THE INTERNATIONAL EDUCATIONAL EXPERIENCE OF JAPANESE NURSES

By

Dawn Doutrich, M.S., R.N.

A Dissertation

Presented to
Oregon Health Sciences University
School of Nursing
in partial fulfillment
of the requirements for the degree of
Doctor of Philosophy

May, 1993

APPROVED:

[redacted]

Christine A. Tanner, R.N., Ph.D., F.A.A.N., Research Advisor

[redacted]

Marie Scott Brown, R.N., Ph.D., Committee Member

[redacted]

Sarah E. Porter, R.N., Ph.D., Committee Member

[redacted]

Carol A. Lindeman, R.N., Ph.D., F.A.A.N., Dean, School of Nursing

Acknowledgements

This research project reflects contributions from many people and could not have been completed without their support. First I would like to thank the Japanese nurses who took time from extremely busy schedules to relate their narratives. They made me welcome in Japan, extended their collegial network, and took care of me in countless ways, from inviting me to philosophical seminars, showing me how to ride the Tokyo subways, nursing me when I was sick, and touring me around Japanese beaches and Nara. I want to thank Dr. Noriko Katada, Ms. Yuki Ashikaga, Ms. Noriko Kawana, Ms. Keiko Okaya, Ms. Tomoko Yuasa, Dean Yasuko Higuchi, Mr. Shinobu Iwase, Dean Junko Kondo, Mr. Masashi Kawano, Ms. Mariko Koyama, Ms. Emiko Endo, Ms. Mitsuko Inoyoshi, Ms. Junko Takano, Ms. Fusako Ozaki. To the others, who chose to remain anonymous I also want to say sincerely, thank you.

Yoko Nakayama, my friend and classmate, arranged for many introductions in Japan and for my sponsorship at St. Luke's College of Nursing. Without her input and continued support, this project would have never been. Dr. Hiroko Minami provided personal sponsorship, introductions, paved my way in Japan, and her articulate ability to explain her culture and mine made my task less formidable. To Dr. Minami I would like to express my genuine appreciation, *domo arrigato gozaimasu*. I am also grateful to the President and the Dean of St. Luke's College of Nursing, Dr. Hinohara and Ms. Tokiwa, who made facilities at St. Luke's available during my stay in Japan. My friends and schoolmates, Iku Inoue, Ekiko Sato, Masako Ono, and Shizue Suzuki showed me "Japanese caring" in both the U.S. and

Japan. In addition, I am deeply appreciative of the effort, time, and encouragement of my student colleagues, Linda Budan and Peggy Wros, who provided insight and conceptual wisdom during the interpretation of findings and provided support throughout the dissertation process. I would like to extend a special thanks to Junichiro Suzuki. He opened his home and his life to my husband and me during our stay in Japan and was the most patient and easygoing of roommates.

I would like to thank Dr. Caroline White, my former teacher, for encouraging me to consider a Ph.D., for her continuing friendship, and for her many hours of editing. I owe much to my committee. They pushed when I needed pushing and backed off when I needed independence. They have believed in the value of this project and transfused their faith when I was in doubt. Dr. Sarah Porter shared her interest in understanding the lives of international nursing students and pointed out ways the findings of this study were important to her practice as a U.S. nursing faculty member. Dr. Marie Brown lent her humor, wit, and anthropological understanding to the process. Dr. Christine Tanner, mentored the project and me, showing through her example how to guide students as a way of being. She nurtured my creativity, trusted my strengths, and gently molded the product toward practice applicability.

I would like to thank my family for their patience, tolerance, and support through our many years of graduate school. My Dad and Barb have faithfully been there for me. Without Michael, my partner, the journeys across cultures would have been frightening and most likely lonely, whereas together, they continue to be cosmic

and comic adventures. Maggie, my stepdaughter and Justina, my granddaughter grounded me, helped me prioritize daily, and helped give me the motivation to finish. Finally, this book is dedicated to the memory of my mother, who taught me that it is good to be a woman, and who showed me that women can be strong and smart and caring.

ABSTRACT

TITLE: The International Educational Experience of Japanese Nurses

AUTHOR: Dawn Doutrich

APPROVED: [redacted]
Christine A. Tanner, RN, PhD

The purpose of this interpretive study was to describe the international educational experiences of Japanese nurse scholars in order to develop more understanding within academic settings in the United States (U.S.). Experiences that took place in the U.S. and experiences that occurred when participants returned to Japan were described. Background meanings important for interpretation and understanding of the experiences were explained.

Participants for this study were twenty five Japanese nurse scholars who had received or were in the process of receiving masters or doctoral degrees from schools of nursing in the U.S. Participants were selected based upon their varying lengths of time since their returns to Japan. Forty two interviews were conducted, thirty eight in Japan over a five and one half month time period, and four in the U.S. in four separate months. All interviews were tape recorded and transcribed verbatim. Interviews with three Japanese nurse scholar consultants who aided in specific explication of themes and early analysis were also transcribed and treated as data.

Data were analyzed using interpretive analysis methods. The analytic process used overlapping strategies, including early reflective interpretation of the transcripts, identification of principal themes, coding and data retrieval according to a plan devised by the interpretive group, and interpretive writing based on exemplars and

paradigm cases illustrative of the major themes (Wros, 1992).

Two main topical areas were delineated in the narratives describing the U.S. experiences. They were "the changing self" and "being a student in the U.S." One of the strongest themes to be uncovered concerned the sense of self in relation to the other. The sense of self changed for many of the Japanese nurse scholars during the U.S. experience. In order to survive in the U.S. the Japanese nurse scholars said they had to "toughen." This involved two types of change. They described "growing" a more distinct, individualistic self. And, they became less willing to allow dependency in their relationships. In Japan certain dependent relationships are encouraged and idealized. These are called *amae* relationships.

In Japan, it is believed that through understanding and attending to the other, preferences may be distinguished. This idea is elemental to Japanese caring. In the U.S. Japanese nurse scholars began to focus less on the other. They worried about becoming less "kind" and what constituted their notions of care changed to some degree.

Another important theme related to the changing self concerned mental health disturbances that the participants experienced during acculturation. Mental health disruptions included depression and paranoia, and drops in self esteem were said to be common. Hallucinations, suicidal ideation, feeling "demented" and "schizophrenic" were reported but were more rare.

In the "being a student in the U.S." topical area, a theme emerged that concerned the importance of the advisor to student success. Differences in the student

role and differences in the organization of the education process between the U.S. and Japan were also important themes uncovered in this study. Japanese nurse scholars tended to have difficulty speaking out in classes and understanding what was expected of them in classroom groups.

Two main topical areas were also delineated in the narratives highlighting the experiences of the Japanese nurse scholars on their returns. These topic areas were titled, "the meaning of Americanization" and "practice differences." Personal loss and the meaning of the U.S. sojourn to careers emerged as two of the most profound themes from the reentry experiences. Participants described losing their world, losing their 30's, losing their friends, and losing their free time. They described coming home to "start at the bottom," problems with bosses, and trouble keeping quiet. They talked about coming home and having nursing colleagues look at them suspiciously because they had gone to the U.S., and having colleagues devalue what they had learned, saying that it was American knowledge, not Japanese.

Other reentry themes concerned practice differences between the U.S. and Japan. The narratives reflected differences in the U.S. and Japan regarding relationships among health care providers and recipients, and, between men and women. For returnees, the U.S. experience seemed to highlight the hierarchical nature of Japanese culture and to delineate contrasts in the decision making process between the U.S. and Japan. Participants also brought home new teaching strategies. After their experience in the U.S. nursing education system, they brought new expectations in regards to their students. For example, some returnees pushed

students to develop their own opinions and to share them in class.

A culminating theme to emerge from the reentry stories was the pride with which participants talked about the Japanese spirit of caring. When asked to describe an area where Japanese nursing excelled, participant after participant named "caring" as the fundamental element of Japanese nursing.

This study has implications for promoting caring teaching practices, particularly for this group of Japanese nurse scholars. With a deeper understanding of the lifeworld of the other, more tactful, caring, responses become possible.

TABLE OF CONTENTS

TABLE OF CONTENTS (con't)

TABLE OF CONTENTS (con't)

TABLE OF CONTENTS (con't)

TABLE OF CONTENTS (con't)

TABLE OF CONTENTS (con't)

TABLE OF CONTENTS (con't)

LIST OF TABLES

> This formulation certainly does not mean that we are enclosed within a wall of prejudices and only let through the narrow portals those things that can produce a pass saying, "Nothing new will be said here." Instead we welcome just that guest who promises something new to our curiosity (Gadamer, 1976, p. 9).

CHAPTER I

INTRODUCTION TO THE PROBLEM

Linda Richards, a nurse from the United States (U.S.), consulted with the Japanese in the 1800's to assist in the formalization of the process of nursing education in Japan (Mooneyhan, McElmurray, Sofranko, & Campos, 1986). Since then, a special relationship has existed between Japanese nursing and U.S. American nursing (Mooneyhan et al., 1986). ("U.S." or "U.S. American" will be employed throughout this dissertation to distinguish citizens and customs of the United States of America from those of other North and South American countries.)

Moreover, "after World War II, Japanese nursing was directly and systematically guided by the occupation forces" (Minami, 1985, p. 312). Nursing education in Japan has been changed radically over the last thirty to forty years by the influence of U.S. American nursing (Kojima, 1987).

Some change has come from U.S. American nursing theories, many of which have been translated into Japanese and are widely read by Japanese nurses and nursing students (Minami, 1985). In addition many Japanese nurses have studied nursing in the United States and have returned to directly and indirectly influence Japanese nursing.

Statement of the Problem

Numbers of international students attending U.S. nursing colleges and universities continue to rise (Alexander & Shaw, 1991; Gay, Edgil, & Stullenbarger, 1993; Shearer, 1989). Although a vast literature now exists concerning international students (Paige, 1990), there are few research reports focused on international nursing students. Little is known about the implications of the international education experience on nurses' lives or on their practices. Still less is known about the lived experiences of these nurses either during their sojourns in the U.S. or on their reentries back to their home countries. And there are no descriptions of the lived experience of Japanese international nursing students.

Based on Heideggerian phenomenology, this interpretive study explores the lived and reflected experiences of Japanese nurses who have obtained or are in the process of obtaining masters and/or doctoral degrees in nursing from schools of higher education in the United States. The purpose of the study is to describe the experiences of Japanese nurses in order to develop more tactful, thoughtful understanding within academic settings in the United States. The descriptions draw on the nurse scholars' narrative accounts and their subsequent reflections of their educational experiences, both positive and negative, which were judged transformative of their professional lives by the nurses themselves.

International Students in the U.S.

There is an extensive body of writing about international students (Paige,

1990), but most of the articles selected for this review were chosen on the basis of their discussion of concerns that were relevant to participants in the current study, international students coming from Japan to study in the U.S. Literature about the nature of problems experienced by international students is presented here as context for this study. The review is organized in two major sections. First, concerns of international students are presented. The concerns which proved particularly relevant to the current study include the meaning of context to cultures and issues of acculturation, culture shock, and reentry. Issues specific to international nursing students are presented second. Exploration of writings describing these areas enhances understanding of the research questions and the findings.

In addition to the literature review presented here, literature elucidating the philosophical and the nursing contextual background for the study is presented in Chapter II. And, a description of certain contextual aspects of health care in Japan is offered in Appendix A. Additional literature illuminating interpretation of the findings of the study is interwoven into the discussion of the findings.

Issues of International Students

There is an enormous amount written about international students; Paige (1990) identified over 3000 references from 1965 to 1988. The meaning of context, a matter of concern to international students, was of particular concern to participants in this study. Japan is a highly contextual culture where the message tends to be delivered indirectly, nonverbally, and is encoded in the context of the communication.

The U.S., on the other hand, is a low context culture where messages tend to be imparted directly in verbal speech.

A second matter which proved relevant to the current study is the concept of acculturation and the attendant stress. Behavioral manifestations of acculturation stress may include anxiety, depression, hostility, or other mental health changes. These were of concern to study participants.

A third aspect of the international student experience is the notion of culture shock and the adjustment of sojourners to the new culture over time. This adjustment has been described as a U-shaped curve, as a learning deficit, as a response to uprooting, and as a generator of ontological change.

A final point of concern for international students and the study participants is the notion that sojourners returning home have many worries and concerns about how life will be when they arrive there. Because each of these aspects of international student life are important in the current study they will be explored more fully.

The Meaning of Context in Cultures

Hall (1976) differentiates cultures based on predominant communication styles. A high context culture, according to Hall (1976), is one where the information in a communication or message is mostly contained in the physical context or internalized in the person. Little must be directly stated because there is an empathy and deep involvement. On the other hand, a low context culture is a culture where the information in the communication is coded explicitly in the message. The context in

which the message is given and the relationships of the persons involved are less important.

Hofstede (1984) surveyed multinational corporate personnel from 40 countries twice, once in 1968 and again in 1972, producing over 116,000 questionnaires. Respondents were surveyed on four dimensions labeled power distance, uncertainty avoidance, masculinity and individualism. Individualism was measured along a continuum with collectivism providing the opposite pole. The questionnaires were analyzed and Hofstede then ranked the 40 countries on the four dimensions. Gudykunst and Ting-Toomey (1988), culture and interpersonal communication researchers, argue that Hofstede's individualism-collectivism continuum essentially measures the same domain as Hall's high-low context differentiation. Individualistic cultures, like the United States, tend to be low context. Conversely, collectivistic, group oriented cultures, like Japan, tend toward high context. In high context cultures a crucial aspect of the communication depends on the relationships of the participants which in turn hinge on the relative status, position, age, seniority, and at times, gender, of those involved in the contact. The situation, rich with the relationship context, gives the meaning to the communication. This discrepancy in the meaning of context between Japanese and U.S. American cultures makes communication between members of the respective cultures complex at best, and at times a conundrum.

Furthermore, collectivistic/high context cultures and individualistic/low context

cultures tend to emphasize different values in relation to concepts of the self. Members of collectivistic cultures, such as Japanese, tend to value group belonging and a "we" identity, while, in individualistic cultures, the "I" identity takes precedence (Gudykunst & Ting-Toomey, 1988). Shifting values in relation to the self and changes in self identity were of profound significance to many of the participants in the current study.

Acculturation

Broadly defined, acculturation is what happens when people from different cultures interact with each other over time. Changes occur in both directions although the sojourner or new comer will usually change more than people in the established culture (Berry, 1980). Acculturative stress refers to the disorganization or even disintegration of behavior that often accompanies social and cultural change (Berry, 1980). The individual experiencing acculturative stress may exhibit hostility; altered mental health especially confusion, anxiety, depression; feelings of marginality and alienation; a heightened psychosomatic symptom level; and identity confusion. Berry (1990) suggests that these symptoms are frequently present in acculturating individuals and represent the "negative side of acculturation" (p. 246). Successful adaptation is the positive side.

Furnham and Trezise (1983) suggest that the problems facing acculturating international students are essentially three-fold. Besides acculturation stress, international students are often vulnerable developmentally. Like their local student

colleagues, they are often young people, moving away from family dependence toward independence. And they are often highly stressed academically, working extremely hard, sometimes with poor English capacity and little social support.

Culture Shock

Early views concerning results of acculturative stress studies suggested that culture contact and change inevitably led to stress. Sojourner's responses--"frustration, anxiety, uncertainty, anger, extreme homesickness, and depression--are popularly referred to by the term 'culture shock'...." (Paige, 1990, p. 167).

Culture shock has been conceptualized in several different ways, changing over time (Adler, 1987; Furnham & Bochner, 1986; Oberg, 1979). Oberg, an anthropologist, is first credited with using the term culture shock in the late 1950's (Adler, 1987). At that time culture shock was conceptualized as a form of anxiety resulting from the loss of familiar signs and symbols of social intercourse. It was thought that the individual, on being confronted with different background meanings, was unable to make sense of the new world. The person undergoing culture shock combated his or her anxiety through any number of defense mechanisms such as repression, isolation, regression, and rejection. These were expressed as anger, frustration, loneliness, and self questioning of competence (Adler, 1987). Within this paradigm, culture shock was considered inevitable and pathological. It was thought of as an illness which resolves in four stages, beginning with excitement and euphoria, moving to discomfort and at times confusion and disgust with aspects of the

new culture, changing to understanding and sensitivity, and eventual "recovery" or biculturalism (Adler, 1987; Brink & Saunders, 1976; Upvall, 1990).

The adjustment of sojourners to the new culture over time has been found to resemble a U-shaped curve (Berry, Poortinga, Segall, & Dasen, 1992). Often sojourners are initially enthusiastic and excited by new experiences. However, over time, feelings of frustration, loneliness, and anxiety take over. Still later, as the sojourner learns to cope in the new culture, feelings of well-being increase again. The U-shaped curve, resembling Oberg's stages of culture shock, has been extended to include reentry readjustment and is described as a double U, or W (Berry et al., 1992).

Other conceptualizations would suggest that "newcomers to a culture have problems because they are unfamiliar or not at ease with the social norms and conventions. Gradually sojourners will learn what they need to know in order to handle social encounters competently" (Berry et al., 1992, p. 341). This model, called the learning deficit model, unlike Oberg's stages and the U-shaped curve descriptions, is not founded on assumptions that categorize sojourners responses as inevitable or pathological (Berry et al., 1992).

In 1990, Berry proposed that the level of acculturation stress experienced is moderated by a number of variables including individual characteristics such as acculturation experience/psychological characteristics, and cultural characteristics, such as the degree of pluralism in the host society and the degree of acceptance or

prestige of the acculturating group or individual. In addition, Berry (1990) proposed the amount of perceived control over the acculturation process and the degree of discrepancy between expectations and actualities influence the mental health of the acculturating individual. Higher levels of perceived control and less discrepancy between expectations and actualities tend to result in better mental health (Berry, 1990).

Although there are many differences among international students (e.g., country of origin, age, gender, and/or educational goal), and differences in the adaptation of international students to their environment, Upvall (1990) maintains the one common experience that all international students share is that they are uprooted. Uprooting involves an abrupt transition from a familiar to an alien environment, and one's response to uprooting is existential in nature (Upvall, 1990). Upvall (1990) analyzed two factors, academic satisfaction, and social contact with U.S. Americans, as predictors of international graduate students' mode of reaction to uprooting. With a sample of 101 graduate international students, most of whom were male (n=83), most of whom were studying engineering and the physical sciences (77%), and all of whom were from Taiwan, India, China [sic], or Korea, Upvall (1990) found academic satisfaction to be non predictive of the mode of reaction to uprooting. However, limited social contact with U.S. Americans was found to be predictive of an inadequate mode of reaction to uprooting. Surprisingly, length of stay in the U.S. and English proficiency were not related to level of social contact. Although Upvall's

(1990) study provides a different way of conceptualizing the adaptation of the international student, Upvall does not sufficiently explain the meaning of "mode of response" or how the labels "adequate/inadequate" are ascribed to the individual's response to uprooting.

Another way to think about the experience of exposure to a new culture is to conceive of it as a catalyst for ontological change. "Culture shock" is now a term used by the lay population to label some of the more unpleasant aspects of travel (Furnham & Bochner, 1986). Most writers agree exposure to new cultures is stressful, yet for many individuals the exposure leads to personal growth (Furnham & Bochner, 1986). "Culture shock is seen as a transitional experience which can result in the adoption of new values, attitudes and behavior patterns" (Furnham & Bochner, 1986, p. 50). There is anecdotal support for this perspective. For example, in his book The Anatomy of Dependence, Doi (1971, 1973), a Japanese psychiatrist who studied in the United States, asserts "I had come to realize that something had changed in myself as a result of the 'culture shock' I suffered when I first went to America" (p. 17). Doi (1971, 1973) goes on to discuss how first his perceptions and understanding of his own culture changed, and in turn, how his psychiatry practice changed as a result.

Reentry

Paige (1990) states that "the literature suggests that 'reentry shock' is as powerful as culture shock and that there are many issues associated with reintegrating

oneself back into the home culture" (p. 181). Issues of concern to international student returnees include anxiety about finding employment congruent with their education. They are also concerned about how they are going to infuse what they have learned into the home culture. A third concern involves peer acceptance at home. A related consideration involves whether they will fit back into the home culture. They worry about family life and obligations they temporarily left behind. The returnees worry they may have come to prefer their new values and habits. Another concern is that they will lose the skills they have acquired.

Although the concerns identified above relate to international students in general, there are issues more specific to Japanese returnees (White, 1988). As an archipelago, Japan has been relatively isolated and homogeneous and has come to regard isolation and homogeneity as values. Moreover, conceptually, there is an important distinction between inside and outside that has profound influence on Japanese life. For example, the custom of removing one's shoes at the door stems from not wanting to pollute the inside with outside dirt (Ohnuki-Tierney, 1984). Likewise there is clear demarkation between the Japanese insider (*miuchi*--literally, inside the body) and the outsider (*tanin*--literally, the other). The Western foreign visitor to Japan often receives the "red carpet treatment" from his or her hosts. There is a fascination with "the other" yet a distance is maintained (Ohnuki-Tierney, 1984). However, Ohnuki-Tierney (1984) argues, the Japanese have an "ambivalent or downright negative" (p. 43) attitude toward marginal outsiders, like overseas

Japanese. Thus when Japanese international students return home, they often find "they are no longer considered 'real Japanese,'" (Kidder, 1992, p. 383). There is discrimination (Ohnuki-Tierney, 1984). And "conceptually, these people [returnees] occupy a position 'betwixt and between'-they are neither Japanese nor foreigners" (Ohnuki-Tierney, 1984, p. 43).

Issues of International Nursing Students

The issues for international nursing students have been described in broad terms by Grace, a distinguished nursing educator, who claims that "U.S. nursing educational programs frequently have little understanding of the background" of the international nurse (1990, p. 559). Grace suggests that there is little understanding of the international nurse's education and past nursing experience. Moreover, there is "little appreciation of the expectations for this nurse when she [sic] returns to her home country" (p. 559). Grace (1990) maintains that it is important to understand the setting from which international students come and the setting to which they will return in order to provide appropriate educational experiences.

Although Grace's writings are concerned with international nurses returning to developing countries, she identifies several issues germane to the current study. For example, she notes that female nurses who have advanced to a position to be considered for educational programs abroad have often had to overcome obstacles related to expectations for women within their societies (Grace, 1990). Most nurses educated outside of the country return to faculty positions (Grace, 1990). Often

returning nurses are pushed into a leadership role (Grace, 1990).

Many nurse educators have noted there are few investigations into the lives of international nursing students (Abu-Saad & Kayser-Jones, 1981, 1982; Alexander & Shaw, 1991; Gay et al., 1993; Kayser-Jones & Abu-Saad, 1982). One of the earliest systematic investigations of issues of concern to international nursing students was done by two nurse educators, Abu-Saad and Kayser-Jones. Abu-Saad and Kayser-Jones interviewed 26 international nursing students enrolled at the University of California, San Francisco for questionnaire development. They sent the questionnaire to schools of nursing across the U.S. which had ten or more international students enrolled and asked that the questionnaires be distributed to international nursing students. Of 277 questionnaires mailed, 82 were returned.

The authors theorized the low response rate was in part due to the timing of the questionnaire distribution which was at the end of the academic year. They suggested that therefore academic pressures "took precedence over completion of the questionnaire" (Kayser-Jones & Abu-Saad, 1982, p. 306). Moreover, distribution coincided with the beginning of the hostage crisis in Iran and in view of the political crisis, some schools reported "it was difficult to gain the cooperation of Middle Eastern students" (Kayser-Jones & Abu-Saad, 1982, p. 306). However, the returned questionnaires were geographically representative of U.S. nursing schools and the sample included students from every continent.

"Loneliness emerged as the predominate problem" for all international nursing

students "regardless of age, marital status, or country of origin" (Kayser-Jones & Abu-Saad, 1982, p. 302). "Language difficulties, faculty unfamiliar with foreign cultures," the rapid pace of curricula, and the competitive atmosphere were factors inhibiting adjustment to the specific nursing programs (Abu-Saad & Kayser-Jones, 1981, p. 399). Other issues leading to problems in adjustment were differences in attitude towards parents or authority, differences in women's roles, and differences in expectations for behavior in student and nursing roles.

The most frequent factor to aid in adjustment was "American friends" (Kayser-Jones & Abu-Saad, 1982, p. 309). Other factors found to facilitate adjustment included financial security, support groups, orientation to the community, and host families. International nursing students also claimed "supportive faculty who are willing to listen, faculty and students who are knowledgeable about their culture, and understanding, positive attitudes on the part of faculty and students would be helpful" (Kayser-Jones & Abu-Saad, 1982, p. 309).

The role of the advisor in facilitating or hampering adjustment was also identified by the international student respondents (Abu-Saad & Kayser-Jones, 1981). Students who had positive relationships with advisors were enthusiastic in their responses, while students with negative advisor experiences were scathing (Abu-Saad & Kayser-Jones, 1981).

Student Expectations and Socialization

In addition to describing international nursing students' problems and factors

that might facilitate adjustment to the U.S., Abu-Saad and Kayser-Jones (1982) explored students' expectations of their international educational experience and the process of socialization to student and nursing roles. The authors reported that international nursing students in the U.S. find "different patterns in personal and professional socialization" from those of their home countries (Abu-Saad & Kayser-Jones, 1982, p. 7). For example, strong assertive behavior in women was an aspect of professional socialization in the U.S. that required adaptation. Styles of teaching and learning were also often quite different. The majority of the student respondents stated that their expectations were "fairly closely met; however, personal and professional socialization, such as studying and taking tests, questioning people of authority, and being assertive" were aspects of nursing student life that were unexpected (Abu-Saad & Kayser-Jones, 1982, p. 8).

A second theme was lack of congruence between the school's expectations and the students' expectations with regard to nursing practice and the educational program. To aid in the achievement of congruence between the school and the student, Abu-Saad and Kayser-Jones (1982) recommended: (a) detailed lists of program requirements including clinical prerequisites, be sent to applicants; (b) correspondence contact with the academic advisor or faculty mentor before the student's arrival; and (c) an introductory course describing the nursing system including terminology and role delineation, patient rights, and liability.

Abu-Saad, Kayser-Jones, and Tien (1982) analyzed responses from a subset of

Asian nursing students selected from the larger sample of international nursing student respondents. Most common difficulties of the Asian students included language problems, lack of faculty awareness of foreign cultures, and lack of flexibility in the program. For these Asian students language difficulties included extensive reading assignments. They suggested this was unusual in traditional Asian education where emphasis is placed on memorizing details of certain subjects. U.S. nursing education instead emphasizes synthesis and critique from many sources. Asian nursing students tended to fall behind. Moreover, according to Abu-Saad, Kayser-Jones, and Tien (1982), faculty often lacked awareness of specific differences unique to distinct cultural groups.

Though this study does provide a springboard for understanding of the international student's experience in schools of nursing, it is over ten years old. The authors did not separate undergraduate and graduate student responses so there is a lack of information about potential differences. Furthermore, the collapsing of international students into one category or subcategory (e.g., Asian students) may obscure themes specific to particular nationalities, a limitation identified by the authors.

A more recent study by Alexander and Shaw (1991) explored the concerns and coping of 16 international students at one college of nursing. Analysis of ethnographic open-ended interviews that examined the culture and everyday life of the international nursing students resulted in an international students' "wish list." The

wish list evolved into ideas for interventions that would occur before the student's arrival, during orientation to the new culture, and ideas supportive to living and studying in the U.S., many of which were implemented in a 1-year pilot study. For example, a handbook with information about the academic program, administration, faculty, students, and services was made available to incoming students. In addition, faculty advisors were provided with information about the cultures and possible needs of incoming students. Finally, an intensive student mentoring program was instituted. The investigators have planned an evaluation of the usefulness of the interventions to the students, faculty, and administration.

The purpose of Alexander and Shaw's study was to identify concerns and coping in the international nursing student population. They did not explore reentry issues, culture-specific concerns or methods of coping, nor did they identify whether differences in coping and concerns might exist between graduate and undergraduate nursing students.

Tien (1982) wrote a first person anecdotal account of her experience of graduate nursing school. The purpose of her paper was to share her experience as a foreign graduate nursing student in the U.S. Her account identifies issues similar to those delineated by Kayser-Jones and Abu-Saad. As a Taiwanese international nursing student, Tien encountered communication difficulties exacerbated by her culture's proscriptions against assertion and confrontation. She exhibited physical symptoms which were aggravated by acculturation stress. Tien clearly describes the

importance of the relationship of the advisor and the devastation she felt when she failed her preliminary examination during her doctoral education process. Tien's story is moving and provides some information about the lived experience of one international Taiwanese student but hers is a single voice.

Strategies for Teaching International Nursing Students

There have been calls for increased diversity and multiculturalism within the nursing profession for years (Furuta & Lipson, 1990; Loustau, 1986; Meleis, 1987; Uhl, 1993). However, to be effective in communicating with students from diverse cultures nursing educators may need to employ new strategies for teaching in the multicultural milieu. Loustau (1986) has made broad suggestions for teaching students with English as a second language (ESL). For example, she suggests that teachers avoid assuming that a smile and nod indicate understanding in the case of an ESL nursing student. She advocates the creation of a learning environment where "asking questions or saying 'I don't know' can be done safely" (Loustau, 1986, p. 93). Shearer (1989) has expanded Loustau's suggestions. She makes concrete recommendations for teaching international students such as, including class schedules, home phone numbers, office hours and locations in the course syllabus (Shearer, 1989). Shearer (1989) urges nurse educators to demonstrate their availability to students by inviting students to call or drop by and urges them to initiate guidance with international students. The provision of notes of lecture content, the provision of criteria for written assignments in a simple, concrete

manner, helping students network, and the provision of hands-on experiential learning opportunities for international students are other strategies Shearer offers nurse educators. She suggests that terminology on exams needs to be congruent with that used in class and counsels educators to avoid culturally specific cliches. Finally she urges educators to be aware of inherent U.S. American concepts, like Judeo-Christian ethics, which may be non-existent in other countries. When such concepts are aspects of the course curriculum, special explanations my be required for international students.

Gay, Edgil, and Stullenbarger (1993) describe a group of 42 international graduate students attending a "large school of nursing in the U.S." and offer strategies for dealing with the problems experienced. Gay et al. (1993) identify the importance of the advisor to provide support and advice on everything from shopping to personal safety in U.S. America. Advisor/faculty understanding the cultures of the incoming international students, their concerns, and their daily lives are all identified as helpful components of a successful international student educational experience.

Moreover, Gay et al. (1993) claim specific criteria for international student admission go far toward ensuring a successful educational experience. For example, students must score at least 530 on the Test of English as a Foreign Language (TOEFL) because it is thought that to admit a student without English proficiency could be a "set up for failure" (p. 105). Moreover all graduate students including international students must pass the Registered Nurse-National Council Licensure

Examination (NCLEX). The examination of the Council of Graduates of Foreign Nursing Schools (CGFNS) is a prerequisite to sitting for the NCLEX exam for foreign nurses so it too is required for international nurse applicants. Additionally, doctoral students must have a combined score of 1500 on the three sections of the Graduate Record Examination (GRE).

Even with the admission criteria, there are often language problems with those international students whose first language is not English. For example, many ESL students have little opportunity to hear and speak English prior to coming to the U.S. Moreover, some ESL students, particularly women, speak softly, a polite expectation in some cultures, and therefore, are difficult to hear. Often reading skills and the ability to synthesize content are good in the international student but he/she may be lacking in writing skills. Because written assignments may require frequent editing and rewrites which may be best achieved with one-to-one tutoring, Gay et al. suggest that the faculty/university should be prepared to assist students with this resource if needed.

The paper of Gay et al. (1993) is useful and descriptive but did not propose to provide a systematic study into the lives of international students. The teaching strategies identified are practical and experience based but the perspective is that of the nurse educator and is not particularly descriptive of the lifeworld of the students.

Review Conclusions

Concepts relevant to international students and specific concerns of

international nursing students have been delineated. Grace (1990) and Alexander and Shaw (1991) support the notion that it is important for educators to understand the lifeworld of the international nursing student in order to enhance the likelihood of successful and relevant educational experiences. Abu-Saad and Kayser-Jones (1982) and Gay, Edgil, and Stullenbarger (1993) note the dearth of research literature focused upon international nursing students. Abu-Saad and Kayser-Jones' (1981; 1982) investigations into problems and adaptation of international nursing students and Abu-Saad, Kayser-Jones, and Tien's (1982) description of Asian international students introduced problems specific to these students in schools of nursing. Alexander and Shaw (1991) also concentrated on the concerns of the international nursing student. Yet, an in-depth understanding of the day to day lived experiences of these students was not the goal of these studies. This, together with the breadth of the samples precludes the possibility of their satisfying Grace's recommendation for a deep understanding educationally and experientially of international students' backgrounds and their likely futures. Most of the literature on international nursing students does not differentiate between graduate and undergraduate students, yet these groups may be different developmentally and experientially. Moreover, the literature is not culture specific. Furthermore, no research studies have explored the lifeworlds of international graduate nursing students when they return home.

Significance of the Study

The literature refers to international "students" and while some international

nursing students are young and professionally inexperienced, many graduate international nursing students are nurse leaders and scholars in their own countries and therefore will be referred to as "nurse scholars" or "participants" in this study. Numbers of Japanese international scholars at schools of nursing in the U.S. are on the rise. Yet little is known about their lived experience. The aim of interpretive theory is the understanding and description of the lived experience so as "to increase one's thoughtfulness and practical resourcefulness or tact" (van Manen, 1990, p. 4). Interpretive theory is an explanation of a phenomenon in meaning terms (Benner & Wrubel, 1989; Haylor, 1992). Interpretive theory produced by this study will enable caring academic practices through understanding. Although interpretive theory based upon the lived experiences of the Japanese international nurse scholars cannot be said to be generalizable to other international nurse scholars or to non-international nurse scholars, exemplars of their experiences may carry meaning that fits in differing contexts. Furthermore, the stance of developing caring academic practice by entering the lifeworld of the student/scholar through understanding, the purpose of interpretive theory generation, does "generalize" to a philosophy of caring nursing practice.

Research Questions

This study was framed from an interpretive science perspective. From this perspective common themes and shared meanings are sought from the analysis of narratives. The questions specific to this study were:

1. What are common themes and shared meanings of the Japanese nurse scholars'

experiences during their study in the U.S.?

2. What are common themes and shared meanings of the Japanese nurse scholars' experiences when they return to Japan.?

CHAPTER II

BACKGROUND

Rather than presuming that the international education experience is the simple acquisition of advanced theoretical and scientific knowledge, this study is based upon the assumption that the international educational experience constitutes an ontological transformation, a change in the self, which in turn transforms the professional lives and the practice of the nurses involved. Inherent in this foundational assumption are embedded assumptions concerning the nature of humans and the nature of practice. In this chapter, literature from philosophy, philosophy of science, and nursing, as well as English literature about nursing and health care are synthesized to explicate the background for this research.

Philosophical notions about the nature of human life, aspects of personhood that are often assumed and implicit, are examined in the first section of this chapter because they are foundational to the conception and methodology of the study. In the second section, conceptions of practice are described, with special attention to describing Japanese nursing within the context of the Japanese health delivery system. The purpose of this discussion is to provide a starting point for understanding the context of participants' practice lives.

Notions About Humans

Four aspects of humanness will be addressed. These include: The role of background meanings; the meaning of "situated freedom"; the meaning of "self-

interpreting"; and the role of the situation in human life. Differences between Japanese and U.S. cultural assumptions will be explored. Each of these aspects is interwoven and interdependent, and, although presented separately, should not be construed as discrete.

Background Meanings

According to Heidegger, who lived from 1889 to 1976, humans live through their background meanings, take them for granted and seldom have either the need or the capacity to make them conscious and explicit (Gadamer, 1960, 1975). One acquires background meaning through being raised in a culture. Background meanings allow for the perception of the factual world (Benner & Wrubel, 1989). This view differs markedly from the view traditionally held in Western culture which asserts that the world is understood through formal, explicit knowledge.

We as humans constitute and are constituted in and by our situations and our concerns (Benner & Wrubel, 1989). Each person is situated in webs of social relations, meanings, and concerns. These "webs of significance" may be called culture (Geertz, 1973, p. 5). People enter into situations with their own sets of background meanings, habits, and perspectives, and their ways of being in the situation are predicated on these. To understand the individual's world, his/her background meanings must be explored. It is through these that the individual lives and they are for the most part not explicit. Cross-cultural encounter is one way to tease out explication (Doi, 1971, 1973; Field & Morse, 1985; Ohnuki-Tierney, 1984).

Background meaning, according to Heidegger (1927, 1962) is shared public understanding. Merleau-Ponty (1964, 1968) likened background meaning to a light. While one does not notice the light itself, without it all would be in shadow. One sees the world through the illumination (Benner & Wrubel, 1989). Taken-for-granted background meanings are given by one's culture, one's family, one's life experience. From birth, background meanings set up what is of concern (Heidegger, 1927, 1962). So of course, background meaning and concern are culturally specific.

Yet an explication of "dominant cultural values" tends to lump all members of a culture under one anthropological umbrella. Such explications tend to be culturally stereotypic and often express the values of the most powerful of the culture's groups (e.g., wealthy white men in the U.S., Navarro, 1986). These characteristic values are generalized abstractions and should not be construed as predictive for individuals. Clarifying the value differences among individuals may illuminate differences within a culture and between it and other cultures.

Nursing is often considered a "woman's profession" in both Japan and the United States, and indeed ninety-seven percent of nurses in both countries are women (Long, 1986; McCloskey & Grace, 1990). It follows that although dominant cultural values inextricably influence the women's cultures of both countries, the majority of nurses, being women, do not belong to the dominant culture (Belenky, Clinchy, Goldberger, & Tarule, 1986; Gilligan, 1982; Schaef, 1981).

The Meaning of Situated Freedom

Situated freedom, a concept that is derived from the Heideggerian view, contrasts to that of Husserl, Heidegger's teacher. Husserl described human beings as being unfettered in their possibilities for apprehending and acting in their worlds. Husserl's philosophic rendering of the Cartesian subject/object, mind/body dualism resulted in a concept of the person wherein humans represent their worlds and ascribe meaning to their situations. Husserl's interpretation implies that each person has radical freedom, infinite choice, and individualistic control. There is a metaphysical quality, a suggestion of spiritual freedom, which enables "humans to stand outside the context of human emotions in order to determine what is truly important" (Gordon, 1988, p. 41; Taylor, 1985a).

However, the Heideggerian assumption of background meanings results in a view that individuals have limited freedom of response. An individual's potential for adaption or adoption of new possibilities is grounded in the context of the person's background meanings. Nonetheless, new possibilities for ways of being in a situation can be learned. More specifically, the person grasps the situation directly and apprehends its meaning "because the very act of apprehension is based on taken-for-granted meanings embedded in skills, practices, and language" (Benner & Wrubel, 1989, p. 42). Thus, understandings of new situations are both limited and defined by background meanings and webs of relationships. This assumption illuminates the situation of the Japanese nurses and their transformative experiences.

The Husserlian viewpoint is based upon Cartesian ideas, ideas that have had profound impact on U.S. American culture. Descartes' epiphanistic "*Cogito! Ergo sum*" established a being with a thinking self separate from "the body." Descartes who lived from 1596 to 1650, instituted the assumption that humans are made of two separate entities, body and mind, "linked during life but profoundly different in kind" (Dubos, 1968, p. 84). For Descartes the mind was the home of the spirit, the soul, while the body was reducible to a machine whose structure and operations fall within the domain of science (Dubos, 1968). The Cartesian "body as machine" metaphor is pervasive in Western and biomedical thought. Human bodies are conceived as machines capable of mechanistic explanation and manipulation (Kirmayer, 1988). When the machine malfunctions, the patient-owner brings the body to the physician for repairs. The Cartesian view with its mind/body split is echoed in Western cultural assumptions and loudly resounds in biomedicine (Kirmayer, 1988).

Embedded in the Cartesian mind/body split within the context of biomedicine is the reified concept of the body as a mechanistic entity. Also embedded are issues of control, responsibility, authority, rationality, and embodiment. Parenthetically, Kirmayer (1988) argues that physicians have "exaggerated standards" for rationality, based in part upon their distancing from emotion, and furthermore, issues of authority and power are at stake. Gordon (1988) and Taylor (1985a) argue that the basic and fundamental issue at the core of biomedical assumptions and dominant American and scientific values has to do with notions of the self, individuality and independence.

Mechanistic metaphors extend to other entities in addition to the body in some U.S. American thought. Stewart (1987) asserts that the American's concept of the world is rational because he or she believes the events of the world can be explained and the reasons for particular occurrences can be determined. Moreover, Stewart (1987) claims, the U.S. American's rationalism derives from an assumption that the world is mechanistic.

In medicine and nursing differences in cultural value orientations profoundly influence etiological assumptions and have consequences for health care practices. Japan has not had the same romance with the "body as machine" notion because there is not the same Cartesian mind/body split in Japan. "There has never been a split between psyche and soma in Japanese thinking" (Lock, 1987, p. 138). Furthermore, in Japan, where harmony in relationship is of extreme importance, there is a reluctance to carry rationalism to the point where it makes the individual too aware of the separateness of the people and things around him/her (Doi, 1971, 1973). The assumption of radical freedom, the mechanistic model, and the mind/body split is pervasive in Western medical and nursing theory. There is a conceptual incongruence, a dissonance, when ideas pregnant with these background meanings are overlaid on Japanese nursing practices.

