

# **HEALTH AND HEALTH CARE OF JAPANESE- AMERICAN ELDERS**

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## **DESCRIPTION**

This module reviews the demographics, history, health risks, and traditional health views of Japanese American elders. Suggestions for issues to consider in assessment and treatment are also included. The module is designed to use in conjunction with the Core Curriculum in Ethnogeriatrics.

## **LEARNING OBJECTIVES**

After completing the module, learners should be able to:

1. Describe briefly the history of Japanese immigration to the U.S.
2. Identify and explain three areas of health care assessment and treatment that may be affected by the level of acculturation of the older Japanese American patient.
3. Discuss the impact of Shintoism and Buddhism on end of life care.
4. List three health risks that have changed over time in the U.S. for the Japanese American population.

# CONTENT

## I. Introduction and Overview

### A. Demographics<sup>1</sup>

In the 2000 census, 796,700 residents of the U.S. identified their “race” as Japanese, although there are likely to be many more of Japanese ancestry among the 1.6 million Asians who indicated their background included two or more “races”. In the 1990 census, 847,562 residents of the U.S. identified themselves as Japanese Americans, with about 52% living in California and 41% in Hawaii. Of these, 104,932 were 65 years or older, 17.2% of whom were not born in the United States. For other characteristics of Japanese American elders from the 1990 census, see the chart in the Introduction section of the Asian/Pacific Islander modules.

For further information, see the census web site [www.census.gov](http://www.census.gov).

Most immigration to the United States from Japan occurred in the late 1800s to early 1900s. The generations in the U.S. are often referred by numbering the generations, i.e. first, second, third. The terms are in fairly common usage and include: 1) *issei*, the generation born in Japan who came to the U.S.; 2) *nisei*, the first generation born in the U.S., 3) *sansei*, the next generation; 4) *yonsei*, children of the *sansei*. *Kibbei* is the term used to describe Japanese Americans who were born in the U.S., sent abroad to Japan to be educated and who then returned to the U.S. It should be recognized that for any given individual, the generational terms are not related to age. An elder could be of any generation, and currently most are *nisei* and *sansei*.

### B. Language

Compared to other American elders of Asian background, a much higher percentage of Japanese elders speak English. In 1990, only 36% said they did not speak English very well. Although the spoken Japanese language is different from the Chinese language, between the fourth and fifth century, the Japanese borrowed written Chinese characters and further adapted them for their use. The Japanese language is one of syllables. Inherent in the spoken language is the degree of politeness used to address others of different social status. 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 immigrants from Okinawa often faced discrimination from immigrants from Japan within the Japanese community. This discrimination was probably rooted in a very interesting history of Okinawa, at one time an independent kingdom with close ties to China.

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<sup>1</sup> With a few exceptions, there are no references cited in the text. Information is taken from the sources listed in the Reference List in the last section of the module.

### C. Religion

In Japan, generally speaking, two religions - Shintoism and Buddhism, and one code of ethics - Confucianism, have influenced the Japanese way of life and view of the world. Shintoism is the indigenous religion of Japan with origins in prehistoric Japan. It is 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. Being unclean and impure is considered disrespectful to the spirit gods. Therefore, before entering a Shinto shrine one must wash his hands in the designated wash area. *Torii* gates, usually three consecutive *torii* gates, leading to the shrine are symbolic for purifying the heart and mind before entering the shrine.

Buddhism was introduced to Japan by way of Korea in 500 to 600 AD. Prince Shotoku of Japan converted to Buddhism in the 7<sup>th</sup> century and Buddhism subsequently flourished. Conflicts between Buddhism and Shintoism arose and were resolved by two Buddhist saints in the 8<sup>th</sup> century by devising a doctrine basically stating that no conflict exists between the two religions and that Buddha was a form of the old Shinto gods. During the time of Japanese immigration abroad, the majority of Japanese accepted both religions. Thus birth and marriage rites were Shinto rituals and end of life beliefs and funerals were often Buddhist. 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 and social order. Thus inherent in the importance of family becomes the importance of taking care of one's parents, or filial piety.

## **II. Patterns of Health Risk**

The Honolulu Heart Program studies began in 1965 with a cohort of 8006 Japanese American men and is still continuing. Much of what we know about the health and aging of Japanese Americans is based on the several hundred publications that have come out of the studies of these men, and now some women, as they age.

