

Japanese Americans and self-care

A lesson in cross-cultural care

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Information about cultural patterns presented in this article and others in this series represents generalizations, which should not be mistaken for stereotypes. Cultural generalizations will not fit every patient, but awareness of broad patterns can give practitioners a starting point from which to provide appropriate care. The information on Japanese American activities of daily living in this essay is taken directly from Gayle Shiba and Roberta Oka's chapter in *Culture and Nursing Care: A Pocket Guide*, edited by JG Lipson, SL Dibble, and PA Minarik.

Tome Tanaka, a Japanese man in his 60s, was admitted to a rehabilitation unit after a stroke left him with significant left-sided weakness. Self-care was an important part of his therapy. He had to relearn to feed himself, dress, shave, use the bathroom, and do other activities of daily living. Kathy, his nurse, took great care in explaining to Mr Tanaka and his family the importance of these tasks to his rehabilitation and how the staff would work with him to accomplish them.

During his daily physical therapy and occupational therapy sessions, Mr Tanaka learned to walk with a cane and required minimal assistance with self-care activities. Despite his progress in therapy, however, whenever his wife or 1 of his children arrived, he regressed. On one occasion, after his grandchildren had left the hospital, Kathy discovered Mrs Tanaka waiting on her husband as though he were an invalid. Mr Tanaka refused to do anything for himself and continually barked commands at his wife, demanding that she brush his teeth, shave, and dress him.

After 4 weeks of care in the rehabilitation unit, Mr Tanaka was discharged from care, almost as dependent as when he first came to the hospital. Kathy and

the other nurses who worked him were frustrated by Mr Tanaka's dependency, especially because they saw that he was capable of taking care of himself and took his "failure" personally, as though they were not doing their jobs properly.¹

INTERDEPENDENCE VERSUS INDEPENDENCE

American health care professionals must realize that emphasis on the importance of self-care is not always the result of medical necessity, but rather the influence of American values and social structure on health care practices. Self-care is important to Americans, in part because independence is valued so highly. Furthermore, self-care may be a practical necessity because there may be no one to help with daily tasks. In contrast, the emphasis in Asian cultures is on family interdependence over independence. Many Asians live in large extended family households, where someone is usually at home to care for the patient.

HIERARCHIC FAMILY STRUCTURES

Another significant factor in caring for Japanese Americans is the difference between egalitarian and hierarchic cultures. In an egalitarian culture such as found in the United States, everyone theoretically is equal and no one in the family is considered subservient to anyone else. In hierarchic Asian cultures, some members of the family are clearly dominant (men and elders) while others are clearly subordinate (women and children). The Tanakas demonstrated the proper roles of wife and children in hierarchic cultures. It is their duty to obey and care for the dominant family member—the husband and father.

DOMINANCE

Control may also play a role in the failure to care for oneself, especially in cultures where men are dominant. When reduced to a state of physical weakness by a medical condition, men who issue orders and have their family attend to their every need demonstrate their dominance. It may masquerade as helplessness, but it is a way of maintaining control.



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Japanese Zen Buddhist abbot at prayer with a younger disciple

MODESTY

Japanese Americans, particularly women, tend to be modest with family members, especially their elders, and those of the opposite sex. It is best to assign same sex caregivers.²

PERSONAL HYGIENE

Cleanliness and hygiene are of great importance. They are linked to the belief in and importance of the purification of the body to help restore health. Daily tub baths are the preferred method of bathing, in the evening before bedtime. Use of the bathroom is primarily for privacy. Hair washing occurs daily or several times per week, and nails are generally kept short and clean. Washing after using the toilet is customary.

SELF-CARE

Personal hygiene is generally performed by the patient, if able. A family member, particularly a spouse or elder

daughter, may be able to provide assistance and may be preferred by the patient over a health care professional. Older adults may be more dependent on family members when ill.

OTHER CONSIDERATIONS

Special clothing or amulets may be desired. For example, Issei (first generation Japanese in the United States) may use prayer beads, particularly if the individual is Buddhist.

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Rural elders and long-term care

This is the final article in our 4-part series on rural health. Previous articles were "Physicians and rural America" (November 2000, pp 348-351), "Hospitals in rural America" (December 2000, pp 418-422), and "Rural children's health" (February 2001, pp 142-147). All articles were adapted, with permission, from Ricketts III TC: *Rural Health in the United States*. New York: Oxford University Press; 1999.

The aging of Americans has dramatic implications for the health care system. About one fifth of the elderly population—defined as persons aged 65 years and older—lives in rural places, accounting for 8.2 million people in 1995. Although in the past, rural areas have had higher concentrations of older people, this trend appears to be changing.

Rural elders differ in several important respects from the stereotypical rural older person living in an idyllic home in a quaint country setting surrounded by a large multigenerational family. Compared with urban elders, rural elders have lower incomes, are more likely to be poor, and have less formal education.¹ Although they are more likely to own their homes, those dwellings are more likely to be substandard. They are more likely to be in poorer health than their urban counterparts. Yet, their health and long-term care needs are less likely to be met owing to problems in the availability of health and social services and the obstacles to delivering services in rural areas, including low population densities, limited transportation, and longer travel distances.²

Summary points

- About a fifth of elderly persons—those aged 65 years and older—in the United States live in rural places
- Elderly residents of rural areas are more likely than those of urban areas to be classified as "poor" or "low income"
- Self-rated health, which is associated with mortality and quality of life, is worse in elderly living in rural areas than in those in urban areas
- Well-documented deficiencies exist in the availability and accessibility of health and long-term care services to rural elderly
- 2 key barriers need to be overcome to address these deficiencies: the current financing of long-term care in general, and the need for better models for delivering services in rural communities

Patterns in the availability and use of health and long-term care services among rural elders suggest several important policy challenges. Federal and state efforts to shift the use of services away from costly institution-based care in hospitals and nursing homes will be particularly difficult to achieve in rural areas. The rural system of long-term care service is characterized by a larger supply (per elder) of nursing home beds than in urban areas and fewer community-based, in-home service, and residential care options. These factors may contribute to the higher-than-usual rates of institutional service use among rural elders.

Changes in federal and state policies, consumer pref-

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