Humans As Self-interpreting Beings

When it is said that we as humans constitute and are constituted by our situations and concerns (Benner & Wrubel, 1989), two other assumptions about the

nature of the human emerge. First, this conception of humans presupposes that humans are self-interpreting. Heidegger (1927, 1962) stated, "understanding constitutes rather the Being of the 'there' in such a way that on the basis of such understanding, a *Dasein* can, in existing, develop the different possibilities of sight, of looking around, and of just looking" (p. 385). From the German, *Dasein* is translated "being there" (Benner & Wrubel, 1989, p. 407). According to Benner and Wrubel (1989) Heidegger used *Dasein* to signify embodied human experience and everyday existence. Heidegger's *Dasein* refers to the idea that "what happens and what is taken in, and the way in which what happens is understood, are greatly affected by the possibilities available in a culture" (Benner & Wrubel, 1989, p. 104). Heidegger's person exists and knows within a situational matrix, not from Husserl's reflective outside. And the person's concern is not abstract knowing but the kind of knowing that occurs from standing in the situation (Benner & Wrubel, 1989). This self-interpreting person is not congruent with the Western ideal of the individual being one who possesses objective clarity (Taylor, 1985a).

Second, this self-interpreting person is a being for whom things have significance and value (Leonard, 1989; Geertz, 1973; Taylor, 1985a). Through an understanding of the relational and configurational context one can find what is significant and valued by the person. Significance is highly situational and culturally specific. For example, what constitutes shameless behavior, what comprises dignity, what passes for moral goodness, differs remarkably across cultures (Taylor, 1985a).

What shows up as significant and of value differs greatly by culture and background meaning.

The Role of the Situation

Descartes claimed that one achieves understanding through self-reflection, bracketing all prejudices. But according to Gadamer there is no understanding without prejudice (Bernstein, 1983). Furthermore, one cannot hope to reach total self-transparency because one is always standing in the situation one seeks to understand or within which one is acting.

Gadamer (1960, 1975) defines the concept of situation by saying that "it represents a standpoint that limits the possibility of vision. Gadamer (1960, 1975) writes, "the very idea of a situation means that we are not standing outside it and hence are unable to have any objective knowledge of it" (p. 301). From within the situation total illumination is impossible. There is shadow. And we as humans are always within a situation, a tradition, historically. "To be historically means that knowledge of oneself can never be complete" (Gadamer, 1960, 1975, p. 302).

Essential to the concept of situation is the concept of "horizon." "The horizon is the range of vision that includes everything that can be seen from a particular vantage point" (Gadamer, 1960, 1975, p. 302). Horizons change for a person who is moving. This concept is particularly relevant to the current study. For the Japanese nurses, the international education experience, complete with "culture shock" (Adler, 1987; Furnham & Bochner, 1986) and reentry (Kidder, 1992; Paige, 1990; White,

1988), provides a metaphoric change of horizon along with the participants' personal transformations and physical relocations.

Situation and tradition are intricately interwoven. Heidegger (1927, 1962) and Gadamer (1960, 1975) divide tradition into three aspects: fore-having, fore-sight, and fore-conception or *vorhabe*, *vorsicht*, and *vorgriff*. Tradition includes the total background of practices, vocabulary, concepts and hypotheses that humans bring to an encounter (Gadamer, 1960, 1975; Heidegger, 1927, 1962; Thompson, 1985). This is the person's horizon. These preunderstandings or "prejudices" (Gadamer, 1960, 1975) do not just flavor human understanding but influence all knowing (Gadamer, 1960, 1975; Bernstein, 1983). *Vorhabe* (fore-having) refers to the totality of practices or the disciplinary matrix with which we approach a problem and which helps us to perceive what is salient. *Vorsicht* (fore-sight) refers to vocabulary and conceptual schema, the scientific boundaries, and what is culturally or paradigmatically valued. And *vorgriff* (fore-conception) are those specific hypotheses we enter into the encounter carrying which can be confirmed or disconfirmed by the data, the encounter, the experience (Thompson, 1985).

Thus the situation is determined by the prejudices that we bring with us. Likewise prejudices constitute the horizon because they represent that beyond which it is impossible to see (Gadamer, 1960, 1975). According to Bernstein (1983) interpreting Gadamer, both "blind and enabling" prejudices are constitutive (p. 128). Blind prejudices are those which while constitutive remain in shadow, those of which

we are not aware, yet which define our horizons. Enabling prejudices are those prejudices productive of knowledge (Bernstein, 1983).

It is "through the dialogical encounter with what is at once alien to us," yet has a claim on us, that we can find which of "our prejudices are blind and which are enabling" (Bernstein, 1983, p. 128; Thompson, 1985). This premise is the foundation of Taylor's (1985b) cross-cultural interpretive science. Through the dialogical encounter, we come to understand "their practices in relation to ours" (Taylor, 1985b, p. 129). Furthermore, Taylor (1985b) argues, in the process of understanding their practices in relation to ours, our self-understanding ought to be altered. Taylor (1985b) maintains an interpretive approach in cross-cultural science can provide an alternative to ethnocentrism, offering a true fusion of horizons, an understanding of practices, the others' and our own.

To return to the assumption initially advanced--the international education experience is an ontologically transformative one; when self-understanding is altered, the being is changed. Traditionally, practice has been conceptualized as flowing from epistemology however, when practice is conceptualized as ontological, changes in one's being are changes in one's practice.

Conceptions of Practice

The notion that changes in one's being are changes in one's practice is based upon a conceptualization of practice as an ontological as well as an epistemological endeavor. This is the primary practice assumption which guided this study.

The first section of "conceptions of practice" is comprised of a discussion of the assumptions concerning the relationship of theory to practice inherent in the Socratic tradition. The first section also includes discussion of alternatives to those assumptions. The second section is an argument in defense of conceptualizing practice as an ontology as well as an epistemology based on the notion of practice happening within a situated context. In the third section aspects of the situated context of the practices of the Japanese nurse participants are explored.

Theory and Practice

Heideggerian phenomenology provides a perspective on theory in practice which is an alternative to the Socratic model. In contrast to the Socratic ideal from which came the current family of positivist sciences (Lincoln & Guba, 1985), interpretive science does not conceptualize theory as something standing before practice to "inform" it. "Rather, theory enlightens practice" (van Manen, 1990, p. 15). From this perspective, practice always comes first and theory comes later as a result of reflection on practice (van Manen, 1990). Moreover, the aim of interpretive science, rather than the production of abstract theory, is the understanding and description of the lived experience.

The tradition that emanates from Socrates sees theories as explicit, abstract, universal, and reducible to elements in relationships described by laws or rules (Dreyfus & Dreyfus, in press). Socrates valued craft or practice that could explain itself in terms of articulated theory and dismissed craft that could not, regarding

expertise in such practices as "mere knack." Expertise in intuitive practices, which could not self-consciously and rationally explicate theoretical involvement, was dismissed by Socrates as lacking in knowledge (Dreyfus & Dreyfus, in press).

Physicians maintain that medical expertise is a combination of theoretical knowledge, experience, and judgement. Yet judgement is an activity which includes intuition and skilled know-how (Benner & Tanner, 1987; Dreyfus & Dreyfus, in press). Still, the dominant view in science continues to elevate the Socratic ideal, valuing theory, and those professionals who cover themselves with a profusion of theory, over those more involved in practice, with their implicit, concrete, holistic, and intuitive surroundings.

The development of nursing theory has been a recent happening. Early nursing practice was "characterized by blind obedience to medical authority and by a belief in biomedical theory as the theory of choice" (Kidd & Morrison, 1988, p. 222). Later theory from other disciplines, education, psychology, sociology, anthropology, and physiology was imported into the nursing discipline (Kidd & Morrison, 1988). Eventually specific nursing theory was defined and developed (Kidd & Morrison, 1988). And nursing theory based upon Socratic notions of abstractness, discreetness, universality, and context-freeness, reflecting the dominance of theory over practice was produced. Kidd and Morrison (1988) claim that "in their haste to prove the credibility of nursing as a profession, nurse scholars have emphasized primarily reductionism and empirical validation" (p. 223). Benner and Wrubel (1989) maintain

that because most nursing theories are produced to satisfy nursing curriculum requirements (Meleis, 1985), there has been little nursing theory shaped by the practice of nurses (Benner & Wrubel, 1989).

Situated Practice

Interpretations of Heidegger and Gadamer presented earlier describe the ways in which human beings live in and interpret their worlds. This contrasts to the Socratic view and forms the basis for an alternate conception of practice. In spite of this alternative conception, the breach between theory and practice persists, epistemologically reflected in the methodology valued by the dominant scientific paradigm and in the continued undervaluing of practice expertise (Schon, 1983). Schon (1983) maintains that in the professions of law and medicine, practice is epitomized as the scientific, rational application of standardized knowledge and general principles to concrete problems. And, he illustrates ways in which this model leaves out those aspects of practice that are complex, uncertain, unstable, unique, and filled with value conflict, the essence of the practice situation that requires the art and intuition of the practitioner.

Schon (1983) argues that this professional model, the overlay of theory onto practice, has two significant short-comings from the perspective of practice realities. First, it leaves out the setting of the problem. And second it assumes clear, fixed, agreed upon ends (Schon, 1983). In practice, however, conflicting paradigms of professional practice often result in differing disciplines valuing differing outcomes or

ends.

With the Socratic professional model there is an emphasis on problem solving. Decisions are reached through the selection, from choices available, of the one best suited to meet established ends. However, "in order to convert a problematic situation to a problem, a practitioner must do a certain kind of work" (Schon, 1983, p. 40). Schon (1983) calls this work "problem setting" which he defines as a "process in which, we name the things to which we will attend and frame the context in which we will attend to them" (p. 40). The practitioner identifies/prioritizes that which is of concern and situates his/her concerns within a context. Discussing the practice of medicine and defining disease as an alteration in biological structure or functioning, Kleinman (1988) notes, "disease is what practitioners have been trained to see through the theoretical lenses of their particular form of practice" (p. 5).

Nursing is a profession in a unique position with regard to the issue of theory and practice. Nursing practice involves the application of biomedical and other theory, and expert nursing practice is characterized by deep understanding of these theories (Dreyfus & Dreyfus, in press). Although biomedical theory has been described as generalizing across cultures, that is, context free, this assumption has been criticized and questioned (Kleinman, Eisenberg, & Good, 1978; Lock & Gordon, 1988). Kleinman, Eisenberg, and Good (1978) in their seminal discussion of biomedical culture claim:

> Contrary to the usual belief of health professionals, this biomedical viewpoint is both culture-specific and value-laden: it is based upon particular Western

> explanatory models and value-orientation, which in turn provide a very special paradigm for how patients are regarded and treated (p. 256).

Practice does not allow for a simple, instrumental application of research to problems. Practice is situated within a complex context and cannot be construed to be culture or context free.

Kleinman (1988) defines illness as the lived experience of the sick person and his or her family. This includes how they live with and respond to symptoms and disability. It is the lived experience of illness, characterized by suffering, that is the privileged place of caring nursing practice (Benner & Wrubel, 1989; Dreyfus & Dreyfus, in press). This is a practice that depends upon the application of theory, yet goes far beyond straightforward theoretical application and analytic rationality. It is a caring practice where expertise demands a level of involved understanding and shared meaning, a discipline where practice is a way of being (Benner & Wrubel, 1989; Dreyfus & Dreyfus, in press).

The change in the practitioner from the user of an epistemology to an ontological being, profoundly changes the conception of practice. Expert nursing practice demands a level of involved understanding which derives not simply from "the knowing" of the nurse but which often stems from her or his way of being in the situation.

U.S. nursing epistemology has influenced Japanese nursing (Minami, 1985). And U.S. traditional values are embedded in Japanese nursing epistemology. In fact, Minami (1985) claims "the Japanese traditional ethical frame has not been clearly

transmitted in [Japanese] nursing education" (p. 313). Furthermore, Minami (1985) asserts, Japanese nurses "lack an awareness of the confusion between traditional [Japanese] and Western value orientations" (p. 313). She illustrates this statement with the example of the goal of nursing activity to assist the patient in becoming as independent as possible (Minami, 1985), a goal which reflects traditional U.S. American values (Bellah, Madsen, Sullivan, Swidler, & Tipton, 1985, de Tocqueville, 1835, 1945a; de Tocqueville, 1835, 1945b), yet which may well be an aspect of shared nursing culture. Regardless, the caring practices designed to move the patient towards the goal of independence are expressed in profoundly different ways in the U.S. and in Japan. Moreover, Minami (1985) states "if the American nurse observes the nursing interventions provided by the Japanese nurse, she may view it as 'interdependence' or even 'dependence'" (p. 313).

There are fundamental differences in the U.S. American's sense of self (Gordon, 1988; Stewart, 1987; Taylor, 1985a) and that of the typical Japanese person (Doi, 1971, 1973). In the Western tradition, individuals are thought to have a "self" that is distinct, boundaried, and the difference between the self and "not self" is usually clear (Gordon, 1988). The self is thought of as an absolute, existing separate from a situational context. The self is also thought of as different from "the body." These ways of defining the self as reified, autonomous, and context free are quite different from the Japanese definitions. The Japanese person is usually defined in terms of context, a socially relative being (Lebra, 1976). In this way the Japanese

self depends on webs of relationships for personal definition and meaning (Doi, 1971, 1973). Yet in U.S. American culture, to define oneself in terms of relationships is considered weak and limited or feminine (Belenky et al., 1986; Gordon, 1988; Schaef, 1981).

Differences in the notion of the self and differences in what is meant by "independence" prescribe differing caring practices designed to promote "independence." Minami (1985) clearly identifies patient independence as an aspect of nursing epistemology that is shared by Japanese and U.S. American nurses in their respective practices. But she also points out the profound differences in nursing comportment within those respective practices, situated within differing cultural contexts with differing background meanings and values, and thus differing ways of being with the ill patient.

The Situated Practice of Japanese Nurses

The situated practice of Japanese nurses is presented as the third practice element relevant to the background of the study. For a discussion of the Japanese health care context with information about Japan's health care policies, and financing and reimbursement in Japan, please turn to Appendix A.

There are writings published in English that describe Japanese health care and the Japanese delivery system (e.g. Abe, 1985; Goto, 1988; Hinohara, 1990; Iglehart, 1988a; Iglehart, 1988b; Kawamura, Gotoda, & Yoshikura, 1985; Kiefer, 1987; Lock, 1984; Long, 1984, 1986, 1987; Norbeck & Lock, 1987; Ohnuki-Tierney, 1984;

Steslicke, 1987). Yet few of these studies mention Japanese nursing. Japanese physicians publish widely in the English press, while articles written by Japanese nurses are rare (Long, 1984). An extensive Japanese nursing literature exists. However, little of it has been translated to English. The Japanese context for health care may be partially appreciated by U.S. nursing faculty, but an in depth understanding of the context for Japanese nursing practice is unlikely. The nursing context is introduced to provide more understanding of the background of the Japanese international nurse participants. The exploration is limited by my lack of literacy in Japanese.

Physicians and Nurses in Japan

The authority and dominance of the physician in the health delivery milieu is reinforced by Japanese law (Iglehart, 1988a) as well as by custom (Long, 1984, 1986, 1987). Deference shown to physicians by nurses and other non-physician health care workers may be traced in part to Japanese patterns of male-female role behaviors (Long, 1987). More than 90 percent of physicians are men while 97 percent of nurses are women (Long, 1987). In addition, most nurses "receive their training [sic] at special vocational schools that are generally considered inferior to college and university programs in terms of faculties, facilities, and educational curricula" (Long, 1987, p. 80). This perpetuates the educational and social gap between physicians and nurses in Japan (Long, 1987).

Long (1986), an anthropologist, explored the relationship between gender and

work roles in biomedicine in Japan. Her year long study included observations and interviews which took place in 19 Japanese hospitals and clinics. Long (1986) maintains that physicians in Japan are seen as "educated, scientific, mental laborers, and clean, as well as male" (p. 81). Nurses, on the other hand, are seen as "uneducated, emotionally responsive, manual laborers and are seen to do the dirty work of medical care" (Long, 1986, p. 81). Long (1984) found that terms used to describe nurses in Japan included, "meek" and "powerless" (p. 141). She (Long, 1984) claims that "in the eyes of the Japanese public, nurses in Japan appear subservient" (p. 141). She identifies three reasons for this. First, most Japanese nurses lack a sense of professionalism, attributed by the Japanese nursing elite to the low educational levels of the nurses (Long, 1984). Second, Japanese nurses function as intermediaries between their patients and the patients' more socially distant physicians (Long, 1984). And third, Long (1984) suggests "Japanese nurses might be considered the 'housewives' of the hospital in terms not only of their physical duties but also of their caretaking role" (p. 141).

The Nursing Shortage

Najmaie, a professor of business, and Modjeski, a nursing instructor, have written from their perspectives claiming that U.S. nursing is in trouble. The trouble they write of includes job dissatisfaction, low morale, a severe nurse shortage, a high turnover rate, and rapid cost increases. They further claim that problems in Japanese nursing are much less severe (Najmaie & Modjeski, 1990). Moreover, they state,

"the Japanese nursing industry has no shortage" (Najmaie & Modjeski, 1990, p. 53). Most authorities on Japanese nursing and health care disagree with this statement (Anders & Kanai-Pak, 1992; Hinohara, 1990; Inoue, 1983; Kojima, 1987; Nursing in Japan, 1993; Steslicke, 1987). Steslicke (1987) states, "In Japan, it is generally agreed that the most pressing personnel problem in the medical care sector is the acute shortage of nurses" (p. 42). Hinohara (1990) maintains, "currently the ratio of nurses per bed in Japan is only one third of that in the U.S." (p. 8). Anders and Kanai-Pak (1992) write of one potential result of the nursing shortage, *karoshi*, or death from overwork. Following the death of Junko Yoshida, a 22 year old nurse who died from heart failure after returning home following her 34 hour "shift," a Japanese hospital is being sued (Anders & Kanai-Pak, 1992). According to Anders and Kanai-Pak (1992), nurses at Fujita Memorial Hospital were required to work a 36-hour schedule five times per month. Although the hospital did provide a rest area, "because of the shortage of nurses and workload," Ms. Yoshida was unable to take a break (Anders & Kanai-Pak, 1992, p. 186).

Najmaie and Modjeski (1990) further suggest that attrition, that is nurses leaving the work place/the profession, is a primary problem in the U.S. nursing shortage. They indicate that this is not the case in Japanese nursing. This view is not reflected in the literature (Anders & Kanai-Pak, 1992; Kojima, 1987; Nursing in Japan, 1993). For example, Anders and Kanai-Pak (1992) claim that the turnover at most hospitals averages 30-35% per year and the average length of employment is

3.5-4.5 years with most Japanese nurses leaving the profession when they marry around 25.

Najmaie and Modjeski (1990) imply the U.S. could well learn from Japanese nursing management techniques. They propose flexible time scheduling, improved orientation, and better management-staff communication to improve the attrition rate in U.S. nursing. These ideas make common sense. And while these notions may be found in the Japanese business world, Najmaie and Modjeski (1990) indicate that these are typical of Japanese nursing. Again, this is not supported by other literature on Japanese nursing. For example, Najmaie and Modjeski (1990) claim flexible time scheduling "allows employees to determine their own arrival and departure times within specific limits" (p. 54). Yet most Japanese hospitals do not hire part-time employees (Anders & Kanai-Pak, 1992). And in most facilities the nurse is required to work all three shifts in rotation with up to eight night shifts per month (Anders & Kanai-Pak, 1992). In a survey of unemployed Japanese nurses, 48% indicated a desire to return to work on a part-time basis so they could choose their own schedules, demonstrating a desire for flexible scheduling but a lack of part-time positions (Nursing in Japan, 1993). The unemployed nurse respondents indicated "working hours" were the most important consideration in deciding whether to return to work (Nursing in Japan, 1993).

Najmaie and Modjeski's (1990) idea of improved management-staff communication is intuitively a good one. Yet to imply that Japanese nursing

management-staff communication is effective is also debatable. In Japan the director of either a hospital or clinic is, by law, a physician (Iglehart, 1988b). In the Japanese health care milieu, Anders and Kanai-Pak (1992) found that for nurses "the impotence in managing physician/nurse conflict was a major source of job dissatisfaction" (p. 189). In part because of this conflict, it is rare to find a nurse over the age of 50 still practicing in the hospital setting and because few senior nurse managers remain in the health care system, "their ability to change the practice environment is extremely limited" (Anders & Kanai-Pak, 1992, p. 189).

The notion of importing ideas from Japan to solve problems in U.S. nursing may be useful, and some of the ideas Najmaie and Modjeski (1990) propose are good ones. Yet to claim that Japan has no nursing shortage, to imply that there is little attrition in Japanese nursing, and to suggest that most Japanese nurses enjoy flexible scheduling and experience minimal communication conflict is misleading.

Burnout in Japan

Hisashige, Koda, Kurumatani, and Nakagiri (1989) studied the occupational influences on burnout among hospital nurses in Japan. Using the Maslach Burnout Inventory, they queried 898 nurses at four prefectural and municipal hospitals. They also surveyed 255 non-nurse municipal workers. They found that in Japan nurses scored significantly higher on the inventory than did municipal workers and that they scored higher on all subscales. "Problems with working life," which mainly resulted from shift work and "working conditions," which mainly referred to work load, were

shown to be the main risk factors for burnout syndrome among Japanese hospital nurses (Hisashige et al., 1989). To interpret these findings it is important to recall that Japanese hospital nurses most often rotate shifts. Furthermore, the 5-day workweek was introduced in Japan in the latter half of the 1980's (Nursing in Japan, 1993). Although 45.9% of the workers in private industry worked a 5-day workweek in 1991, only 7.7% of the nurses employed by private hospitals enjoyed this schedule (Nursing in Japan, 1993). More typically, Japanese nurses are required to work 11 days every 2 weeks (Anders & Kanai-Pak, 1992).

Attendance Care and Nursing in Japan

Inoue (1983) suggests that an important characteristic of Japanese hospital nursing is the "existence of attendance care" (p. 172). On the average, according to Inoue (1983), between 11 and 30 percent of all patients in Japanese hospitals have an attendant. Most of the patients' attendants are family members. Goto (1988) too alludes to the idea of attendance care, claiming that one reason for the relatively low Japanese hospital "room charge" is that patients' families often are involved in providing personal services like bathing, feeding, and administration of oral medications. According to Inoue (1983), attendance care refers to "taking care of the patient at the hospital by way of a contract from him [sic] only" (p. 172).

Attendance care is said to fit culturally with the Japanese emphasis on strong family relations (Inoue, 1983). Within the family circle, one need not exhibit *enryo*, (Inoue, 1983) that is, hesitation, self-restraint, or reserve. When a family member is

providing personal care, the patient may feel more comfortable than when care is provided by an "outsider." Although attendance care has been an accepted aspect of hospital patient care historically and culturally, now because of the nursing shortage, attendance care has become a method for hospital administration to save money (Inoue, 1983). Insurance reimbursement for hospital nursing care is too low to cover nurses' salaries (Inoue, 1983). Rather than hire additional nursing staff, which may be difficult because of the nursing shortage, administration often believes it is more cost effective to ask patients to have attendants (Inoue, 1983). Nurses too in Japan have come to depend on attendants to perform more personal care for some patients. In the situation of understaffing, the nurses manage high level therapies and assessments.

There are problems with the attendance care system. The numbers of available caretaking family members, most often women, has decreased as an increasing proportion of Japanese women work outside the home. Attendance care leaves unlicensed persons providing for patients' basic needs. And the issue of accountability and responsibility becomes blurred with the current system (Inoue, 1983).

Nursing Roles Lack Clear Definition

Inoue (1983) noted the lack of clear definition for responsibility and role explication in nursing in Japan. This problem is echoed in Kono's study (1989). Kono (1989) surveyed 280 nurses engaged in occupational health positions in

Kanagawa Prefecture, Japan. Fifty-five percent of the respondents in the study reported that their work positions were not clear. They lacked definition of the role and job descriptions (Kono, 1989).

Nursing Education

The final aspect of the nursing context to be reviewed here concerns nursing education in Japan. The nursing education system in Japan is very complicated and there are multiple types of educational programs for nursing (Kojima, 1987). There are six types of educational programs that prepare registered nurses: (a) a four year baccalaureate program; (b) a three year junior college program which offers an associate degree; (c) a three year nursing school diploma program; (d) a two year program for high school graduate LPNs or; (e) LPNs who have been working as such for more than three years; (f) a post junior high school health and nursing three year course taken instead of general high school allowing the student to take the LPN licensure and progress into the two year program outlined in (d) or (e) (Kojima, 1987).

Kojima (1987) identifies two major problems in Japanese nursing education: "the coexistence of various types of basic nursing education programs, resulting in different levels of qualification" (p. 100); and, "an insufficient number of properly prepared nurse educators" (p. 100). In fact many of the Japanese educators in nursing are physicians rather than nurse educators.

Japanese nursing care has become increasingly complex with more demand for

highly developed techniques and specialized services while at the same time the nursing shortage has increased nursing workloads. In 1982, the Japanese Nurses Association (JNA), in response to these problems, proposed that basic nursing education should be at the baccalaureate level (Kojima, 1987). "It should be of four years' duration and sufficiently comprehensive to prepare students of public health nursing, midwifery, and nursing practice" (Kojima, 1987, p. 100). In 1987, eleven baccalaureate schools of nursing were extant in Japan (Kojima, 1987). By April, 1993, there were twenty one with more planned (Nursing in Japan, 1993).

The second major problem identified by Kojima (1987), the lack of highly educated nursing faculty is also being addressed in Japan. In 1987 there were two graduate degree programs in nursing in Japan, one masters program at St. Luke's College of Nursing which began in 1980, and another at Chiba University which opened in 1979 (Kojima, 1987). Now there are seven masters programs and three graduate programs offering doctoral degrees in nursing in Japan (Nursing in Japan, 1993).

Kojima (1987) notes that over the last thirty to forty years Japanese nursing has looked to the U.S. for direction yet in Japan there seems to be "a widening gap between the theory and practice of nursing" (p. 101). She proposes that Japanese nursing has:

> begun to formulate something in both practice and education that can be called Japan's own. We still have much to learn from nurses in other countries, yet we, in turn, also want to be useful to these same colleagues, to share what we are learning in our efforts to develop the profession in Japan (p. 101).

At the end of World War II, with the establishment of the General Headquarters (GHQ) of the Occupation Army of the Allied Forces in Tokyo, Japanese nursing underwent a massive reformation (Nursing in Japan, 1993). At that time there was movement toward upgrading education so that nurses could function, not only as assistants to the physician, but in the performance of the unique function of nursing care (Minami, 1985). The Public Health Nurse, Midwife and Nurse Law passed in 1948. This law set up definitions for nursing and defined nursing curriculum in Japan, based largely on Western ideas of nursing (Minami, 1985). Some nursing schools in Japan, St. Luke's College of Nursing, to name one, have a history of inviting nurse educators from the U.S. According to Minami (1985), these educators taught "not only professional knowledge and technology but also the moral knowledge behind them" (p. 312). Moreover, many Japanese nurses have been to the U.S. as exchange nurses, visitors, scholars, and baccalaureate and graduate nursing students. These international Japanese scholars and visitors have aided in the importation of many notions of nursing. Yet Minami (1985) maintains that the underlying cultural assumptions and beliefs that form the foundations for these imported nursing notions have not been examined critically. Potential conflicts exist between these underlying assumptions and beliefs and Japanese traditional values. Japanese nurses' notions of professional socialization have been influenced by Western values while the nurse's personal life may be steeped in traditional Japanese values (Minami, 1985). For example, according to Minami (1985), in Japan the

frame of reference for ethical decision making is based on whether one's actions will result in betraying the group to which he or she belongs. Rather than ethical decision making being based on universal abstract principles there is a situational frame which depends on one's group allegiance. Minami (1985), like Kojima (1987), suggests that it is time for Japanese nurses to look to their own practices and cultural traditions, to participate actively in values clarification, in order to make clear that which is uniquely Japanese nursing.

To summarize, the Japanese nursing context is one where physicians tend to dominate and where hospital administrators, physicians by Japanese law, tend to expect nurses to work full time, rotating shifts. Rotating shifts and high work loads for nurses are associated with burnout.

The practice of having either family members or personal attendants provide personal care for patients, and a lack of clear job descriptions add to nursing role confusion.

Nursing education in Japan is undergoing change. New baccalaureate schools are opening and extant baccalaureate programs are adding graduate nursing curricula. The need for professional nursing education in Japan is recognized, yet Japan still lacks graduate prepared nursing faculty. And, physicians continue to provide much of the nursing education in Japan.

These first two chapters have explored the assumptions and philosophy which guided the study. In addition concerns of international nursing students have been

examined. Some of the issues and contextual background specific to Japanese nurse scholars have been considered. Next, methodological concerns and the study design will be described.

CHAPTER III

METHODOLOGY

Design Overview

To describe the meanings of the educational experiences of Japanese international nurse scholars, a Heideggerian phenomenological approach was employed. Hermeneutics is a method wherein the inquiry objective is the interpretation of meaning and the data analogue is text (Taylor, 1985a). Consistent with hermeneutics is text comprised of concrete examples from everyday life. Interpretive theory can be derived from the study of contextual and culturally embedded everyday practices (Geertz, 1973). The purpose of interpretive inquiry is not the production of objective, contextless, abstract "predictive" or "prescriptive" theory for purposes of control or manipulation. In contrast to formal theory, the goal of interpretive theory is an understanding of a phenomenon presented in "meaning terms" (Benner & Wrubel, 1989). The aim of interpretive theory is to enable comprehension of the meanings contained in "thick, rich" (Geertz, 1973), culturally and contextually embedded text. Data for the current study were comprised of text from 42 interviews with 28 Japanese nurse scholars.

Sample and Setting

Setting

Thirty eight interviews were conducted in Japan and four were conducted in the U.S. In Japan, interviews were conducted at thirteen separate sites, in seven

different cities. Interviews took place on Honshu and Shikoku, two of the four main islands of Japan. In both Japan and the U.S. participants were asked where they wished to be interviewed. In Japan most interviews took place in the schools or places of work of the participants; however, some were conducted in coffee shops or apartments. In the U.S. all interviews took place in the apartments of the participants. Interviews were conducted in Japan over a five and a half month time period between October, 1991 and March, 1992. Interviews were conducted in the U.S. in July, August, and September, 1991 and in June, 1992.

Sample

Twenty five Japanese nurses served as the purposive participant sample; four were male. Nurses who had received or were in the process of receiving masters or doctoral degrees from U.S. schools were selected as participants and were asked to describe their lived experiences in the U.S. and Japan. In addition to these twenty five, three Japanese nurses who provided consultation to the study in Japan were interviewed and their four interviews were analyzed as data. The three nurse consultants for this study were Dr. Hiroko Minami, an internationally knowledgeable nurse leader and educator; Ms. Keiko Okaya, whose master's research explored the concept of *omakase* as a coping style for Japanese patients; and Ms. Tomoko Yuasa, a community nurse with her own home health nursing business.

The twenty five participants can be divided into two groups. The first group was comprised of five participants who were still in graduate school in the U.S. at the

beginning of data collection. The second group consisted of twenty participants who had completed their graduate studies and had returned to Japan for varying lengths of time.

The second group of twenty participants were selected based upon the length of time since each returned to Japan in order to explore stories from recent returnees adjusting to Japanese life and stories from those who had time to reflect upon their experiences. Time back in Japan varied from three months to thirty years.

Numbers of interviews with individual participants varied from one to three. Numbers of participants fitting each "years since return" category and total number of interviews for each category are presented in Table 1.

Table 1

Years Since Return to Japan and Number of Participants and Interviews Per Category

Categories by Years Since Return	Number of Participants Per Category	Number of Interviews Per Category
Still in the U.S.	5	6
<1	3	7
1-5	5	8
6-10	6	12
11-20	4	3
>20	2	2

The total number of interviews categorized is 38 and total number of participants, 25. The 4 interviews with the nurse consultants are not reflected on this table. In the category 11-20 years since return one can note more participants than interviews.

This is because of one group interview with members of this category. Potential participants for the study were identified in five ways. The first group of nurse scholars still involved in their graduate education were all known by the researcher. Potential participants for the second group were identified: (a) through the Japanese Nursing Association (JNA) (n=14); (b) through personal contacts including Japanese doctoral students (n=4); (c) through the project's sponsor in Japan (n=5); and (d) through referrals from interviewees in Japan (n=2).

Staff of the JNA identified potential participants, listing those Japanese nurses who had received scholarships through the International Council of Nurses (ICN) for study in graduate schools of nursing within the United States. The JNA provided information in Japanese about potential participant's U.S. American alma maters, the years in which they received scholarship monies, and their current addresses. Letters of introduction and information about the project, some written in Japanese, were sent to sixteen of the potential participants identified by the JNA while the researcher was still in the U.S. Fourteen of the sixteen agreed to be interviewed. Four other potential international graduate participants were identified through personal contacts while the researcher was in the U.S. Two participants were identified through a network technique when, during interviews in Japan, participants identified other potential participants. And five participants were identified by the project's sponsor during data collection in Japan.

Twelve of the twenty five participants were masters prepared having received

masters degrees from U.S. schools of nursing. One of the twelve was in a doctoral program in Japan. Two participants were working on masters degrees in the U.S. at the time of data collection and have since finished. Eight of the participants were doctorally prepared. Of the eight, four received both masters and doctoral degrees from U.S. graduate schools. Two of the eight doctorally prepared participants received masters degrees in Japan and doctoral degrees from U.S. schools of nursing. Two other doctorally prepared participants received masters in nursing in the U.S. and doctoral degrees in Japan. Three participants were in doctoral programs in the U.S. at the time of data collection. Two had received masters degrees in Japan and one had a masters from a U.S. school of nursing but was not counted as part of the group of twelve.

Participants spent varying lengths of time in North America. Lengths of stay ranged from seven months to twenty five years. At least seven of the interviewees took part in nursing practice "exchange" programs in the U.S. before their graduate work. The exchange programs through Rotary Club or other organizations were often a first exposure to U.S. nursing practice. At least seven participants practiced clinically as staff nurses in the U.S.

Clinical specialty areas of the participants included mental health, oncology, gerontology, critical care, pediatrics, and medical-surgical nursing. The mental health specialty was the most represented with eleven participants reporting this specialty. At the time of the interviews, sixteen of the participants were engaged in teaching

positions in schools of nursing in Japan. Two participants had yet to begin teaching positions but would be doing so within the year. Four were primarily engaged in practice or were employed in hospital in-service education positions. One of the participants was the dean of a nursing school during the time of the interviews. Two other participants were planning to assume dean positions within one year.

Data Collection Procedures

Interviews

The hierarchical nature of the Japanese culture (Lebra, 1976) and the cultural prescriptions for harmony and homogenous agreement (Cathcart & Cathcart, 1972; Haglund, 1972) made private interviews more likely to result in fruitful data than group interviews. However, two groups of participants from two different sites indicated that they would prefer to be interviewed together. The first group, a group of three, were experienced professors of a similar status who were comfortable sharing stories with each other. The second group, a group of two, asked that they be interviewed together to ease the difficulty of speaking in English so that one of the group who had spent more time in the U.S. might help the other with areas of foggy translation. All other interviews were private, with only the interviewer and the participant in attendance.

It was thought that repeated contacts with individual participants would create greater comfort and therefore more disclosure. Most often this proved to be true. Moreover, subsequent interviews were used to follow up on themes identified in the

primary interview and to validate early data. However, because of the travel distances involved in Japan and because of the busy schedules of the participants, at times only one interview was possible. Three participants were interviewed three times. Nine participants were interviewed twice. Eleven participants were interviewed once. Interviews lasted between forty five minutes and two and one half hours.

Rather than proceeding with particular questions or specific probes, the interviews for this study, like other hermeneutic interviews, usually were concerned with involved listening to episodes from everyday life (Diekelmann, 1991). With Benner's permission, the "Guidelines for Recording Transformational Stories" (see Appendix B) adapted for this study from "Guideline for Recording Critical Incidents" used by Gordon and Benner (Benner, 1984) to stimulate memories of nursing clinical episodes. The purpose of the interview guide was to help locate the participant in the "general region" (Diekelmann, July, 1991, personal communication) of phenomenological interest and to provide a direction as to what constituted an episode. The "Guidelines for Recording Transformational Stories" contained information about what to include in a narrative or story. There was also a personal history page for demographic description that included a request for information on length of stay in the U.S., practice specialty, years in practice, and, when applicable, years since return from the U.S.

Participants were asked to describe incidents that they recalled about their

adjustments to the U.S. They were asked about problems and to describe incidents when they were surprised, shocked, or embarrassed by what they found in nursing practice and in their everyday lives. They were also asked how "things had been going" since their return. Specific episodes were requested with concrete detail. Areas of divergence in practices emerged in early interviews; for example, the Japanese "spirit of caring" and the concept of *omakase* in health care delivery were identified as starkly different from what participants observed in the U.S. Mental health changes during acculturation to the U.S. and losses during reentry were themes identified early in data collection. Questions were added to the interviews to reflect these concerns and the interviews changed to include more exploration of them.

In the early phases of the project the "Guidelines for Recording Transformational Stories" were sent to participants to orient them to what they would encounter in the interview. Originally, the "Guidelines" had been conceptualized as a structure for written self-reports that could then be explored in further depth during the interview. However, as participants gave feedback, it became clear that the "Guidelines" were difficult for participants to understand. A few participants made memos on the document and one participant wrote out her transformational stories, but for most participants, reading the forms and preparing their personal histories in English, their second language, was a burden. The amount of time needed to write in English was incompatible with the multiple responsibilities of the participants. After the first few interviews, orientation to the type of data needed and the completion of

the personal histories were done verbally at the beginning of the initial interview.

While in Japan, I transcribed twenty nine interviews. In the case of repeated interviews, copies of the initial transcribed interview were sent to the participant prior to the subsequent interview(s) for validation or changes.

The unstructured nature of the initial interviews coupled with anxiety about speaking English to a stranger often seemed to set up a tension in the interviews. In part to remedy this and to aid in analysis, a summary and specific follow up questions were prepared before the subsequent interview. The summary was read and the questions were usually discussed at the beginning of the second and third interview.

Interviews were tape recorded, and transcribed verbatim, coded, and subjected to interpretive analysis. Data were managed using Seidel's, ETHNOGRAPH 3.0 (1988) software program. Any memos and/or self reports were included with interview data. In addition some participants had written scholarly papers in English during their U.S. sojourns. When applicable these were included to add to textual interpretation.

The Issue of Language

Language was problematic in the study. The Japanese language is comprised of three written analogues; two provide phonetic alphabets, *katakana* and *hiragana*, while *kanji* is based on Chinese ideographs. In the year prior to data collection in Japan, I studied conversational Japanese at Portland State University and had a novice's understanding of *katakana* and *hiragana*. Data for the most part were

collected using the English language. Yet the idea that language is both constituting and constitutive is provocative in considering interviews in a second language for participants. This idea was first associated with Herodotus, 484-430 B.C. (Gould, 1989). In the 1930's Whorf (1956) introduced the modern version of this notion in his statement that language determines thought (Berry et al., 1990).

Taylor (1985a) argues that language enables human comportment in three ways. Through language we can make explicit that which was known previously only implicitly. Second, through language we can constitute a "public space," create a connection, rapport. And third, it is through language that we delineate our concerns.

Interpretive analysis requires a deep understanding of background meanings. At times the interpretation becomes clear only from specific word usage and language. In Japanese several complex concepts and their relationships may be illustrated by the *kanji* character used to depict an idea. For example, the *kanji* ideograph depicting "phenomenology" contains two characters. One character may be translated, "being at present." The other character translates as "whole picture"; used alone this character also may be translated as "elephant." There is an interpretive richness available through explanation of the characters. When difficulty in cross-cultural understanding was apparent, participants were often asked to describe the *kanji* they might use to portray the concept in question.

Several problems emerged in the use of a second language for textual analysis. One language problem became apparent rather quickly in my interviews. Many

participants had a difficult time recalling concrete stories. They suggested that this might be in part because Japanese is not a particularly concrete language. Words are likely to have multiple meanings depending on the context in which they are used. Participants suggested that Japanese people tend to avoid the concrete, finding comfort in ambiguity. And, Japanese people tend to avoid verbal self disclosure. It was of great interest to note that although the interviews were conducted in English, some participants still had difficulty recalling concrete stories. Moreover, during self disclosure, more than one participant suggested that they could not have shared their stories in Japanese and were relieved to be speaking about such personal things in English. During interpretation of text three Japanese doctoral students assisted with areas of inadequate understanding, cross-cultural translation, concept clarification, and analytic interpretation.

Ethical Considerations

Potential participants were contacted in writing after approval by the Oregon Health Sciences University Human Subjects Review Committee. A written explanation of the purposes of the study was included in the consent form and, for the first twenty participants invited to participate, the "Guidelines for Recording Transformational Stories" were included in the initial contact. A letter of introduction written in Japanese was also enclosed. After feedback about how participants found the "Guidelines" form confusing, it was dropped from the initial contact package, although it continued to guide interviews.

Potential participants who agreed to take part in the study signed and returned the consent to participate. Consent to participate was conceptualized as a process (Munhall, 1988). An important ethical concern connected with this research involved the issue of privacy/confidentiality. There was concern with the small sample that individuals might be identified (LaRossa, Bennet, & Gelles, 1981), particularly in the relatively small population of reference that is known one to another. Consistent with the conceptualization of consent to participate as an ongoing process, the Japanese nurse scholars were made aware they might withdraw entirely from the study, or might withdraw specific episodes, at any time prior to publication. Furthermore, confidentiality renegotiation occurred at intervals during data collection.