The cohort of Japanese men in the Honolulu Heart Program studies has a life expectancy that is longer than their counterparts in Japan, and Japan has the longest life expectancy of any country in the world. With a few exceptions noted below, the risk of most diseases that have been studied is lower among Japanese American elders than among other older Americans.

### **A. Heart, Cardiovascular Disease, and Stroke**

Japanese Americans have been found to have much lower risks of heart and cardiovascular diseases than their white American counterparts. With increasing adaptation to the western diet (high meat, less roughage), however, there appears to be an increase in coronary artery disease.

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 decline 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 found in a study by Iso et al. (1989).

### **B. Cancer**

Breast cancer in older Japanese American women is lower than in most other U.S. populations. Ovarian and prostate cancer is also low, although longer residence in North America has been correlated with an increase in risk for prostate cancer, which in turn has been noted to be associated with increased saturated fat intake. Likewise colon cancer seems to be increasing with the adaptation to Western diets. Japanese Americans have a rate of stomach cancer that is twice as high as most other populations in the U.S., which is thought to be related to eating nitrite-rich salty foods (e.g. cured meats).

### **C. Diabetes**

One disease that has a higher prevalence among Japanese Americans than their counterparts in either Japan or Caucasians in the U.S. is Type II Diabetes. In Seattle studies, 20% of Nisei men between 45 and 74 were found to have diabetes, half of which was not diagnosed, and 56% had abnormal glucose tolerance. Those rates are over twice as high as comparable samples of men in the U.S. 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.

#### **D. Dementia.**

With the general longevity among the Japanese and the reluctance to report alterations in mental status, the frequency of undiagnosed dementia may be common. In the Honolulu-Asia Aging Study, the prevalence of vascular dementia among Japanese-American men appears to be higher than Caucasian men. The prevalence of Alzheimer disease appears to be similar to Caucasian men but higher than in Japan.

### **III. Culturally Appropriate Geriatric Care: Fund of Knowledge**

To care for Japanese American elders effectively, it is important for providers to have background knowledge concerning: 1) the historical experiences of the cohort of elders and 2) traditional Japanese health beliefs and practices.

#### **A. 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 opportunity. The Hawaiian sugar industry boom brought many Japanese to Hawaii so that in 1910, Hawaii had four times as many Japanese as the U.S. mainland. It is said that between 1882 and 1908, 150,000 Japanese moved to Hawaii and about 30,000 to California. On the mainland, economic opportunity initially came primarily in the form of domestic and unskilled labor, for example work in logging or building railroads. During this time, the native born Japanese group was growing, and by 1930, native-born Japanese Americans were said to exceed those born in Japan by eighty percent. Many initially worked as contract laborers and subsequently when the opportunity arose, they acquired land or built businesses.

The widespread internment of all Japanese Americans on the West Coast during World War II had a devastating effect, especially economically. Businesses built up over a lifetime had to be sold or liquidated quickly, with great losses. Despite this great setback, many native-born Japanese Americans later advanced economically by pursuing education into white-collar professions.

A second wave of immigration occurred after World War II with Japanese wives of US servicemen moving to the United States.

(For more information on historical experiences influencing Japanese American elders, see Appendix A: Japanese Americans: Significant Dates and Periods in Immigration and History.)

## **B. Health Beliefs and Practices**

**1. Filial Piety.** The Japanese concept of filial piety stems from Confucianism with its origins in China. This Confucian thought was brought to Japan in the seventh century and has been passed down through the ages. In Confucian thought which places importance on family and social order, filial piety was felt to be extremely important. Children were expected to obey and respect their parents, bring honor to their parents by succeeding in work, and support and care for parents in their old age. Additionally, for many Japanese immigrants, “*kodomo no tame ni*” or “for the sake of the children” became the motto by which they endured to bring a better life standard for their children’s generation. Thus an element of expectation from parents and sense of obligation on the part of the children to support and care for their parents may exist. Even though adequate care may be difficult to render by the children, reluctance is often accompanied by guilt if parents are placed in an institutional long-term care facility.

