and non-confrontational.

Another behavior that may be observed is that of *enryo*. An elder may hesitate or refuse information or assistance initially, even if needed or desired, so as not to appear aggressive or greedy. However, the individual’s attitude may be changed if the invitation is pursued and encouraged.

### Health Promotion

In most cases, health promotion would not be a difficult topic to discuss with Japanese American elders, especially, immunizations and maintaining healthy habits of diet and exercise. There may be rare variable receptiveness to the concept of cancer screening, however, which may be seen by some as the equivalent of “looking for something potentially bad.” Clinicians should be mindful that as the incidence of stomach cancer is high, maintaining a high index of suspicion for this group might be beneficial. Although not recommended in the United States, in Japan, stomach cancer screening programs have been effective in mortality reduction (McCracken et al., 2007).

For those Japanese Americans with hypertension or who are at risk for hypertension, educational counseling on a low salt diet may be necessary as the traditional diet is high in salt. Some of the high salt dietary items may not be understood as being very salty, such as soy sauce (*shoyu*), preserved meat and fish, miso soup, and pickled vegetables. In discussing dietary issues, such as calcium intake for prevention of osteoporosis, it should be noted that the prevalence of lactose intolerance is high, as high as 80 to 90%.

In general, common barriers to health care access such as lack of insurance, low health literacy, and language barrier have not been significant, but do exist in some cases.

## CULTURALLY APPROPRIATE GERIATRIC CARE: DELIVERY OF CARE

### Decision-Making and Disclosure

Short of a formally designated decision maker for healthcare issues, decision-making, in a very traditional Japanese family, is a family matter and follows a hierarchy. The first decision maker would be the husband or spouse. Next in line would be the oldest adult son, though the son would most likely make a decision compatible with what his parent and family would want. In a very traditional family, one would not see “open discussion and arguments” in front of a physician, as this act would be shameful and reflect negatively on the family name. The physician should be respectful by seeking and approaching the appropriate family member.

Traditional Japanese elders often place less value on personal autonomy as opposed to group or family consensus. In this regard, group or family decision-making led by the appropriate hierarchically designated family member may be the preferred model for decision-making. In the West, disclosure is the norm and is related to personal autonomy and it is felt that without disclosure, a person cannot be expected to make an informed decision and, thus, exercise personal autonomy.

In the traditional Japanese society, full disclosure to the patient, such as in terminal cancer, may not be acceptable or valued. It is felt that such disclosure may lead the patient to possibly give up hope, not fight the illness, or become depressed. The family often serves as a buffer and filter. As personal autonomy is less valued in a very traditional Japanese family, full disclosure to the patient is less relevant if decision-making falls on the group or family.

Studies of acculturation have suggested that group decision-making might be preferred even with an increasing gradient of acculturation (Matsumura et al., 2002; Bito et al., 2007).

Japanese American elders may also want to avoid being a burden to their adult children or other family members. Decisions might then be based on the perceived degree of burden upon loved ones.

### Advance Directives and End-of-Life Issues

Dying, death, end-of-life care, and advance directives should be approached with courteous respect. Open frank discussion on dying and death may be difficult depending on the degree to which a person or his or family maintains traditional Japanese values. Traditional elders may wish to defer decision making totally to their adult children, often to their oldest son, whereas more acculturated elders may prefer to participate in end-of-life decision making.

In Japan, it is a common saying that Japanese are born Shinto but die Buddhist. In Shintoism, the emphasis is on purity and cleanliness. Terminal illnesses, dying and death are considered “negative” or impure and akin to “contamination.” Frank discussions on death and dying may be difficult at first. However, at some point most Japanese are said to embrace Buddhism in later life. As such, death is considered a natural process, a part of life. Life continues in the form of a rebirth. These individuals may be more open to end-of-life discussions.

It is also very important to bear in mind that a number of elder Japanese Americans are Christians and embrace a Christian view of the meaning of dying, death, and end-of-life issues.