Participants were initially offered two confidentiality alternatives (see consent form, Appendix C). In an effort to acknowledge the excellence they found in nursing practice, Benner and Wrubel (1989) had recognized the authors of particularly meaningful paradigm cases and credited the authors with ownership by naming them. Confidentiality in the hermeneutic tradition is not necessarily the norm. Participants were asked to designate whether they would prefer to be named as contributors or whether they preferred not to have their names known. For those choosing the former, a list of names and the corresponding alphabet letters with which narratives were labeled can be found in Appendix D. If participants indicated the latter choice, nonsignificant demographic variables such as the schools from which they graduated, were changed to obscure identification, no authorship was credited, and no alphabet

labels were used. The last protection was to decrease the chance of readers identifying specific participants through reading several excerpts with the same alphabet label, piecing together a particular participant's story. However, because some critical episodes and situations were concrete and contextual, participants were offered the opportunity to judge whether their interpreted episodes were sufficiently protective of their confidentiality. Some participants neglected to indicate option 1 or 2. For these participants, option 2, that of anonymity was assumed.

Confidentiality was additionally protected by coding tapes and transcriptions with numbers, with the name list of participants and their respective numerical codes kept in a locked file cabinet separate from the tapes and transcripts. The transcripts were reviewed only by the researcher, the dissertation committee, and members of the interpretive team.

Although all care was taken to protect confidentiality for those participants who desired it, the population of potential participants is finite and their numbers are small; therefore confidentiality was not assured. This lack of assurance was discussed frankly in the initial consent form and in the initial interview.

Scientific Rigor

The scientific merit of a study is determined by a combination of the study's significance and the extent to which scientific rigor was employed in the research design. Lincoln and Guba (1985) call scientific merit, "trustworthiness." They claim that in conventional research--and by conventional they refer to positivistic science,

there are four criteria that are involved in the determination of trustworthiness. The four criteria that Lincoln and Guba (1985) identify are: (a) truth value; (b) applicability; (c) consistency; and (d) neutrality.

In "conventional" science truth value is determined by internal validity; applicability is judged by external validity; requirements for consistency are met by high reliability correlations; and neutrality is determined by the extent to which the study contains rational objectivity. However, Lincoln and Guba (1985) maintain that these criteria depend for their meaning on assumptions of a single truth, linear causality and the notion that "objective data" is more likely to produce "truth" than subjective data. They argue that in value-laden "naturalistic" or qualitative science, these suppositions go against the assumptive grain. Nevertheless, qualitative studies also demand trustworthiness and accordingly, Lincoln and Guba (1985) have identified ways in which qualitative studies may be judged for rigor.

Credibility

Truth value refers to the extent to which one can establish confidence in the findings of a study. In interpretive studies, "credibility" is the counterpart to internal validity in ensuring truth value. Although in an interpretive study, there is an assumption of multiple perspectives from which many truths are shaped, Lincoln and Guba (1985) outline several ways that one can increase faithful descriptions and interpretations, the essence of credibility. Prolonged engagement and persistent observation are activities said to increase the credibility of the findings produced

(Lincoln & Guba, 1985).

Although I lived in Japan only five and one half months, the investment in learning rudiments of the Japanese language and features of the culture was not made lightly nor quickly and had transpired over several years, a "prolonged engagement" (Lincoln & Guba, 1985, p. 301). In this study nine of the twenty five participants were interviewed two times and three were interviewed three times. This corresponds to Lincoln and Guba's bid for "persistent observation" (p. 301).

Lincoln and Guba (1985) identify "member checks" (p. 328) as another activity devised to increase credibility. Member checks refer to the process of having participants in the study validate both the text of their narratives and the interpretation(s) of that text. Data and interpretations from early interviews were summarized and submitted at subsequent interviews to allow for "participant validity checks" (p. 314) and comments from the validity checks became new text. In the case of single interviews, the typed verbatim interviews were sent back individual participants so that they might have the opportunity to validate or withdraw all or part of the transcripts. Although no participants withdrew transcripts, three withdrew small portions of their transcripts to improve the likelihood of anonymity.

The major threat to credibility according to Sandelowski (1986) is enmeshment or "going native" by the researcher. It is a paradox that the closeness of the participants and the investigator both enhances and threatens the credibility of the study. I used three techniques to aid in maintaining consciousness about the separate

worlds of investigator and participant. First, with the exception of the time I was living in Japan, I continued with "peer debriefing sessions" (Lincoln & Guba, 1985, p. 328). Second, although I did the central interpretive work, the interpretation was reviewed by my doctoral advisor. In addition, five analytic teams performed interpretation of the data, balancing areas of my interpretive blurring. These teams were comprised of: (a) a qualitative seminar, composed of doctoral students and two faculty from Oregon Health Sciences School of Nursing; (b) a group of doctoral students and their advisor, skilled in interpretive methods; (c) the Japanese consultants in Japan; (d) three Japanese doctoral students in the U.S.; and (e) members of my dissertation committee.

Third, Sandelowski's concern of "going native" in Japan is likely moot. Both the language and the culture impose the boundaries advised by Sandelowski (1986). Furthermore, "Japanese expect foreigners in Japan to retain their foreign identity, even if they are Japanophiles and well versed in Japanese culture" (Lebra, 1976, p. 25).

Transferability

Fittingness (Sandelowski, 1986) or transferability (Lincoln & Guba, 1985) is the parallel in interpretive criteria to external validity or generalizability in the quantitative method. It refers to the "fit" of the findings into contexts outside the study situation. One way to increase transferability is to be sure the data reflects "thick description" (Geertz, 1973; Lincoln & Guba, 1985). The point of interpretive

work is understanding and meaning. Geertz's example (1973) illustrates this conception: Geertz contrasts as examples of thick versus thin description, winking, with eyelid contractions. In winking the cultural overlay, the cultural meaning of the activity, is an aspect of the description. "He winked at me" has different meaning than "his eyelid contracted." Rather than a behavioral "flat" or "thin" description of the minutiae of action, the cultural layer of the behavior is included in the description making it "thick."

The chance of getting data that reflects "thick description" in this study was increased by returning to data sources several times. Often initial interviews were tension filled. The lack of structure and need for prolonged, detailed discussion in English was anxiety inducing for some participants. Subsequent interviews with the same participant allowed for history in the relationship, allowed for summarization and initial analysis of themes, and allowed for a more structured probing of experiences. All of these techniques tended to decrease the tension surrounding the interviews and increase the thickness of the data.

Lincoln and Guba (1985) suggest that the touchstone of whether or not the study has transferability is to have individuals not connected with the study read it for relevance. The large number of interpretive themes uncovered by this study argue for its transferability.

A final threat to fittingness according to Sandelowski (1986) is the "holistic fallacy." This refers to the practice of condensing data and/or juxtaposing them to

have data appear more congruent than they are. This is an analytic issue where conclusions drawn are assumed to represent the data set, but do not. The ethic in hermeneutics of "remaining true to the text" precludes this kind of flaw. At times narratives were edited and condensed for readability in the results and discussion chapter of this dissertation. But in areas of confusion or where many diverse interpretations were possible, interpretation was done within the context of the data in its entirety, employing the interpretive team for consensual validation.

Auditability

In quantitative studies, reliability corresponds to the concept of consistency. If a study has reliability, there is dependability and stability. Leonard (1989) states that in hermeneutics studies, one assumption asserts that participants exist in time, and therefore, the study can never be replicated exactly. Instead in hermeneutics consistency is demonstrated by auditability (Guba & Lincoln, 1981; Sandelowski, 1986). A study has auditability when another researcher can follow the "decision trail" used by the investigator. Decisions about numbers of interviews and numbers of participants for this study were chronicled in the author's personal letters and discussed with the research sponsor in Japan, those decisions becoming part of the data. Decisions about interpretation were discussed with the interpretive team again being added to the data. Participant validity checks, mentioned in the "credibility" discussion, described how ideas about interpretation of data were discussed initially with the participants themselves. Impressions of interpretation from previous

interviews were summarized and presented during subsequent interviews, taped verbatim, and input from participants on interpretation became data. In this way validity was increased and decision making about interpretation was made more easy to audit.

Confirmability

Guba and Lincoln (1981; 1985) identify neutrality as the final scientific criterion for rigor in research. Neutrality refers to a freedom from bias in the research process and product. This is the role played by objectivity in quantitative studies. The assumption of value-free science dictates the distancing of the scientist from the object of interest and the attempt at objectivity. In hermeneutics neutrality is not the issue so much as confirmability and meaningfulness. Qualitative research values subjectivity and declares itself value-laden. In fact hermeneutics is based upon the Heideggerian assumption of value, humans are beings for whom "things matter" (Benner & Wrubel, 1989, p. 47; Leonard, 1989).

Confirmability according to Sandelowski (1986) is achieved when auditability, truth value, and applicability are established. Yet this seems weak, maintaining that four criteria exist but the fourth is contingent upon successfully "establishing" the first three. Confirmability has been discussed more coherently by ethnographers (Chesla, 1988) who recognize that the scientist and participants live in different cultures or worlds of meaning which overlap. In reporting the transaction between the two worlds the best account sits in neither world, but somewhere in between (Chesla,

1988; Gadamer, 1960, 1975). The confirmability of this study can be judged by the findings and discussion.

Analysis

Hermeneutics is an approach to understanding prosaic human behavior through text interpretation. It was first used with Biblical exegesis. Analysis in hermeneutics is a conversation between the parts and the whole, a dialectical tacking (Taylor, 1977) back and forth between pieces of the text and the whole. Analysis for the current study occurred in several iterative phases and began with the first interview.

In interpretive studies the researcher serves as the instrument of data collection and analysis. Therefore, a few specifics concerning how the data were acquired need to be mentioned. Participants were asked questions about problems or shocking aspects of life in the U.S. and were asked to describe specific incidents related to these. Similarly, they were asked to describe problems they experienced coming back to Japan. Some questions during interviews concerned differences in practices, clinical and academic, participants might have observed. And, most participants were asked to describe where Japanese nursing excelled and what aspects of Japanese nursing might be exported to the U.S.

The first phase of the analysis took place while in Japan. Twenty nine of forty two interviews were transcribed while there. Extensive interpretive work was done with them to guide subsequent interviews. Initial interviews from the twelve participants who were interviewed more than once were transcribed, summarized, and

analyzed for distinctive and common themes. Questions from that initial analysis served to guide second and third interviews. From the transcripts of participants interviewed one time only, the investigator made notes about topics and common themes to pursue in upcoming interviews. Thirteen interviews were transcribed after return to the U.S.

As soon as data were collected, each case was read and reread in order to arrive at a global analysis (Leonard, 1989). After several cases were read, lines of inquiry were identified from the theoretical background for the study and from themes that emerged consistently in the data.

A theme, in hermeneutic analysis, is the essence of the meaning of the textual episodes, the focus or point of the phenomenon one is trying to understand (van Manen, 1990). Thematic analysis involves reading and rereading text to find that which is consistent and essential, "to discover aspects or qualities that make a phenomenon what it is and without which the phenomenon could not be what it is" (van Manen, 1990, p. 107). Exemplars are stories or vignettes that capture the meaning of a situation in such a way that the meaning can be recognized in another situation (Benner, 1985; Leonard, 1989).

Themes that emerged were thought of as "experience-distant" and "experience-near." According to Geertz (1983), whose terminology was borrowed here, experience-near concepts are those which the informant might effortlessly use to describe aspects of everyday life, whereas an experience-distant concept is one which

various experts might use to forward their scientific, philosophical, or practical aims. For example in the current study, an experience-near concept was the *amae* relationship in nursing. An experience-distant concept was "acculturation stress." During data collection as themes were identified, subsequent interviews concentrated on gathering more specific information on them. For example, when the *omakase* concept emerged as an important theme early in data collection, an interview was arranged with a Japanese doctoral student, whose masters thesis was concerned with *omakase* in Japanese practice. Another example of a theme that emerged early, which was incorporated into subsequent interview questioning, concerned the "spirit of caring" in Japanese nursing.

During data collection in Japan, three sources in addition to the participants provided guidance. Transcriptions of early interviews were sent to a group of doctoral and post doctoral students and two faculty from the Oregon Health Sciences University School of Nursing, knowledgeable on qualitative methods of analysis. Prior to leaving for Japan, I had been a seminar member and the group was familiar with the study. Tape recordings of the interpretive session was returned to Japan along with members' memos and transcript notes. A second guide to analysis in Japan were letters to and from my dissertation advisor. A third help to interpretation while in Japan were the Japanese nurse consultants. When initial themes were uncovered early in data collection, meetings with the three Japanese consultants were arranged for specific exploration of certain themes.

After returning from Japan the remaining thirteen interviews were transcribed. At that time meetings with an interpretive team comprised of my dissertation advisor and two doctoral students versed in hermeneutic methods began. From the thematic analysis, themes were identified, an interpretive plan was made, and a coding protocol was developed by the interpretive team (Leonard, 1989). It was applied to the entire data set and search strategies were developed. Exemplars and participant's responses to them were coded together (Leonard, 1989). When areas of misunderstanding occurred in the interpretation, one or more of the three Japanese doctoral students who provided consultation throughout the U.S. phases of the project were contacted and conferred with. During this process there was a continuing update of the codes and a continuing reflection on the themes of the original text. Eventually the final Code List was developed by the interpretive team (see Appendix E). The ETHNOGRAPH 3.0 software package was employed to manage the data and to carry out computerized code searches. Using the established codes each of the 42 interviews was scrutinized by computer for data labeled with the code. Consistent themes and exemplars illustrative of certain themes were identified.

The final phase of interpretive analysis was the interpretive writing. This was done in the U.S. with the guidance of my advisor and committee members. It involved the identification of paradigm cases (Benner, 1983; Leonard, 1989). Paradigm cases are particularly elegant examples, richly descriptive, embodying strong instances of patterns of meaning (Benner, 1983; Leonard, 1989). Paradigm

cases provide understandings about how an individual's actions and interpretations are situated in his/her context. Thus, data analysis in hermeneutics studies consists of three interwoven processes: thematic analyses, analysis of exemplars, and a search for paradigm cases (Benner, 1983). Leonard (1989) notes that it is important to acknowledge that "the taken-for-granted, everyday, lived world can never be made completely explicit" (p. 52). It is critical to recall the goal of hermeneutic analysis is not to "extract theoretical terms or concepts at a higher level of abstraction" but to "discover meaning terms and to achieve understanding" (Benner, 1985, p. 10).

CHAPTER IV

FINDINGS AND DISCUSSION

Experiences in the U.S.: Changes in the Self

Introduction

The findings and discussion of this dissertation is separated into two chapters. Chapter IV concerns themes that emerged from the stories of the Japanese nurse scholars as they talked about their U.S. experiences and is presented first, titled "Experiences in the U.S.: Changes in the Self." Chapter V is comprised of the themes that emerged from the stories of the Japanese nurse scholars as they talked about their reentry back into Japanese practice and is titled, "Coming Home." Findings are organized into general topical areas, themes, and concerns or issues. Background meanings and literature that provide a deeper understanding of the text will be included in the discussions of the themes. The themes of particular interest are those identified by the participants as transformative. Ontological and epistemological changes which participants experienced will be examined. And those ways in which the international educational experience changed participants as humans and as nurses/teachers will be explored.

The excerpts selected to elucidate the study participants' descriptions were chosen purposefully. Common themes and shared meanings, ones that were seen in the descriptions of several participants, were sought in analysis. When these were identified, an exemplar was selected as evidence for the interpretation and to aid in

understanding the phenomenon described in order to allow the reader to validate and to "establish the adequacy of the study" (Kondora, 1993, p. 12). Quotes from participants are used liberally in this presentation, as they often are in Heideggerian studies of this type. Each exemplar presented is representative of many. Typically, the excerpt chosen best describes the phenomenon. The exception to this practice is when contrasting cases are presented to elucidate alternative explanations or experiences unlike the typical or when the best cannot be used because of confidentiality issues. When a contrasting case is presented, it is labeled, not as a common theme, but as an exceptional circumstance.

In the circumstance of a paradigm case, the excerpt used is particularly illuminating of the interpretation, and is given a descriptive label. These labeled excerpts are particularly meaningful, are usually referred to several times in the interpretation. All labeled excerpts are not paradigm cases, instead in some cases the label is used to orient the reader to the specific excerpt.

Often an exemplar or paradigm case will have embedded within it background meanings. These lend a richness to the description and are discussed in the explication of the themes. Literature from cross-cultural communication experts and experts on Japanese psychology and anthropology provide interpretive support for the discussions surrounding the themes.

Two main topical areas were found in the narratives describing the U.S. experiences. They were "the changing sense of self" and "being a student in the

U.S." The changing sense of self emerged as the most common and most significant. Given the foundational assumption guiding this study, that the international educational experience results in ontological change, and because transformational stories were sought, it is not surprising that change in the self emerged as a major area. It was however, exciting to discover and document more precisely what those changes were and how they came about.

The Changing Sense of Self

Text from "the changing sense of self" is dense, has multiple embedded meanings and contains numerous interpretive layers. Major themes included in the changing sense of self area are: (a) changes in the self in relation to the other; (b) the role of context in Japanese communication; (c) language and culture; (d) culture shock, sojourners' response, and mental health changes; and (e) changes at the core. Each of these themes is comprised of concerns or concepts important to the study participants. The theme, changes in the self in relation to the other, was associated with four concerns that consistently emerged in the narratives: becoming "tough," movement toward independence, the meaning of caring to the Japanese person, and the *amae* relationship.

The role of context in Japanese communication was reflected in narratives about harmony in relationship in Japan, making individual choices, and hierarchy in Japan. Language and culture was reflected in text about participants' notions of loneliness, lack of fit, and the public and private self.

Mental health changes, plummeting self esteem and impaired judgement, and biculturalism were concerns associated with the theme, culture shock, sojourners' response, and mental health problems. And the fifth theme uncovered in the changing sense of self topical area, "changes at the core," was comprised of textual information about a "new flexibility," the logic of English, a new way of thinking, and includes a contrasting case, the narrative of a participant who felt the international educational experience had not profoundly changed her.

The first excerpt offered in this chapter of findings refers to the beginning of the U.S. experience. The text comes from a Japanese man who went to the U.S. for the first time to matriculate as a masters nursing student. He practiced nursing briefly in Japan before leaving for the U.S., but was relatively inexperienced as a nurse. In fact, as he makes clear in his narrative, he was young and lacked life experience at the time of his arrival in the U.S. Four of the five major themes comprising the changing sense of self area are depicted in this excerpt, (a) changes in the self in relation to the other; (b) language and culture; (c) culture shock, sojourner's response, and mental health problems; (d) and changes at the core.

"I Became Tough"

> It was the first time for me to fly on an airplane, so when I left Japan--my first experience out was so strong that I was not able to remember the name of my advisor. Her name was Catherine, a common name for an American. She said her name, but I was not able to understand what she was saying at all. I was just smiling and didn't say anything. That was the first experience that I can remember. I felt totally strange. I felt I was stupid and an idiot. My self esteem dropped very low....after three or four months I gradually had better listening ability, so I thought I could take some nursing classes. After that I

> had very good contact with Catherine. I gradually regained my self esteem after I had better English ability. I started to speak out in my classes. That was about--I'd say--one year later....I was basically a shy person and I was ambivalent. I felt that I was unstable as a person. But, the young undergraduate students in school helped me to establish my confidence as a man, as a person. It began there...at that time I was not a mature person. I didn't have an established cognitive world like an adult. The American culture pushes you to be very independent, but not so in Japan. In Japan you can be interdependent of course. I went to the U.S. and I became tough. It is a Japanese manner to be soft, soft to the other person. You don't need to be very tough to the other person. Being tough implies being independent or creating distinctions between you and the other person. That toughness continues now to some extent. It may have been useful in my work because as a research person you've got to be very competitive. That is one merit of my U.S. experience. And the second one is English capability. Now I can read English papers and research work without much difficulty. The third thing is my perspective was [changed]--I became able to look at things from different directions. You know I was born in Japan, grew up in Japan; so I was looking at things from one direction as a Japanese. But in the U.S.A. you have many different ethnic groups and you get acquainted with more kinds of cultures. I don't know how, but I can use that aspect.[1]

Changing Self in Relation to the Other

The first participant clearly portrays himself as a young, inexperienced, and unsophisticated sojourner when he arrives in the U.S. His disastrous first contact with an advisor whose name he cannot catch and poor English facility, leave his self-confidence, what little he has, reeling. He is nodding, smiling, not understanding any of the conversation--feeling stupid. His self concept is not well formed and the picture one gets is of a shy, undefined, uncertain young person. He describes

---

[1]Participants who chose confidentiality option 1 are identified by alphabet letter. Names corresponding to the letters of those participants who agreed to be identified can be found in Appendix D. Excerpts have been edited for English readability.

becoming aware of a distinct self emerging beginning with his international education experience.

Becoming "tough." The young man claims that the U.S. American value of independence "toughened" his immature undifferentiated self. He explains that the toughness learned in the U.S. is less common in the softened relationships of Japan. His independence, and one infers, his defined sense of self, his individualism, have served him well in the competitive research world of his adult career.

Becoming "tough" is a concept echoed in other narratives. Differences in the Japanese sense of self and the U.S. sense of self have been discussed by authors conversant with Japanese and U.S. psychology and communication (e.g. Barnlund, 1989; Doi, 1971, 1973; Doi, 1985, 1986; Minami, 1985; Reischauer, 1977).

The sense of the self as a being distinctive from others, in Japanese persons, tends to be an awareness that is more fluid, less fixed than the sense of self for people from more individualistic cultures. Barnlund (1989), a cross-cultural communications researcher who has studied Japanese communication styles more than twenty years, proposes that the fluid sense of self of the Japanese may come about from an emphasis on obligations to others, beginning in infancy. Benedict (1946), in her classic work on the Japanese, The Chrysanthemum and the Sword, discusses the many words the Japanese have for obligation. For example, *giri* is a debt which can be repaid. *On*, on the other hand, is an obligation which one can never repay. The power of the *on* is regarded as "rightly overriding one's mere personal preferences"

(Benedict, 1946, p. 103). In Japan, "obligations have a higher priority than rights" (Barnlund, 1989, p. 163).

Movement toward independence. Like the "toughening" young man in the first excerpt who spoke of how the "American culture pushes you to be independent," reflections of personal changes from Japanese interdependence toward U.S.-style independence emerged frequently in the participant interviews and were cause for contemplation. Several participants talked about a feeling in Japan of being connected in an energy field with others. Softer distinctions between the self and the other may allow for an awareness of the energy flow.

Moreover, in Japan, self identity is predicated on interactive reflection. That is, self identity is grounded in part in the thoughts and feelings of others. Without this projected image many Japanese experience a loss of self, becoming unsure of who they are. In the United States with less emphasis on the other and more importance assigned to the individual, some participants said there was a time when they "lost" themselves. The Japanese word for "man," *hito*, implies "an individual who is supported by the other" (Minami, 1985, p. 316). There is no person without the other, according to the Japanese concept (Minami, 1985). One participant described the interconnectedness of human relationships in Japan in this way:

> You know I think human relationships are very different in the West than in Japan--not only Japan--I shouldn't say that, but in the Orient. Because in your country the individual is very important. You think that you are quite different from me. I think that you are quite different from me. But in Japan somehow there is some field and in that field we possess each other at the same time. I, as a human, am in that world, in space....That field is

> something interrelated, more than related. The field is like in the same place that we are. We are feeling that with the other all the time, so that we are trying to understand without words. But this is not always so good--Western culture and Japanese culture, I think both of them are very important.

The U.S. self was described as distinct, different from the other. On the other hand, the Japanese self was described as existing within an energy field projected by the other. Participants described a mutuality of existence, an interrelatedness that was different. Japanese existence within an energy field or energy flow was a repeating concept, common to many narratives.

Reischauer (1977) wrote of the strong connections of the Japanese that might require them to "subordinate their individualism" (p. 146) to the well-being of others. "Even the word 'individualism' (*kojin-shugi*) is still an ambivalent word in Japan...suggesting as it does to the Japanese selfishness rather than personal responsibility" (Reischauer, 1977, p. 147).

The notion that identity is "forged, expressed, maintained, and modified in the crucible of social life" (Schlenker, 1986, p. 24) implies a process of self development that is culturally specific. Doi (1985, 1986) writes, the Japanese translation of identity, *doitsuka*, contains the meaning to identify with someone or something. According to Doi (1985, 1986), this understanding of identity provides evidence that the "awareness of self is constituted on the basis of connections with others" (p. 80). Likewise, study participants contend that not only is the process of self development different in Japan from that in the United States, but the product, the Japanese self, is distinctly different from the U.S. self.

Minami, commenting on the Japanese sense of self said:

> The way we think is always thinking of the other person's feelings and thinking. If I cannot predict what you think, what you feel, I am lost completely. I don't know how I feel and nobody is really thinking about what I feel, what I think....But Japanese, because we have less ego boundaries, we don't have "I" or "you" or that kind of thing. (personal communication, 11/27/91)

The difference in the U.S. sense of self was often disconcerting for newly arrived Japanese nurse scholars. As the adjustment and adaptation to U.S. life occurred for the participants, the change in the sense of self was one of the most lasting and most consequential. One participant equated the change as one from a person who would "take care" of the other to someone less "kind." This participant spent three years in the U.S. and at the time of her interview had recently returned to the U.S.

"Before...I'm A Much Kinder Person"

> I think before last year or two years ago I'm more kind towards another person but now I'm not....Why? I can say why I changed. This is the way which I learned to survive in the United States. Three years I survived in United States. I got what is called independence. So now if a Japanese person comes here I require them to become independent. If it's only a visitor staying one or two weeks I would take care of them but this summer my previous colleague came. She is younger than me and also she is my student previously. She wanted to come to the U.S. and meet with a clinical nurse specialist. I required her to get independent. I said, "I will get some information but you have to write a letter yourself and you have to arrange [the meeting] yourself. Then I can help you." ...before I came to United States usually I'm a much kinder person. I would have called her and said, "would you like to come? If you want an appointment with the hospital nurse specialist, you have to write a letter, but if you cannot, I will."...This is different. You remember Heidegger's "solicitude"? Two kinds of solicitude....I have changed how I relate with people. Now I don't want to do something instead of another person. So that I require even though they might

> be Japanese that they become independent. But you remember Heidegger's solicitude is very related to person--self. So I establish my self and also you have a strong self. Our relationship is independent. But if your self is very weak I think I will do something instead of you. Now I require Japanese people to get a strong self. Now my concern is focused on people's self. Self or some kind of individual independence....So that the boundary is very clear. Between you and I, this boundary is very clear--yourself, myself, the boundary is clear. (A)

After three years in the U.S., this participant adamantly declares her very survival depended on developing her "independence." The participant's sense of herself as distinct from the other was strengthened. The boundary between her "self" and the other has become "very clear," changed from the softened, more fluid interrelationship described as typical of the Japanese. She describes the loss however, of a kinder self. Her notions of care and concern for the other have changed qualitatively. She is no longer willing to "take care" of her younger colleague, her former student, in the same caring yet engulfing way. She demands a degree of independent action from her colleague.

A distinctive self emerges. The distinctive and independent self is essential for survival in the U.S. Yet with this participant, who moves back and forth between Japan and the U.S. often, one can also detect a judgment implicit in her text. She is no longer "as kind" as she was before her time in the U.S. Heidegger writes of two kinds of solicitude. They are "that which leaps in and dominates, and that which leaps forth and liberates" (Heidegger, 1927, 1962, p. 159). Implicit in this narrative is the idea that with fluid boundaries and interdependence an aspect of "taking care" of the other in the past may have resulted in domination. To put it another way, the

bid for dependence invites leaping in to control.

Heidegger (1927, 1962) writes of the "possibility of solicitude which does not so much leap in for the Other as leap ahead of him [*ihm vorausspringt*] in his existentiell potentiality-for-Being, not in order to take away his 'care' but rather to give it back to him authentically...(p. 158-159). There is an inference that the solicitude this participant would have shown towards her colleague in the past would have fit more with Heidegger's first kind of caring, "that which leaps in for the Other," whereas her solicitude now with her more boundaried, independent self, is the second kind, "that which leaps ahead."

The meaning of caring. Embedded in the immediately preceding narrative are certain notions of what constitutes caring and concern. These may be quite different in Japan than the U.S. There is an underlying assumption in Japan that when true connected caring, being in the energy flow, is happening, there is little need for words, mirroring the nonverbal mother-infant bond. It then becomes impolite or uncaring to question verbally. A participant describes the value of nonverbal caring this way.

"The Tea Ceremony"

> For example, in the tea ceremony when some soldiers come from the very hot outside, they adjust the way of serving the tea. It becomes cold or hot or the amount changes without anyone saying, "please add a little bit more than usual because I'm thirsty." If the other person has to say that, we have not cared much. Those kind of things [are Japanese ways of caring]. So that without saying--understanding the other person, the others person's existence, the being--we should have done so without saying or asking.... However, I think that nowadays this value has been changing so that I think this kind of thing

> has become very difficult. This kind of caring needs two persons--one person who allows you to do it and one to do it. Then this caring can exist. It is alright to take care and it is alright to be taken care of. (B)

This kind of care is based on the loosely boundaried self. If one must use words to determine what is wanted or needed, one has "not cared much." There is a subconscious awareness of the other that constitutes baseline caring. Moreover, overt intention to attend to the other is culturally valued by the Japanese. Taken together these have important implications for caring in general and nursing care specifically. Minami (personal communication, 12/26/91) described the way of caring of the Japanese nurse like this:

"The Energy Field"

> Patients report this as *ki ni kakeru*, being close, being concerned, your energy is spread to others. It's the field, like an energy field. You are caught in the energy field and feel good about it. But often that happens only if you are from the same culture because the symbols are the same. And when you work, you put your eyes on the patient and the patient feels, "she is concerned. She is caring for me." But if you are not from the same culture, they don't know why you are watching. Because the culture has been changing, I do not have quite that feeling anymore. I know that elder patients like to get that kind of care. But younger ones want to have more concrete, more verbal, more intellectual kinds of interaction with nurses. Still just being there in silence is a very crucial kind of caring in our culture. In your culture, if two persons are sitting together you speak and you don't have a high tolerance for silence, just being there and being comfortable. But [in Japan] perhaps the patient is not sleeping but just closing their eyes and the nurse is just sitting, just being there. It's a kind of interaction and energy flow.

Again there is reference to existence in "the energy field," "the energy flow." When one is in the flow, not only is it impolite to resort to asking about preferences but it is also unnecessary. To ask implies a lack of attention and caring. Instead, to

care in silence is a "crucial kind of caring." Moreover, Minami in the immediately preceding excerpt, suggests that this is a caring that depends on homogeneity in the culture, on intuitive understandings of background meanings and cultural symbols. She contrasts this quiet caring with U.S. nursing care and suggests that silence is uncomfortable for the verbal U.S. American.

The *amae* relationship. A kind of caring highly valued in Japan is epitomized by the *amae* relationship. According to Minami (1985), "the uniqueness of the Japanese view of man [sic] leads to the creation of patterns of human relationships" (p. 316). The *amae* phenomenon is one of these patterns (Minami, 1985). The *amae* relationship may describe a "range of interpersonal dependency from intimacy to pathological symbiosis" (Minami, 1985, p. 316). The *amae* relationship begins with the passive dependency of the infant on the mother. The "good mother" knows what the infant thinks, feels, and needs and provides for it. There is scarcely a sense of separate self between the two (Barnlund, 1989). In Japan this kind of oneness and "selflessness" is idealized and serves as "a model of how adults should strive to relate to one another" (Barnlund, 1989, p. 163). There is a presumed "sweetness," a self indulgence, and a presumption of "some special relationship that exists" (Doi, 1971, 1973, p. 28). This kind of connected relationship depends on nonverbal awareness and is common throughout the Japanese culture.

The *amae* relationship in later life may be conflicted (Doi, 1971, 1973) and there may be a clash in impulses between that which benefits the self and that which

serves others. However, in Japan the individual with little concern for how his or her behavior affects others, is often despised and shunned (Barnlund, 1989). According to Minami (1985), *jibun*, the Japanese concept of self, controls the *amae* relationship. The participant who in a previous excerpt, talked about becoming less kind after living three years in the U.S., became less willing to accept the *amae* of her younger, former student, colleague and instead insisted her colleague develop independence and a more solid *jibun*.

The *amae* relationship is complicated by the hierarchical nature of Japanese society (Reischauer, 1977). For example, it is more common that the overt dependency role will be assumed by the younger person or the person of lower role status in the *amae* relationship whereas the caretaker role will be assumed by the older individual of higher status. The "less kind" participant's disinclination to accept her colleague visitor's *amae* was likely more difficult because the colleague was both younger and a former student.

Minami (1982) maintains that the *amae* phenomenon is not unique to Japan but in other countries, phenomena which in Japan might be termed, *amae*, are "labelled as friendship, mentorship, colleagueship, intimacy, attachment, love, pathological dependence, passive-aggression, symbiotic, and so on..." (p. 15). What is different in Japan from U.S. America is the acceptance and institutionalization of the overt dependency (Minami, 1982).

Ideas about Japanese caring relationships have been introduced in this section.

They will be further explored in Chapter V, Coming Home. Important aspects of Japanese caring delineated in this section include: (a) the value of attention to the other; (b) the fluid sense of self allowing for increased connection with the other; (c) the Japanese tolerance for caring that "leaps in" and takes over, especially in relationships where one person is of a higher status than the other; (d) the acceptance of dependency in certain relationships in Japan.

The first major theme of the "changing sense of self" topical area was that of the changing self in relation to the other experienced by the Japanese international scholar. This theme was consistent and pervasive in the narratives. It is a complex and multilayered theme. Each layer introduced new aspects of the Japanese international students' U.S. experiences. As participants reflected upon the new ways of being that they learned in the U.S., they contrasted those with ways of being in Japan. A second theme related to the changing sense of self is the role of context in communication.

The Role of Context in Japanese Communication

The facility to understand context and grasp the implications of a situation without ever receiving a direct verbal message is a communication characteristic which varies with cultures (Hall, 1976). As participants talked about the Japanese self "being in the flow" they also alluded to "trying to understand without words" the experience of the other. Compared to the United States, communication in Japan tends to be more situational, contextually dependent, and less verbal. Most Japanese

words have multiple meanings depending on the situation. One participant put it this way:

> I feel, with Japanese people, communication is abstract, not concrete. So it's always vague. And with the nurse-doctor, doctor-patient, and nurse-patient relationship they may give information but it is not concrete or clear. So it's vague and we are always guessing. Maybe this means one thing? Maybe another? That kind of vague communication is not only found in the medical situation. For example, Japanese politicians often say, "I'll do my best." American people get angry with this vagueness. "What will you do? Give me a concrete plan." But we just say, "I'll do my best." (C)

As this participant suggests, Japanese communication is less direct than that in the U.S. "Communication is abstract"; it is vague and not concrete. This participant states this tends to anger information-seeking Americans who want to know precisely what, for example, a politician's plans might be. Hall (1983) alleges the "Japanese do not get to the point quickly" (p. 63). He states, "the Japanese think intelligent human beings should be able to discover the point of a discourse by the context, which they are careful to provide" (Hall, 1983, p. 63).

Moreover, Hall (1983) discusses how different cultures expect the message in the communication to be delivered with differing velocities. As might be expected, Japanese communication is geared for a slower message delivery format than U.S. communication. In Japanese communication, there is great attention paid to the relationship of the communicators. This may take precedence over other aspects of communication and a sense of the relationship may become the primary message. Three concerns related to the theme, the role of context in Japanese communication, were pervasive in the narratives of the international participants. These were: (a)

harmony in everyday life; (b) making individual choices; and (c) hierarchy in Japanese life.

Harmony in everyday life. Harmony is supported by the fluid boundary of the Japanese self and by the cultural propensity for nonverbal communication. The attention to the other and the slower message delivery format allows individuals to tune in to each other rather than move with direct precision toward an outcome or product. The Japanese comfort with ambiguity allows for assessment of the situation. The feeling of being together in the flow, being one with the group is highly prized. The primary intent of everyday social intercourse is to achieve a harmonic understanding within one's group. One participant illustrated this notion with a description of a typical interaction of three colleagues out for lunch at a restaurant.

"Three Curries For Lunch"

> In ordinary day to day life, for example, three of us go to the restaurant. What do we want to eat? One person says "Oh maybe curry rice." Then "me too!" "Me too!" Three curries. That's our way. If two persons say curried rice and one person says another thing, "oh no--you change to curry. It's easy for them." If I say "no, I like this one" and assert myself, it's a kind of disharmony. We are very shocked by the American peoples' value system. "Coffee? Do you take sugar? Cream?" They ask and then comes the coffee the way that really I want to drink it. In our value system, I have to know about your favorite. So first I try to use kind of weak coffee and see if you are satisfied or not. And maybe you like a more strong one. Next time I try that....To ask is more like feeling close in the U.S. Here, to ask is kind of *mendo*. It makes me worry. I don't want to do that kind of thing. Or I don't care for the feeling. The *kanji* for *mendo* is two characters. This one is "face." This is maybe "hit." (C)

The narrative above illustrates the Japanese lack of tolerance for diversity or self expression. *Mendo* translates as "disharmony," "trouble," "complications," a

"nuisance." *Mendo*, when written in *kanji*, is made of two characters, telling in their juxtapositions. The first, "*men*" translates "face or mask." The second character making up *mendo* is "*do*" and translates as "breakdown" or "overthrow." To express an individual desire in the lunch restaurant is trouble, a nuisance. It breaks the flow, interrupts the face of harmony. It requires decision making and personal expression and may disrupt the genial collegial compatibility.

The "three curries for lunch" participant says, "in our value system, I have to know about your favorite." Then he describes a process of careful experimentation with the strength of coffee and minute attention to the other's response designed to discern the "favorite." Through trial and error and acute observation, the likes and dislikes of the other are established, rather than the direct U.S. American method of asking what the other wants. Two implicit ideas are inherent in this process. First, once the Japanese person's likes and dislikes are established, it may be difficult to change. And second, the Japanese process of trial and error is based upon an assumption of long term relationship.

In Japan, harmony takes precedence over the expression of personal opinion. Thus the reaction of family members or friends might be more important than the satisfaction of eating or drinking what one really wants. Furthermore, with a fluid sense of self, for the Japanese individual, "what one really wants" is likely to be situationally influenced rather than individualistically determined.

Making individual choices. Making decisions, expressing opinions, stating

preferences--all expected personal behavior in U.S. culture may be shocking or foreign to the new international scholar from Japan. Yet as the participants in this study developed increasing competence with these, some recognized this competence as changing who they were, transforming the core of themselves. Participants talked about how societal norms in the U.S. require continual specification of individual preferences even for the most basic human needs like food.

> I have to make a selection or I have to make myself decide when and what to eat. And that is something which I had never experienced....before when I made my own choice, it always mattered to me what the reaction of my family members or my friends would be. They came first to me. But after I spent years in the United States, it was always "how do I think about it?" And what other people think about me or how people feel about what I have chosen became not too important.

As illustrated in the preceding two excerpts, participants often had little experience with individual choice in everyday decisions, like menu selection, before their U.S. experience. Generally, self expression and personal choice became less threatening after being in the U.S. Moreover, it was suggested that the process of making continual everyday choices in the U.S., served to facilitate development of the individual self. In the process of continually asking and responding to "what do I want"?, the participants' "I" changed and became more individualized with definite preferences, and became less based on group determinants.

Hierarchy in Japanese life. The idea that status might make a difference in the expectations in relationships was introduced in the discussion of *amae*. The notion of hierarchy emerged as a strong and recurring concern in the narratives. Participants

described Japan as a "vertical society" as opposed to the U.S. which they classified as "horizontal." Hierarchy in Japan may be defined in terms of gender, age, and role.

One participant explained the Japanese inclination towards hierarchical ordering with regard to gender comes in part from the influence of Confucianism in Japan:

> Before the war there was the philosophy of Confucius. You know, the woman should be obedient and serve the man....Not now, now things are getting changed because of American influence. We have democracy. The boys and the girls are equal.

Long (1984) notes that Confucian precepts degraded any woman who worked outside the home, especially those who had physical contact with men, like nurses. Furthermore Confucianism prescribes a fairly rigid hierarchy complete with dictates on loyalty, duty, responsibility, and power, not only in the family but also within the community at large. Although now more than fifty percent of Japanese women work outside the home (Long, 1986), the influence of Confucianism on the position of women in Japan, and the Japanese propensity for hierarchy, may be lessening but remains significant.

Language in Japan reinforces the hierarchical order and serves as another way to contextualize situations (Lebra, 1976). Lebra (1976) claims Japanese status orientation is supported by the "cultural bias for empathy and dependency" (p. 72). For example, baby talk in television commercials is effective in appealing to the audience's empathy for the helpless, while at the same time gratifying their sense of superiority (Lebra, 1976). "The Japanese are still basically bound by a hierarchical

frame of reference, lacking alternatives, even when they compulsively try to be egalitarian" (Lebra, 1976, p. 72). In a manner completely baffling to the novice foreign student of the Japanese language, one uses differing forms of address and even different words depending on the relationship, saving formal polite forms for those older, in higher positions, and outside "*miuchi*," the inner circle. On the other hand the language used with children, younger family members, and sometimes with women depending on the relative roles, would be considered extremely rude, patronizing, insulting, and offensive if used in public with adults. Language differences based on gender may play a role in hierarchical ordering in Japan. A female participant stated:

> In English people are equal, but in Japanese the woman is lower than the man. She is in an inferior position. So that's why sometimes I switch to English on purpose. Language has power. (D)

Like English, certain Japanese words contain connotations of sexism. For example, *okusan* is the most common term for wife and has been "vulgarized into an all-purpose term for women" (Cherry, 1987, p. 67). "*Oku*" translates as the internal depths, far inside a building. "*San*" is the honorific meaning Ms., Mrs., or Mr. But there can be no Mr. Interior. That title is reserved for Japanese females and reflects the Confucian value of women staying home, inside, even though the Japanese reality has changed and many Japanese wives work outside the home.