**2. Informed Consent and End of Life Care.** 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.” Thus, open frank discussions that occur with informed consent procedures, choices in treatment, and advance directives 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 after death in the form of rebirth. They may be more open to end-of-life discussions. Conversion to Christianity or other religions would certainly have some impact on views of death, dying, and end-of-life issues

Traditionally, organ donation is not favored because of the importance of dying intact, and because the concept of brain death, as opposed to death occurring “naturally” when the heart ceases to beat, is sometimes difficult to understand.

**3. Mental Illnesses.** There is a general stigma associated with mental illnesses. Thus there is less seeking of direct medical assistance by either the person afflicted or their family. There is the concept of shame or “*hazukashii*”, in which the individual is taught to avoid bringing shame to his family name.

## **IV. Culturally Appropriate Geriatric Care: Assessment**

### **A. Level of Acculturation**

The initial concerns regarding assessment of the Japanese-Americans include the degree to which a particular person and his or her family still maintain the traditional beliefs of the ethnic group, i.e., their level of acculturation. The degree to which a particular person and his or her family maintain the traditional beliefs is very important because of the marked variability 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 held in the family, the person and his family may be more "Americanized", having adopted the Western culture and outlook on life. 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. However, traditional values may still influence their decisions. Adopting and embracing the American value of individualism would be a change from the Japanese value of the group (family/society) over the individual.

### **B. General Approach**

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

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

(For a complete list of domains of assessment, see Module Four of the Core Curriculum in Ethnogeriatrics.)

## **V. Culturally Appropriate Geriatric Care: Treatment**

### **A. 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 variable receptiveness to the concept of cancer screening, however, which some may feel as the equivalent of “looking for something potentially bad.”

For those Japanese Americans with hypertension or at risk for hypertension, it may be worth noting that educational counseling on a low salt diet may need to be elaborated upon 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, 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.

### **B. Working with Families**

In working with families, if the traditional hierarchy is maintained, then the word and decision of the master of the home, the husband, would preside. The next in line for decision-making would be the oldest adult son, though the son would most likely make a decision compatible with what the wife 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 of approaching the appropriate family member.

### **C. End of Life Issues**

Dying, death, end-of-life care, advance directive and informed consent 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 culture. Elders may wish to defer decision making totally to their children, often to their oldest son.

In the presence of a terminal illness, discussions may be a little easier since often the “*shikata ga nai*” view may be held. The meaning of “*Shikata ga nai*” is “it cannot be helped.” This view takes any blame or feeling of failure off of the person and his or her family. It embodies an almost stoic acceptance of a difficult circumstance.

The concept of organ donation may not be received well.

## **V. Access and Utilization**

If there is access to health care services, then they are most likely to be utilized for medical problems, but there would be more reluctance with respect to mental illnesses. The general stigma associated with mental illnesses may reduce the patient and family's initiative to seek psychiatric assistance.

Traditional remedies referred to as *Kampo* may be sought in parallel with ongoing medical treatment. *Kampo* strives to restore energy flow, and its beliefs have origins in China. Herbs are used and, additionally, use of acupuncture, moxibustion, and shiatsu are not uncommon.

The Japanese Americans are less likely to utilize nursing homes for their elders compared to their non-Asian American counterparts. As the Confucian influence of filial piety fades with increasing cultural integration and assimilation, it will be of interest to note trends in nursing home statistics. Japanese community organizations in three West Coast cities have built nursing homes especially oriented to Japanese elders, 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, were not available (McCormick, et al., 1995).

## INSTRUCTIONAL STRATEGIES

### CASE STUDIES

**Case 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. Her landlord has noticed that her previously meticulously manicured garden has become unkempt. In the past year, she has locked herself out of the house four times. The last two months, she has forgotten to pay rent. When reminded, she sent multiple consecutive checks with the wrong dates. Two weeks ago, she left the stove on and burned a pot.*

*The concerned landlord had her seen by the geriatric consultative service at a nearby hospital. The social worker at the hospital, arranged for a hired Caucasian caregiver to cook for her. Over the next several weeks, the Japanese-American woman experienced diarrhea, cramping and abdominal pain. She was given over-the-counter Kaopectate and Immodium. Symptoms persisted. She was further evaluated at the medical clinic for her symptoms.*

#### Questions for Discussion:

1. What might explain the gastro-intestinal symptoms, the elder was having?
2. Are there any other services that could be considered for her support?