In traditional Japanese culture, there is a term, *shikata ga nai*, literally meaning, “it cannot be helped.” Sometimes, in the presence of a terminal illness, discussions may be a little easier because this fatalistic view takes any sense of blame, responsibility, or feeling of failure off of the person and his or her family. It embodies a concept of stoic acceptance of a difficult or impossible situation or circumstance.

## INSTRUCTIONAL STRATEGIES

### Case Study 1

An 85 year-old Japanese American woman has resided in her apartment independently since her husband passed away 10 years ago. She has no children or known relatives. Over the years, her osteoarthritis has limited her abilities to cook and clean her apartment.

The concerned landlord has her seen by the geriatric consultative service at a nearby hospital. In the process of evaluation by the geriatric interdisciplinary team, the geriatric social worker has arranged for a Caucasian caregiver to cook and clean for her.

After the first several visits by the hired caregiver, the Japanese American woman indirectly tells the caregiver that her apartment has been quite clean because of her and that for now she can do well without cooked meals. She tells the caregiver to take a break.

When the Japanese American woman visits the geriatric clinic in follow-up, she is found to be weak and exhausted, having lost about 5 pounds. She is also noted to have some bruising on her knees.

On further respectful questioning, the Japanese American woman reveals that she has been having diarrhea since the caregiver started cooking for her. This stopped when she asked the caregiver to take a break. When asked about the bruising of the knees, the Japanese American woman explained that she has been kneeling to clean the floor but has stopped doing this since the caregiver has taken a break.



### Questions for Discussion

1. What might explain the gastro-intestinal symptoms, this elder was having?
2. What might have led this elder to clean the floor so much after the caregiver started to come?
3. What are some etiquette issues in the home to consider when visiting a Japanese elder?

### Suggestions

One consideration is the possibility of lactose intolerance. Lactose intolerance is prevalent among Japanese. It may be that this elder did not want to offend the caregiver and ate whatever was cooked, even if she did not like the food because traditional Japanese elders avoid offending others.

The other consideration is home etiquette when visiting the home. Did the caregiver remove her shoes? Did the Japanese American elder kneel to try to clean or “purify” her apartment thus sustaining bruised knees, especially if the caregiver “contaminated” the floor with her outside shoes? The elder may not have been able to ask that shoes be removed prior to entering her apartment for fear of offending the caregiver.

**(INSTRUCTIONAL STRATEGIES CONT'D)****Case Study 2**

A 68 year-old nisei or second generation Japanese American man who was well and independent, and whose only chronic medical condition was eczema, was involved in an automobile accident. He was Buddhist. At the hospital, he was declared brain dead. His acculturated adult children who had all converted to Christianity offered to donate his organs if it could help anyone. This Japanese American man did not have any formal advance directives.

While on life support, this Japanese man's brother and sister flew in from Japan and were furious and appalled when they heard that he had been volunteered to become an organ donor:

- They claimed that he would not have wanted to be an organ donor were he able to express his wishes.
- They could not understand why he was declared “brain dead” if his heart was still beating, his skin color looked well and his body was still warm.
- They could not understand how their brother could be “brain dead” and still be alive.
- They subtly accused his adult children of planning to “take his life.”

A terrible rift was created in a previously close-knit family.

**Topics for Discussion**

1. Religion and end-of-life issues including organ donation.
2. Level of Acculturation.
3. Family conflicts and communication issues.



## STUDENT EVALUATION

### Objective Questions

*For answer key, see page 18*

1. Regarding Japanese American older adults, the level of acculturation (choose ONE correct answer)
  - A. Is important to understand when working with the elder and his or her family
  - B. May differ even among members of the same family
  - C. Is directly related to the occupation of the elder
  - D. Both a and b
  
2. Regarding mental illnesses, (choose ONE correct answer):
  - A. Traditionally, there is a stigma associated with a mental illness.
  - B. Traditionally, there is openness about mental illnesses.
  - C. Traditionally, a mental illness is not associated with shame.
  
3. The Japanese concept of filial piety, (choose ONE correct answer):
  - A. Stems from Confucianism with its origins in China.
  - B. Is a new post World War II philosophy.
  - C. Is not in conflict with institutionalizing one's parents.
  