The context of communication, a major theme from discussion of their experiences by the Japanese nurse scholars, reflected changes in the self. The value

of preserving harmony in the group, the lack of experience in making decisions, and the notion of hierarchy in Japanese relationships all illustrate the importance of context in Japanese life. Each of these three concerns, group harmony, decision making, and hierarchy emerged in other areas in the participants' lived experiences and will be touched upon again. For example, many participants had difficulty with group work in U.S. schools in part because of their attempts to foster harmony rather than focus on completing the task. And participants talked at length about the influence of hierarchy on their lives as nurses in Japan. But the important idea to keep in mind at this point is that these three concerns influenced participants' self concepts and played a role in their changing sense of self.

Language and Culture

Like the young man from the first excerpt, many participants experienced episodes of self doubt. And like him they suggested these periods were linked to poor communication skills and lack of English facility. Language and loneliness, a lack of cultural fit, and the public self and private self are issues illustrative of the theme, language and culture.

Language and loneliness. Language facility has been identified in the literature as being fundamental in determining acculturation trajectories of sojourners, refugees, and immigrants (Abu-Saad & Kayser-Jones, 1981; Kayser-Jones & Abu-Saad, 1982; Miller & Harwell, 1983; Upvall, 1990; Westermeyer, Neider & Vang, 1984). For example, lack of English proficiency was associated with depression in

Hmong refugees who had been in the U.S. 3.5 years (Westermeyer, Neider, & Vang, 1984). Furthermore, international students from English speaking countries tend to adapt to U.S. schools with relative ease (Kayser-Jones & Abu-Saad, 1982). Lack of English facility was identified as a major source of frustration and as a primary cause of loneliness and depression by study participants. The participant from the following excerpt was a mental health nurse. She describes her frustration with her lack of English.

> The stories that I often told my Japanese friends was how language was a big problem. I still remember very clearly that I told many of the people, my colleagues and my friends, that the most difficult part was the language barrier. Because the first and second year I was not so--I wasn't able to express myself in English so well, especially at the treatment meeting or conference. There were so many things that I wanted to tell other staff but I couldn't express properly. So I always felt some frustration. It was alright for me in a one-to-one situation. I didn't feel so much of a problem when I interviewed the patient or when I talked with my supervisor. But the treatment meeting or conference was a group setting. It was very difficult to explain what I was thinking or what I was planning to do with the patient so that was a kind of frustration....And I didn't feel depression. I wasn't depressed, but sometimes I cried. I cried many times on the bus when I went back home, when I went back to my apartment, because I was frustrated. I felt so much frustration that I couldn't express myself in the treatment meeting....

Crying in frustration at her lack of ability to communicate, her difficulty in group situations was a predicament echoed by many participants. Although this woman denies she felt depression, many other participants endorsed depression as a major problem caused in part by their isolation, resulting from their lack of English. Typically, when study participants recalled early U.S. experiences, language difficulty, depression, isolation, feelings of inferiority, and assaulted self esteem

surfaced as common reflection topics. The next excerpt is from a participant enrolled in doctoral program in nursing who had been in the U.S. seven months when she was interviewed.

"My Feelings Went Down and I Got Depression"

> The most difficult thing is to speak English. I always get confused speaking English. I want to speak it but I can't. My self esteem always goes down. I think I am foolish woman. I am like a child. It's hard for me. But living in America is not so difficult....If I don't want to relate with someone, I'm OK. But if I want to speak with someone or I want to study from someone, then my language is a big problem. It's hard for me. I can't speak English with my friends. My Japanese friends can speak English with their friends. I envy them. I'm sad not to speak English with someone. I'm not happy. When I arrived in America, first month my esteem is OK, because other international students can't speak English--same. Two months is OK. Three months is OK. But four months, five months, six months--my self esteem gradually went down. Six months is peak. My sadness is peak. Because after six months some international students can speak English well, but I can't. Some Japanese friends in Japan asked me, "can you speak English well?" I can't speak English well. I am sad to say so. I'm not happy. At night in my apartment, I'm alone. My feelings went down and I got depression. At night I sometimes weep. I don't want my Japanese friend to know because she sometimes advises me. She told me people always felt depression. And I know. But now I feel....And I don't want to express my weakness. I don't want to say so much. Sometimes I feel depression or sadness and when I tell someone, I regret it. Therefore sometimes I say to myself, "You can do so!" "You can do it!" It's my coping behavior. Or I call Japan. I can relax then. And when I felt sad, I go to bed. (E)

One can picture this participant weeping softly in her bed, not wanting to be heard by her more acculturated housemate. The difference between knowing something without involvement and experiencing a thing from a position of engagement is sharply contrasted in her poetic pronouncement: "She told me people always felt depression. And I know. But now I feel."

It is interesting to note that for this participant, talking about her sadness was counterproductive. It made her feel worse, whereas calling home, repeating positive statements to herself, and going to bed were helpful. The assumption that "venting" or talking about problems is usually helpful or therapeutic may be a culturally specific notion.

Other participants said that the time of their most intense isolation was also the time when they were most challenged by English and often most depressed. The amount of energy to "connect" in English was too much for them to expend during this depression. Another concern reflecting the major theme, language and culture, had to do with the "lack of fit" many participants stated they felt with the U.S. American culture.

Lack of fit. The next excerpt portrays the international student as the outsider. The participant describes herself as lonely and yearning to be accepted, but always conscious of the chasm between herself and the other hospital people, created by gaps in shared culture and role differences. In this participant's story, the emotional heat and family atmosphere of the psychiatric hospital milieu compounded her feelings of being excluded.

"The Adopted Daughter"

> The unit where I worked was a long term psychiatric unit, a closed unit. And the chief psychiatrist was a Jungian psychoanalyst....I must tell you one example--because I was graduate student from the University, I was not a real staff. And also I had a language barrier, language problem, and I am from Japan, I'm not an American. That hospital was such a white anglo saxon culture, WASP....So I always felt that I was not a real member of that

> organization. The chief psychiatrist was the father, and nursing supervisor was the maternal figure, and nursing staff, social worker other staff were all siblings. I was not a real sibling. I felt as if I were adopted daughter....I realized that there was a big big gap between myself and the people at the hospital. I realized we had different lives....They have their own ideas of life. They have their own Jewish or Irish cultures and they are rooted in life in that city, but I am not. I was just a temporary person, studying the masters program as an international student so it was quite true that there is a big difference between their life and my life. I always feel that kind of gap or difference. Sometimes I felt lonely in that sense.

This excerpt reflects the exclusion of one who does not share the same background meanings as those in the majority culture. Her "adopted daughter" status barred her from the close knit unit "family." First, as a student in the intense atmosphere of the closed psychiatric ward she felt excluded as a temporary person, but she was secondly isolated by her cultural separation. This participant said elsewhere in her interview, when she first arrived in the U.S., she had considered staying and making it her home. This factor perhaps intensified her disappointment. She stated that her obviously dissimilar culture and even her dissimilar physical appearance in the unrelenting WASP world of the hospital served to emphasize her "Japaneseness."

The lack of cultural fit that participants identified stimulated reflection. On the basis of identified contrasts, participants were able to consider their "Japaneseness" in new ways during their U.S. experience. For the participant in the following exemplar, the longer she spent in the U.S., the more difficult it became for her to "find her way as a Japanese."

> It's really different from my concept or my vision, my concept of my God.

> So the concept or the religion in American life is much clearer and somehow seems like it's a basic assumption. The more I stayed in America the more I felt like it might be difficult to adapt to that society....I couldn't find my way how to live in America as a Japanese. (F)

This participant went on the say that Christianity in the U.S. seemed pervasive. As an oncology nurse, dealing with terminal patients, she encountered situations where people were often wanting or needing to talk about their religious beliefs. She could only listen. The difficulty adapting she anticipates seems based on her deepened understanding of U.S. cultural assumptions and her discomfort with its discrepant background meanings to those in Japan. The longer she stayed in the U.S., the more she became aware of the widespread influence of "religion" on the lives and practices of the North American people and the lack of fit with her Buddhist belief system.

Alternatively, other participants suggested their feelings of isolation and lack of fit in the U.S. decreased the longer they stayed.

> I think it depends on how many years you were in the United States. I think I had the feeling of not fitting in when I was maybe in the U.S. three or four years. But when I was in the States more I worked very hard, right? I didn't realize I was Japanese. But I went to the bathroom, went to look in the mirror. I am Japanese! My skin is yellow, something like this. But with American nurses, I don't really feel I am Japanese. I am part of them. They are part of me.

It should be noted that generally participants who recalled integration into the U.S. nursing culture were in the U.S. in the late 1960's and early 1970's. Besides going to graduate school, most worked in the U.S. And, most had been back in Japan over 10 years.

The public and the private self. According to Barnlund (1975), cultures

mediate the content of conversation an element of which is the level of self disclosure. Barnlund (1975) studied differences in communication patterns between U.S. Americans and Japanese, finding that there are a sharp differences in the depth of conversation considered appropriate in interpersonal encounters. For example, Barnlund (1987) found that Japanese people tend to communicate with fewer persons and are much more selective than Americans. Japanese are more likely to prefer fixed patterns of communication which tend to be more superficial compared to U.S. Americans' preference toward more spontaneous patterns. Barnlund (1987) also found Japanese tend to be less intimate in verbal communication, tend to use more defense mechanisms, and do not self disclose at the same level as U.S. Americans. Japanese persons tend to "express themselves only 'in general terms' even with their closest associates--parents and intimate friends" (Barnlund, 1975, p. 156). On the other hand people from the United States tend to fully share complete details about themselves in about half of all communication with intimates, indicating a much higher level of self disclosure than the Japanese seem to display (Barnlund, 1975).

Overall, Japanese tend to expose themselves less than U.S. Americans do (Barnlund, 1975; Minami, 1985). In Japan there is a lower value placed on verbal communication, a comfort with ambiguity, and cultural values that advocate restraint, humility, and reserve. It is not surprising that most Japanese people feel uncomfortable sharing full details about themselves and their opinions.

Barnlund (1975) calls that portion of the self that one shares with others, the

"public self" whereas that portion that remains concealed is the "private self." Barnlund (1975) claims that the precise boundaries of the "public self" and the "private self" in Japan and the United States may be estimated using data from his study of self disclosure. Barnlund (1975) devised a model to represent the self. The center of the model is the unconscious, the core of the self. The private self is represented by a concentric circle surrounding the unconscious. And the public self is depicted as a second concentric circle encompassing both the unconscious and the private self. Not surprisingly, according to Barnlund's findings, in general, the Japanese boundaries of the private self take up much more space that for the average individual from the U.S. whose public self tends to dominate.

Initially Japanese international scholars are likely to feel they are in a "no win" situation. If they self disclose, go public with details of their lives, they may feel a loss of self. Minami states:

> You are expected to disclose yourself in your [U.S.] country. If you don't you are isolated. But for a Japanese it is very difficult to do that because actually this is the ego boundary and so you feel like your self is going away. Or if you cannot do that [self disclose] you feel you are a failure. You have to make the choice (Minami, personal communication, 11/27/91).

The following excerpt contains a description by a participant who "lost her self" during the first six months of her stay in the United States.

> When I came here to the U.S. I had some confidence in myself from my social life and my private life. But I lost my confidence when I came here. Who am I? I lost myself....

Her self esteem dropped and her self confidence plunged. She experienced a period

of intense depression.

In the U.S., closeness and understanding are achieved through verbal self disclosure. To refrain from self disclosure can result in being isolated. Furthermore, appropriate levels of self disclosure are culturally agreed upon. Knowing how much to disclose and to whom usually is learned through being brought up in a culture. When one is from a different culture learning this requires making judgments and qualitative distinctions. Most likely these are based on practical experience. For the participants in this study, achieving close relationships with U.S. classmates and teachers and feeling like they fit in was a challenge generated, first, by a lack of English facility and, second, by the no win predicament: avoid disclosure and be isolated; disclose and lose your self.

Culture Shock, Sojourners' Responses, and Mental Health Problems

The fourth major theme in the changing self area has to do with culture shock and mental health changes, consequences of the situations and phenomena already described. Three issues will be discussed in this section, mental health changes, plummeting self esteem and impaired judgement, and biculturalism. Participants reported many difficulties during their adaptation to life in the U.S. Mental health problems including hallucinations, suicidal ideation, "feeling schizophrenic," "feeling demented," diving self esteem, depression, isolation, loneliness, and somatic complaints were among the mental health changes reported by participants. Paige (1990) maintains that mental health disturbances are common among international

students during psychological acculturation to the host country. Participants showed varying degrees of distress during their initial months in the U.S. and many experienced symptoms reflecting disturbances in mental health.

Mental health changes. Participants reported radical changes in their mental health status, including rarely reported hallucinations, paranoia, and almost universally described periods of depression. The following exemplar describes life in graduate school for a young family man, an experienced teacher, and seasoned clinician.

"I Feel So Isolated And The Wall Comes Close"

> When I went to the U.S. I was already married. I was a teacher in Japan and I had clinical experience before being a teacher....Already I was 30 years old or 29 and I had a family, and I was going to be a student. I thought about money--how much I used each day. The amount was a very small amount and I'd worry about $10 or $30 like that. It's very much--how can I say it--somehow, sad. How come I have to think about this small amount of money at my age? And also I was staying at an off campus dormitory, a private one. Other students--everybody was young--regular student's age. And one room--the inside is white walls. I always see the white walls and sometimes I feel so isolated and the wall comes close to me--kind of--just a little bit--a hallucination. This happened the first two or three months. (C)

This participant's concern over money is a worry reflected in other narratives. And the periods of isolation he describes are common, even among those in other circumstances. The participant in the excerpt immediately above describes his reality as shifting slightly as the white walls in his isolated dorm room begin to close in on him, a brief hallucinatory experience.

Other mental status changes were commonplace. Suicidal ideation was

reported.

> I was suicidal. I was depressive. I didn't have hallucinations but I was acting very bizarre. Because---weakened ego. I think this probably happens for any international student.

One participant, a mental health nurse, reported feeling schizophrenic. She said she felt isolated and separate from the larger culture and unable to make sense, to connect, or to communicate with the larger culture, a state she compared to schizophrenia. She claimed her experience of culture shock increased her understanding of the lifeworlds of psychotic patients. Another participant reported that the lack of continuity and connection in her life could be compared to dementia.

"No Continuity In My Inside"

> In the morning I'd feel so funny or so strange. There were no connections towards someone. And then by evening--I spent all day with classmates and I'd do some things and by the end of the day it's fine. But the next day--there is no continuity in my inside....After I came back and I visited an elderly home and dementia patients....I thought well this is just--their experience is the same as my experience in the United States.

One clearly pictures the participant's lack of connected continuity and can extrapolate the anxiety associated with this kind of free-floating instability. Her lack of connection may be in part a result of her being "out of the flow." For Japanese international students with their more fluid boundaries between the self and others and comfort in "the energy field," lack of connection may make more difficult adaptation to U.S. life. Early in the adaptation process participants were especially vulnerable to acculturative stress. In part because of their less differentiated egos and cultural proscriptions against self disclosure, in part because of the absence of Japanese

"caring," they were susceptible to experiencing a "loss of self" and other mental status changes.

Plummeting self esteem and impaired judgement. Most participants reported periods of depression and lowered self esteem. Like the young man from the first excerpt who felt "stupid" and "like an idiot" when he could not understand his advisor, self esteem was often associated with lack of language facility. Diminished self esteem was also associated with loss of role. Some, though not all, participants studying in the U.S., gave up high status positions as professors or high ranking clinicians, and the concomitant income, to assume the ambiguous role of the usually non-income producing student. Furthermore, participants talked about feeling regressed and of their inability to judge situations with confidence.

"My Judgment Was Not Reliable"

> My self esteem got low of course. I felt that I was a baby in society. My landlady had a five year old boy and he knew even little things that I didn't....Here in Japan, I can do anything by my judgment, or almost anything independently. But over there, my judgment was not reliable so always I needed help....Like when I met somebody I couldn't judge [whether] she was a good person or a really weird American. It was really hard to judge. (F)

This participant went on to explain that her inability to judge people was a problem during her graduate nursing practicum. For instance, she was unable to ascertain from behavioral cues whether clients were alcoholic, addicted to drugs, or personality disordered in some way. She implied that these judgements were impaired because of the cross-cultural situation and were not a problem for her in Japan where she could evaluate inappropriate behavior with little difficulty.

The idea of being unable to judge people or situations with any accuracy also had implications for participants in their help seeking behavior. At times they reported that even when they knew they needed to seek out connection or contact with others, they just did not have the energy required. Moreover, often they were unable to accurately assess their situation and were either unaware they needed help or unable access it. For example, this doctorally prepared participant said:

> If I think about when I came here I didn't ask somebody when I needed social support....when I came to the U.S. I didn't realize what kind of things I needed....I didn't realize my situation so I didn't understand what kind of help I needed. My teachers and everybody told me "if you need some help please call me, anytime is acceptable so please call" but I didn't because I can not realize what kind of help I need. (A)

This participant went on to suggest that not only is the person sometimes incapable of understanding his or her situation, but also, at times when seeking help, the signals indicating help is needed might be expressed incorrectly or unclearly. For example, in Japanese language commonly, "*hai, hai*" which translates "yes, yes" is a signal to indicate to the speaker that the other is listening attentively. This is often accompanied by a head nod. So in Japan, polite listening behavior often is indicated by nodding and repeating the Japanese equivalent of "yes, yes." In the U.S. this same behavior indicates agreement. The signal received may be an assumption of agreement while the signal sent may be "I am listening."

Biculturalism. Related to this signal confusion was also the occasional response of U.S. faculty who at times attributed differences in cultural values and nursing practices to "problems with the language." The excerpt below comes from a

woman who entered graduate school in nursing with abundant cross-cultural experience. She had travelled and lived out of Japan prior to matriculation. Perhaps because of her previous experience, she was aware of her need to "split" in order to give acceptable responses in her classes. Although she was unable to articulate her situation until later in her life, she was aware of her circumstance.

"I Had To Split My Brain"

> When I took psychology--introductory psychology, I had to split my brain. In order to pass my exam I would have to respond in a certain way. "If they question this. I answer this way." But truly if I answer from my heart if they give me such a stimuli, I would say my response would be different....I approached nursing teachers a couple of times--"My nursing approach is quite different and I don't know why." And I seriously discussed that. I remember--I fought with one Filipino nurse. The Filipino nurse said, "nursing is nursing where ever you go. It's just the same, no difference at all." And I didn't know the reason but I knew there was a difference--some difference. And I said, "No I don't think so. We have quite different nursing." And I approached my teacher a couple of times. "I have quite a different idea and I don't know why but probably my 'better care' is this and such." She didn't know cross-cultural concepts probably. She said, "that's OK. You have an English problem at this moment. When you overcome your English problem, you'll be all right." So she patted my back and she sort of tried to relax me. But I was never satisfied with her answer. Always I said, "No I think it's not only English problem, but something else is there." (D)

Although certain nursing concepts may be the same everywhere, when the self is defined differently, care and concern are also different. For example, Minami (personal communication, 12/26/91) told of a care practice difference.

> For instance patients become emotional in your culture and cannot tolerate it because they are not in control and then patient may say, "Leave me alone." And you respect that. And you leave the room. We don't, we never leave the room....because that's the time when they really need our help with their instincts.

In the U.S., privacy and autonomy dictate that when a patient requests the nurse to leave, if safety is not at stake (e.g., the patient is not actively suicidal), the nurse will usually leave and return later. Yet in Japan, if the patient demands that the nurse leave, the Japanese nurse will usually stay, assuming the patient really needs help at that point. It is clear that what constitutes "better care" depends upon the culture in which the care is being given. The participant from the preceding exemplar who had to "split her brain" intuitively understood this notion but her teacher lacked this comprehension.

The participant went on to explain that as she actually became bicultural, she was able to move back and forth between cultural values and expectations without the same sense of "splitting." She implied that for her the process of "splitting her brain" was connected to her acculturation process. This particular participant spent over twenty years in North America. At the point she had adapted, she no longer was conscious of having to "split" to come up with culturally appropriate responses or practices but she was able to clearly recall the splitting process.

The faculty who assumed that the participant's problem was her lack of English may have been responding to the fact that many problems for the international scholars do stem from this lack. Participants identified language as the factor with the greatest influence on their adaptation to life in the U.S. Lack of language fluency was reported to increase isolation, decrease self esteem, exacerbate depression, and otherwise negatively influence mental health. Nevertheless, to suggest that

differences in responses to nursing situations, differences in practice or values, are a product of the lack of English ability is to miss the importance of background meanings--cultural influences on practice--and reflects a constricted and antiquated view.

Becoming bicultural was a theme that emerged in several narratives. Becoming bicultural was done with relish:

> And if people start to acculturate to your country then we can enjoy to be like this. I enjoy to be like this. Because usually I spend some time in the United States or Europe, I behave like this. (Minami, personal communication, 11/27/91)

Biculturalism means to move back and forth between cultures, languages, and values with freedom, grace, and flexibility. Biculturalism reflects adaptation, acculturation, and a change in the self at the core, the next major theme of the changing self.

Changes at the Core

Many concerns in the changing sense of self topical area have illustrated ontological changes. For example, the participant who talked about understanding more of the experience of her psychotic patients through her own experience of culture shock underwent an ontological change. Participants identified typical ways in which they changed ontologically. They became more flexible, more logical, and their organization skills changed. Three related ideas make up the theme, changes at the core: (a) a new flexibility; (b) the logic of English; (c) and a contrasting case, where the international educational experience was not construed to have catalyzed ontological change.

A new flexibility. The young man in the initial "becoming tough" narrative talked about his ability to see things from multiple perspectives after living in the U.S. That issue is expanded upon in the following narrative, from another participant who was an international scholar in the U.S. twice, once during her masters degree. She returned again for her doctoral degree.

> After I came back, I think all that we call a "*koda wari*," the frame, or the frame which we think we have to stick--was gone. I think that what I learned or earned most, was perspective differences. There is not only one way. You have freedom in doing things. You have lots of free choice. And sometimes before I felt there was some way to do a thing. After I came back, I know there are many ways. So I really don't have to stick to it...."*Kodawaru*" means that you have one way of looking at things....(B)

The most significant change in her self was a new ability for recognizing a variety of options and appreciating a multitude of perspectives. Furthermore, the liberating awareness of the value of multiple perspectives is an ontological change that may not always be reflected epistemologically but surely has impact in all areas of participants' lives.

The logic of English. Another theme that reflected change in the core was the acquired ability to think and write logically. The Japanese language is not linear and logical thinking is not as valued in Japan as in the U.S. Minami (personal communication, 11/27/91) stated:

> From my personal experience I think the thing that most affected me from being and studying in the United States was perhaps learning logical thinking....Because I can read the Japanese language, many senior faculty whom I respect, ask me to translate a summary of their research papers into English. Usually the younger ones don't ask, but the senior ones always do. The paper is very good but when I try to translate it into English, it's not

> logical. English is a very logical language. Sometimes in the Japanese language we don't have a subject. We don't have an object. It's very vague.

Doi (1985, 1986) claims that Japanese language reflects a situational perspective. For example, the word *omote* is the aspect of a thing that is visible; the *ura* is that which is hidden. When the perspective shifts the *omote* and the *ura* may change places. Doi (1986, 1985) states, "the Japanese usually do not make an issue of the fact that there is a lack of logical consistency between the two" (p. 29). He speculates that this is because the Japanese give precedence to the logic of the two together over logical consistency in language. The Japanese are neither "very attentive to using words analytically" (p. 29) nor "enthusiastic about relying on logical consistency" (p. 29). Valued U.S. writing descends from a topic sentence in a linear and logical way. Points are made directly. Japanese writing styles, like verbal communications, tend to be connotative, implicit, and indirect (Murray, 1991). To be unsubtle might insult the intelligence of the reader. One participant identified value differences in literary explicitness,

> Japanese students are taught how to read between the lines. That's very important....One of my American friends said, "there is nothing between the lines!" That's funny.

Participants reported that U.S. graduate school demands upon them for logical thinking and writing proved to be very useful later in their lives. A related transformation that participants pointed to was their increased ability to organize information:

> Most important? I learned how to organize knowledge....I can collect information, and then I can organize the information and knowledge and I can present it. That I think is my most powerful [change]....I can integrate it....maybe I figure out some of the issues and organize, point out some of the issues and create some new way....I never looked at the nursing research field as a whole. But when I came back, I had to organize [information] for the students....many things that I did were totally new areas....It is not content....It is more methodology for me....

For this participant and for many others the ability to organize and integrate information in creative ways was identified as an important transformation. Though much of this change could be a result of graduate education and maturity, this participant perceived that the changes took place during her doctoral education which was in the U.S., not during her masters education in Japan. She attributed part of this to differences in the organization and expectations of the education process in the U.S., yet the logic imposed by the English language relative to Japanese may also influence this transformation.

A contrasting case. It should not be assumed from the previous narratives that all participants endorsed the international educational experience as ontologically transforming. Although most participants described major changes in their sense of self, one participant denied being "changed at her core." Of course, she said, she had aged and adapted to certain aspects of U.S. culture. But these changes, she insisted, were really superficial, like the changes which she found in Japan on her return.

"The Core Of Myself Is The Same"

> I really didn't feel that I was changed so much. Maybe my value system was influenced by American culture--I was in America for many years so I took it for granted that I was influenced by American culture. That was quite natural.

> I wasn't quite sure what part had changed or what part was different but I just thought there should have been some differences. I was not quite sure but I told my friends "I am I."...While I was living in the U.S. I always said that I was tied to Japan like I had some invisible umbilical cord. I never felt that I was detached or that I was differentiated from the Japanese culture....The core of myself is the same and is not so changed. And maybe I have grown up a little bit, but the core of my self has been consistent. Some superficial behaviors or the way I spoke, that kind of thing, might have changed a little bit.

This participant went on to explain that when she came home to Japan, the media were different. There was an explosion of new journals. Television idols and slang had changed but the cultural values, the values of her parents' Japan, in her view, remained unchanged. She likened these surface societal changes to the superficial changes that had taken place within herself. The core of her self remained unchanged, like the deeper cultural values of Japan.

Summary of Changes in the Self

Most participants described changes in what constituted the core their selves, changes that occurred as a result of their international educational experiences. They described the change from a softly boundaried interdependent being to an independent, sometimes competitive, individual. They described differences in expectations about what constitutes the self. Rather than a self based on obligations designed to satisfy the other and founded on one right way of behaving, they became free for a time to "tune into" themselves and to see many options and ways of doing things. They suggested the time in the U.S. served as a touchstone for hardship later in their lives and they described "becoming tough." "Becoming tough" referred to

developing a more distinct sense of self but also related to hardships endured during the U.S. education experience. Some participants characterized their U.S. scholastic experience as sustaining them during hard times in their careers. One states:

> I really had to work very hard at school in the U.S. in order to get my degree. So I felt that working in Japan is not so hard for me since I had it so hard in the U.S. I would study until late at night to write many papers. I spent a lot of time writing. I really worked hard. After finishing my masters program in the U.S., I felt working in Japan is very easy.

Sometimes for the first time in their lives, depression, lack of continuity, poor self esteem, paranoia and other mental health changes surfaced as issues for participants. The ability to survive, succeed, and grow in the face of great hardship, and challenge, changed and molded many of their lives.

On Being a Student

Although the Japanese nurse scholar participants for this study came from varied backgrounds, some were well placed to discern differences in student-teacher relationships, student roles, and teaching methods having been faculty at schools of nursing in Japan. Three major themes fitting the topical area "on being a student" were uncovered in this study. The first concerns student-teacher relationships; the second involves the student role. The third theme concerns the organization of the educational experience.

Student-teacher Relationships

Participants characterized student-teacher relationships in Japan as generally more formal than those in the U.S. and said the Japanese student-teacher hierarchy

tended to be rigid. Yet they also discussed the *amae* relationship between students and teachers in Japan. Participants talked about their U.S. mentors or advisors and at times associated these teachers with the *amae* relationship. Another idea participants related to student-teacher relationships was the concept of *enryo*, or hesitancy. Because of the elevated status of teachers, students reported they were hesitant to bother them.

Amae in the student-teacher relationship. Participants talked often about U.S. faculty and especially advisors who helped them through their graduate programs. They also talked about differences in the ways U.S. and Japanese faculty relate to students. Typically participants talked about their positive impressions of the more casual, "looser" manner of relating that characterized the U.S. faculty.

> American instructors are very friendly. They are not authority figures. And in the classroom most of the instructors know how to relax the students and how to conduct the class. That I learned.

In Japan, commonly, students prepare the classroom for the teacher. They arrive first and when the teacher enters, students stand and bow. The hierarchical nature of the relationship there may prevent more informal or collegial student-teacher relationships that sometimes are initiated in graduate school in the U.S. And, appropriate student behavior in Japan usually precludes students questioning teachers or presenting alternative opinions.

On the other hand, *amae* relationships between teachers and students are not uncommon in Japan, with the student allowed to lean dependently on the teacher for

support and direction, presuming upon the "sweetness" of the affiliation. One participant described his feeling towards his students as steeped in *amae*. Most Japanese undergraduate nursing students are young women between eighteen and twenty two.

> I am the only male nurse instructor and those students are female and I have no child. Students are like my children, so I am not tough enough. I'm too protective. *Amae*? *So ne*. It is true.

The mentor or advisor. Participants described their gratitude for U.S. faculty and advisors who helped them "make it through." Using similar imagery to descriptions of *amae*, some participants, like the one below, characterized U.S. faculty as helping "a great deal."

"My Advisor, She Is A Very Kind Lady"

> So my advisor, she is a very kind lady. She's an associate professor--she said when I talked about this, "You came here to study nursing, not to study English. I know you are a knowledgeable person when you are in Japan so let's work together." She helped me a great deal. She corrected my papers asking--looking at my original paper--"OK you want to say this, right?" And she wrote it down. "OK do you want to say this?" And she helped write my paper and she even typed it. And I handed it in....In another class when my professor found out my English was not good enough--she asked me, "before you hand it in, please bring it and I'll check it over." So she very patiently checked my English and I brought it to her before.

Often helping with English writing skills was a task crucial to the participant's overall scholastic success that fell to either the participant's advisor or the faculty mentoring the student. Frequently the advisor was the student's mentor. The importance of this relationship was a recurring theme underscored by many participants.

> Maybe they can't choose but they need a very good, kind person, a close

> person such as an advisor. If you find a kind advisor, there is no problem I would say. She will help in your personal life or academic life. But otherwise, I would have been miserable.

Often participants chose to come to the U.S. for higher education because they wanted to study a specific subject with an expert in the area and could do this only in the U.S. For example, although many times Japanese nurses care for families as a matter of course, family nursing has not routinely been presented in Japanese nursing education as an integral part of the curriculum. Furthermore, the participant in the following excerpt went on to explain, she was interested in studying qualitative research methods. She could not find Japanese faculty to provide guidance either in her content area of interest--terminal care with a family emphasis--or mentoring in her methodological area of interest.

> I was interested in family nursing and patient care for the terminally ill, but in Japan research for terminally ill patients....is always like case reports....and then I didn't have leading teacher. I wanted to study more but I couldn't find a teacher who could lead me about terminal patients' care or family nursing....In Japan there are a lot of great practitioners, but they don't do research so much....(E)

Given this high specificity of goals, one can imagine how for some participants, the linkage to mentoring U.S. faculty would be of ultimate importance. Often prospective Japanese international students will write or visit U.S. faculty with whom they wish to study.

The expectation for a high level of faculty involvement is implicit in some of the preceding excerpts. Though some international students may not need this kind of guidance and some participants neither expected nor required intensive mentoring, for

others the commitment of faculty to work with the international nurse scholar may imply an essentially *amae* relationship. The following excerpt describes an expectation on the part of U.S. faculty for a more self sufficient student role, conveyed to the participant early in the sojourn.

> When I started my school, I felt very lonely, because the teacher said "we cannot do special things for you because you are Japanese." My friend [at another school] said she had some support because she is Japanese and she cannot speak English very well. But my teacher said "we cannot do that kind of thing." So I was very anxious about taking some classes because of the English. And I asked "if I have some questions can I ask you?" And she said, "yes you can ask me but you need to tape record. Tape it and listen about two or three times and after that if you have some questions you can come to my place." And so I felt I must do everything by myself.

Although initially very anxious, this participant was able to successfully complete her nursing doctoral program in the U.S. In her situation the level of initial faculty involvement was significantly less than that described in the excerpt with the advisor and faculty checking and actually helping to type papers in English. And, although the faculty member in the second example did not provide any "special things" because of the participant's international student status, the educator was clear about her expectations. Early exploration and explication of both faculty and student expectations can encourage alternative contracts for mentoring if necessary, and can reduce discrepancies between faculty and student expectations.

Participants were extremely grateful to faculty who extended themselves in more personal ways, for instance, inviting the students to their homes. The participant in the following excerpt recalled several years later the kindness of his

dean.

> The dean--he was very supportive to me. One reason is I was very poor in English so he was very worried about my academic advancement. He corrected my English. And he was emotionally also very supportive. He invited me to dinner sometimes. (C)

Japanese people are less likely than U.S. Americans to entertain in their homes. Typically, teacher-student relationships in Japan are more formal. Most participants appreciated the informal U.S. teacher-student interaction which they characterized as casual and unpretentious.

The next exemplar reveals this difference in role expectations in the classroom:

> The teachers say "we respect your opinion" and that kind of thing, so I don't need to think much about teacher-student relationships or age differences or gender differences or position differences. How to speak is different but I can say whatever I want. That's really a nice feeling for me.

Teachers were described as "being there" for their students and "students were the main guests" in the classroom.

For some participants, U.S. teacher-student relationships were an aspect of their ontological transformation. The next excerpt is from a nurse who received her masters from a U.S. school of nursing.

"I Think I Changed At A Very Deep Level"

> In graduate school teachers looked attentive and interested in their students and students were very active. Observing the relationships between was my pleasant experience. In the school of nursing, my teachers welcomed me when I wanted to see them. Sometimes I said "I don't want to bother you" when I was with my teacher. Actually, I was afraid I was wasting her time. But she said, "You don't bother me at all." I felt every teacher welcomed me and was willing to help and support me. I liked to see my teachers and to talk with them. My friends called my name and smiled whenever they found me.

> I felt that I was treated as a valued person. These experiences gave me self confidence and I could enhance my self esteem. Now I am trying to treat my staff as I was treated in the U.S. I am trying to look at good points in them and express my positive feeling in any way. I think I have changed from living in the U.S....I think I changed at a very deep level at this point. (G)

The participant from the above excerpt describes an increase in her self confidence and self esteem which she says occurred as a result of her U.S. experience. Her interactions with people in the U.S., especially teachers, gave her a new sense of her self as a "valued person."

Enryo, the hesitancy to bother. The woman above who experienced change at "a very deep level" at first portrayed herself as "not wanting to bother" her teachers. The idea of "not wanting to bother" teachers is common concern which surfaced in many narratives. Just as the participant in the preceding exemplar did not want to bother her teachers, the following participant describes a student "hesitating" to intrude, even when she has been asked.

"Maybe It's A Burden"

> Sometimes faculty offer, "Why don't you come, because your English is not good enough. Maybe if we spend some time, it might be helpful for you. So, why don't you come."...but students cannot take that advice because there is so much hesitating. Students think that maybe it's a burden on faculty so then the student doesn't visit the faculty's office. The faculty is getting angry because the student never shows up. It is a missed communication.

Enryo translates roughly, "restraint," "holding back," or "hesitancy" (Doi, 1971, 1973). The *kanji* is comprised of two characters: "*En*" which means "distant" and "*ryo*" which means "consideration" or "anxiety." According to Doi (1971, 1973) *enryo* is "a negative yardstick in measuring the intimacy of human relationships" (p.

38). Doi (1971, 1973) claims "the Japanese behave 'reasonably' when '*enryo*' is present, but the circle in which '*enryo*' must be exerted is itself experienced as an 'inner' circle in relation to the outside world where no '*enryo*' is necessary... (p. 43)."

Enryo was uncovered as an aspect of the *omakase* physician-patient relationship. The participant from the excerpt offered below stated that she had not thought much about *enryo* while in Japan but while in the U.S. she began to really look at aspects of Japanese culture.

> It's different in the United States. In Japan the doctor has the authority so you cannot talk too much. You cannot ask too much. So you have *enryo*--hesitancy, and some ways you must be leaving everything to the doctor, *omakase*.

Omakase refers to a "trust" relationship which will be explained more fully in the Japanese "relationships" section of the coming home chapter of the findings. But *enryo* also emerged as a powerful theme when participants talked about student-teacher relationships. They spoke of their "hesitancy" in "burdening" teachers in the U.S. and the distance between teachers and students in Japan. They talked often of a lack of this distance in the their relationships with teachers in the U.S. An aspect of *enryo* is the hesitation to disturb those above one in status. In a manner similar to the patient hesitating to disturb his or her physician, the Japanese student seems to bring an initial hesitancy into the teacher-student relationship. Once convinced that their presence was not construed as bothersome, participants, like the one below, described access to teachers in the U.S. in glowing terms. Even the idea of holding office

hours was enthusiastically embraced as evidence of a "kind of student rights."

> In Japan we can visit any time but sometimes the professor is away or the professor has a meeting. So we hesitate to visit. But in America, we can. We can see the professor's open [office] hours in the class schedule.

The Student Role

The student role in the U.S. and the student role in Japan was said by the participants to differ somewhat. And getting used to the differences was said to be difficult for many of the Japanese nurse scholars. The most universal difficulty participants described in acculturating to U.S. graduate schools was learning to speak out in class. How to comport oneself in a group in the U.S. was another significant difficulty. Four other aspects of the student role in the U.S. emerged as concerns: (a) dealing with racism; (b) making friends; (c) having the opportunity to learn; and (d) the meaning of counselling to the Japanese student.

Speaking out in class. The first excerpt in this section comes from a participant who received her masters from a U.S. school of nursing and later became a doctoral student in the U.S. She reflects on her astonishment as she came to understand expectations for classroom verbalization in the U.S.

"Students Talked A Lot"

> In the masters program the first class was a huge class, "Introduction to Research." At that time more than 200 students were there, 210 or 220....Even though it was a huge class, students talked a lot! Sometimes it was hard to get through the content. In the beginning I could not understand much English and I was thinking, "Wow! They know a lot!" And after the quarter was halfway over I was getting so I could follow what was going on. And then I realized--many students are not relating their comments to any content in the class and I said "What? This is not only the clever person

> questioning and challenging the faculty." They are asking questions and talking about things totally unrelated to the content....Really surprising. In Japan it's very hard to get the student's opinion. So that if the student has a question, that means she really wants to know, and she knows what she's asking, and it will be very much related to content. No one would just say "I think this....I think that...." No, it would never happen. The first thing we learn in elementary school is just sit down, keep quiet, to listen carefully, and to remember the whole thing--whatever the teacher said. So it's really a hard thing. Actually the faculty [in the U.S.] are pushing the students to speak up. So I realized--later on I realized if I didn't speak up--they would think I cannot understand, or I'm not interested in the class. Either way is a negative thing. Of course I think they're expecting us to ask or discuss related topics but still, speaking is much better than remaining quiet. (H)

This participant was stunned when she finally understood enough of the class comments to recognize that each speaker was not necessarily making a clever point or question related to the content. In fact, often a comment was a personal opinion or non sequitur. She eventually began to believe that any verbalization was preferable to silence. Another participant reported:

> The instructor told us in one class, "if you are silent, you are an idiot. Whatever you say, it's OK. The comments you make are good." So the instructor calls on me, "speak up, yes or no--anything, say it."

The U.S. teachers described by participants valued verbal expression and the ability to assertively state one's opinion.

In Japan, on the other hand, there is distrust of speech. Barnlund (1987) sums up the value placed upon verbalization there, "intuitive communication, through means other than words, is praised and revered. Articulate persons, especially talkative ones, are seen as foolish or even dangerous. Eloquence can even disqualify one for positions of authority or influence" (p. 164). It may be considered the height

of foolish danger to speak out to one higher in the vertical position, for example a teacher. Like the first participant in the "speaking out in class" section states, students in Japan learn to "sit down, keep quiet, and listen carefully" in order to recall what the teacher said. Consequently, the demand to speak out in U.S. graduate schools was culturally dystonic although at times, after acculturation, quite freeing and exciting for participants.

Participants related variations on the issue of learning to speak up/out in the classroom. For example, one participant reported a situation where she was confronted by a classmate, accused of "not trusting" the class enough to speak out. The participant confessed that this accusation had caused her great stress and that as she tried to explain her hesitancy to the class, based on her poor English facility, she had started to cry, causing her further embarrassment.

Another participant explained his English ability was such that he was unable to translate as topics were being discussed. Rather than simultaneous translation, he would understand conversation at a slower pace, often a topic behind. Because he was still required to participate in class, he decided to prepare his class discussion beforehand and he would say his prepared piece at the beginning or the end of the discussion.

Another related issue had to do with one participant's complaint; when she was unable to grasp meaning in English, especially during a discussion, it was assumed that she was not bright enough to understand the content.