Suggestions: One consideration that should be looked into is possible lactose intolerance. Lactose intolerance is prevalent among Japanese. It may be that this woman who also appears to have dementia may have a lifetime of avoiding foods containing lactose. With a non-Japanese caregiver now cooking her meals, it is possible that she is being served foods containing lactose and does not understand or communicate well enough to explain this to the caregiver.

**Case 2.** *A 68 year-old Japanese-American man who was well and independent, and whose only chronic medical condition was eczema, was involved in an automobile accident. At the hospital, he was declared brain dead. His children offered to donate his organs if it could help anyone.*

*This Japanese man's brother and sister flew in from Japan for the funeral and were furious and appalled when they heard that he had 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 had "died" (brain death) if his heart was still beating. They subtly accused his children of "taking his life." A terrible rift was created in a previously close-knit family.*

Questions for Discussion:

1. How could the health care providers have helped to reduce the likelihood of the family rift?
2. How might health care providers deal with family members who don't understand "brain death"?

Suggestions: Traditionally, the concept of organ donations for those Japanese-Americans who maintain traditional beliefs, are not well received. This may need to be handled carefully. Usually, when a decision is being made about organ donation, there is limited time to educate extended family members. In as much as possible, however, it may help the family for healthcare providers to be available to extended family members who have difficulty understanding the concept of brain death and organ donation. If it appears that a family rift is looming, having persons of authority and knowledge available for education and counseling to the extended family may ease if not totally prevent the rift. It may be helpful to remember that even in the United States at one time, the concept of brain death and organ transplant was new and met with resistance. With increasing acculturation, the concept of organ donation may become more acceptable.

## STUDENT EVALUATION

### Questions

1. (*True or False*) With general longevity among the Japanese, the frequency of silent and undetected dementia may be common. *Answer: True*
2. (*True or False*) The prevalence of lactose intolerance is high among Japanese Americans. *Answer: True*
3. (*multiple choice*) Regarding mental illnesses,
  - a. traditionally, there is a general stigma associated with mental illnesses.
  - b. traditionally, there is openness about mental illnesses.
  - c. traditionally, mental illness does not bring about the concept of shame or “hazukashii.”

*Answer: a*

4. (*multiple choice*) The Japanese concept of filial piety,
  - a. stems from Confucianism with its origins in China.
  - b. is a new post World War II philosophy.
  - c. is not at all in conflict with institutionalizing one’s parents.

*Answer: a*

5. (*True or False*) The degree to which the Japanese-American person or family maintains traditional beliefs is of utmost importance. With the passing of generations in the U.S., the person and or his family may have become significantly “Americanized” having adopted the western outlook on life.

*Answer: True*

6. (*True or False*) In a traditional family, the direct and confrontational style is the best style to use in a family conference. *Answer: False*

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#### OTHER:

I would like to thank Dr. Gwen Yeo of the Stanford Geriatric Education Center for her valuable input and chart on Asian/Pacific Islander Elders 65 and over, 1990, selected characteristics.

#### INTERNET RESOURCE

<http://www.census.gov>

**Appendix A**  
**JAPANESE AMERICANS (JA)**  
**SIGNIFICANT DATES AND PERIODS IN IMMIGRATION AND HISTORY**

<u>YEAR</u>	<u>PERIODS AND EVENTS</u>	<u>U.S. POP.</u>
1868	Japanese immigrants to Hawaii as contract laborers.	141
1869	Japanese immigrants arrive in California; Wakamatsu Colony on Gold Hill.	
1882	Chinese Exclusion Act, stops immigration from China; increased demand for JA immigrants to West Coast; population of married women jumps from 410 in 1900 to 22,193 in 1920.	
1906	San Francisco School Board places children of "Mongoloid" ancestry in segregated schools.	24,300
1900-1920	Primary period of Japanese immigration to the U.S.	
1908	Gentleman's Agreement, Japan will not to issue visas to Japanese laborers; but wives, children, and families are allowed.	72,100
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.	
1922	Cable Act, anyone marrying an Issei loses citizenship (repealed in 1936).	111,000
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."	
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 et al., 1998