4. In a traditional family, with respect to family meetings, (choose ONE correct answer)
  - A. Direct and confrontational style is the best to "lay all the options out in the open."
  - B. If some family members do not say much, then this means they agree with everything that has been said and planned.
  - C. The most vocal member of the family can be assumed to be taking the leadership role and speaking for the whole family.
  - D. None of the above
  
5. In advising a traditional Japanese American elder with high blood pressure to reduce salt intake, it would be helpful to: (choose ONE correct answer)
  - A. Suggest that they follow the American low salt diet recipes and change to American foods.
  - B. Obtain a dietary history and then help modify salt intake based on what they are currently eating, without asking them to make a radical change to American low salt diet foods.
  - C. Be knowledgeable that miso soup, pickled vegetables, and shiokara (fermented fish products) are high in salt.
  - D. Realize that all Japanese foods are healthy and not high in salt.
  - E. Both b and c



### Answer Key

1. D    2. A    3. A    4. D    5. E

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**Internet Resource**

Census 2000 Demographic Profile Highlights

<http://www.census.gov>

## APPENDIX A: SIGNIFICANT DATES IN IMMIGRATION & HISTORY

Japanese Americans—Significant Dates in Immigration and History		
Year	Periods and Events	U.S. Population
1868	Japanese immigrants to Hawaii as contract laborers.	141
1869	Japanese immigrants arrive in California; Wakamatsu Colony on Gold Hill.	
1882	The Urban League was founded to assist migrants; WWI included 100,000 Negro soldiers who fought overseas; colored units honored for their valor; Ku Klux Klan (KKK) active; “Red summer” when GIs and others victims of bloody anti-colored rioting.	24,300
1906	San Francisco School Board places children of “Mongoloid” ancestry in segregated schools.	
1900–1920	Primary period of Japanese immigration to the U.S.; population of married women jumps from 410 in 1900 to 22,193 in 1920.	72,100
1908	Gentleman’s Agreement, Japan will not issue visas to Japanese laborers but wives, children, and families are allowed.	
1913	California, “aliens ineligible for citizenship” prohibited from land ownership; only “free white persons” eligible for citizenship; 3 year limit on land leases; similar laws in ten other states.	111,000
1922	Cable Act, anyone marrying an Issei loses citizenship (repealed in 1936).	
1924	Immigration Exclusion Act ends all Asian immigration except Filipinos.	
1937	U.S. breaks off relations with Japan after invasion of Nationalist China.	
1941	Japan attacks U.S. fleet and military base in Pearl Harbor; U.S. declares war on Japan, Germany, Italy; incarceration of JA community leaders.	126,900
1942	JA of draft age declared “enemy aliens”; Pres. Roosevelt signs Executive Order 9066, JA exclusion from West Coast; incarceration of 120,000 JAs in “relocation centers.”	

## (APPENDIX A CONT'D)

Japanese Americans—Significant Dates in Immigration and History		
Year	Periods and Events	U.S. Population
1943–1944	Military recruitment for all-JA combat unit, 442nd RCT activated; internees denied right to vote; confusing loyalty questionnaire administered in camps causes family conflicts; 200 men convicted and sentenced to 3 yrs in prison for refusing induction.	
1945	45,000 Japanese war brides enter the U.S.	
1946	U.S. drops atomic bombs on Hiroshima/Nagasaki, ends war with Japan; JA resettlement on West Coast; meet with hostility/housing shortages.	
1952–1956	Walter-McCarran Immigration and Naturalization Act passed, Asian immigrants allowed to become naturalized citizens; repeal of Alien Land Laws in California.	
1959	Hawaii becomes 50th state; First JA, Daniel Inouye, elected to Congress.	464,000
1980	Commission on Wartime Relocation/Internment of Civilians reviews Executive Order 9066 constitutionality, reports “personal justice denied”	
1988	Civil Liberties Act, apology/payment of \$20,000 to 60,000 survivors.	
1990	First apologies and redress payments sent to survivors, oldest first.	847,500 (105,900 are 65+)

Source: Yeo, G., Hikoyeda, N., McBride, M., Chin, S-Y., Edmonds, M. & Hendrix, L., 1998