> People think if you cannot understand the language that means you cannot understand the content. It's not true for myself and it really put me down. This was a big thing to go through. It helped that several persons knew that "cannot understand English" does not mean "cannot understand content." (H)

Comportment in a group. The second most commonly cited problem in adapting to the U.S. student role concerned difficulty in learning the skill of comportment in a group.

"Someone Was Producing Some Confusion"

> We had a group of students that came from all over the place. And we had to do one project. I don't remember what the project was exactly but anyway--we made a group. And we decided who would do what and things like that. And I think some people didn't like whatever this leader decided....Anyway some other people came to me and they said they don't like this way and that way. So I sort of went through from the back. And I said to this leader, "you know, this girl doesn't like the things that she was assigned or the way she was assigned" and things like that. And I think we talked about it back and forth a couple of times. This is the Japanese way. And I thought I was doing it with my good will but eventually it turned out someone was producing some confusion. Because people didn't know their assignments or what they had to do or how they'd come up with results and things like that. Because of me! And I said, "Gee I thought I was thinking of everybody else's mind." I was reading everybody else's mind and I was sort of moderating those things with the leader. I never thought I was producing confusion. But actually at the end it came out as confusion, really and truly. And I said to myself, "why did things come out like this?" Because I thought I was giving comfort to everybody else. And the leader was a very nice person and she came up and she said, "You know, everything has to be discussed on the table, not behind. That's why it got mixed up and didn't come clear"....But anyway later on when I looked back I thought, "ah hah, probably I judged the way I used to do before. And I really didn't adapt to their way of doing things. That's why I introduced this confusion. That was really embarrassing....But in Japan it's different. They go through everything behind first. And then they make sort of harmony when they come up to say they're all ready....And they know what is coming up to the table. And it's a kind of ceremony you know at the end. (D)

This participant was trying to iron out all the conflict and deal with it "behind" in

private, so that harmony would prevail within the group. She discussed problems with assignments and the group process individually with various group members and tried to influence the group leader privately to change assignments. In her caring Japanese way she was "giving comfort," "moderating," and "reading everybody's mind," making assumptions about what everyone else wanted and attempting to get it for them. Instead she found that she had created confusion. She was embarrassed, but was able to reflect upon the process later to her greater intercultural understanding.

Other participants also had trouble working within groups. One student said that she was not highly verbal and leadership in the U.S. depends upon assertiveness and verbal skills. So her feelings about things were never sought in the U.S. group. She indicated that in Japan, group members, in their concern for the other, would have worked to discover the opinion of their quiet colleague. This idea was iterated by Minami in a different context.

> Another side is people in your country have the assumption that when people think about things they will speak out. That is the assumption so people don't make so much effort to pull the other person's thinking out. And coming from Asian country although they have certain things to offer, but they don't push out....There are certain [things in which] we have much more richness, but we don't know how to present it (Minami, personal communication, 11/27/91).

One participant talked about feeling guilty over not contributing more to her group. She claimed other members, though understanding, were forced to take up the slack created by her lack of verbal skills.

Group process may be difficult for many U.S. graduate students. Negotiating

personalities in order to complete a task is often neither smooth nor easy. However, negotiation of the group process for the study participants was fraught with extra obstacles. Discrepant background meanings, different cultural assumptions, uncomfortable verbal values and requirements, and unknown norms, jumbled their group process mediation.

Dealing with racism. When asked, several participants admitted to being the recipients of racist or nationalistic insults. Interestingly, early sojourners who arrived in the U.S. shortly after World War II disclaimed any racist incidents and made a point to assert they were treated with utmost generosity.

One participant had a patient who blamed her as a Japanese person for the loss of his job as a steel worker, claiming that "her kind" were responsible. Another participant stated that when he went to get his car license, the licensing official made racist slurs about "Asian drivers." A third participant complained that while in the U.S. a Filipino physician continually tried to blame her for problems on the unit where they both worked. When finally confronted, the physician admitted that she had lost part of her family during World War II to the Japanese fighting force in the Philippines and did harbor ill will towards Japanese people in general.

Unless pushed, participants did not disclose racist incidents. Yet some U.S. politicians have blamed the current economic downturn on "unfair Japanese trade practices." Recent popular novels and films like Crichton's (1992) The Rising Sun both reflect and contribute to the prevailing climate in the U.S. that encourages Japan

"bashing." Though no statistics on the incidence of hate crimes toward Japanese international students were found, the present mood in the U.S. seems to invite an increase in racism and violence aimed at Japanese nationals.

Friendships. Though the larger U.S. current climate may be increasingly inhospitable toward Japanese nationals, participants concentrated on positive relationships and friendships they developed with U.S. classmates and teachers. The participant from the excerpt below talked of the experience of visiting the homes of classmates.

"I Visited The Homes"

> I visited the homes of some classmates and spent a couple of days with them and with their families. And that helped me to get better understanding of their personal life. I visited my classmates. Most of them were married and they had their own families and their own places. At that time I was single. So I visited some of the families of my classmates and had a very nice time in their homes. That was a very good experience for me. The home atmosphere is different from the atmosphere in class. Very! You can see the different aspects of your classmates at home. I was the only foreign student in my class. The rest of my classmates were Caucasian students. I felt that I had a much better understanding of the way of thinking of Caucasian people at their home. How they communicate with their family and with the children. In Japanese student life, you rarely share your family life with other students. But the situation was different in the U.S. You can share.

This nurse scholar points out that the opportunity to visit classmates in their homes really allowed a new level of understanding of "Caucasian life." The participant was able to observe classmates' relationships with their children and really "share" in their lives. Although not all participants made lifelong friends during their U.S. sojourn, most did. The theme of grateful appreciation for the development of deep, lasting,

collegial relationships which bridged an ocean was common to the participants' narratives.

The opportunity to learn. Another concern to emerge in the participants' approach to the student role was their excitement at having the opportunity to learn. One participant announced enthusiastically: "In America I was free!" When she was asked what she was free to do, her eager response was--"I was free to study!"

Most participants studied incredibly long hours especially during the first few quarters or semesters of graduate school, sometimes going without sleep or sleeping only short periods. For example, one participant talked about how during the first few months of her U.S. sojourn, she slept only two hours a night. The rest of the night she wrote and rewrote papers. However, by the end of her stay in the U.S. her sleep pattern was back to a more normal eight hours. Another participant said:

> I had to study. I was concentrating all my energy to study. I would stay up until 3 and 4 o'clock in the morning to study. The girl that lived in the dorm room next to me used to come over and she would say "it's 4 o'clock in the morning!" My [Japanese student] friend and I used to sleep 2-3 hours a night. The rest of the time we studied. I got excited. I was always excited. Exciting life! (D)

Because of difficulty with English, participants often had to read articles for classes over and over, using their English-Japanese dictionaries, and at times still had trouble grasping meanings. Thus, particularly in the beginning of the graduate experience, the time needed for class preparation was often significantly longer for participants than for native speakers. Participants, like the one below, were stunned at the opportunities and resources available for additional education, not used by local

nurses.

> Their resources are there and they have so many chances to develop their nursing science. But they are not interested so much. And I thought why? You know most scholars are very much eager to advance their science day by day. Why are nurses not so eager compared to other disciplines? That's my second shock. I thought if we had such a chance in Japan--probably so many people [would be] jumping to utilize those social resources. (D)

Graduate education in Japan requires a full time commitment and students usually have to quit their jobs. Japanese schools are not set up to be particularly flexible or to offer alternatives for continuing education. Furthermore, the number of graduate programs in Japan is small, so when the Japanese nurses noticed the plethora of educational opportunities available in the U.S. and the relatively small numbers of U.S. nurses taking advantage of these options, they were perplexed.

The meaning of counselling in Japan. The final point to be discussed in the theme of the student role, concerns the meaning of counselling or therapy. Faculty will occasionally suggest that an international student having trouble adjusting, seek counselling. Even for international students familiar with mental health practices in the U.S., suggestions to seek counselling can be alarming. The following excerpt is from a participant who was asked by faculty to help with communication between the faculty member and another Japanese international student.

"The Final Alarm"

> They [the students] need help but they just believe they can manage. And so then, they lose the chance to get help. And it's so painful because they wouldn't need help if they are in Japan. For some, partially they know they need help; but they think this is a kind of a language problem or just try to deny the problem. So one time the faculty asked for me to come because

> another Japanese student had a problem. This faculty believed that she [the student] had an English problem. But her English was perfect. Still they can't negotiate. And the faculty tried to make a contract with student; the student said, "Yes, yes, yes." But did not really. So, faculty believed the student agreed and the student believed the faculty understood her situation; but they couldn't make an agreement. Both of them had a different perspective. And then the faculty asked, "Why don't you get student counselling?" And the student's situation was getting worse and worse. The suggestion to get counselling at first really upset her. We don't need counselling. The concept of counselling or therapy is quite different. We think of that as a kind of final alarm. But for the faculty it was just a kind of advice.

This excerpt contains several key points. First, it provides support for the notion that at the point of needing help, the international student is not always able to ask for it or to even be aware of the kind of help he or she needs. Second, at first it seems the faculty and the student would like to ascribe the problem to language difficulties. However, it may be the problem is one of personality styles or cross-cultural communication difficulties rather than language. The teacher portrayed in this narrative is unquestionably committed to furthering communication and is concerned about the student's understanding. Yet, one gets the sense that for both the teacher and the student the emotional tone of the incident is one of frustration, a series of missed cues and signals gone awry.

The notion that advice to "seek counselling" may mean one thing to the faculty and quite another to the Japanese student is evident from this excerpt. There are times when international students do need counselling. The mental health changes including depression described by the participants may in some cases require active intervention. However, each situation demands a case-by-case judgment. No specific

rules for when or how to suggest counselling can be abstracted. The important thing for faculty to understand is that the suggestion to "seek counselling" may signify to the Japanese international student that the faculty believes he/she is suffering from a very serious and potentially stigmatizing condition.

Organization of the Educational Experience

Many participants talked about organizational surprises in the U.S. classroom. For instance, participants tended to be surprised by the lack of structure and allowance for and expectation of class participation. The number of papers expected in classes was also a shock that emerged as an issue for many participants. And, the idea of syllabi with long term objectives for learning was new to some participants. The following excerpt depicts these three organizational differences in U.S. nursing education.

"Controlling and Uncontrolling"

> The United States is in some ways more organized. In some ways, more unorganized. I don't know why. I think for the Japanese faculty, maybe the depth of the content is different....I thought in the United States, the faculty gave the student more free time in the class discussion part. I thought of this as a kind of lost time. Why don't you teach? And in some ways American faculty are not controlling in the classroom. But in other ways, they are slowly controlling over the class as a course--organization or the demands of the task. So, the structure they organized. But each class, they didn't organize. The combination is quite interesting for me. In Japan masters students--we don't produce so many papers. So, each task, each class task is less but--I don't know--we don't have so much discussion time either. So I don't know how. Maybe the faculty in the United States have a special skill--controlling and uncontrolling.

Controlling the classroom. The participant from the excerpt above, with a

masters from a Japanese school and a doctoral degree in nursing from the U.S., was surprised by the amount of unstructured time spent in student discussion in her U.S. doctoral classes. She initially perceived this as lost time. She did not define whatever was happening in her classes as "teaching." The classroom was "not controlled." Other participants suggested that Japanese classrooms tend to be much more formally structured with a mostly didactic format and fewer opportunities for student interaction. The participant from the "controlling and uncontrolling" excerpt hints at her admiration for teachers who manage to have students learn in their classes though not through "teaching." This notion of teachers flexibly fostering learning, though not necessarily through structured lecture material, was common to the narratives.

The high number of written assignments. A second organizational difference alluded to in the excerpt immediately above concerns the high number of written assignments required. Many participants were shocked by the high number of papers and exams expected in their U.S. graduate classes. Responses to these requirements varied. One participant said, "I was dying," when he was required to produce a paper every three weeks in one class, at a time when his English facility was low. However, another participant claimed that the opportunity to score on many assignments improved her grades. Before, in Japan, her marks would be conferred on the basis of perhaps only two exams. Her response to the relative high number of assignments in the U.S. was to be appreciative. Whatever the response, participants

agreed that there was a difference in the number of required assignments. There were significantly more in U.S. classrooms.

Short term and long term goals. Participants were also surprised by the general structure of U.S. classes. Some students were not familiar with syllabi. They remarked with some surprise that teachers had references, bibliographies, and class requirements prepared before classes began. International students were grateful for the opportunity to prepare for classes using syllabi and references before the beginning of the quarter or semester. Participants understood that teachers had clear long term goals for the quarter or semester. This was a revelation for some of them. The trend in Japanese nursing education seems to be moving toward prepared syllabi with references, but still for some participants, U.S. graduate school was their first experience with these.

Summary of Being a Student in the U.S.

Not only are there differences in content taught in Japanese and U.S. nursing schools, but there are also dissimilarities in the process. International nurse scholars may come to U.S. graduate nursing schools to study a distinctive content area with a specific individual faculty member or they may have more global goals, for instance to learn about clinical oncological nursing. They may come expecting to work with a specific faculty person or they may be assigned by the school to work with an advisor. From the previous discussions and excerpts one thing is clear. By whatever process the student-teacher connection occurs at the U.S. school, differing

expectations by the student and the teacher about the character of the relationship may almost be assumed.

Clearly there are fundamental differences between what is expected of students in the U.S. and what is expected in Japan. In the U.S. students are expected to be verbal, speak out in class, to have and share their opinions--all behaviors less valued and at times disparaged in Japan. Yet the Japanese nurse scholars did adapt to the U.S. graduate climate. They successfully completed group projects in situations where process dynamics are likely to be foreign. They may have had to cope with racism/nationalism. They unquestionably coped with misunderstandings. Yet, most participants recalled their U.S. student experience with grateful enthusiasm, treasuring the "freedom to study."

Most participants grew to enjoy the opportunity to express opinions and to verbalize in classes. They began to value this method as a sound way to teach. However, for some participants it became a problem again as they returned to their own teaching practices in Japan. This will be discussed more fully in the chapter on coming home.

To be in control of the overall direction of the class yet at the same time to freely offer students the opportunity to come to their own understandings through interaction was seen by many participants as a strength of the U.S. nursing faculty and an important aspect of their education experience. Through these methods, students were encouraged to think on their own, to hold and express opinions.

Though this may occur in Japanese nursing education, the means to encourage this were seen by participants as organizationally fundamentally different.

CHAPTER V

FINDINGS AND DISCUSSION

Coming Home

Introduction

In The Japanese Overseas: Can They Go Home Again? (1988), White begins chapter I with a Japanese children's chant that translates, "Leaving is good, but it's frightening to return" (p. 1). The chant accompanies a playground circle game where children unclasp their hands and raise their arms to signal that the one who is "it" may leave freely. Then they quickly grab hands and move together to prevent the child from getting back inside the circle. White (1988) claims the tightly "closed circle may be taken as a symbol of the exclusion often felt" (p. 1) by persons returning to Japan. A number of the participants from the current study experienced their own difficulties getting back inside the circle.

It is important to recall that the transformational stories which were sought in interviews focused on difficulties and problems. Most participants treasure their U.S. educational experiences. They value the relationships they made and the changes that occurred in themselves. Many of the participants are in high positions and are influential in Japanese nursing, in part because of their overseas educational sojourns. However, what is presented in the first topical area in the coming home chapter reflects less upon the benefits to either participants or more generally to Japanese nursing, and more upon the sacrifices participants made.

The first topical area concerns the meaning "Americanization" had on participants' lives when they returned home to Japan. Two major themes emerged in this area, personal loss, and the meaning of the U.S. educational experiences to careers. Participants often talked of losses when they described their lives after return to Japan. Depression and disappointment were common. The second theme "the meaning of the U.S. sojourn on careers" includes exemplars describing concerns about finding a suitable position and the participants' fit within the Japanese professional nursing hierarchy. The second topical area in the "coming home" chapter involves practice differences and is divided into three themes, hierarchy and decision making in Japan, contextual and cultural differences, and caring practices.

The Meaning of "Americanization"

When participants returned home to Japan they often had difficulty reintegrating into Japanese nursing culture. Problems varied from feeling a sense of personal loss to wondering about where they might fit. The first theme, personal loss, includes descriptions of losses that returnees perceived in their lives.

Personal Loss

Difficulties readjusting to Japanese ways of relating and lifestyle losses, like the loss of leisure time are concepts illustrative of the theme, personal loss. Loss of one kind or another emerged as one of the strongest themes in the coming home division. In some ways, the response of participants returning was the area in which the participants were the most divided. For those nurses who were in the U.S. for

doctoral degrees most recently, reentry was generally perceived and recalled as harder than for participants who received master degrees or for those doctoral participants who had been back for over ten years. The reasons for this are unclear. Perhaps recently returned doctoral participants are situationally at a point in the reentry process where reentry shock is most penetrating. On the other hand, their difficulty could be due to actual differences in their coming home experiences, could be because of differences in the level of recall, or some combination of reasons. The next two excerpts provide some support for actual differences in the coming home experience. These participants believe it has gotten harder.

The following "coming home" paradigm case is from a nurse, who was in her 40's, had been back over three years at the time of the interview, and was ambivalent about how the U.S. sojourn had transformed her life and the lives of Japanese returnee nurses in similar situations.

"My Generation Is Really Suffering"

> My generation is really suffering. It's not only me but all of my generation. Other persons are also questioning or asking themselves--what should we do? I think that we have to encourage the younger ones to get doctoral degrees, but then they ask me what is the benefit? It's really ambivalent. Then the young persons ask....some of them are looking at my situation which is painful--the sacrifice of personal life. Then they say, "It's not my life." And other persons....they want to go for the doctoral degree without looking at the sacrifices. My question is as old as my dilemma. How I can recommend to them to go to the United States...? Our group became more visible and then we get attacked from others. "You don't know the Japanese system. You bring American knowledge. Instead of developing our knowledge, you bring other knowledge." And so if we do, we are easily attacked....Our group became so strong. That's a problem too. We don't show enough respect towards others. We became more direct people. And so the weak person is

> as afraid as a student....Maybe I have to develop a softer atmosphere but this group--we are so busy, therefore we are all more task oriented.

This excerpt contains many of the reentry concerns, salient especially to the group of returnees who are not at the head of an institution but who are active and recognized in the Japanese nursing community. The absolute lack of personal life and free time is perhaps the most bitter sacrifice they make on return. This participant suggests that some younger nursing colleagues look at her lack of personal life and say "It's not my life," meaning, "it's not for me." Others want the doctoral degree but are unrealistic about the level of personal sacrifice required.

Because this group of participants tend to be extremely busy and because of the U.S. cultural influence, they may become task oriented, more direct and less willing to pursue change "softly" from behind. This kind of behavior in Japan is considered individualistic and opens the participants to attack by other nursing colleagues. Because some participants are high profile in the nursing community, they become easy targets for those with ambivalent feelings. And, the new nursing knowledge from the U.S. is suspect.

The difference in reception accorded nurse scholars on their return home by the nursing community is attributed by Minami (1991) to the change in the political and economic context in Japan which has come about in the last 10 to 15 years. About these changes, Minami states:

> Once upon a time, I think that 10 or 15 years ago, the United States was considered as a model for the Japanese society....dreams came from the United States, like "America, America" from "West Side Story." That's the

> feeling. Everything coming from the United States is fine. At that time people can speak, people are proud to speak about their experience....But suddenly because of our economic development, people started to see that we [in Japan] are not so bad....From our Japanese view, America is patronizing so there is some kind of emotional resistance to the United States. We have ambivalent feelings. On the other hand, we know nursing in this country can still learn from the United States. We know that. So that's why there's such ambivalent feelings. So when you come back from the United States, in the olden times....it was very easy. Now it is very difficult. You have to behave as if you didn't learn anything. You have to be careful because people have ambivalent feelings. People listen to you and people respect you. But people say, "that's their way. That's not ours." That kind of thing. Now people coming back from the United States have more difficulty. (Minami, personal communication, 11/27/91).

Isolation, depression, self esteem assault, bewilderment, financial constriction, visa nuisances, and role confusion are common aspects of many participants' overseas educational experiences. To come home to ambivalence about the value of the information they bring because "it's not ours," may be partially predicted by participants, but upsetting nonetheless.

Relationship adjustments. The following excerpt is from a participant who had been back in Japan only a short while.

> Here [in Japan] I have--I don't know if it's depression or not--but I have a very hard time with relationships. Because in America if I said, "I cannot speak English," they will assume I cannot speak English. They won't think I am hesitant to speak. They won't feel I really can speak English but I said I cannot speak English....They take your word directly. But in Japan, they don't take your word directly. In Japan even if you can play the piano very well, you say, "I am not a good player." That is the Japanese way....So when I came back to Japan, I knew even if I can play the piano very well, it's not a good thing to say, "I am a good pianist." You must say, "I am not good, but I can play the piano" that kind of thing. Maybe I think too much about that kind of relationship. But I thought I must be about careful how I express myself. And there are only a few nurses who have doctoral degrees, so I don't want to say, "I have a doctoral degree." In America it's not unusual,

> but here it's unusual....In America I can say anything about myself. If they don't like it, they say, "I don't like it." So conversation is really easy. They say directly to me. But here I don't know what they feel about that....For me it's easier to be in America. I don't know maybe two years later I will say a different thing.

For this participant the sense of what is appropriate and proper in Japanese conversation was no longer second nature on her return. She had to think about when to hesitate--how much *enryo* to use and how much to self disclose. Self-censure to convey humble modesty, an aspect of her life in Japan, required more conscious energy after her return from the U.S. She missed the direct, frank style of U.S. communication.

Lifestyle losses. The relaxed lifestyle and the relative low cost as well as the relative sparseness of the population in the U.S. were difficult for some returning participants to give up. The same participant from the excerpt directly above, describing lifestyle losses on her return, relates:

> In Japan it's really expensive and you don't have any time. If you want to go even if you have the time and you have the money, every place is very crowded and the highway is very crowded....I miss my life and my friends, my teachers.

Japan is a country the approximate size of Montana with a population of about half that of the U.S. so it is very densely populated. Vacations, like New Years in January and "Golden Week" the first part of May, are usually scheduled at the same time throughout the country, so many people are travelling or are at vacation spots at the same time. Recent economic changes favoring the value of the *yen* to the U.S. dollar have made life in the U.S. less difficult economically for some participants.

The participant directly above also talks of "missing her friends." This was a recurring concern for participants. The distance of international friends and teachers, the time required for written communication in English, and the lack of leisure time in Japan made keeping close relationships difficult.

Another recurring concern participants recognized on their returns was related to the loss of shared history. The excerpt below comes from another doctorally prepared nurse in her 40's. She is from the same generation as the participant from the coming home paradigm case, "my generation is suffering," and she too is suffering.

"I Lost My 30's"

> When I [first] came back I wasn't aware about the loss of that period but now I feel a loss about the blankness of my life in my 30's. Of course I lived my 30's in the U.S. But my life in Japan during my 30's was so small. Somehow now I feel about 7 years were lost. The 30's are a very important time for adults. And that type of feeling--there is nothing in here. So I didn't feel lonesome when I was in America, but now I am feeling. I feel I have lost some of the years in my 30's.

The emptiness she experiences is related to those important years spent out of Japan. Her 30's were "lost" and now she expresses feelings of isolation. It is almost as if during the time she was gone she lost the background meanings and shared culture of her homebound cohorts.

The loss of shared culture is expressed with a different twist in the following excerpt.

"I Lost the World"

> When I started to think about personal loss, then I lost the world because it's not accountable. Usually we shouldn't say this is my personal loss, because we know also we are getting something. So getting and losing is a balance....American students also lose the time [spent in graduate school] but the meaning of the time is quite different because in Japan "being" is important....So personal loss if I count it comes out time and money. Maybe the way of living is quite different. My lifestyle might be different. Maybe this is Japanese women's problem too....In Japan becoming a masters student, applying to a masters program or graduating from a masters program--is quite meaningful. It's clear cut in terms of career development. So for us, graduating from a masters program--that means she has made a decision. She will develop her career....There may be pressure--it's hard to hide from too. In many ways I feel pressure because of getting a doctoral degree. Then when I feel the pressure, I feel maybe if I don't have the doctoral degree maybe I would have an easy, enjoyable life.

This participant lost her "world." The time she spent in graduate school may have been the same number of years as those of her U.S. student peers, but the meaning of the years are different. In the U.S., nurses with master's degrees usually go to new positions in institutions and they receive credit for their degrees and their past experience. In Japan, it is more important to be present at an institution accumulating seniority than to have been gone, accumulating degrees/knowledge and financial obligations: This is the meaning of "being." So for this participant her losses include time and money. Her salary did not increase during her absence and her education loans have resulted in indebtedness. Moreover, she points out, in Japan continuing on for a higher degree in nursing, while not necessarily ensuring financial reward (which is based on seniority), implies a pathway of career development. Duties and responsibilities precipitated by her receiving a doctoral degree have resulted in

increased pressure. She wistfully imagines how without the degree her life might have been more easy and enjoyable.

Veiled in the notion of career development for women in Japan is the view that career development and family life are incompatible. This may be slowly changing. But although all four male participants in this study were married, few of the women participants had husbands. Fewer still had children.

A contrasting case. Not all aspects of reentry are difficult. For some people returning brings a great relief, a restoration to being "in the flow." Minami (1991) described her return from her doctoral sojourn in the U.S. as a happy one.

> I missed certain things [from the U.S.]. I missed friends, food, and the kind of conversation. But I was drinking tea from morning to evening. I was drinking tea in the kitchen on the third floor. People came one after the other and we are talking about nursing. We are talking about many things but not seriously. So I really enjoyed (personal communication, 11/27/91).

For the first six months she drank tea on the third floor of her school with welcoming colleagues. She, however, returned as an experienced faculty member to the same school where she had previously taught, not as a novice teacher. For some participants, especially those returning from masters programs in the U.S. to the same institutions they had left in Japan, reentry was much easier than acculturation to the U.S. For others, however, coming home was as difficult and traumatic as leaving.

The Meaning of the U.S. Sojourn to Careers

This theme includes exemplars describing participants' worries about where they would work. What sorts of positions would be open to them as returning

graduate nurses emerged as a primary concern. Most participants were anxious about the response of Japanese people to their "Americanization." Some chose to keep quiet about their U.S. experience, discussing it only with close friends. Others talked about holding back personal opinions, hesitation or *enryo*, in interactions with faculty or nurse colleagues, so as not to appear too assertive, too verbal, too Americanized. Another reentry issue concerned participants' fit into the Japanese nursing hierarchy.

"No special position." Issues of coming home and reentry for participants included concern about finding positions suitable to their education and experience levels. A recently returned masters student, a highly experienced nurse who worked clinically in both Japan and the U.S., talked about the process of interviewing for positions.

> At the job interview she told me "I know you have a master's degree and that you specialized in oncology and also you are interested in patients with chemotherapy." But she told me that she couldn't guarantee that I could get a special position. She said, there is no special position for you so you have to be a staff nurse. That means there is no space for a masters prepared nurse like me. There is a position for a staff nurse, or a charge nurse, or a nursing director--that's it. One of my friends is also masters prepared. And she worked for a few years in the U.S. And right now she is working in a transplant unit. It's really a specialized area. She wants to come back to Japan to get a job like an educator for CCU or ICU nurses or something like that. But at one hospital she went for a job interview, the nursing director told her "if you want be an educator, you must start as a staff nurse and work a couple of years." I don't know how long. So she refused their offer. (F)

Both this participant and her friend were masters prepared experienced nurses who had worked clinically. Yet even with masters degrees and several years of clinical experience, the expectation was that when one starts at a new institution, one starts at

the staff nurse level. Staff nurses often work as equal members of a collective team, with RNs and LPNs sharing team leadership. The team leader in most nursing groups, according to participants, is often chosen by chance or rotation, rather than by any individual leadership criteria, such as experience or education. Thus the notion of team nursing translates into Japanese practice quite uniquely.

Although Japan is perceived as a vertical hierarchical culture, hospitals make few distinctions in nursing based on license or education levels. Participants seemed ambivalent about practice distinctions in Japan. On the one hand, they noted with envy that in the U.S., registered nurses and licensed practical nurses have discrete job descriptions that provide clear boundaries for differences in the duties they are expected to perform. On the other hand, some participants felt that the clear divisions in the U.S. tended to compartmentalize patient care, such as in the case of a nurse only observing heart monitors on a cardiac unit. Furthermore, it was felt that at times in the U.S. more educated/more experienced registered nurses might become distanced from direct patient care. Yet in Japan the lack of separation causes problems of its own. The following excerpt is from a doctorally prepared nurse who notes the lack of role differentiation in Japanese nursing.

> Somehow after the World War we thought equality was important but our definition of equality is quite different from the United States....We can't distinguish the groups. Sometimes the RN or even the head nurse can't make clear the difference between RN and LPN. This causes the RNs' self esteem to go down. And also sometimes we say to the LPN--"we are same nurse, let's work together. Harmony is important." So we approach the LPN in those ways. Therefore the LPN is also confused. "What is the difference?...Our job is the same. The only difference is salary."

Superficially this lack of position differentiation in nursing seems inconsistent with the hierarchical character of other aspects of Japanese culture. There are two factors to consider in explaining this. First, in the hospital, staff nursing as a whole takes its place in the hospital hierarchy, the staff nursing force reflecting one group--one horizontal rung on a vertical ladder. Parenthetically, it should not be assumed that this equality among nurses of differing education and experience extends to nurses in academic practice.

Second, as is evident from the excerpt, after World War II Japanese nursing was systematically restructured and was greatly influenced by U.S. nurse consultants during the time of MacArthur's GHQ. At that time Japan, an economically impoverished and defeated country, was in the process of importing many ideas from the U.S. including ideas about democracy and equality. However as these ideas filtered through Japanese background meanings, such as *miuchi*, the inner group, they transformed into a practice unique to Japan.

The lack of opportunity for expanded clinical roles was of grave concern to many of the younger returnees who had not established academic careers. In fact, the requirement to "start at the bottom" clinically pushes many returnees into academia where their education is more valued.

A very few participants were sent by their institutions to the U.S. to pursue higher education and did not lose their institutional positions. However, the majority of participants made the decision to seek graduate education in the U.S. independent

of institutional support. For those few who were sent, finances were often less of a problem and the issue of "where will I fit when I'm finished" did not loom so large. But for the many others, the Japanese cultural assumption that tends to value seniority, the length of time at the institution and age, over other factors was often a cause of apprehension and anxiety on their return to Japan.

Hospitals and nursing schools lean towards advancing those staff or faculty who have worked for them the longer time, and education levels are less valued. "The position problem" was identified as an issue by several of the Japanese nurse scholars. It is delineated in the following excerpt.

> Maybe this is not a unique story. I am talking about the position problem....Each institution has its own rule which is mostly governed by the Japanese culture. And some people who have a doctoral degree, still have to work under a person who doesn't have a master's degree. So we have to negotiate how, what kind of a situation we will accept and which situation we will fight. If the other person is ten years older, maybe we have to accept this.

Besides length of time at the institution, age is an important factor in position advancement in academic arenas in Japan. Young, highly educated participants returning to Japan with no history at an institution were most concerned. Even though they had graduate degrees and sometimes were certified clinical specialists, the Japanese system made little allowance for their advanced education. Instead, they were the newcomers, often expected to start at the bottom.

Keeping quiet. *Americagaeri* is a mildly pejorative word that is sometimes used to describe a returnee. It literally means America returnee but it connotes

assertive, outspoken, direct and frank behavior, and speaking without knowledge of the context. Rather than have the *Americagaeri* label, a common concern from the coming home narratives involved restriction and self-censure in an effort to fit back into the group. For example, the participant from the following excerpt returned after her masters to work clinically.

"I Needed To Keep Me Quiet"

> First time I went to the clinical....And I know there is a lot of old type head nurses so I was telling myself, "always be careful." "Don't use foreign words." "Don't do this." And I needed to keep me quiet. For them *katakana* words are foreign words. You know--too much. And if I use them a lot, for them, I'm different. I'll never be in the group. Also I'm new and young. I'm still in my 20's at that time. I should behave that way--like a young, new person. I know because that's the old hospital. (H)

This young woman very deliberately decided to "keep herself quiet," censuring even her language. She used more traditional Japanese words rather than imported *katakana* words in order to be part of the group. "Keeping quiet" is typical behavior for young, Japanese women. To keep from being considered too "Americanized" or assertive, many returnees reported working hard to keep quiet.

Some participants returning to faculty positions reported that colleagues who stayed at their institutions had advanced while they, who had been in the U.S. for years busy with higher education, were welcomed back "almost like children" who had left the nest and returned, with little acknowledgement of increased qualifications or maturity. In Japan the individual is rewarded for staying with the group so persons who leave are often suspect on return. In particular, persons returning from the U.S.

might be questionable. Minami (1991) described covert derision that returnees might engender.

> *Americagaeri*--that's a joke. It's not a good word. It's used like "she's *Americagaeri*." People don't use that word to that particular person. I have not been called *Americagaeri* by anybody. But when I'm living here and new persons come back then I hear behind the curtain people say "she is *Americagaeri*." It means she is Americanized, self assertive, not really looking at the context. She speaks out of context. (Minami, personal communication, 11/27/91)

In Japanese both assertive and aggressive behavior are translated as "rude." Minami suggests that "behind the curtain" or behind one's back, offensive behavior for a returnee might be labeled *Americagaeri*. Another example of the Japanese distaste for assertion involves a Japanese couple who were in the U.S. visiting their participant friend and some U.S. friends.. All were hiking together when the American hosts asked, "shall we go the long way or the short way back?" Voicing her opinion, the participant, who had been in the U.S. about a year, replied, "I want to take the short way." Soon after that the male Japanese visitor said, "You know, she has really gotten aggressive in America already."

Although in the U.S. participants preparing for return talked about potential reentry problems, when back in Japan, discussion becomes inappropriate. Minami (personal communication, 11/27/91) pointed out an important aspect of the reentry experience. The decreased level of self disclosure and the decreased value on verbalization made shared discussion of the reentry experience in Japan unusual.

> They can talk about it when they are in the United States and they can anticipate it. But when they come back because of this culture, people don't

> speak. They don't discuss it....Usually when you have a Japanese group in the United States, you can support each other because you are there together, but those who are coming back, they come back individually and it is very difficult to find a person who is in similar state....

The next exemplar also illustrates keeping quiet on return to Japan. This participant's first experience out of Japan was as a high school student. She returned to Japan after her masters degree and taught. She went back to the U.S. for her doctoral degree and returned once again to Japan. She points out that what one says on return depends on to whom one is saying it and one's returning situation. However, both times she returned from U.S. educational experiences, she consciously made the decision to keep quiet.

> I do not know how much people want to listen to the experience you had in the USA....And especially when I came back, I felt I shouldn't tell so much about the United States in order to get acquainted and in order to confirm my status as being non threatening. And so cognitively I think I tried not to speak about United States....That is because of Japanese cultural things. I learned after you come back from the United States you don't brag about it....I think in Japan there is a saying that you should not speak at least one year to see what is going on. You should be quiet. I think that sometimes is a very clever way because you do not understand the situation....(B)

She stated that observers might not perceive her as keeping quiet because she is not "so much quiet" by nature, but she was aware of the cultural expectations and implied that she tried to follow contextual rules.

Trying to fit into the nursing hierarchy. Another returning participant explained that although she had some difficulties on return, her elevated position in the institution may have alleviated depression.

"I Came To The Top"

> Probably I think why I didn't go into depression is my position. I came to the top. Japan is a vertical society and whenever you are on the top you can do whatever you like. You can order what ever you want. And you know it's much easier than getting in from the bottom. If you have someone on the top above you I think probably you will become depressed because you are not understood by your boss. (D)

The position to which one returns will affect the stress of coming home. This participant went on to suggest that frequent visits and close contact with the leaders of the Japanese nursing community from whom she received and continues to receive much support also helped to smooth her reentry. In addition her age upon return was such that she could move into a more powerful position within the hierarchy of her institution. Yet she prophetically describes possible misunderstandings by "your boss" for those coming into less supervisory positions.

After spending time in the U.S., participants often had problems readjusting to the Japanese nursing hierarchy, especially if they did not "come in at the top." The next excerpt clearly depicts this problem.

"I Really Wanted To Speak Up"

> The biggest difficulty which I faced in reentry into Japan was in interpersonal relationships. I was in America for about 12 years or so totally. I was invited to work in a national nursing department. And I had some difficulty relating to people, especially my boss. In the meeting I just wanted to say what I had to say. But my boss did not expect me to speak up. Just listen. To me that's not a meeting, that's a message from top to the bottom. I said, "it's funny." And whatever I said, she would say "You don't know anything about Japan because you have been out of the country for 10 years. Before you speak up, you have to look at what happened. You have to know what's happening in Japan. Then you can speak up in discussion." What I really meant was that Japanese people in the meeting--the boss does not expect staff members to

> speak up--just obey, that's the message. For example, I was in a big conference, a big meeting. And at that time I was a chief in a small section, right? And there was a meeting or seminar and then there was a free discussion in a big auditorium and the microphone was passed around, right? And I volunteered to pass the microphone to other people. After that meeting my boss called me and told me that "you are not supposed to do this because you are a chief." See in the United States, anyone, a president or a director could pass it around--they could do anything. But my boss felt that the higher position person was not expected to do this. That was the difficulty. One of the frustrations in the United States for me was the language in the seminar or group work, especially in graduate school. This was not totally in lecture--but also always in group discussions. I was so frustrated. I really wanted to speak up, on many, many things but the topic was moving around so quick, and American women--American people really like--you have to speak up. I pushed myself to speak up in the United States. I was accustomed to that, then I came back to Japan. It's totally different.

Embedded in this excerpt are ideas about speaking out of context, a sense of what is appropriate within the Japanese hierarchy, and conflicted values. Moreover, participants claimed that learning to speak up in a group was among the most difficult of all new behaviors they had to master in the U.S. This participant and many others came back to Japan only to find they were having the opposite problem with groups in Japan. Instead of learning to speak out and discuss issues directly, they needed to relearn the value of keeping quiet and being less candid. The most frustrating aspect of this for the participant in the immediately preceding excerpt was that in Japan where he could easily follow all the topics discussed in the group, where language did not keep him from speaking, he was expected to sit quietly in agreement. The description of this academic group mirrors Stewart's (1988) description of Japanese business groups with decisions made by the administrator or leader and the group providing a forum for the presentation or "selling" of those. Furthermore, the

participant's boss was offended when, at a big meeting, he passed the microphone around, a task, in her opinion, more fitting to someone lower in the hierarchy. The participant was displeased with the Japanese group process and lack of equality. This participant had so completely adapted to U.S. expectations for group behavior that he expected the Japanese group to be an open forum for informational exchange.

Other participants who had been out of Japan for shorter time periods also had difficulty their bosses, with group behavior, and with the Japanese hierarchy. For example, at the time of our interview, the following participant had recently returned from the U.S. after receiving a masters degree. He was one of many participants who moved from a clinical position to an academic position after completing graduate school. He makes clear the transition has not been easy.

> I have been spending a very difficult time because it was my first experience to teach as a regular instructor or a regular faculty. I had power in the hospital but I don't know the power politics in this college. But in the meeting I am almost behaving like an American. Even when someone has authority or someone has long experience as a professor, I don't care what she wants to say, I tell them my own opinions. I don't know if that has made trouble for me. Maybe some professors have bad feelings for me but it doesn't matter. (I)

This participant is "almost behaving like an American," speaking out candidly, voicing opinions in meetings and not attending to the power differential in the college.

One last exemplar, illustrative of the meaning of Americanization and the difficulty fitting into the Japanese nursing world, comes from the story of a doctorally prepared nurse back in Japan less than five years. From this exemplar it is clear that difficulty fitting back in is not limited to problems with those higher in the hierarchy.

"Now You Are An American. You Are Not Japanese"

> People told me that, some of them told me that I was changed; that I was Americanized a little bit. Some people--maybe kind of joking--but some were asking me, "why did you come back to Japan? Why didn't you stay in America for good?"....And they said to me, "Now you are an American. You are not Japanese so we have to be careful if we have a big meeting or we have a big conference."

The message implied is that colleagues must be careful of the increased directness and the new assertiveness of the returning person. Although this participant iterated that her colleagues and friends "were joking" with her, the nature of the joking emphasized the returning participant's difference and separateness.

Summary of the Meaning of Americanization

Participants were specifically asked to discuss problems or difficulties with reentry, and yet initially they were not asked about losses per se. Losses emerged from the reentry stories as an important theme. The losses which were perceived spanned many aspects of the participants' lives. The sacrifice of personal life was especially difficult for some of the doctorally prepared returnees. Although participants usually did not discuss their family life, few of the international graduate women participants were married and fewer still had children. According to Long (1986), "public opinion polls indicate that Japanese women in all age groups place their highest values on children and family" (p. 82). Clearly, the participants in this study are not typical Japanese women, however one wonders whether an undiscussed loss or area of ambivalence for some of them was the decision to "develop their careers" rather than concentrate on having families.

Some returnees had wondered where they would work with their new degrees. They had worried that there would be no place for them and that once they found a place, colleagues might be suspicious of their "foreign" knowledge. Some made conscious decisions to keep quiet and neither talked about their U.S. experiences nor spoke up in meetings, not disclosing until they "understood the context." Others spoke out in their new positions. Many of those who did talked about trouble with their bosses. To come into a position "at the top" tended to ease some of the participants' stress in recalling appropriate comportment within the Japanese professional hierarchy.

Practice Differences

The second topical area in the coming home chapter of findings and discussion concerns nursing practices. Three major themes emerged in this area, hierarchy and decision making in Japan, contextual and cultural differences, and caring practices. Hierarchy and decision making includes descriptions of Japanese and U.S. contrasts in relationships between physicians, nurses, and patients, and, attitudes toward change and decision making. Decision making in nursing academics is also discussed in this section. The theme of contextual and cultural differences includes participants' observations that in several ways Japanese nursing lags "behind" U.S. nursing. This theme is comprised of an explication of Japanese cultural values and compares these to the U.S. values that drive such health care concerns as informed consent and "truth telling" in the case of a "bad" prognosis. This theme also contains aspects of

Japanese and U.S. teaching practices that were highlighted when participants returned to teach. The final major theme in this topical area is the theme of caring practices.

Hierarchy and Decision Making

Many of this study's participants spoke cogently, with eloquence, and at times with anguish, of differences in assumptive stances in professional nursing in the U.S. and Japan. Some of their understanding likely came from studying what to expect in the U.S. and from published cross-cultural analyses; however many of the understandings are based on their own experience of differences. Predictably, when participants returned to Japanese practices, differences were highlighted and are discussed below.

Important differences in relationships between the physician, nurse, and patient were uncovered in this study. Doctor-patient, doctor-nurse, and male-female relationships are touched upon in the following exemplar. This excerpt comes from one of the four male nurses interviewed. He received his masters degree in mental health nursing from a school in the U.S. Although his primary position is that of a teacher of nursing, he is committed to practice, and he continues to find time in his schedule to work clinically.

"The Doctor Is On The Top"

> One difference between U.S. and Japan is the interpersonal relationship--nurse-patient, doctor-patient, nurse-doctor. We are hierarchical and the doctor is the top, the nurse helps the doctor, and the patient is the bottom....Our doctor and nurse relationship is pretty similar to the husband and wife relationship. The husband shows the power. But Japan is a little bit different from the American person's relationship. In front of the patient, the doctor shows the

> power but back at the nurses' station, the nurse controls the doctor. Like within the family when in public the husband has the power but the wife has the money. (C)

This passage depicts two important ideas having to do with aspects of relationship in Japanese health care and culture. First, this participant refers to the hierarchical nature of Japanese culture and physician, nurse, and patient relationships. Second, he hints at the fundamental male-female component of physician-nurse relationships. Many of the differences in the context of nursing in Japan have to do with the differences in women's and men's roles.

Doctor-nurse-patient relationships. The hierarchical nature of the doctor-nurse-patient relationship is an example of a vertical ordering. Yet as illustrated in the excerpt above, the hierarchical structure is not a simple linear ordering. The participant in the excerpt suggests that the relationship between the physician, the nurse, and the patient in Japan is hierarchically ordered yet there is a subtle interplay of power and control between the physician and nurse. He claims this is similar to what occurs in more traditional Japanese husband-wife relationships.

The issue of hierarchical ordering in the relationships between the doctor, nurse, and patient was common to many narratives. The relationship of the Japanese physician, nurse, and patient was described as rigidly hierarchical, based on a strict overt power differential. The physician orders the nurse and patient; the nurse orders the patient. The patient has little input or option but to acquiesce to the orders or to passively resist. One participant put it this way.

> What I find is that Japanese patients don't collaborate because they're "inferior" to the nurse. The power distribution is physician, nurse, then patient. The Japanese patient is forced to behave in the sick role by the power distribution.

This participant went on to suggest that one reason for the relatively low levels of collaboration between patients and health care professionals in Japan relates to a difference in the Japanese interpretation of "human being" and "individual." She had learned about the importance of the individual patient as she studied in Japan before her graduate education in the U.S. However, in the U.S. her understanding of the meaning of "individual" changed. Furthermore, rather than a passive recipient of doctors and nurses orders, she found the U.S. patient has certain rights and responsibilities, including access to information and input into their plan of care.

Male-female relationships. Though there may be an interplay of power between the physician and the nurse with the nurse coordinating day to day care for the patient, the power differential is clearly on the side of the physician (Long, 1984, 1986, 1987; Steslicke, 1987). Long (1984) claims that, in part, because the majority of physicians are male, and the majority of nurses are female in Japan, nurses are dominated by physicians. Long (1984), like the participant in the first excerpt of this section, found that nursing role definition included the "housewife of the hospital" role.

On the surface, in public view, the Japanese husband will appear to be all powerful, making decisions and directing the wife. But often behind the scenes, the wife will be controlling the finances of the family, the husband having turned over his

pay check to his wife, only to have her decide his daily allowance which she controls. The wife will also be subtly orchestrating the daily family activities.

Likewise, the Japanese physician will appear to direct all decisions concerning the patient, even such minutiae as when the post surgical patient may have his/her first shampoo. Yet, in many cases, behind the scenes the nurse will be firmly coordinating the day-to-day care.

Change is strange. The participant providing the next narrative was one of the few who actually wrote out her stories prior to our interview. At the time of our interview, she had been back in Japan for only one year. A seasoned clinical veteran, her readjustment to Japanese clinical nursing life after her sojourn in the U.S. was extremely difficult even though she had been out of Japan a relatively short time. Returning to Japan to work as the chief of in-service education, this is the same participant who reported she had "changed on a very deep level" as a result of her U.S. educational experiences. Besides disillusionment with the Japanese hierarchy, this paradigm case of "difficult reentry" to a clinical setting delineates the participant's impatience with rigidity and the inflexibility of her institution. The excerpt contains descriptive allusions to practice issues surrounding decision making and attitudes towards change.

A Difficult Reentry

> Reentry back to Japan was more difficult than entry into the U.S. for me. I was really shocked by and frustrated with Japanese nurses' culture in this hospital and I still cannot get used to it....The first day I was very surprised with the atmosphere in our office....The nurses went straight to the desk of the

> chief of clinical practice and staffing and stood there....The nurses reporting looked nervous and seemed frightened. After reporting they left in a hurry. I felt as if I were in the military! I wondered why the chief looked only at their negative points. Why didn't she say, "good job," or "great," or "you can do it next time?"....Their [the nursing section chiefs'] authoritative attitudes made me sick. They seemed to think orders and rules were the most important thing in the hospital organization and being strict was the best way to train subordinates to be professional nurses. To my surprise most head nurses were similar to their superiors! They were very strict with their staff nurses on the units. I thought the nurses were not treated as valued individuals. They were like soldiers in an army. They looked expressionless, shrinking, and somewhat childish. Actually they did not express their opinions and seemed to like being ordered. I thought the climate in this hospital was smashing such virtues as humanity, independence, and creativeness--virtues important to professional nurses. This hospital is not exceptional....the staff nurses are just waiting for orders. They do not like to make decisions....I wanted to talk much more about American people or American life styles to them. At first they didn't want to listen to my experience....But gradually they wanted to hear about it....I told them about some theory or how to make change in this hospital--change theory. And I used the theory and we organized a discussion group. That was very interesting. The staff said they have many problems and they can recognize many problems on their units, but when we started the discussion they were embarrassed. "What problem? I cannot recognize any problems," they said. I think they cannot identify their problems. The problems are very vague. They cannot make their problems concrete. I'm a radical. Another section chief looked at a paper I had written "How to Make Change in Your Unit." And she said, "the new chief of the in-service education section is doing strange things." Seriously. (G)

Participants quoted previously had problems with bosses and difficulties readapting to Japanese hierarchical organizational lines. Similarly, the participant from the excerpt immediately above describes with indignation and distaste the treatment of "subordinates" by superiors. She points out that the poor treatment is mirrored at all levels of the hierarchy. Chief nurses are harsh and abrupt with head nurses and assistant head nurses, who in turn treat the staff on their units "strictly." The unit staff she sees as childish, waiting for orders, unwilling to make decisions. And she

insinuates that this stems in part from rigid hierarchical thinking. Elsewhere in her interview she talked about trying to start educational groups which "anyone" could attend. These were thwarted by her colleagues in the top positions, likely because the open invitation was threateningly democratic. Yet she eventually did start groups, and as she modeled more benevolent and supportive comportment towards employees, change began to happen in the hospital.

The attitude toward change expressed by the section chief saying, "the new chief of the in-service education section is doing strange things" communicates a perspective that reverberates throughout the reentry narratives. Although change comes slowly and with great difficulty at times in the U.S., nurses are taught to be "change agents." Change is at times equated with empowerment and change theory is included in nursing curricula. Classes on "innovations" may also be included. Japanese society has changed rapidly with industrialization, yet consistency, continuity, and tradition are valued over change. Change is viewed as "strange" and may be distrusted. Another component of the change process which is hinted at in the paradigm case, "A difficult reentry" concerns problem identification. While the staff nurses at the hospital were able to initially claim there were problems on the unit, when it came to specifics they were "very vague" and could not "make their problems concrete." Like other descriptions of Japanese communication, in this situation, the lack of explicit language impedes problem identification which in turn inhibits change. In the following excerpt, another participant offers a comparison of

attitudes toward change and action.

> Like you say--the American belief of never give up. Whatever you want to do, you can do. You can change yourself. I got a lot of positive things. American people value the positive side and positive thinking. I think I got that some....I saw there were more options and more possibilities in nursing. In Japan we get stuck and we usually think, "I can't do that." But in the U.S. there are more options. So they try to think about the options. You can do this or do that. In that way, I can think of alternative ways when I get stuck. And also I value more options and more chances. Before I went to America, I used to think "I can't do that." It's kind of like I couldn't see another option. (F)

Distrust of change, a concern for the one right way of performing practice, and adherence to a fixed hierarchy were highlighted aspects of Japanese nursing culture which participants contrasted with their U.S. experiences. An historical examination of U.S. nursing culture might reveal similar characteristics in the not so distant past.

As mentioned in a previous excerpt, "being" is highly valued in Japan, whereas, action is more valued in the U.S. (Stewart, 1987). These are likely some of the cultural assumptions underlying the U.S. propensity for change and the Japanese inclination to declare it "strange."

Significantly, both participants in the immediately preceding excerpts maintained positive stances toward change and flexibility on their returns to Japan even in the face of resistance. Moreover, not only did they have an increased appreciation for change, they also were able to conceive of alternatives and options, new ways of thinking about things and doing them. This is in the face of Japanese cultural assumptions which value acceptance, argue against innovation, and which would label those who "rock the boat," "immature." The doctorally prepared

participant from the "my generation is suffering" excerpt describes this phenomenon.

"To Complain Is Childish"

> I feel to complain of this or to look at this is immature. I am not a mature person in that way. In Japan, in Japanese culture, if you are mature, you have to accept. You have to deal with the system. So, to complain about the system or to complain about the situation, it is childish. So accept. Change never comes.

Differences in Japanese and U.S. attitudes towards change are highlighted in this excerpt. The important point concerning change here is the response implied in not accepting the system as it is. When one does not, one is perceived as immature. Thus to push overtly for changes in the system may result in the impression that one is childish and cannot accept reality. Yet rather than accepting the system "maturely" the three international scholars from the above excerpts continue to advocate for change.

Decision making. Another issue suggested in the "difficult reentry" excerpt concerns notions about decision making. The participant maintains that staff nurses at her new hospital are "childish" and unwilling to make decisions. She notes that the oppressive rigidity of the institutional climate squelches such virtues as "humanity, independence, and creativeness--virtues important to professional nurses." In the U.S. it is likely that these characteristics contribute to accountability, critical thinking, and the capacity to make expert clinical judgments in nursing. Yet independent nursing clinical judgments are probably not the norm in Japanese hospitals, with a more collective nursing orientation. The participant from the "difficult reentry"

excerpt talked about how after a Japanese nurse friend had translated from English to Japanese the widely read nursing book, Independent Nursing Interventions, by M. Snyder (1985), her friend was unable to find a willing Japanese publisher. The participant's assumption about why this occurred was "because independent nursing intervention is too early in Japan."

The following excerpt from a doctorally prepared nurse further describes Japanese team nursing practice and some possible reasons for differences in decision making in Japan and the U.S.:

"Making Decisions From Scratch, Starting as Babies"

> The team nursing concept has been widely used in Japan. However I do feel there is quite a difference between the United States team nursing and here. Because in team nursing in the United States, there was one team leader or two or whatever and there are team members. The team leader will delegate to the members or make assignments and use the LPN, LVNs, and RNs according to their job descriptions or their positions. However, in Japan the team concept means everybody is equal. In Japan the LVN or the new, inexperienced nurse--their job description doesn't reflect their experience. Everybody is on the team so everybody is doing the same thing. And, everybody makes a decision as a team. But in the United States if they're using the team methodology--I think the team leader will make decisions a lot of time. They might delegate the responsibility and the way of decision making might be different at times but I think that usually the decision will be made by the leader, even if they make it in the conference. So that I think that a clinical difference does exist....the group dynamic is quite different. In Japan nurses tend not to make many valid decisions in part because of the relationship with the physicians. Nurses are often encouraged not to make decisions so they have not been practicing that. However when I was in the United States, people make decisions because they are individualistic. What I mean is they make decisions all the time. They have practice making decisions about themselves from scratch, starting as babies. (B)

The above excerpt contains several important points. First, this excerpt gives

credence to the notion that imported theory is transformed, changed, sometimes radically, in the application (e.g., the notion of team nursing). Second, this participant further describes the collective nature of hospital staff nursing in Japan. Third, she suggests that within the medical hierarchy, with physicians on top, Japanese nurses are not encouraged to make clinical decisions. And fourth, she suggests that for Japanese people, the process of decision making is very different from that in the U.S. because of the American proclivity for individual choice in the most prosaic aspects of life, beginning with the acceptable articulation of personal preferences "from scratch, as babies."

When nurses are not encouraged to make decisions because of the hierarchy and when culturally there may be less opportunity for individual decision making, how are clinical judgments affected? Though the answer to this question is beyond the scope of this dissertation, the question did arise as a concern of the participants.

Hierarchy and decision making in nursing education. The discussion of equality in responsibilities and the collective decision making style of Japanese hospital staff nurses should not be inferred to generalize to nurses in academic settings. There, the vertical Japanese hierarchy is well in place. In Japan the power differential is mainly defined by seniority, a combination of age and length of stay at the institution. Higher education tends to have less influence on movement up the academic chain of command in Japan than it does in the U.S. nursing academic world.

Japanese management techniques have been proclaimed in the U.S. and it has been suggested that U.S. businesses and industry could profit from the widespread application of these techniques (Stewart, 1988). Specifically, the notion of consensual decision making where workers take part in the decision making process has been extolled as a way of increasing employee commitment and dedication to the company and the decision. However, among other arguments against indiscriminate importation of Japanese management techniques, Stewart (1988) suggests that Japanese managers rather than using a consultative decision making style simply talk with their workers face-to-face more than managers in the U.S. And, what appears to be consensual decision making is instead consensual understanding, the selling of the managers' ideas and decisions.

Certainly, decisions in the Japanese academic nursing world are described as being made from "the top down." Persons in lower ranking positions sit quietly and offer few remarks in meetings where major decisions have been made by supervisors long before the meetings begin. There is little debate regarding decisions, dissension being looked upon as an expression of disharmony. One participant put it this way.

> In the U.S. they're open and they discuss everything on the table and once they decide, they go with it. But in Japan it's different. They go through everything behind first. And then they make a sort of harmony when they come up to say they're all ready. That's *nemawashi*. And they know what is coming up to the table. And it's a kind of ceremony you know at the end.

Nemawashi is a word that refers to the idea of private politicking to amass allies before the public meeting. In the situation where controversial decisions are being

introduced the practice of *nemawashi* usually has smoothed the way for the change to be initiated with little discussion. The *kanji* for *nemawashi* recalls the Japanese practice of cutting the roots of the tree to change its growth configuration, a long procedure requiring patience and diligence. These aspects of the Japanese nursing academic hierarchy and the requirement for overt consensus in academic meetings were particularly vexing for some of the Japanese international nurse scholars on their return to Japan.

Contextual and Cultural Differences

Often the contextual aspects of a practice are taken-for-granted. However, experiencing the practice within different cultures can illuminate differences, and contextual or cultural "taken-for-granteds" may move into a new clarity. One concern to unfold from the narratives involved the idea that in many areas of nursing, Japan lags behind the U.S. To provide context for this concern, an historical examination of informed consent and truth telling in the U.S. health care milieu, and the Japanese cultural values guiding practices related to truth telling, the *omakase* relationship, and informed consent, are addressed.

Japanese nursing is "behind." Many participants talked about how Japan's nursing culture is "20 or 30 years behind the U.S.'s." In the following excerpt the participant describes her early nursing education experiences. She first came to Canada as an exchange nurse. She earned her BS at a Canadian University. She worked clinically and taught in Canada for many years and then moved to the U.S.

where she also worked and taught for several years. She completed her masters degree in nursing at a U.S. school for higher education. She made little distinction between her Canadian and her U.S. experiences lumping them together as North American nursing, but did distinguish between North American and Japanese ideas of nursing.

> When I first I got out of Japan I went to Canada. At that time Peplau was the leader of the nursing world in North America and I remember I was shocked the day I reached the University....I was told, "nursing is an interpersonal relationship." "What?" I thought? I learned disease and the treatment of disease....I never learned anything about interpersonal relationship....And I was shocked. I said, "I've got to learn from scratch." (D)

At the time this participant arrived in Canada over twenty five years ago, the most shocking aspect of her introduction to North American nursing was the difference in the definition between nursing in North America and nursing in Japan. According to Kidd and Morrison (1988) early U.S. nursing practice "was characterized by blind obedience to medical authority and by a belief in the biological model" (p. 222). This was similar to the nursing model this participant brought from Japan. Her first surprise in North America was the push in nursing to define the profession and the struggle toward nursing theory development. Thus the most shocking difference for this participant was in the definition of nursing as a profession distinct from biomedicine with its focus on pathology. More recently nurses coming from Japan to U.S. graduate schools are familiar with nursing theory. But according to participant in the excerpt immediately above, who recently returned to teach nursing in Japan, many Japanese nursing instructors cling to the old definitions.

> I would say half the [Japanese] teachers are still stuck with disease and treatment and nursing. Nursing comes at the end, right?....We have to understand humans first, and how humans develop, and we are promoters of human development and things like that....I mean the U.S. did the same thing. But I think we are getting into those areas at this moment. Japan is changing from a disease oriented--medically oriented--we could say--model to a nursing model, truly human oriented. This is a big curriculum change at the moment. (D)

In a second interview when asked about clinical judgement, this participant went on to describe some of her nurse educator colleagues:

> "You must follow"--they always emphasize--you must follow--so the students start to follow. They become good followers to physicians. And this is a big problem with nursing education from the beginning. (D)

One likely reason for the continued focus on the medical model and perhaps the concomitant "blind obedience" to medical authority that this participant describes is explained by the simple fact that most teachers in Japanese nursing schools are physicians.

> I mean most of them [nursing instructors] are doctors. You know physicians. And they teach research and everything else, but from a physiological point of view rather than a nursing point of view. Because they don't know--they never practiced nursing. They never learned nursing. How can they teach it? I think two-thirds of the nursing faculty are physicians and only one-third are nursing teachers. (D)

Fewer than ten percent of Japan's nurses are university educated so there is a huge shortage of qualified nursing teachers. Ninety percent of Japan's nurses have been educated in diploma, technical, or hospital schools. Now however, Japanese college and university nursing programs are beginning to increase at a rapid rate. Yet, there is still a great lack of nurses with baccalaureate or higher degrees in Japan. The

dilemma facing Japanese nursing is clear. Although there is an immense need for more nurses, there simply are not enough nursing faculty to provide the education. More physicians could be recruited for faculty positions yet then the continued narrow definition of nurses as "followers of doctors' orders" is likely to be perpetuated and the more recent understanding and fragile definition of nursing may be co-opted.

The strong Japanese Medical Association, the hospital hierarchy, and the lack of clinically focused graduate programs have impeded development of expanded roles in nursing in Japan. The following exemplar is from a Japanese nurse in graduate school in the U.S. now. She is a doctoral student and received her masters in nursing from a Japanese school of higher education.

> I feel Japanese nursing education is thirty years behind America. Basic nursing education is not so different, but graduate education is behind 30 years, because there are few teachers and few graduate schools. Many graduate school teachers teach graduate students mainly quantitative research. I want to study qualitative. A second example is that we don't have practitioners. I think in Japan we need practitioners or specialists. But in Japan very few nurses have masters degrees, therefore it's difficult to make the position of practitioner or specialist. In Japan most nurses don't have bachelors degrees only technical degrees. Maybe, I'm not sure, but maybe 90 percent or more don't have bachelors....I heard around 1960 in America you had the same problems as Japan, poor research methods and no specialists. (E)

According to this participant, nursing research tends to focus on case studies and surveys. The few graduate programs in nursing in Japan emphasize quantitative research. There are few clinical specialist positions and no licensing for practitioners. In the opinion of this participant these factors leave Japanese nursing "behind" the U.S.

Though specific reasons varied, the concern of believing Japanese nursing to be lagging behind U.S. nursing in many domains, was prevalent. This perspective is legitimate on one level. Indeed, parallels exist and Japanese nursing and the health care milieu is now dealing with some nursing issues which were characteristic of U.S. nursing and health care at an earlier time (e.g., what to do about the lack of nurses with higher education).

Yet, this perspective must be examined in the context of underlying background meanings/cultural assumptions so that a deeper understanding of what constitutes Japanese nursing practice can happen, and so that another dimension of the returning experiences of the Japanese nurse scholars might be described. To do this, a deeper exploration of the *omakase* relationship and other Japanese cultural concepts is offered.

The trusting relationship in Japan: *omakase*. The *omakase* relationship in medical decision making was a recurring issue discussed by many participants and common to many narratives. The male mental health nurse from "the physician is on top" excerpt in the hierarchy and decision making theme previously described physician, nurse, and patient relationships. Below, he explores the trusting relationship between the physician and the patient in the Japanese medical world.

Omakase: "I Trust The Doctor"

> But it's not simple [the relationship]. It's very complicated. The patient says, "I trust in you, doctor. So my life is on your hands." When that kind of trusting relationship is established, the therapy can go well. We have the appearance of, "I trust the doctor. My doctor understands everything about

> me and my body and my feelings." But often the doctor can't understand the patient's feelings. He may understand the body, but not the patient's feelings or family relationships. Then the patient becomes angry or frustrated, and thinks, "I don't want to be your patient." It's a sort of an *amae* relationship. "You should know about me, because I trust you." Usually the doctor already knows the patient trusts him so the doctor [gives] all his energy to the patient. The doctor does his best. Therefore the patient doesn't question much. They may ask a little like "When is my operation?" But that's all. If the patient has the feeling, "OK I can trust him," then the patient won't feel so much anxiety or worry. It's different from America. In America the relationship is more equal. The patient knows about himself, his illness. The doctor knows and gives the information to the patient, the patient says to the physician, "I trust in you, doctor. So my life is in your hands." (C)

In Japan, fiduciary relationships like nurse-patient or physician-patient relationships, are based on trust. *Omakase shimasu* means "I put my trust in you" and is a common background meaning found in the most prosaic aspects of Japanese life. For example, when Japanese friends needed a new TV, rather than spending time in research with "Consumer Report" or watching for the newspaper advertisements and comparing prices, they called their family appliance shopkeeper and asked him to deliver "the TV he thought would be right for them." He promptly delivered the television. It suited them nicely.

Restaurants often have an *omakase* dish, the "chef's choice." Customers can, in Western terms, "abdicate responsibility" by ordering the *omakase* dish and avoid decision making. Likewise medical decisions may be relinquished to *omakase.* Okaya (personal communication, 12/28/91) identified the trust relationship as a pre-surgery coping strategy for Japanese stomach cancer patients. Okaya (personal communication, 12/28/91) studied 25 Japanese stomach cancer patients. She

interviewed each patient twice preoperatively and once postoperatively. She found that all but two of the twenty five used some form of *omakase* with their physicians, "leaving it to the doctor," in order to cope preoperatively. In her analysis Okaya was able to distinguish between *omakase* in patients occurring as a positive expression of their ability to allow the physician to shoulder the burden of their anxiety, and patients who used *omakase* to cope preoperatively out of a fatalistic sense of personal powerlessness (Okaya, personal communication, 12/28/91).

The mental health nurse from the "*omakase*: I trust the doctor" excerpt went on to describe ways in which *omakase* hinders informed decision making in health delivery.

> I feel like this *omakase* makes it very difficult for the Japanese people to get information and make self decisions. We are gradually learning about "informed consent" and we believe it is great. But somehow Japanese people are feeling "I don't mind. You make the decision. Doctor, you make the decision" (C).

When the self is contextually dependent, when the assertion of personal preferences creates disharmony, when to ascertain preference directly implies an impolite lack of care and attention, and when the idealized relationship is comprised of a passive trust in the other, it may be that the requirement and ability for making independent decisions decreases. Certainly in the medical world, information seeking and informed decision making by patients is uncommon in Japan.

One study participant told a story highlighting U.S.-Japanese differences in acceptable patient behaviors. Before coming to the U.S. the participant and her

husband were given orientation classes through his company which was transferring them. One component of the orientation dealt with health care. The orienting teacher emphasized that when in the U.S., orientees needed to question their physicians about their treatments and the medications prescribed or else "the doctors will think you are not intelligent." In contrast, "many people in Japan still think that obedience to their physician is mandatory" (Brahams, 1989) and to question a physician about a medication or treatment could be construed as exceedingly rude. Although the *omakase* relationship makes it difficult for patients to get information, *omakase* is a component of what constitutes caring in Japan. As Minami states:

> *Omakase* takes away the pain, encircles the pain, that's true. You get relief if you can *omakase* to the other person, especially the doctors and the nurses and you don't have to suffer from it....It's related to their [the patient's] anxiety about the future which is affected by the illness. It is removed by the doctor....One of the weaknesses or strengths of our culture is that the individual is not strong enough to carry their anxiety. In our culture--caring--being kind--means not to give anxiety toward the other....If I give information to you, you have to face it. You must confront it. That is giving pain and suffering. In order to avoid this, in order to protect you, we use the *omakase*. So the patient is in my hands. I'll take all the pain with me and I'll not tell the truth. That's one thing. But another thing is we never are very good at talking about the emotional--the real things, very important things between two people. We simply don't talk because we don't we don't trust language communication. We deliver a certain message without talking about it. You are seriously ill. That kind of message comes through other [ways], but not talking. Confrontation is not in our culture. We are very weak with confrontation. We deal with ambiguity. If you can live with uncertainty and ambiguity, it means you are living in the same culture. Otherwise it's very difficult. But because we are not living anymore in the same culture, that has been changing. So that's why information, informed consent, the issue of informed consent or saying the truth; it's our issue now. We have to face it. We have to confront it. And we'll have to trust the strength of our patients. (Minami, personal communication, 11/27/91).

Minami's narrative contains points about the *omakase* relationship. Her excerpt also provides support for the importance of context in Japanese understanding. She refers to the Japanese individual who is "not strong enough to carry their anxiety" or "good at" directly confronting problems but is more comfortable with ambiguity. There is little facility for dealing verbally with emotionally laden issues. Moreover, there is a distrust of verbal language. Nevertheless the patient's situation is indirectly revealed allowing the message that the patient is seriously ill "to come through." Still, anxiety about the future can be given over by the Japanese individual to the protector. This is *amae*. From this position the caring Japanese physician or nurse cannot confront the patient with a poor prognosis.

Related to this notion, Suzuki, Kirschling, and Inoue (1993) propose that to understand the care of the terminally ill in Japan, one must be familiar with the meanings of *ishin-denshin, satoru, omoiyari,* and *omakase*. They state *ishin-denshin* "is an idiom which means that immediate communication of truth occurs nonverbally from one person's mind to another" (p. 39). This is the idea that understanding the other can be achieved without verbal communication (Suzuki et al., 1993). *Satoru* refers to the idea that the terminally ill patient will recognize that death is imminent through understanding the context or circumstances (Suzuki et al., 1993). *Omoiyari* is a guiding concept in Japan that refers to the value of treating the other with sympathy, compassion, and consideration. In part, it is the concept of *omoiyari* that keeps health care providers from confronting terminal patients with their diagnosis.

Instead a social contract evolves wherein the patient is given comforting ambiguous verbal messages and the nurse and/or physician carries the patient's anxious burden of knowledge. The "truth" is not spoken.

This way of providing care contrasts with legal mandates guiding practice in the U.S., and with current U.S. nursing philosophies, the orienting perspectives for U.S. graduate education in nursing. To information seeking U.S. Americans, the notion of denying a patient access to their own diagnosis is shocking. Yet, frankly disclosing "bad" medical news is relatively recent in the U.S. (Woodard & Pamies, 1992) Until the 1970's, most U.S. American physicians believed their patients should not be informed about the diagnosis of cancer (Woodard & Pamies, 1992). In 1961, Oken surveyed 219 physicians on staff at a Chicago teaching hospital and found that 90% did not tell their patients of the diagnosis of cancer (Oken, 1961). Oken (1961) found that most physicians disclosed only enough to keep patients cooperative in treatment and that the vast majority of physicians felt that most patients did not want to know their diagnoses/prognoses, regardless of what the patient might say. Decades later Komrad (1983) argued, "all illness represents a state of diminished autonomy and therefore the doctor-patient relationship necessarily and justifiably involves a degree of medical paternalism" (p. 38). Komrad's statement sounds much like the Japanese justification for *amae* and *omakase* in the patient-physician relationship in Japan.

By the late 1970's, most physician attitudes toward disclosure had changed in

the U.S. and the majority of physicians favored disclosure (Woodard & Pamies, 1992). The idea that informed consent, and thus full disclosure, is a patient's right is based upon the concept of self-determination and has evolved legally in the U.S. (Woodard & Pamies, 1992). In Japan, informed consent and disclosure are still at initial stages (Hattori, Salzberg, Kiang, Fujimiya, Tejima, & Furuno, 1991). For example, in 1989, the family of Kazuko Mikino filed suit after she had been told by her physician she had gallstones and that he recommended surgery for them. In fact, Mrs. Mikino's physician suspected gallbladder cancer but did not mention his worry. Mrs. Mikino, a registered nurse, knew that gallstones are not life threatening and refused surgery. The cancer spread and she died six months later. Judge Kuniharu Ito ruled that although it is a doctor's duty to "explain accurately and concretely about the sickness to the patient" the decision whom to tell, when to tell it, and how much to tell, is at the physician's discretion because "such disclosure can affect the recovery of the patient" (Brahams, 1989; Swinbanks, 1989, p. 409). Japanese approaches to ethical issues have been "characterized by the cultural values of consensus and deference to authority" (Hattori et al., 1991, p. 1007).

Novack, Plummer, Smith, Ochitill, Morrow, and Bennett (1979) suggest that in the U.S., the change in disclosure came in part because of improved therapy options. The diagnosis of cancer was no longer synonymous with certain death. Celebrities acknowledged the diagnosis and public education was promoted through the American Cancer Society (Novack et al., 1979). Kubler-Ross's work with "death

and dying" changed perceptions of the dying process (Novack et al., 1979). And, the rise in consumerism has argued against paternalism (Novack et al., 1979). Lear (1993) asserts that powerful anti-authoritarian forces including the consumer advocacy movement, the civil rights and women's movements, and the anti-Vietnam movement all pushed U.S. American physicians towards informed consent.

Now, in the U.S., communication between a patient and his/her health care team is regarded as indispensable so that therapeutic decisions based upon the patient's preferences can be made (Kai, Ohi, Yano, Kobayashi, Miyama, Niino, & Naka, 1993). In Japan, however, direct communication between a patient and a physician rarely takes place in the health care setting, especially when the patient's prognosis is poor (Kai et al., 1993). For example, in 1992, even in Japanese hospices, 30 to 50 percent of the patients were not told of their diagnoses (Suzuki et al., 1993) However, Kai, Ohi, Yano, Kobayashi, Miyama, Niino, and Nakaet (1993) found that the majority of the Japanese public prefers to be fully informed about their current medical status in all events. But not only do Japanese physicians seldom offer candid information to patients with poor prognoses, many would not acquiesce to a patient's request for candid information "even if the patient begged for it" (Kai et al., 1993, p. 1153). The Japanese physicians studied by Kai et al. (1993) sound much like the majority of U.S. physicians in Oken's 1961 survey who were disinclined to fully discuss prognosis/diagnosis with their patients regardless of what the patients might say.

In the "*omakase*: I trust the doctor" excerpt at the beginning of this section, the participant presents a typical situation where the patient trusts the physician, but "the doctor can't understand the patient's feelings," which results in the patient becoming angry or frustrated. Rather than a consumer of health care the patient is conceptualized in the narrative and generally in Japan (Suzuki et al., 1993), as a recipient of care. The distinction implies a difference in power, in rights, and responsibilities. Kai et al. (1993) claim that the physician ethically can invoke the *amae* relationship as warranting an absence of direct communication "only when the physician correctly infers the patients' preferences" (p. 1152). They found that while approximately 80% of the Japanese patients preferred candid information about diagnosis and prognosis, physicians were correct in their estimation of to whom to disclose what, only in about half of the cases.

Minami's (personal communication, 11/27/91) proposal that ambiguity and uncertainty, and thus *amae* and the *omakase* relationship, are tolerated in a homogenous culture may also be important in understanding Kai et al.'s findings. Japanese culture is becoming more diverse. Younger patients tend to be more individualistic than their elders and tend to want more choice in medical decision making (Kai et al., 1993). Clearly, Japan is changing and expectations about collaborative decision making, informed consent, and tolerance for paternalism in health delivery are changing too. Yet Japanese truth telling in the health care milieu continues to be influenced by the concepts identified by Suzuki et al. (1993), *ishin-*

denshin, satoru, omoiyari, omakase. In Japan there is a taboo against speaking of death and this too influences truth telling in health care.

Omakase and nursing practice. Specific issues relating to *omakase* in nursing practice emerged as important in the Japanese nurses' narratives. For example, the role of the nurse in providing education and information is limited when *omakase* is occurring. The ideas of mutual goal setting and collaborative decision making are simply not part of the nurse-patient relationship in Japan. Moreover, nurses talked about the difficulties they faced in trying to be informed consumers of health care relating this to *omakase* in practice. And, nurses talked of the "burden" of colluding to "keep secrets" from patients.

Participants say oncological nursing lags behind the U.S. for many reasons. A recently returned participant expressed her feelings about Japan's oncological nursing situation.

> I would say the situation in Japan is like thirty or twenty years ago in America. The surgeon really dominated oncology. There were no oncologists, and chemotherapy was not considered a measure or a treatment. When I went to America and started studying oncology, I thought, "Wow, it's quite different." The concept is different. Oncology in the U.S. is more like a chronic disease. (F)

She maintains that in Japan, because oncology is conceptualized as an acute problem, requiring surgical intervention, nursing practices and even treatment settings in Japan have been limited. Suzuki et al. (1993) note that although there has been an increased interest in hospice care in Japan since the beginning of the 1980's, growth in the number of hospice programs has been very slow compared with the U.S., and in 1992

Japan had only 21 known hospice programs.

The participant quoted above goes on to note when oncology is thought of as an acute illness, the surgeon is in the important role. The nurse's function is restricted.

"The Nursing Practice Is Really Limited"

> And the nurse follows the doctor's attitude. They just follow the patient's acute pain. So that means there is not much respect for nursing in oncology....You know, I feel like there is no oncology nursing in Japan right now. Because there is surgical oncology, but there is no medical oncology and we are just starting to look at hospice for terminal care....In Japan, we don't tell a patient, "You have cancer."...So we are guilty about the secret. We have a secret. And the family feels guilty because they have a secret....And in Japan we don't speak out frankly so when I give good care to the patient and family, they don't respond. You know, it's kind of hard to get feedback from the patient. And also in the cancer unit we always have a secret from the patient. So that makes us--every nurse feel guilty. In the U.S. we emphasize patient self care or getting the information to the patients and their families. So the educational part is a really big part of oncology nursing. Most specialists give a lot of educational information to the patients. But in Japan, cancer is a secret from the patient. We cannot give any educational information to the patient. So that means the nursing practice is really limited. (F)

Oncological nursing practice, according to this participant, is limited and restricted because of how the disease is conceptualized in Japan and because of the common practice of keeping the diagnosis from the patient. Yet, Japan is beginning to change. In the last two years, several Japanese movie "idols," with unusual candidness, announced their successful treatment for cancer. Informed consent has been introduced and in 1990 the Japanese Medical Association advocated for it, including diagnostic disclosure (McDonald-Scott, Machizawa, & Satoh, 1992; Suzuki et al.,

1993), but in practice patients still remain excluded from the decision making process (Hattori et al., 1991). The recently returned participant goes on.

> So, I complain a lot about their system and also about their attitude, the doctors' attitude towards the patients. And also patients are really dependent on their doctor. For example, I'm really used to getting an informed consent. The doctor tells all the information to the patient and the patient agrees to the doctor's treatment but there's no rule over here. So, the doctor doesn't give all the information. And also the patients don't agree to everything. But the doctor just goes on with their treatment. And the patient has a lot of complaints. But they don't talk to the doctor. I don't know why. Just the system or the custom. You know the patient is supposed to depend on doctor in every aspect. The patient-doctor relationship is not equal. And if the patient objects to the doctor's treatment; they have to take responsibility. That's the American way and I'm used to that attitude. But here patients don't take responsibility, they just complain, but they don't ask the doctor why they are having such treatment. I give my opinions and my feelings to the staff nurses. They just don't quite understand. (F)

Although the concept of informed consent has come into the Japanese health care system, Japanese patients are not the verbal, information seekers, and consumers of health care that U.S. patients have become. The tiers of hierarchy between the Japanese patient and his or her physician cause collaborative decision making about treatment issues to be difficult. The secrecy surrounding the diagnosis keeps nurses from freely supplying educational information. And, nurses are caught feeling guilty with the secret, lacking patient feedback, unable to give information to patients who may be either relieved to be told the truth or unwilling to receive it. Patients are "supposed to depend on the doctor in every aspect." They are not supposed to question or seek information from their physician who is carrying the burden of their illness. Yet some patients do have questions or complaints. Rather than "take

responsibility" and object to their treatment directly to their physician, Japanese patients, according to this practicing nurse, "don't take responsibility, they just complain," often to the nurse. "The patient-doctor relationship is not equal." This nurse has practiced both in Japan and the U.S. and she makes comparisons and judgments about Japanese physicians and patients. Yet when she shares her opinions, the other Japanese staff nurses "just don't quite understand."

There is an apparent conflict of values between collaborative decision making with patients and the Japanese guiding concepts related to truth telling identified by Suzuki et al. (1993). How does the Japanese nurse synthesize "truth telling" and informed consent with *omoiyari*, compassionate consideration for the patient's feelings? How can the Japanese nurse ask patients to explain their feelings or state their preferences when in doing so the nurse admits s/he is not so good at *ishin-denshin*, or empathetic telepathy? *Ishin-denshin* is considered a crucial ability for the Japanese nurse and to ask patient preference or if the patient is in pain could jeopardize the nurse's credibility. How does the nurse talk about death with patients when to speak of death is taboo? When *omoiyari*, or consideration for the patient is guiding practice, should the nurse push the physician to tell the patient that when he wakes from surgery he will have a colostomy or is it kinder to keep quiet about the surgical outcome and carry the patient's anxiety a little longer? If the nurse is uncomfortable with the power hierarchy which sees the Japanese physician on top and considers the patient a being with few rights or responsibilities, can the nurse ethically

foster *omakase* as a method of coping? These are only a sample of practice issues which, through contrasting practices with U.S. nursing, were identified as conflicted by Japanese international nurse scholars. Minami (1985) and Kojima (1987) have suggested that nurses in Japan are now working to discover what of Japanese nursing is distinctly Japanese and to identify areas of conceptual, cultural, and ethical conflict. The international scholars, informed by their U.S. experience, returned to wrestle with conceptual and ethical dilemmas that were likely less conflicted for nurses practicing within the taken-for-granted background meanings and expectations in Japan. Moreover, the conflicts for the international scholars extended beyond issues related to specific patient care because many returned to responsibilities and roles as Japanese nurse educators and nurse leaders.

Friction with physicians: Nurses and reentry. The assumption of *omakase* between physicians and patients was one of the more difficult aspects of Japanese life that participants faced at reentry. Japanese nurses may be initially shocked by U.S. nursing, yet during their U.S. sojourns, most the participants seemed to incorporate U.S. ideas about advocacy, rights, and nursing autonomy, and were socialized into a new nursing role, based upon individual patient rights. On their returns to Japan, at times it was hard for participants to navigate between U.S. notions of proper patient, nurse, and physician comportment and what they found back in Japan within both personal and professional spheres. For example, the following exemplar is from one of the few participants who was a married working mother in Japan. In the excerpt

below as the patient's family member, she refused to reassume the expected passive health care recipient's role and took the role of advocate, particularly when she determined her child's health or family's health was at stake.

"He Was Furious!"

> Once my son had a cough a long time and we really thought it was pneumonia--a kind of pneumonia. And then we thought we wanted the physician to take X-rays. So I asked him, "please take X-rays." He became furious. "Why do you ask me? I know! I am diagnosing and if you don't like my diagnosis you can go to another hospital!" He was furious. Then I stopped going to him....Patients' consciousness is different. But here I think that there is a tendency of *omakase* for physicians. And there is a tendency for patients to think, "we shouldn't ask anything of the physicians." And sometimes my family members call me, "I'm feeling such and such. And I'm taking a blue drug and white drug." And I ask them, "What is that?" And they don't know. So I say, "ask the physician the name of the drug." "Oh can I do that?," they usually say....They're afraid of asking physicians and they're afraid of disturbing physicians.

Although this participant said she usually tried to keep quiet about being a nurse when her children were patients she also said that she would often ask what medication was being prescribed. At first when the questioned, the physician responded vaguely with, "oh, it's cough medicine." When the participant requested more specifics, the physician wrote it down. But the doctor "didn't like it."

This participant's response to the issue of hesitancy by patients to make contact with physicians was to become a more conscious advocate for patients. Her opinion is that Japanese society is slowly changing.

> I think Japanese mass media is changing as well. They are saying that patients have rights, and to ask.

She believes that nurses in Japan have an added responsibility. With patients who

tend to hesitate to ask questions and physicians who tend to withhold information, it is up to nurses to create "an atmosphere for the patient to be able to speak out freely." Yet, "to ask" is still unusual for Japanese patients and from the exemplar about her child, one might conclude that it may be considered offensive by the Japanese physician.

Advocacy within the cultural assumptions of the Japanese health care system posed problems for the participant in the following excerpt.

> When I came back actually, to Japan, when I give information to patients, I always get their [the patients'] permission or I get some feedback. And they have right to decide what they want to do.

This participant further claimed that her advocacy stance lead to trouble with physicians.

"We Are Not Patient Advocates Yet"

> The doctors don't like to give all the information to the patient. They believe they control the patient. They only think the patient needs a tiny, little bit of information. Some good doctors think they are protecting patients. But from my point of view which is a consumeristic perspective, they are not doing a good job for the patient even if they think they're protecting the patient....[For example], when a patient doesn't want to have chemotherapy I think there are other ways to treat the patient. But if the doctor decides to give him chemotherapy treatment, the patient has to follow the doctor's order. So I do not argue, but I try to discuss it with the doctors. They don't like to take an opinion from a nurse. We are not patient advocates for the patient, not yet, but we try.

This participant mentioned that many Japanese nurses now have been educated abroad and many have written nursing articles in Japanese on patient rights and collaborative decision making. Yet, she says, "in the real situation we are still in the traditional

nurses' role."

Clearly differences exist in the relative roles and positions between U.S. nurses and physicians and those of Japanese nurses and physicians. Both U.S. nurses and Japanese nurses generally have less power than their physician counterparts. Yet, in the U.S. participants were exposed to more assertive nursing practices. In the U.S., ethical comportment demands that the nurse confront the physician if the nurse determines it is critical for the good of the patient. There is not the same emphasis in U.S. nursing on "following the doctor's orders" that appears in the Japanese narratives in part because in the U.S. physicians are now rarely found teaching in nursing schools.

Moreover, the status of women and the status of nurses are inextricably connected (Kalisch & Kalisch, 1987). Women's status generally and nurses' status specifically is higher in the U.S. than in Japan (Long, 1986). Nurses in both countries may learn to get what they believe their patients need in indirect ways (Stein, 1967; Stein, Watts, & Howell, 1990; Long, 1984). Yet, in the less hierarchical U.S., the relative status and position of nursing, most participants conclude, is higher.

The most extreme example of dissimilar power differential and actual abuse imposed on the Japanese nurse is offered below. This excerpt is from the woman who had "a difficult reentry."

"You Are A Fool"

> Most Japanese nursing is just follow the doctor's order, especially in a university hospital. And do you know how doctors treat the nurses? Doctors are the most important people in the hospital and doctors--some doctors say to the nurses, "you are a fool!" Or "you are *bacca*"--do you know? Means fool. Some doctors say in front of the patients, "Nurses are all fools!" (G)

This participant was outraged at some of the physicians' abusive treatment of nurses in her hospital. She perceived that within the hospital's system, the elevation of the medical hierarchy had allowed disrespect to nurses to become prevalent. The participant from the "we are not patient advocates yet" exemplar implied that physicians were unused to eliciting or valuing nurse's clinical opinions when treatment issues were being decided.

Many participants bemoaned the lack of autonomous nursing practice and the prima dona treatment physicians received in Japan. One story told how, in the recent past, all the nurses on a unit accompanied each physician on "*daimyo* rounds." The *daimyo* was the top person in the *samurai* culture, who when he walked outside was so respected/feared, the populous dropped and bowed to the ground. If they refused or were slow about it, they lost their heads. The participants claimed nurses would accompany the physicians on "*daimyo* rounds" in order to take care of the doctor, not the patients. As a metaphor for absolute physician power, participants suggest the era of *daimyo* rounds is slowly passing. The following participant claims change is coming.

> Whatever physicians says, the nurse does. That was traditional. Up to now--we are doing that. But now it's changing, really. We are talking to them

> [physicians] that what we are doing is different, is different from the medical. Nursing science is different from medical science. That's what we're trying to talk to them and trying to let them understand. (J)

The participant who shared the *daimyo* rounds story did caution that change comes relatively slowly in Japan and the Japanese medical establishment has the reputation of being very conservative even for conservative Japan.

On the other hand, one participant, who had readapted to Japanese nursing practice and who had been back six years, described a different medical-nursing division of labor. The participant from the exemplar below is the mental health nurse who provided the "*omakase*" exemplar. It is important to know that there tend to be fewer physicians in mental health than in the medical milieu and nurses tend to have more autonomy in mental health. However, the participant also said that even in the medical milieu, the situation described below could occur.

"They's Never Show It In Front Of A Patient"

> Sometimes already the medication is decided. The nurse decided. "Doctor this patient would like this so you need to sign." Just only sign. And "doctor, this medicine is good for this patient." And the doctor ordered another thing, "Oh, it doesn't work," [the nurse said]. "Better this one." They would be as direct as that but they'd never show it in front of a patient. Only in the nurses' station....And the doctors said, "Oh, OK, I trust you, OK I'll just sign." These kind of doctors and nurses make good decisions, both trust. And then doctor goes to the patient. "How is your condition?" The patient says, "Doctor the medication was very good." "OK" [the doctor takes the credit]. (C)

In this exemplar, nurses control day-to-day unit decisions and may directly and indirectly influence physicians, advocating in patient treatment decisions, when they know the patient well, when they have experience, and when the physician knows

them well, a description similar to U.S. nursing practice. (Tanner, Kodadek, Haylor & Wros, in press). Yet, in front of the patient the physician appears to be in total control of the medical decisions, a drama that some say is changing in the U.S. (Stein et al., 1990).

Coming back to a teaching practice. Many of the participants returned to academic careers bringing ideas of U.S. education and culture with them. The last area of differences in context and cultural expectation concerns the participants who came home to teach. A common issue concerned the student teacher relationship. After experiencing a more informal collegiality with faculty during their U.S. education experience, some participants worked at decreasing the tiers of distance between themselves and their students, only to be disappointed.

> I tried! I really tried to do that. But I couldn't because these are Japanese customs and students call me *sensei* and I couldn't make the contact the same.

Yet other teachers said that after their experience with faculty in the U.S., they invite students to their homes and meet with them on a more social basis. The point of working to mirror the more casual student teacher relationships participants had experienced in the U.S. once they returned to Japan recurred in the text.

Many participants had trouble readjusting to Japanese students and classroom expectations. For example, the following participant went home to teach after receiving her masters degree.

"Students Never Speak"

> When I went back home I really had a fantasy I could do something like [U.S. discussions] in a class. I had hard time. Students never speak....And the first class I told the students "Let's make circle." Bachelor's students. "Let's make circle in the classroom. I don't want to teach--you know lecture you. I don't want to write on the blackboard. I want to discuss with you." Second year students, the second time of sophomores--I ended up doing some lectures. I asked them several questions, throwing out discussion questions. They never answered anything. They asked my opinion. They wanted to know what I am thinking. They wanted to know what I thought was the correct way. (H)

Several of the participants who returned to teaching talked about their disillusionment with early attempts at class discussions. Some talked about ways they adapted the "free discussions" of U.S. classes to Japanese classroom expectations.

A few participants did find that through their continued fostering of creative expression and the explicit and implicit continuation of this as an expectation in their classes, eventually their Japanese students changed, becoming more willing to "open their mouths." Most Japanese undergraduate students are young women between 18 and 22 years old. Older students are rare. This participant points out that beyond age and culture, men in Japan tend to be more verbal than women.

> I want to dialogue with students....But it is difficult because they want to be the same. They don't want to be themselves, like specifically themselves. They're so scared to be excluded and always they want to be included. Maybe this is partially their age....Maybe it is the culture. I really don't know but I don't want to say it is just because of culture. Maybe it has something to do with women as well as the culture. Because men open their mouths much easier than women, I found. And girls are much more hesitant to create their own ideas and even after creating their ideas, they don't open their mouths....I encourage them to be creative and to come up with their own ideas and whenever they come up with even little, small new ideas, I really admire them. So that they come up second time and third time and things like that. But they are improving. I can see their advance. (D)

Through sculpting her students behavior, encouraging each small creative expression, this teacher felt that eventually after three years, the class had become much more verbal. The importance of the ability to speak their ideas and express themselves was tied to the ability to think critically and perform professionally by many participants.

Related to the ability to think critically, another participant said:

> I really thought student-teacher interaction is very important. So in my class I ask questions. I try to move their head, their brain--use their brain during the class, rather than writing their notes. And I teach the senior students. I usually teach the last semester of the program. And then if I ask them questions the students are very confused and sometimes they don't like it.

This participant has adapted her teaching methods so now she asks some questions but also does some lecturing so as to not cause undue stress on her senior students. Yet suggestions of increased demands placed upon students to question, think critically, and speak out their opinions were common to the narratives on teaching practice changes.

Participants thought a lot about how to foster critical thinking and encourage clinical judgment in a culture that prizes conformity and discourages individuality and this emerged as a recurring concern. Besides fostering creative thinking and self expression in the classroom, participants imported several teaching strategies to encourage students to grow as individuals. For example, participants from one school talked about the use of "T-groups" for their undergraduate nurses, a technique faculty had been introduced to during their educational sojourns in the U.S. One participant uses journalling imported from his U.S. educational experience to support his

students' individual sense of self. His comments in the journals focus on ontological growth rather than epistemological development. He believes that kind of support helps create individuals more sure of themselves. He also insists that students in one of his classes make their initial contacts with agencies by themselves without an introduction from him or the school, in a manner similar to what was expected of him in his masters clinical work in the U.S. This is very unusual in Japan and is highly stressful for some students but the goal is to strengthen self reliant, independent behavior.

It is important to understand that some participants talked about the great rewards they felt in teaching Japanese students. Rather than needing to mold, stress, and sculpt the students, they were more focused on supporting their students and on enabling the students' sensitivity and caring.

One participant told a particularly moving story of her student who in caring for a crippled and dying toddler realized the child could not see outside the window because he was too small. The student picked him up and ensured that he could look beyond the walls of his room and the little boy was overjoyed. The student made him a complicated activity book with buttons to fasten and cared for him during his last days. The child died and the student grieved but knew she had done her best. This participant maintained that students at her school are very intelligent and very special. She says her job is

> not to erase--not to squash the student's behavior. That is the important thing for me. I don't think I need to teach them because they already have the

original thing which I cannot teach them.

The "thing" they have, she goes on to say, is a way of being, a way of caring.

> I think they have the ability to integrate and look at the person holistically. So even if I didn't teach, they will look at the people like that.

Caring Practices

Japanese nurse scholar participants believed that in many areas, Japanese nursing trails behind U.S. nursing. In contrasting U.S. and Japanese nursing care, participants seldom said anything negative about U.S. care and suggested instead that U.S. and Japanese notions of care are "different." Yet when asked what in Japanese nursing they could point to with pride, participants most often responded, "caring, Japanese nurses provide really good care." The ideas, that care is different in Japan, and, that Japanese nurses excel in providing it, were strong and recurred in the participants' narratives. Yet when participants were asked what they meant by "care" or to describe how care looked in Japan, they had difficulty being explicit. Participants could describe certain aspects of how caring differs and aspects of what constitutes Japanese care, but often their descriptions lacked definition.

In nursing like other practice disciplines, expert practice is characterized by "tacit embodied, know-how that allows for immediate recognition of patterns and intuitive responses" (Tanner, Benner, Chesla, & Gordon, 1993, p. 274). Caring is the basis of expert clinical know-how in nursing (Benner & Wrubel, 1989) yet because such know-how is tacit, embodied, intuitive, expert nurses know it, but their descriptions are vague (Tanner, Benner, Chesla, & Gordon, 1993).

Morse, Solberg, Neander, Bottorff, and Johnson (1990) argue that while caring has been called the core (Watson, 1988) or essence (Leininger, 1991) of nursing, caring as a concept remains illusive. They maintain that "there is no consensus regarding the definitions of caring, the components of care, or the process of caring" (Morse, Solberg, Neander, Bottorff, & Johnson, 1990, p. 2). Likewise, Swanson (1991) suggests "caring has long been recognized as central to nursing," yet, "the meaning of caring and the essential components of caring remain unclear" (p. 161).

Morse, Solberg, Neander, Bottorff, and Johnson (1990) identified 35 authors with definitions/perspectives on caring from a review of the nursing literature. Through content analysis of the writings of these 35 authors, Morse, Solberg, Neander, Bottorff, and Johnson (1990) identified five perspectives on the nature of caring. The five categories identified were caring as a human trait, caring as a moral imperative, caring as an affect, caring as an interpersonal relationship, and caring as a therapeutic intervention. These categories are also reflected in the Japanese nurses' discussions of caring in Japan.

Swanson (1991), acknowledging the lack of definition though recognizing the importance of caring to nursing, performed a phenomenological investigation of caring that was conducted in three separate perinatal areas. Caring was described by 20 women who had miscarried, 19 care providers in the newborn intensive care unit, and by 8 young mothers, recipients of a long-term public health nursing intervention.

Swanson's (1991) investigation resulted in the following inductively derived definition. "Caring is a nurturing way of relating to a valued other toward whom one feels a personal sense of commitment and responsibility" (p. 164). Interestingly, for a person from a high context, group oriented culture like Japan this is a natural and valued way of being in the world. From Swanson's investigation, caring for the three groups in her study was found to consist of five caring processes. The first process, "knowing, is striving to understand an event as it has meaning in the life of the other" (p. 163). Knowing is based on the provider's philosophy of personhood and the recognition of the other as a significant being (Swanson, 1991). The second caring process uncovered in Swanson's study is "being with," that is, being emotionally present to the other. The third process, "doing for" refers to doing for the other what he or she would do for the self if possible. It includes performing skills competently, protecting and preserving the dignity of the other. The fourth process, enabling, "means facilitating the other's passage through life transitions and unfamiliar events" and includes informing, generating alternatives, supporting the other and giving feedback (Swanson, 1991, p. 164). The final caring process uncovered in Swanson's study is that of "maintaining belief" or sustaining faith in the other's capacity to get through and find a future with meaning. Maintaining belief includes holding the other in esteem and "going the distance" with him or her (Swanson, 1991, p. 163).

Prior to Swanson's study Benner (1984) uncovered several competencies related to the "helping role," a domain of nursing which emerged in her

phenomenological study of nursing practice. Swanson's caring processes most closely correspond to these competencies and both the competencies and the caring processes are found in some of the Japanese nurse participants stories as they discussed caring in Japan. The specific competencies will be discussed as they relate to the Japanese exemplars.

Caring practices are culturally bound. Leininger (1991) has written about care and caring and theorizes that human caring is a universal phenomenon found in all cultures, yet how that care is expressed is culture specific. The notion of embodied know-how assumes "our bodies as well as our minds are knowers, and this embodied knowledge enables us to move through situations and encounter situations in terms of meaning in rapid, nonreflective ways" (Benner & Wrubel, 1989, p. 42). Though theories or concepts of care may have been imported, caring practices are distinctly Japanese. This idea is iterated in the excerpt below.

> The caring concept came from the United States, however, caring might exist in body knowledge. When I said caring I think that even though caring exists in the Western culture, in Japan I think caring or care itself has a different meaning. (B)

The notion that caring is found in the U.S. and in Japan supports Leininger's position that care is found across cultures and illustrates "caring as a human trait" identified as one of the categories of caring discussed by Morse, Solberg, Neander, Bottorff, and Johnson (1991). Participants iterated caring practices are culturally bound and Japanese caring is different from caring in the U.S. The nurse from the excerpt below practiced in three different countries, including Japan and the U.S.

She contrasts aspects of U.S. and Japanese care.

"Nonverbal Understanding and the Spirit of Caring"

> I think the theory of caring is getting popular in the States but I think Japanese nurses had originally the spirit of caring before we knew it was a kind of theory. So even if I'm saying something to the patient, there is a kind of atmosphere between the patient and the nurse. When I was working in the States it is very job oriented. You know what I mean? And very clear. You say [things] verbally. Your verbal communication is very much important to you....[in Japan] you don't have to say everything in words, like sometimes [we have] nonverbal communication and nonverbal understanding....It is very much different the spirit of caring here in Japan and the States. But I can't say really where it comes from. Probably for myself I think it was the way I was brought up.

Several points are important in her narrative. The participant talks about the "spirit of caring" as opposed to caring as "a kind of theory." She claims the spirit of caring perhaps comes from the way one is brought up, that is, the background meanings and values of the culture and the individual's family. Japanese culture values attention to the other, nonverbal understanding, and elevates the *amae* relationship, all relevant to expectations of Japanese nurses. In Japan, there is a moral and a cultural imperative to show care for the other. Caring for this participant is also clearly an interpersonal relationship.

Benner (1984) and later Swanson (1991) name "presencing" or "being with" as important to caring nursing. The excerpt immediately above implies that presencing is an aspect of the caring relationship in Japan also. Because Japanese people tend to place a high value on "being," more so than U.S. Americans who tend to be more task oriented and focused on "doing," presencing may be foundational to Japanese

nursing. The perception that relationships between the nurse and patient in the U.S. are more clear and communication is more direct and verbal were recurring notions common to many narratives. On the other hand, the "good" nurse in Japan is supposed to be close enough to her patients that she can anticipate their needs before they ask, perhaps as close as the mother to her child--the model for the *amae* relationship. This participant suggests there is a "kind of atmosphere" between the patient and the nurse. They are in the flow. Nonverbal aspects of Japanese care have been described previously where the ideas of *ishin-denshin*, or compassionate telepathy, and *omakase* were explained. These are depicted again in the excerpt below.

> *Omakase* is a very comfortable way for both nurses and patients. So if the nurse asks the patient every time, maybe the patient gets angry. "You don't ask me so much. You have to guess." (Okaya, personal communication, 12/28/91)

In Japan, nonverbal understanding is proof that the nurse is caring. This is similar to the tea ceremony situation described earlier where it is important to understand the guests' needs and preferences without asking and if one has to ask, "we haven't cared much." This kind of "anticipatory care" (Wenger, 1991) sounds somewhat like Swanson's (1991) "doing for" caring process. The difference is in the patient's expectation and perhaps the nurse's sense of obligation that the nurse will "do for" the patient whether he or she needs it or not. "Doing for" in Swanson's study referred to the nurse taking over when the patient was unable to "do for" him or herself. In Japan, "doing for" is more an outward expression of knowing what the other needs

through attention and caring and may look like a fostering of dependence to U.S. Americans.

The next excerpt illustrates an aspect of this difference in caring nursing practice. When this masters prepared participant first returned to Japan after over 20 years of North American nursing, she had difficulty readapting her caring practices to fit her Japanese patients. For example, she gave patients in Japan choices about their care, rather than providing for their unspoken needs. This was confusing for them.

"It's Quite Different From the U.S."

> I have lots of embarrassments and also lots of trouble or questions when I practice nursing since I came back to Japan....Like I was taking it for granted that we have a social contract. So I said in such and such a situation--"what would you like? You have four or five choices. Which choice would you like to have?" And they'd look at me. They'd stare at me sometimes for three or four minutes. For a long time for me but not for them because they are just seeking what I want them to choose....I have a lack of knowledge [of how] to establish good relationships with Japanese patients or clients and how to establish better interpersonal relationships and those things. It's quite different from the United States. (D)

In the U.S. people tend to appreciate choices and caring includes asking patients who can, to specify preferences, but in Japan the unspoken caring connection is more valued. In a fascinating study based upon Leininger's (1991) theory of Cultural Care Diversity and Universality and Hall's (1976) work concerning high context/low context cultures, Wenger (1991) found "anticipatory care" (p. 106) to be a major cultural theme among the Old Amish Order. Anticipatory care referred to the ability to "sense people's care needs" (Wenger, 1991, p. 107). Like Japan, the Old Amish Order is a high context culture and Wenger (1991) states it is the high context

relationships that allow for the prediction and anticipation of the other's care needs. Like the Japanese, members of the Old Amish Order tend to value long term relationships, have a high distinction for "insider/outsider" boundaries, and take more time to integrate change than persons from low context cultures. Moreover, personal preference may have less to do with motivation and decision making than obligation and consideration of others before oneself (Wenger, 1991).

The unspoken caring connection of the Japanese and similarly the anticipatory care of the Old Amish Order are ways of caring valued by those cultures. To provide this kind of care it helps if one is from the same culture as the person for whom one is caring, if one can soften the boundaries between the self and the other, and if one comes from a culture that highly prizes concern for the other.

Caring and nonverbal understanding in the U.S. A deep caring connection and nonverbal understanding were described by participants as typical of Japanese care, yet these concepts are not foreign to U.S. nurses and the unspoken caring connection may be common to expert nursing practice in both countries.

Knowing the patient emerged as a central theme from interviews Tanner, Benner, Chesla, and Gordon (1993) conducted with U.S. nurses who used everyday discourse to discuss their practices. Embedded in the meaning of "knowing the patient" was the idea of "understanding the patient's situation in context with salience, nuances and qualitative distinctions" (Tanner et al., 1993, p. 275). Knowing the patient as a person and knowing the patient's typical patterns of responses were two

key meanings associated with knowing the patient (Tanner et al., 1993). "Knowing the patient" allows for nursing practice to proceed from an involved, engaged stance, a position of deep connection. Moreover, the involved stance becomes an expression of caring as a moral commitment to protecting those patients, made vulnerable by being unable to communicate their needs or preferences themselves (Gadow, 1989; Tanner et al., 1993). Although the U.S. culture tends to be more verbal and more direct, that is, less contextual than Japan's, Tanner et al. (1993) found everyday nursing practice in the U.S. includes "knowing the patient" who is unable to speak, for instance, because he is intubated or because she is comatose.

Tanner et al. (1993) maintain that although knowing the patient is pervasive in the everyday practice of nursing and is a primary caring practice, "it is striking that such a pervasive phenomenon has been overlooked in most research on clinical judgment, and in most formal systems designed" (p. 279) to facilitate nursing practice. Because such systems, like nursing care plans and nursing diagnoses, are derived from the rational model of practice they cover over the significance of knowing the patient and assume that what is important to know about the patient can be explicitly stated in context-free rules (Tanner et al., 1993). Because of this, and because knowing the patient is always specific and situated it has neither been a part of formal academic preparation nor a part of public discourse by U.S. nurses.

Knowing the patient in Japan. For the individual nurse "knowing the patient" is a personal and particular endeavor, but several cultural factors may influence it,

fostering the possibility or inhibiting it. The cultural factors affecting Japanese nurses' potential to know the patient include cultural values. For example, the Japanese are socialized to value attention to the other; allowing/encouraging dependency in certain relationships in Japan is respected; within the Japanese culture there is high value placed on understanding the preferences, needs, responses, and situation of the other and there is the belief these should be ascertained nonverbally, through trial and error, astute observation, and/or *ishin-denshin*.

Additional factors relate to the health care delivery system. For example, Japanese hospitalizations are relatively long, and most nurses work all three shifts and full time, aiding in the possibility to "know the patient," although there is also an acute nursing shortage in Japan, likely to inhibit it. The following excerpt describes some of the factors associated with knowing the patient in Japan.

"Sensitive Service In Daily Living"

> Because Japanese patients stay at the hospital for a long time--even for stomach surgery, they stay for one month--very long, for the patients--it is very important for them to live or to stay at the hospital very comfortably. So Japanese nurses give them very sensitive service in daily living. For example, the nurses try to make the patient clean very much. So they often wash their hair and wipe their skin--bed bath....They really want to give very sensitive service to the patients. We have not enough nurses so most nurses are very very busy at their unit....(Okaya, personal communication, 12/28/91).

"Sensitive service in daily living" is made possible through knowing the patient. Parenthetically, in Japan, it is likely that "being made clean" will be highly valued. Generally, cleanliness is of great importance to Japanese persons. The Japanese use the same word, *kirei*, to mean both clean and beautiful. The excerpt immediately

above also illustrates Japanese nursing care as a "therapeutic intervention" (Morse et al, 1990).

Many participants noted that physical care and observation skills were of high quality in Japanese nursing care. Japanese hospitalizations are long by U.S. standards. For example a friend's uncle had a carpel tunnel wrist surgery in Japan. He was hospitalized for two months. Because of the extended stays, hospitals, 80 percent of which are privately owned, in order to be competitive, must be able to offer "sensitive service in daily living." And, because patients may hesitate to ask for their needs and nurses are judged in part on how well they intuit them, nurses become highly adept at interpreting subtle cues, using keen observation.

The difficulty in explicitly describing that which is tacit, like differences in care practices between Japan and U.S. nursing, is illustrated in the following exemplar. This doctorally prepared participant talked about Japanese nursing being "wet" compared to U.S. nursing which she labeled "dry."

"Boundaries"

> The Japanese way of nursing is quite wet. The Western way might be dry. This is a very feeling way of expressing it and is not complete....[The Western way is,] "it is 3:30 and I'm gone"--boundaries. And I don't think it is bad to have boundaries. We can learn together about making boundaries. It becomes much easier for nurses to take care of the patients I feel. But for the patients, I think, it is much more to feel cared for in the Japanese way. So they might have to negotiate that part. Because the patient expects the nurses to take care, sometimes they say, as a mother, without anything being said. Without saying, I should know what they want. The mother could do that. Although the baby cannot say anything, the mother can take care. A lot of time it's a male chauvinist [thing] I think (laughing). But when the people become sick and ill they do not have the language to communicate so that it becomes much

> easier for them to communicate without language. And I think that Western culture is language oriented so much so that it may pose a difficulty if they do not have the mother's energy. (B)

"Wet" implies a closeness and an *amae*-like lack of individuation with the patient. The patient feels truly cared for when the nurse, like the mother caring for her child, knows the patient, and what the patient wants or needs. And because the sick person may be vulnerable, dependent and unable to use language to communicate, like the mother with the nonverbal infant, this caring must be done without language. "Dry" implies a more boundaried, edged kind of care.

Many participants characterized U.S. nurses as generally being more distant from their patients, sometimes having more theoretical knowledge, and being more efficient than Japanese nurses, while Japanese nurses were thought to have fewer boundaries. "Boundary" in the excerpt above carried two meanings. One had to do with personal boundaries, the distinct sense of self. The other had to do with role and job description boundaries. Compared to the U.S., nurses in Japan were thought to have fewer boundaries in both areas.

Boundaries. The participant in the above excerpt implied that the lack of boundaries on the part of the Japanese nurse allowed the Japanese patient to feel more cared for. Yet, the lack of boundaries also results in a harder time for the nurse. The participant above implies that U.S. nursing could adopt some of Japanese "wet" nursing (so to speak), decreasing the edge between the nurse and patient, while Japanese nurses would be wise to learn to make more boundaries. "We can learn

together about making boundaries." Japanese staff nurses usually do not have job descriptions. Their responsibilities are not clearly defined or explicitly stated. The distinct margins of responsibility of U.S. nurses were surprising to the participants. For example, one participant who had a child in the U.S. was shocked when the nursery nurses informed her, after she requested their help, that because she was a rooming-in mother, their responsibility to care for her newborn was over five hours after delivery.

Another frequently cited example of the lack of boundaries in Japanese nursing was that of a Japanese patient asking an off duty nurse for a bedpan. Participants said that the Japanese nurse would usually give the patient the bedpan rather than pass on the request to the next shift. If late, the nurse would stay overtime usually for no pay. Participants pointed to unpaid overtime and nurses providing for patients even when off duty as expected aspects of the Japanese nursing role and evidence of the spirit of caring in Japanese nursing. On the other hand, participants, informed by their U.S. experience, also saw expectations for overwork from long shifts, high patient loads, rigid schedules, and unpaid overtime as ways that hospital management takes advantage of Japanese nurses and as contributing to eventual "burnout." This is illustrated in the following exemplar from the masters prepared nurse who practiced in three countries.

"I Act As A Nurse"

> If I am ask for something by a patient before I think "I am off duty," I act as a nurse. I act as a nurse and there are many nurses who are the same. That's

> why some of them are overworked. But even if the nurses are very tired they try to show their patients--they try to treat patients. But in the nurse's mind they are burned out.

Caring in the U.S. and Japan. To "act as a nurse" means to keep a caring connection with the patient. Participants pointed to the holistic focus in Japanese nursing which emphasizes the importance of knowing and caring for the whole person. Participants said that when they were exposed to holistic ideas in U.S. nursing classes, they were surprised at how familiar the ideas were, reflecting Asian philosophies. To look at nursing reductionistically was much more foreign.

"Knowing the patient" as a central aspect of U.S. nursing practice was overlooked because it comes from clinical practice that is tacit and embodied. Likewise, the primacy of caring as the core of expert U.S. nursing practice seemed "secret" until it was exposed by Benner and Wrubel (1989). The notion of the primacy of caring to the practice of nursing is a completely common sense, prosaic notion, known intuitively by expert nurse practitioners and their patients. At the same time, in the U.S., it is a radical explication proposing an alternative to the delivery of nursing care based upon Socratic models of logic which devalue "know-how," that is, wisdom and experience. The primacy of caring expresses an alternative to the primacy of technology. Technology, as it is used here, refers to both "hard" technology, the material products, new implements and instruments, and "soft" technology, research findings, new knowledge. When technology has primacy in practice, practice is likely perceived as epistemological rather than a way of being.

Benner and Wrubel (1989) argue that without care, nursing is flat and technical and nurses are uninvolved and cold. "Excellent care comes from the unity of thought and feeling" (Bishop & Scudder, 1991, p. 105).

Historically, caring in the U.S. was considered a woman's traditional role and her chief contribution to society (Pepin, 1992). With industrialization and the technological explosion, mass production and cost/benefit analysis, became dominant values, leaving caring as "women's work" and mostly invisible, unrecognized and undervalued (Pepin, 1992). At times, U.S. nurses, the philosophical stance from which they practice, and the care they give, have reflected society's ambivalence toward women and caring (Pepin, 1992; Leininger, 1988; Benner, 1984).

Japanese nurse scholar participants compared many aspects of U.S. and Japanese nursing and found much in the U.S. that they admired, including aspects of U.S. nursing technology. Yet in Japanese nursing, just as in Japanese culture, caring has retained its primacy. Participants were clear that caring practices in nursing are situated, based on knowing the patient, on background meanings, and are culturally specific. For example, they suggested that most U.S. patients would have less tolerance for dependency than those in Japan and therefore, U.S. nurses need to foster independence more than do nurses in Japan. Still, when asked "what of Japanese nursing would you export to the U.S.," participants most often responded, "the care." When asked to be more specific, participants contrasted aspects of care, some which have been described above.

In my opinion "the care" for most, meant practices stemming from a deep and connected understanding of the patient's situation and an elevation of the caring relationship as a primary value in nursing. In Japan, knowing the other and caring for the other are cultural values, practices elevated and prized by both men and women. In the U.S., on the other hand, such nurturing practices may be dismissed as "feminine" and are not reflective of dominant cultural values (Schaef, 1981; Belenky et al., 1986). Moreover, because tacit practices are difficult to describe and do not fit with Socratic notions of what constitutes a professional discipline, in U.S. nursing culture, like in the larger culture, such practices may be overlooked and undervalued.

Summary of Practice Differences

Several concerns relating to practice comparisons arose from the participants' reentry narratives. Participants returning were in positions to look at Japanese nursing with new eyes. Coming from exposure to U.S. health care practices and nursing roles, those eyes noticed a tendency toward a hierarchical rigidity and a lack of patient rights and power. Participants returned with new positive attitudes toward making change. They noticed a less autonomous nursing practice taking place in Japan. Moreover, the *omakase* relationship in Japan was seen from a new perspective by some participants. Rather than taking *omakase* for granted and sanctioning the physician's unilateral decision making, some participants began encouraging patients to question their doctors and began questioning physicians themselves. They talked about alternative treatments with patients, and shared opinions with physicians in

ways unlike typical Japanese nurses, and they had difficulty with physicians at times because of this. They had some trouble getting used to academic practices in Japan after being in the U.S. and two concerns stand out related to this. First, they wanted to decrease the formalized distance between themselves and their students. Second, they wanted to push students to think critically and express opinions.

Care and caring practices emerged as a major themes in the practice differences area. Participants described culturally bound caring, and the nonverbal caring connection of the Japanese nurse and the patient. They described "knowing the patient" in Japan and the relative lack of boundaries, related to the self and the nursing role, in Japanese nursing.

Summary of the Findings

One of the strongest themes to be delineated from this study is the notion that for many of the Japanese nurse scholars, the sense of self changed during the U.S. experience. Reasons for this are extremely complex and depend on assumptions about what it means to be Japanese. The Japanese self is more defined by patterns of obligations and webs of interrelations than the U.S. self tends to be. There is an encouragement in Japan to fit in and to rely on inner circle relationships. Without knowing one's position and without the caring of others, the sense of self may fade. Participants described this phenomenon as *jibun ga nai* (no self).

Japanese communication styles tend to be less verbal, less self disclosing, more ambiguous, and there are proscriptions against individualistic expressions of

opinion or strong preference. Yet from understanding and attending to the other, preferences may be distinguished. This attention to the non verbal is one component of caring in Japan.

In order to survive in the U.S. the Japanese nurse scholars said they had to "toughen." This toughening referred to an internal change and resulted in a more individuated stance. The toughening also referred to a change in the nurse scholars' attitudes toward others. They became less willing to allow dependency. In Japan certain dependent relationships are encouraged and idealized. These are called *amae* relationships. In the U.S. Japanese students began to focus less on the other. They worried about becoming less "kind" and what constituted their notions of care changed to some degree.

A second theme strong theme in this study concerned mental health disturbances that the international students experienced during acculturation. Mental health disruptions, including depression and drops in self esteem, were said to be common. Hallucinations, suicidal ideation, feeling "demented" and "schizophrenic" were reported but were rare.

Participants said they tended to have difficulty speaking out in classes and with understanding what was expected of them in classroom groups. Speaking out, questioning authority, and behaving with directness or assertion within the classroom or groups was made difficult by a lack of English facility and by the cultural implications of disrespect and rudeness inherent in the demanded behaviors.

However, by the time participants returned to Japan, many had become used to speaking out in seminars and enjoyed "asking the devil's question" in seminars or other groups.

Loss was one of the most profound themes from the reentry experiences. The nurse scholars described losing their world, losing their 30's, losing their friends. They described coming home to "start at the bottom," problems with bosses, and trouble keeping quiet. They talked about coming home and having nursing colleagues look at them ambivalently because they had gone to the U.S., and devalue what they had learned, saying that it was American knowledge, not Japanese.

Other reentry themes were concerned with practice differences. Attitudes about change and action were different. The sojourning experience changed some of the nurses' notions about their nursing role. Some began to want to inform patients about their treatment options, advocate for informed consent, push patients to question physicians about medications and treatment. At times these new ways of nursing created friction between the returning nurses and physicians.

Participants also brought home new teaching strategies, including T-groups and journalling. And after experience in the U.S. nursing education system, they brought new expectations of student behaviors. They pushed students to evolve their own opinions and to share them in class.

The last important theme to emerge from the reentry stories was the pride with which participants talked about the Japanese spirit of caring. When asked to describe

an area where Japanese nursing excelled, participant after participant named "caring" as a fundamental element of Japanese nursing. Caring is a culturally embedded concept and when participants thought deeply about the exportation of caring they often cautioned that the basis for nursing caring practices in Japan is embedded in the cultural values and the expression of those values in cultural practices.

CHAPTER VI

SUMMARY, IMPLICATIONS, AND CONCLUSIONS

Summary

The purpose of this interpretive study was to describe the lived international educational experiences of Japanese nurses in order to develop more understanding within academic settings in the United States. The specific research questions were:

1. What are common themes and shared meanings of the Japanese nurse scholars' experiences during their study in the U.S.?

2. What are common themes and shared meanings of the Japanese nurse scholars' experiences when they return to Japan.?

Procedures and Analysis

Participants for this study were twenty-five Japanese nurse scholars who had received or were in the process of receiving masters or doctoral degrees from schools of nursing in the U.S. Participants were selected based upon their varying lengths of time since their return to Japan from the international experience. Forty two interviews were conducted, thirty eight in Japan over a five and one-half month time period, and four in the U.S. in four separate months. All interviews were tape recorded and transcribed verbatim. Interviews with three Japanese consultants who aided in specific explication of themes and early analysis were also transcribed and treated as data. Analysis occurred in several iterative phases and began in Japan with the first interview. Twenty-nine of forty-two interviews were transcribed while there

and extensive interpretive work was done with them to guide subsequent interviews. Transcriptions of early interviews were sent to a group of doctoral and post doctoral students and two faculty from the Oregon Health Sciences University School of Nursing, knowledgeable about qualitative methods of analysis. Prior to leaving for Japan, I had been a group member and the group was familiar with the study. Tape recordings of their interpretive sessions were sent to Japan along with memos and transcript notes and were used in analysis. After returning from Japan, meetings with an interpretive team comprised of my dissertation advisor and two other doctoral students versed in hermeneutic methods began. In addition, three Japanese doctoral students aided interpretation particularly in areas of interpretive confusion. The analytic process used overlapping strategies including early reflective interpretation of the transcripts, identification of principal themes, coding and data retrieval according to a plan devised by the interpretive team (made up of my doctoral advisor and my hermeneutic student colleagues), and interpretive writing based on exemplars and paradigm cases illustrative of the major themes (Wros, 1992).

Findings

Themes Related to the U.S. Experience

Two main topical areas were uncovered in the text related to the U.S. experience. These are: "the changing self," and "being a student in the U.S." Changes in the sense of self in relation to the other was the first major theme identified in the topical area called "the changing self." Issues constituting the theme,

include concerns of becoming tough; movement toward independence; caring and concern; and the *amae* relationship. "Becoming tough" alluded to two aspects of toughening. In reflection, participants tended to use their sojourning experiences as touchstones for difficult times. Once home in Japan with tremendously demanding positions they looked back on the enormous amount of work it took them to get through graduate school in the U.S. They seemed to derive proof of their individual strength from reflecting on their sojourn and at times gain sustenance in their current lives from it. A second aspect of "becoming tough" concerned the more distinct boundaries between the self and the other that occurred for many participants. Participants reported that they needed to get tougher in this way in order to survive in the new (U.S.) culture.

Background meanings related to the new boundaries included differences in the Japanese and U.S. sense of self. For the Japanese individual an important component of the sense of self is the idea of "being in the flow." Participants suggested that this refers to the nonverbal, subconscious baseline caring that the Japanese person has for the other. Patterns of relationships within the Japanese culture are based upon these notions of self and caring. The *amae* phenomenon is one such pattern. This refers to an acceptance and endorsement in Japan of dependency within certain relationships.

Another major theme in the "changing self" area is the role of context in understanding. Concerns explaining this notion include: harmony in relationships; individual choices; and hierarchy. An easy harmony with others and a less distinct

self is partially what allows for nonverbal understanding, for the awareness of contextual nuances that permits tacit communication in Japan. Related to the easy harmony is also a tendency towards vague abstraction in verbal communication and a proscription against expressing opinions and stating preferences. Underlying these is a comfort with ambiguity, and clear notions of position in the Japanese hierarchy of roles. These features of the Japanese self and communication patterns are reflective of values in the culture that differ from those in the U.S.

Two other major "changing self" themes were "language and culture," which includes the concepts, loneliness, lack of fit, and public/private self, and "culture shock/sojourner's response/mental health changes" which include concerns about mental status changes, plummeting self esteem and impaired judgment, and biculturalism. Mental health problems during periods of acculturation are not uncommon for sojourners. And, participants reported a variety of mental health changes which occurred during their U.S. stays. For example, lack of language facility was tied to feelings of isolation and loneliness. Some participants reported serious mental status fluctuations. Symptoms included hallucinations and suicidal ideation. In addition, periods of depression were frequently reported as were periods of low self esteem. Some participants reported that they "lost" themselves at some time early in their U.S. sojourn. Without the projected care of the other, without feeling securely "in the flow" or "in the energy field," there was little sense of self.

People in the U.S. are expected to self disclose. It is often through self

disclosure that a sense of closeness and affiliation evolves between people. Japanese people tend to value verbal exchange much less than people in the U.S. Moreover, they are expected to show restraint, humility; personal preferences are often not considered, but rather the harmony of the group is primary. Early in the sojourn, these conflicting values could be problematic. Japanese sojourners with their more fluid boundaries may feel that when they self disclose, they "leak" themselves. They are faced with a dilemma, without self disclosure they may remain isolated from their U.S. classmates and faculty, yet if they self disclose, it may lead to a more intense loss of the sense of self.

"Changes at the core" was the final theme in the changing self area. Notions related to "changes at the core" include a new flexibility and the logic of English. A contrasting case was presented in this section. Participants suggested that the ways they conceptualized the world changed with the international experience. Rather that looking for one right answer, they began to explore many options and appreciate multiple perspectives. They were able to think about things with a new flexibility brought on by their international experience. They also suggested that the English language is more logical than Japanese and that learning to create scientific papers for course work forced them to think with a new logic. And, their educational experiences in the U.S. gave them new ways to integrate and organize information, which participants identified as a significant, and useful change.

Japanese writing styles tend to be circular and points may be understated and

implicit. Important concepts may be "between the lines." Japanese international graduate participants claimed that learning logic and logical writing styles was another area where they learned a new "way of looking at things."

A second topical area called "being a student in the U.S." emerged from the data. The first major theme in this topical care is the student-teacher relationship and includes such notions as: *amae* in the student-teacher relationship; the importance of the advisor; and the meaning of *enryo*, the hesitancy to bother. The importance of the advisor or a mentoring relationship with a faculty member was a strong concern that arose in the U.S. experience narratives. Although not all participants wanted intense relationships with faculty, many seemed to believe that their success could be partially attributed to a high level of faculty involvement. Moreover, many participants came to particular graduate schools to study content areas with specific faculty. In that case, the importance of the faculty relationship was increased. Overall U.S. teachers were perceived as accessible and friendly, and not as hierarchically distant perhaps as some Japanese teachers.

The notion of *amae* within the student-teacher relationship adds a dimension to the understanding of the Japanese student's possible expectations. A second Japanese cultural concept, the idea of *enryo* adds understanding to the "hesitancy to bother" faculty reported by participants. *Enryo* translates as "restraint" or "holding back" and is especially applicable in situations where one is approaching someone higher in the positional hierarchy. Often early in their sojourns, participants suggested, even

though they had been invited to come to faculty for help, they would hesitate. Given these two background assumptions about student-teacher relationships, it is easy to fathom how it was initially difficult for participants to understand U.S. student-teacher relationships and how it often took them a while to "get it right."

A second major theme in this area is the student role. It includes: speaking out in class; comportment in a group; dealing with racism; making friends; opportunities to learn; and the meaning of counselling. Participants reported the two most difficult aspects of the student role in the U.S. concerned learning to speak out in class and learning seemly U.S. group comportment. These two concerns emerged as strong, common, and meaningful to many of the study respondents.

The Japanese propensity to defer to higher authority, the rudeness of stating personal preferences when they might upset the group harmony, classroom expectations to sit quietly and listen carefully to the teacher, the low value placed on verbal expression in Japan, and the participants' lack of English facility all colluded to make speaking out in class difficult. Moreover, in Japan group decisions are often either made by the top and "sold" in group meetings or through the *nemawashi* process. *Nemawashi* is the process of politicking behind the scenes, so that a final decision is brought to the group for harmonious agreement. Group process in the U.S. usually proceeds quite differently.

Another issue that came from the participants' narratives about their student role in the U.S. concerned the difference in meaning attached to counselling in Japan.

Japanese people tend to seek psychiatric care only for serious mental health deviations. People in the U.S. are more likely to seek counselling for guidance or to reach a higher level of insight in their lives. A suggestion to "get counselling" for a Japanese student may contain the connotation that the faculty perceives a serious mental health disorder in the student, which is then perceived by the student as the "final alarm."

The last major theme of this topical area had to do with the way the educational experience was organized for graduate students. This theme included the U.S. faculties' control of the classroom (or lack there of), the number of written assignments, and the organization of short term and long term goals in classes. Participants were surprised by the lack of didactic teaching in the U.S. classroom and by the lack of faculty dominance or control over class discussions. The expectation in college level classes in Japan is that the teacher will lecture. Student discussion may be perceived as a waste of time, not highly valued. Students were also surprised at the high number of classroom assignments. And, U.S. faculty had long term goals and objectives for students and seemed to build on these over the course of the quarter or semester. One participant summed up these differences, saying, "maybe the faculty in the United States have a special skill--controlling and uncontrolling."

Themes From the Coming Home Experiences

Two main topic areas were unveiled in the coming home experiences of the participants. The first is called "the meaning of Americanization" and is made up of

two main themes, loss, and the significance of the U.S. sojourn on careers. Participants reported experiencing multiple losses on their returns to Japan. Losses varied from losing direct ways of relating, to losing friends and relationships from the U.S. The loss of one's lifestyle was one of the most common to emerge. This had two meanings. One meaning referred to the sense of ease or leisure in the U.S. Life in the U.S. is relatively inexpensive, and, compared to Japan, the U.S. is sparsely populated, so leisure activities are easier to afford and access. The other loss of lifestyle participants' discussed was the effect of the multiple obligations that seemed to consume their lives when they returned. Many talked about how they had little personal life, bound by feelings of responsibility to their specific institutions and to Japanese nursing.

Benedict (1946) described the many terms the Japanese use to denote differing types of obligations. A sense of obligation underlies much of Japanese comportment. After the relative ease and high value for leisure in U.S. life, participants described being drawn into excessively busy lifestyles based on layers of obligations. Though rewarding in some ways, the contrast between life in the U.S. and life in Japan, caused suffering in others.

For nurses in higher positions on return, sorrow over having little personal time and ambivalence about excessive obligations seemed to stand out. On the other hand, for nurses not as established in the professional hierarchy, concerns about finding positions that would correspond to their academic and clinical expertise, were

in the foreground.

One's position in the professional hierarchy in Japan depends primarily on one's length of stay at the institution. Age is also a factor. In the hospital system RNs and LPNs work with little discriminating between their positions. A recent returning masters prepared, experienced clinician, might be expected to "start at the bottom" with "no special position" having been given the same work to do as an aging LPN, and making less salary. In the academic setting, higher degrees were said to be more valued than in clinical settings, but still seniority and age were often the deciding factors in advancement. Young returnees seemed to feel especially vulnerable in terms of position.

In addition participants talked about having problems with their bosses. They also talked about "keeping quiet" about their experiences in the U.S. The Japanese mistrust of returning compatriots has been well documented (White, 1988; Kidder, 1992; Barnlund, 1989). For Japanese returning from the U.S., colleagues may watch for speaking out in meetings, expression of personal preferences, directness in communication, "bragging" about one's experience, or assertiveness. The person recently home from the U.S. is labelled *Americagaeri*. *Americagaeri* translates America returnee but carries the connotation of inappropriate outsider. The label is used "behind the curtain," not directly to the person.

The last topical area to emerge from the narratives is that of practice differences. Three major themes arose in this area, "hierarchy and decision making,"

"contextual and cultural differences," and "caring practices." The first major theme in this area relates to relationships in the Japanese nursing context. Relationships discussed in this theme are the doctor, nurse, patient relationship in Japan and male-female relationships. Japanese physician-nurse relationships are based upon a strict power differential that repeats in Japanese male-female relationships. Partly this is because most nurses are women whereas most physicians are men. Some of the gender inequity in Japan is based upon Confucianism. Although the influence of this philosophy is waning, it is still pervasive in Japanese culture. Confucianism prescribes a rigid patriarchal societal hierarchy. Several aspects of the Japanese hierarchy are important to this study. The Japanese patient is the lowest member of the Japanese medical care hierarchy, a passive recipient of care, not a consumer. He or she has little input and there is little evidence of collaborative decision making. There is much emphasis on nurses "following doctor's orders."

Japan is described as a "vertical culture" and there is much emphasis on position and on knowing one's place in the position hierarchy. Yet the power differential between the physician and the nurse has an underlying component. Like the Japanese husband and wife, the physician may in public retain the appearance of total control over all patient related decisions while in private, the nurse may be orchestrating the daily care of the patient and the running of the hospital unit. Likewise in public, the Japanese husband will appear to make all family decisions, whereas in private the Japanese wife will actually make most decisions related to the

children and household. Moreover, although the Japanese husband may be the primary breadwinner, the wife will likely handle the financial aspects of the partnership. This seeming discrepancy between the public and the private is called the *omote* and the *ura*. *Omote* refers to that which is in front, the face, that which shows. *Ura* refers to that which is behind, the back, that which is not exposed. *Omote* and *ura* are two sides of a unity. The logical inconsistency of this concept is not a problem for the Japanese intellect. The public and private aspects of the hierarchical definitions need to be appraised for any understanding of what it means to be a nurse or a woman in Japan.

The second major theme in this topical area is the idea of contextual and cultural differences in the nursing context. A background meaning which is associated with hierarchical relationships in health care in Japan is the trust relationship that ideally occurs between the physician and the patient. This notion emerged as a strong theme in the data, important to understanding nursing practices in Japan. The trust relationship is called *omakase* and underlies the culture. It is found even in the most everyday aspects of Japanese life, not only in health care relationships. *Omakase shimasu* means I put my trust in you. With *omakase*, one can defer to the trusted other for decision making. For example, in the situation of the patient and the physician, the patient expects the physician to make health care decisions. It then becomes inappropriate for the patient to ask questions of the physician or to demand information about his or her diagnosis or treatment.

Typically, individuals from the U.S. begin stating personal preferences, to quote one participant, "as babies, from scratch." Instead the Japanese tend to be concerned for the other, tend to value group harmony over personal preference, and tend to lack a tolerance for deviation. These cultural assumptions may create embarrassment or discomfort with the expression of a personal choice or the process of accountable decision making.

Concepts of nursing in Japan are changing. Participants reported that over half of the instructors in nursing schools are physicians. This has made the definition of nursing as an independent profession difficult. There has been a "doctor's handmaiden" aspect in Japanese nursing and the "follow the doctor's orders" mode of nursing has tended to be accented over the "nurse as a patient advocate" mode. Moreover, the lack of Japanese nurses with higher education, the limited opportunities for advanced education, the lack of expanded licensure all have likely influenced the ways in which Japanese nursing is defined. Participants compared attitudes toward change, action, and decision making in nursing practice in the U.S. and in Japan. As they returned these concepts stood out. Participants explained that expressing dissatisfaction with the system is perceived as being "childish" in Japan, an attitude which hampers push for change. Difficulty in identifying and verbalizing specific problems are added obstacles to change.

Another reentry practice difference concerned the feeling of participants that Japanese nursing was behind U.S. nursing. Specific areas of perceived lag included

research, higher education possibilities, expanded licensure, the conceptualization of oncological nursing, patient rights and the education level of most practicing RNs. Friction with physicians was another concern of returnees. Areas of conflict included discomfort with aspects of *omakase*, physicians lack of acceptance of nursing opinion, and physicians' suppositions that their higher position in the health care hierarchy allowed them to treat nurses disrespectfully. Gender issues may underlie some of the conflict with physicians that participants reported.

When participants came back to teach they often had fantasies about creating U.S. style student-teacher relationships and classroom atmospheres. Participants described their disappointments when students continued to hierarchically distance from them and when students were confused and uncomfortable with the returnees' expectations for unconstrained class discussion.

The last major theme to emerge from the data of this study concerns the excellence of Japanese nursing care. The Japanese nurse scholars described a Japanese "spirit of caring" which they suggested was really based upon cultural values, background meanings, and an ontological way of being in the world as a nurse.

Caring in Japan reflects major cultural assumptions. Caring there is based upon the high value placed on concern for the other, the fluid self, being in the energy flow, and nonverbal kinds of communication. One participant described caring in Japan as existing in "body knowledge." Embodied knowledge suggests that

our bodies as well as our minds are knowers. It allows humans to move through situations in terms of meaning, grasping the situation holistically and immediately. The Japanese nurse scholar participants described Japanese nursing as involving the nurse in a responsibility, an obligation, a posture that does not stop at shift changes and is not easily boundaried. The spirit of caring in nursing is reflective of a way of being. And caring in the Japanese culture and in Japanese nursing practice retains primacy.

Implications for Education

The purpose of hermeneutic research is not to produce rules or theory but to uncover lifeworlds to enhance understanding. Meaning in interpretive works is dependent on text. Separated from the narrative, there is a danger of presenting reductionistic truths as reality. And, there is a danger in presenting implications in that they may become rules to live by or worse, that they may trivialize the stories of the participants into helpful hints. Rather than taking these implications as prescriptions for behavior, the hope is that faculty, with new deeper understandings of the lived experiences of the Japanese students, will incorporate the understandings into more tactful caring practice.

During acculturation Japanese international students may be undergoing a change in their deepest core, a change in their sense of self. This change is brought on partially by the different definitions of self in the U.S. and Japan and by acculturation stress. When the student is away from the grounding of the flow of

concern that is a foundation of self definition in Japan, s/he may experience a loss of self (*jibun ga nai*). This can be compounded by the differences in cultural expectations concerning self disclosure. Through self disclosure people in the U.S. become closer. In Japan there is less enthusiasm for verbal expression and self disclosure may be considered bragging or setting oneself off from the group. It is not congruent with the restraint and humility valued in Japan. Self disclosure may increase the feeling of loss of self. Multiple mental health disturbances may accompany the process of acculturation. Depression was the most common mental health complaint reported but paranoia was said to be common. In addition self esteem usually drops. Sometimes during acculturation participants are experiencing mental health problems for the first time in their lives. Some participants reported that these changes made them more empathetic and understanding of their patients.

On the one hand, it is important for faculty and student services personnel to recognize that mental status changes, including sometimes those associated with psychotic processes like hallucinations and paranoia, were reported by participants successfully completing both masters and doctoral graduate programs in the U.S. And, faculty need to be aware that the suggestion to "seek counselling" likely has differing meanings for the Japanese international student and may signal "the final alarm." On the other hand, active professional intervention may be required and to assume that the student will just get better with time, or to avoid suggesting professional help, might turn out to be irresponsible or tragic. Each situation must be

judged on a case-by-case basis. To be able to offer the student a referral to a native Japanese speaking professional counsellor, though, makes sense. Often at the point of the most alienation and acculturation stress, the demand for the student to verbalize thoughts/feelings in English or to describe his or her situation is too overwhelming or simply not possible. Moreover, a Japanese native-speaking professional may have more culturally appropriate interventions to offer than U.S. American counselling and/or pharmaceutical treatment.

Faculty may wish to honor the autonomy of the international student, showing respect for independence and freedom of choice through waiting until help or assistance is requested. This response reflects typical U.S., values. Or faculty may gently offer help. Yet, at the point the student is experiencing the most profound changes in the sense of self, it is probably not useful to ask the student to "let me know if there is anything I can do." First, Japanese international students must often overcome *enryo* or hesitancy to contact faculty. *Enryo* is a complex concept that in this study was tied to a "hesitancy to bother" faculty/physicians. Even in situations where students had been invited to call on faculty, they often hesitated to do so. This posture tended to fade as students became aware of the lessened hierarchical separations between U.S. faculty and graduate students.

Another reason that asking the student to initiate help seeking, "if there's anything I can do," is frequently futile, is that often when participants were in the most serious trouble, they were not aware of their situations. Or, they knew they

needed some kind of help but could not conceive of what kind. This should not be construed as a suggestion for faculty to ignore or avoid the international student. Rather, caring responses could include such interventions as social invitations to the symphony, viewing a parade, or activities not requiring high verbal skills, but which show caring attention.

Early interactions between international students and faculty often contain miscommunications. These tend to be compounded by the fact that polite listening behavior in Japan includes nodding and repeating the Japanese word for "yes." When Japanese students repeated this automatic behavior in English, faculty assumed they were agreeing when the students were only conveying that they were listening to the conversation, though not necessarily understanding it.

The importance of the advisor to international students has been reported elsewhere (Kayser-Jones & Abu-Saad, 1982; Tien, 1982) and was a strong theme in this study. For the Japanese international scholar there is a tremendous commitment implicit in the decision to study in the U.S. Likewise there is a high level of commitment implied with the faculty agreement to work with the international Japanese student. Recognizing the degree of sacrifice and motivating factors for Japanese international students, such as the desire to work closely with faculty knowledgeable in a specific area, can sensitize U.S. faculty to the level of commitment implied in the mentoring relationship from the international student's perspective. Although it is unlikely that Japanese international students will assume

amae relationships with faculty in the U.S., knowledge of the concept of *amae* and the Japanese cultural value that not only allows adult dependency but idealizes the "sweet" relationship will aid in understanding. Of course, each international student's situation is different but it may be helpful to define what the agreement to "work together" means both to the student and faculty. For instance, if the faculty member knows he or she will be gone on sabbatical during the student's expected program of study, it may be useful to explain this a priori. Sabbaticals are highly unusual among Japanese nursing faculty and are not an expected aspect of graduate life there. Two cautions need to be inserted here. First, early communication with faculty may be compromised by a lack of English fluency and acculturation stress. One might recall the "I got tough" excerpt where the young man was not able to catch even the name of his advisor in his first meeting. Second, one might also recall the higher Japanese tolerance for ambiguity and discomfort with expression of personal preference and the hierarchical differences inherent in the Japanese student-teacher relationship, and predict that clarification will likely be initiated by the U.S. faculty.

Differences in the nursing context between the U.S. and Japan were unveiled as profound and powerful themes in this study. Faculty familiarity with at least some aspects of contextual differences could be useful to enhance the possibility of caring educational practice. Differences delineated by this study included but were not limited to, role and power differences, differences in patient expectations, differences conceptualizing aspects of nursing, and differences in caring practices. For example,

the notion of the nurse as a patient advocate, assertively questioning physician's decisions and/or physician orders was not said to be common in Japanese nursing. Yet in the U.S., being a change agent, an assertive advocate for the patient, and a "truth telling" patient educator are expected aspects of nursing practice. "Truth telling" and informed consent are based on U.S. notions valuing autonomy and individualism. In Japan, other values are primary and in practice, the notions of "truth telling" or informed consent are often enormously conflicted, especially for the U.S. educated Japanese nurse. Abu-Saad and Kayser-Jones (1982) reported that international nursing students in their study found "different patterns in personal and professional socialization" from those in their home countries, aspects of student life that were unexpected and required adaptation. Likewise, this study found Japanese international students may experience cultural dystonia and confusion when required to adopt U.S. views of nursing.

In addition to adapting to nursing role differences, becoming opinionated and verbal in classes, and expressing preferences and personal thoughts, were identified by participants in this study as requiring adaptation and a loosening of cultural proscriptions. Yet, many participants learned to speak out directly and assertively, abilities which they perceived as necessary for success in classes. As they learned these new ways of being and as they came to appreciate collaborative aspects of the patient advocate role, all of which are expressions of U.S. values, they changed. And the changes set them apart from their nursing colleagues home in Japan and

sometimes resulted in more intense experiences of personal loss and alienation at reentry. This is not to suggest that faculty/administration introduce differing requirements for practice or classroom comportment for international students. But it is a plea for faculty to understand the lifeworlds of the Japanese international student and to keep in mind that U.S. American nursing values reflect one perspective on nursing. There are others.

In honoring diversity and preparing students for it in the nursing milieu, international students are uniquely valuable as resources to point out other ways of thinking and other ways of practicing. One way of accessing these perspectives could be to ask recently arrived international students to stay fifteen to twenty minutes after class, so that the U.S. educator can discuss class content with them. This not only allows the student a second chance to discuss content in English, but also it provides faculty with some sense of the student's level of understanding, and can provide a time for faculty to get information about the student's practice in a one-to-one or very small group setting where students might be more able and willing to speak up.

The participants in this study reported that the two most difficult aspects of U.S. graduate education were learning to speak out in class and learning to function in group situations in the U.S. Learning to write in the U.S. style with points laid out explicitly and made in a linear, logical fashion was also described as troublesome at first. Japanese writing tends to be more circumscribed and arguments are implied. There is a circular or spiraling sense to the reasoning rather than a linear demand for

logic. This may be important information in guiding students toward U.S. notions of satisfactory scientific writing. Gay et al. (1993) suggested that faculty and administration need to be prepared to offer international students assistance with writing and this notion was supported by participants of this study.

Grace (1990) claims that it is important for U.S. faculty to understand from where international students come and where they will go. A surprising theme to emerge in this study related to the Japanese nurses' reentry was the overwhelming sense of loss expressed by many of the participants. While for some the loss was associated with a more easy lifestyle and more leisure time in the U.S., for others it meant the loss of a personal life. Caught in the obligations and responsibilities inherent in being in faculty or leadership positions in Japanese nursing, participants reported suffering and feeling childish for complaining about it.

The time spent in school in the U.S. was often thought of as time for oneself. Long hours of study and short sleep were common but there was a sense of freedom from other responsibility. "I was free! To study." Yet, the return to Japan for many of the participants marked the beginning or the resumption of the adult world of obligation. No personal life and little free time were universal complaints, and for those participants who came back relatively young, to mid level positions in the seniority driven hierarchy, the overwhelming responsibilities were coupled with a lack of power and authority within the institution.

Reentry may be especially difficult for Japanese returnees because of current

ambivalent attitudes in Japan toward the U.S. and because of the Japanese conflicted response toward anyone who has left the group and tries to return. Concerns about reentry will often come into the student's foreground before leaving the U.S. and may preoccupy them. Interestingly, while in the U.S. participants talked with each other about difficulties they expected on return, but once back the proscriptions about self disclosure and the staggered arrivals of international students often precluded open discussion. Of course each student's situation is unique but knowing that the student going home may be ambivalent or preoccupied with wondering how things will go may be useful to U.S. faculty.

Japanese caring practices tend to emphasize a nonverbal connected caring. The patient exists in "a kind of atmosphere" shared with the nurse, an "energy flow." Ideally, through keen observation of subtle nuances, trial and error, and perhaps through *ishin-denshin*, or telepathic empathy, the softly boundaried Japanese nurse discerns patient needs and preferences, and cares for the patient as a mother for her child, without needing verbal cues. Some U.S. caring practices, for example, giving patients choices, respectfully asking what patients need or want, or allowing patients privacy and distance, conflict with the Japanese ideal. This is because caring practices, particular, and concrete, are culturally bound. Interestingly, though, "knowing the patient," that is, knowing the patient as a person and knowing the patient's typical responses (Tanner et al., 1993), and engaged caring from an involved stance, seem to be common to expert practice in both countries. Recalling the story

of the woman who had to "spit her brain" to score correctly on nursing tests because her "better care" was different from that identified by faculty, it could be exciting to invite multicultural exploration of what constitutes nurses' "better care."

Implications for Future Research

Context (Barnlund, 1989; Hall, 1976), acculturation (Berry, 1980; 1990; Berry et al., 1992), culture shock (Furnham & Bochner, 1986), and reentry (Paige, 1990) were identified as concepts relevant to understanding the lifeworlds of international students. This study has uncovered these concepts in the Japanese participants lifeworlds, made them concrete, unique, and particular to this group of international students. That there are few studies and articles concerning international nursing students has been well documented by nursing scholars (Abu-Saad & Kayser-Jones, 1981; 1982; Alexander & Shaw, 1991; Gay et al., 1993; Kayser-Jones & Abu-Saad, 1982). Fewer still provide understanding of the lifeworlds of the international nursing student during the educational experience and during the student's return. This study offers some understanding of the Japanese international student's world, illustrating values and meanings, from their perspective.

Exploration into the lifeworlds of other groups of international students could give faculty an understanding of issues relevant to other cultural groups. The illumination of other cultural values and the practices that come through them could increase faculties' understanding of their own values and practices. And, exploration into other cultural groups' lifeworlds could result in uncovering ways to improve

possibilities for these students to have successful educational experiences and perceive that they have been well cared for and mentored by faculty.

One caveat for future cross-cultural researchers is included here. No matter how apparently adept in English your potential participants are, it may be assumed that asking them to read and/or write in English, when English is their second language, will be a burden. Make your initial written contacts in the participants language of origin. Any written material in English should be short.

Because Japanese nursing has been influenced by U.S. theory, the notion of differing practices questionably informed by similar theory has been explored. Minami (1985) noted that some aspects of imported nursing come complete with U.S. values and may be highly conflicted with traditional Japanese values. And she noted that Japanese nurses may accept such imported ideas without questioning the underlying values. For example, ethical decision making is one such idea (Minami, 1985). In Japan the ethical framework is situational rather than universal or fixed, based upon patterns of relationships within the group rather than on an individual sense of "right" and "wrong" (Minami, 1985). Minami (1985) suggested that values clarification is an important area for future research in Japanese nursing.

Participants in this study, returning to Japanese practice, having been exposed to the same nursing concepts in both the U.S. and Japan, observed markedly divergent practices. As a result of this, they were pushed to clarify underlying values, thus uncovering some of the more conflicted aspects of Japanese nursing

practice. For example, the idea of collaborative decision making with the patient an informed participant in his/her health care decisions is an idea, written about and discussed by Japanese nurses. Yet, in Japanese practice, the notion of *omakase*, the hierarchy of the physician on top, the patient a recipient of care rather than a consumer, the differing meaning of what constitutes the individual in the U.S. and Japan, and the proscriptions against discussing "bad" diagnoses in Japan all contribute to differing meanings of collaboration and different collaborative practices in Japan. Although some participants indicated collaborative decision making does not happen in Japan, a current international research project proposes to describe nurse-patient collaboration there.

As Japanese nurses explicate the values inherent in imported ideas, these values are made more clear to U.S. nurses who tend to take them for granted. Yet U.S. nurses care for patients with diverse cultural backgrounds, and need awareness that "better care" for some cultures differs from "better care" for others. Moreover, deeper exploration of underlying values and background meanings inherent in some U.S. current health care issues, (e.g. rule-based ethical decision making), could illuminate practices surrounding these and could humanize policy.

Notions of Japanese care were among the strongest themes to emerge in this study. Differences between U.S. notions of good care based on autonomy and individualism and Japanese ideal care were clarified in excerpt after excerpt, yet the striking similarity in "knowing the patient" and the engaged stance as aspects of

expert practice in both cultures stimulates questions about what other tacit aspects of expert practice might both cultures share. Observations of Japanese nursing practice and stories of expert practice elicited in the Japanese language might provide data to uncover these more tacit practices.

Limitations

When weighing the value of the results of this study several limitations need to be considered. First, most of the participants are colleagues to one another. They see each other at meetings and conferences. Some work together. Many of them are good friends and provide a supportive network both in the U.S. and home in Japan. Some of the narratives were quite possibly stories that had been discussed among the participant network previously. Although this does not negate the commonality of themes that arose, because of tacit agreement among the participant network, some stories that could have emerged perhaps did not. This is not brought forth to suggest that participants purposefully held back stories, but instead because of the relationships between the participants and because of their exchange of stories, perhaps individual accounts of certain experiences simply did not come to mind.

Another limitation has to do with the analysis. Most of the data collection took place in Japan, away from the interpretive group. Although some early interviews were transcribed and sent to the qualitative seminar group and a tape recording of the interpretive session was sent back to me in Japan, this was not the same as participating in group interpretive sessions. And, although I summarized

early transcripts and looked for themes to pursue, the coding protocol was not fully developed and most of the analysis did not take place until my return. At that time even though I wanted to pursue more in-depth data on some themes, I could not return to Japan for more interviews. At points of analytic confusion in the U.S., three Japanese doctoral students were contacted and the point was discussed. The central analysis took place after data collection and was guided by my committee chair and a committee member. Two other doctoral students, versed in hermeneutic methods, contributed enormously in analytic sessions.

A third limitation consists of participants possibly not being fully disclosing because of uncertainty about confidentiality. Participants may have held back stories that were personally or professionally sensitive. A second concern includes judgements that I made about which excerpts to include. When I was anxious that identity of a particular participant's excerpt might be personally or professionally harmful to the participant, I chose not to include that specific story, even though at times it might have been illustrative of transformative themes. There is a third issue related to confidentiality. Although the point of hermeneutic data is to present concrete, in-depth, rich specific stories, in a few situations, when I was concerned about the damaging effects of connecting a participant to a particular excerpt, I "flattened" data purposefully to mask the speaker.

Other limitations have to do with the issues of language and culture. These issues have been discussed previously in the methodology section and also in findings.

However, language and culture issues limited the study in several additional ways. When one is using a second language, as were all participants in this study, it is often difficult to express precise details unless one has an excellent grasp of the language. However, hermeneutic studies depend on these details. Furthermore, an important theme to emerge in the study results concerns the Japanese propensity to avoid concrete discussion in Japanese. Participants repeated in many excerpts the Japanese preference for vague abstraction over concrete description. If indeed Whorf's (1956) notion of language constituting and being constituted by culture is correct, it may be that explicit dialogue is culturally unseemly for Japanese. Certainly the culture proscribes excessive self disclosure. Yet, some participants did disclose very personal aspects of their lives. Those that did so said that to talk about such things in English was a relief and that they never discussed such things in Japanese. Most participants did not talk about the more personal aspects of their lives. For example, only one participant alluded to the effect of the U.S. educational experience on his family life.

Another aspect of language and self disclosure limitations concerns my response to participants' discomfort. When they had a difficult time expressing details in English, I would usually rephrase my question or their statement once or twice. If the meaning remained unclear or vague, I was often hesitant to push for more clarity because of what I perceived as participants' discomfort or embarrassment. Likewise, I was hesitant to intrude with specific questions into participants' personal lives and the effect of the U.S. educational experience on their

more intimate relationships.

A final limitation to the study that relates to language concerns my inability to use Japanese nursing literature to augment my understanding of their practices and lives. There are few translated Japanese nursing studies (Long, 1986) yet the Japanese nursing literature is vast.

Participants' restricted responses may be another limitation. I asked participants about problems that occurred while they were in schools of nursing in the U.S. I also asked them about aspects of U.S. nursing practice which were different from Japanese practices. Participants may have restricted their responses. I believe that the Japanese nurses were at times hesitant to talk about what they saw as shocking in U.S. nursing or U.S. health care because they did not want to offend me as a U.S. nurse. Likewise, they may have hesitated to discuss some aspects of U.S. graduate school/U.S. life with me.

A further limit concerns my inexperience as an interpretative scholar and researcher. Although I was a member of an interpretive team for two studies, Benner and Tanner, (1992) and Wros, (1992) this is the first hermeneutic study for which I was the principal investigator. In hermeneutic studies, the interpretive scholar becomes an "instrument" for data collection and analysis. During most of the research process, my mentor and committee chair, an experienced interpretive scholar was available for guidance. However, during the time of data collection in Japan I needed to practice interpretive science without her close supervision.

My inexperience in teaching also needs to be considered a limitation to this study. Although I have had extensive clinical experience working with clients from other cultures, my teaching experience is limited and my teaching experiences in cross-cultural situations is further confined.

The final limitation to the study concerns my relationships with the participants. I was often in a position of "presuming upon their sweetness" and was taken care of by participants more often than I can count. Their continued support and understanding of my position as a stranger, a scholar in a "foreign" land, may have changed their stories in some ways.

Conclusion

Culture is both constitutive and constituting of nursing professional life and practice. There are aspects of nursing that constitute a shared culture between Japanese and U.S. American nursing. And aspects of situated nursing practice that are profoundly affected by background meanings and cultural values. And, while the Japanese nurses studying for graduate degrees in U.S. schools of nursing reflected on practice similarities, they were also in the unique position of being able to uncover some of the taken-for-granted background meanings embedded in U.S. nursing practices. Furthermore, in the experience of their international education, they were able to reflect on the background meanings contained in their own practices in new and different ways.

Heideggerian phenomenology defines "concern" as a way of being involved in

one's world (Benner & Wrubel, 1989). Concern is related to commitment and caring, and is shaped by background meanings (Benner & Wrubel, 1989). Values are inexorably tied to background meanings which are likewise embedded in the culture (Leonard, 1989). The concerns which drove this study include a commitment to cross-cultural understanding in nursing education and in nursing practice. The values behind the concerns give voice to the belief that it is through understanding that one learns to behave towards the other with tact, thoughtfulness, and resourcefulness (van Manen, 1990), manifesting a caring practice in clinical and academic situations.

References

Abe, M. A. (1985). Japan's clinic physicians and their behavior. Social Science and Medicine, 20(4), 335-340.

Abu-Saad, H., & Kayser-Jones, J. (1981). Foreign nursing students in the USA: Problems in their educational experiences. Journal of Advanced Nursing, 6, 397-403.

Abu-Saad, H., & Kayser-Jones, J. (1982). Applicability of nursing school programs in meeting foreign students' needs and expectations. Journal of Nursing Education, 21(7), 4-10.

Abu-Saad, H., Kayser-Jones, J., & Tien, J. (1982). Asian nursing students in the United States. Journal of Nursing Education, 21(7), 11-15.

Adler, P. S. (1987). Culture shock and the cross-cultural learning experience. In L. F. Luce & E. C. Smith (Eds.), Toward internationalism (pp. 24-35). Cambridge, MA: Newbury House.

Alexander, M. A., & Shaw, E. (1991). International students at a college of nursing: Concerns and coping. College Health, 39(3), 245-247.

Anders, R. L., & Kanai-Pak, M. (1992). *Karoshi*: Death: A nursing problem in Japan. Nursing & Health Care, 13(4), 186-191.

Barnlund, D. C. (1975). The public and private self in Japan and the U.S. Tokyo: Simul Press.

Barnlund, D. C. (1987). Verbal self-disclosure: Topics, targets, depth. In L. F. Luce & E. C. Smith (Eds.), Toward internationalism (pp. 147-165). Cambridge, MA: Newbury House.

Barnlund, D. C. (1989). Communicative styles of Japanese and Americans: Images and realities. Belmont, CA: Wadsworth.

Belenky, M. F., Clinchy, B. M., Goldberger, N. R. & Tarule, J. M. (1986). Women's ways of knowing. New York: Basic Books.

Bellah, R. N., Madsen, R., Sullivan, W. M., Swidler, A., & Tipton, S. M. (1985). Habits of the heart: Individualism and commitment in American life. New York: Harper & Row.

Benedict, R. (1946). The chrysanthemum and the sword: Patterns of Japanese culture. NY: New American Library.

Benner, P. (1983). Uncovering the knowledge embedded in clinical practice. Image: The Journal of Nursing Scholarship, 15(2), 36-41.

Benner, P. (1984). From novice to expert: Excellence and power in clinical nursing practice. Menlo Park, CA: Addison-Wesley.

Benner, P. (1985). Quality of life: A phenomenological perspective on explanation, prediction, and understanding in nursing science. Advances in Nursing Science, 8(1), 1-14.

Benner, P., & Tanner, C. A. (1987). Clinical judgment: How expert nurses use intuition. American Journal of Nursing, 87, 23-31.

Benner, P., & Wrubel, J. (1989). The primacy of caring: Stress and coping in health and illness. Menlo Park, CA: Addison-Wesley.

Bernstein, R. J. (1983). Beyond objectivism and relativism: Science, hermeneutics, and praxis. Philadelphia: The University of Pennsylvania Press.

Berry, J. W. (1980). Social and cultural change. In H. C. Triandis & R. W. Brislin (Eds.), Handbook of cross-cultural psychology, social psychology: Vol. 5 (pp. 211-280). Boston: Allyn and Bacon.

Berry, J. W. (1990). Psychology of acculturation: Understanding individuals moving between cultures. In R. W. Brislin (Ed.), Applied cross-cultural psychology (pp. 232-253). Newbury Park, CA: Sage Publications.

Berry, J. W., Poortinga, Y. H., Segall, M. H., & Dasen, P. R. (1992). Cross-Cultural Psychology: Research and Applications. New York: Cambridge University Press.

Bishop, A. H., & Scudder, J. R., Jr. (1991). Nursing: The practice of caring. New York: National League for Nursing.

Brahams, D. (1989). Right to know in Japan. Lancet, 2, 173.

Brink, P. A., & Saunders, J. M. (1976). Culture shock: theoretic and applied. In P. A. Brink (Ed.), Transcultural nursing. Edgewood Cliffs, NJ: Prentiss-Hall.

Cathcart, D., & Cathcart, R. (1972). Japanese social experience and concept of groups. In L. A. Samovar & R. E. Porter (Eds.), Intercultural communication: A reader (pp. 186-192). Belmont, CA: Wadsworth.

Cherry, K. (1987). Womansword: What Japanese words say about women. Tokyo: Kodansha.

Chesla, C. (1988). Parent's caring practices and coping with schizophrenic offspring, an interpretive study. Dissertation Abstracts International, 49, 2563B.

Crichton, M. (1992). The rising sun. New York: Knopf.

de Tocqueville, A. (1945a). Democracy in America: Vol. I. (H. Reeve, Trans.). New York: Random House. (Original work published 1835).

de Tocqueville, A. (1945b). Democracy in America: Vol. II. (H. Reeve, Trans.). New York: Random House. (Original work published 1835).

Diekelmann, N. (1991). The emancipatory power of the narrative. In Curriculum revolution: Community building and activism (pp. 41-62). New York: The National League for Nursing Press.

Doi, T. (1973). The anatomy of dependence. (J. Bester, Trans.). New York: Kodansha International. (Original work published 1971).

Doi, T. (1986). The anatomy of self. (M. Harbison, Trans.). New York: Kodansha International. (Original work published 1985).

Dreyfus, H. L., & Dreyfus, S. E. (in press). Practice in a theoretical discipline: The uniqueness of nursing. In P. Benner, C. Tanner, & C. Chesla (Eds.), Expertise in nursing practice. New York: Springer.

Dubos, R. (1968). Man, medicine, and environment. Middlesex, England: Penguin Books.

Field, P. A., & Morse, J. M. (1985). Nursing research: The application of qualitative approaches. Rockville, MD: Aspen.

Furnham, A., & Bochner, S. (1986). Culture shock: Psychological reactions to unfamiliar environments. New York: Methuen & Co.

Furnham, A., & Trezise, L. (1983). The mental health of foreign students. Social Science Medicine, 17(6), 365-370.

Furuta, B. S., & Lipson, J. G. (1990). Where is cultural diversity in the student body? In J. C. McCloskey & H. K. Grace (Eds.), Current issues in nursing (pp. 524-533). St. Louis: The C. V. Mosby Company.

Gadamer, H. G. (1975). Truth and method (J. Weinsheimer & D. G. Marshall, Trans.). New York: Crossroads. (Original work published 1960).

Gadamer, H. G. (1976). Philosophical hermeneutics (D. E. Linge, Trans.). Berkeley: The University of California Press. (Originally published 1967).

Gadow, S. (1989). Advocacy with silent patients. Nursing Clinics of North America, 24(2), 535-541.

Gay, J. T., Edgil, A. E., & Stullenbarger, E. N. (1993). Graduate education for nursing students who have English as a second language. Journal of Professional Nursing, 9(2), 104-109.

Geertz, C. (1973). The interpretation of cultures. New York: Basic Books.

Geertz, C. (1983). Local knowledge. New York: Basic Books.

Gilligan, C. (1982). In a different voice. Cambridge, MA: Harvard University Press.

Gordon, D. R. (1988). Tenacious assumptions in Western medicine. In M. Lock and D. R. Gordon (Eds.), Biomedicine examined (pp. 19-55). The Netherlands: Kluwer Academic Publishers.

Goto, K. (1988). Health care in Japan. Minnesota Medicine, 72(6), 339-342.

Gould, J. (1989). Herodotus. New York: St. Martin's Press.

Grace, H. K. (1990). Cultural diversity: The international student. In J. C. McCloskey & H. K. Grace (Eds.), Current issues in nursing (pp. 559-562). St. Louis: The C. V. Mosby Company.

Guba, E. G., & Lincoln, Y. S. (1981). Effective evaluation. San Francisco, CA: Jossey-Bass Publishers.

Gudykunst, W. B., & Ting-Toomey, S. (1988). Culture and interpersonal communication. Newbury Park, CA: Sage Publications.

Haglund, E. (1972). Japan: Cultural considerations. In L. A. Samovar & R. E. Porter (Eds.), Intercultural communication: A reader (pp. 84-93). Belmont, CA: Wadsworth.

Hall, E. T. (1976). Beyond culture. Garden City, NY: Anchor Press.

Hall, E. T. (1983). The dance of life. Garden City, NY: Anchor Press.

Hattori, H., Salzberg, S. M., Kiang, W. P., Fujimiya, T., Tejima, Y., & Furuno, J. (1991). The patient's right to information in Japan--legal rules and doctors' opinions. Social Science and Medicine, 32, 1007-1016.

Haylor, M. (1992). Caring practices in families with autistic children: A hermeneutic study. Unpublished doctoral dissertation, Oregon Health Sciences University, Portland, OR.

Heidegger, M. (1962). Being and time (J. Macquarrie & E. Robinson, Trans.). San Francisco: Harper. (Original work published 1927).

Hinohara, S. (1990). Approaches to health care of the elderly people in Japan. Bulletin of St. Luke's College of Nursing, 16, 1-17.

Hisashige, A., Koda, S., Kurumatani, N., & Nakagiri, S. (1989). Occupational influences on burnout phenomenon among hospital nurses. Journal of Human Ergology, 11(suppl.), 454-466.

Hofstede, G. (1984). Culture's consequences: International differences in work related values. Beverly Hills: Sage.

Iglehart, J. K. (1988a). Health policy report: Japan's Medical care system. The New England Journal of Medicine, 319(12), 807-812.

Iglehart, J. K. (1988b). Health policy report: Japan's medical care system--part two. The New England Journal of Medicine, 319(17), 1166-1172.

Inoue, I. (1983). Attendance care at hospitals in Japan. International Nursing Review, 30(6), 172-174.

Kai, I., Ohi, G., Yano, E., Kobayashi, Y., Miyama, T., Niino, N., & Naka, K. (1993). Communication between patients physicians about terminal care: A survey in Japan. Social Science Medicine, 36(9), 1151-1159.

Kalisch, P. A., & Kalisch, B. J. (1987). The changing image of the nurse. Menlo Park, CA: Addison-Wesley.

Kaplan, G., Haan, M., Syme, L., Minkler, M. & Winkleby, M. (1987). Socioeconomic status and health. In R. Amler & H. Duhl (Eds.), Closing the gap: The burden of unnecessary illness (pp. 125-129). New York: Oxford University Press.

Kawamura, N., Gotoda, Y., & Yoshikura, H. (1985). The rise in medical care expenditures in Japan, trends in disease patterns: 1977-1981. American Journal of Public Health, 75(12), 1442-1444.

Kayser-Jones, J. S., Abu-Saad, H. (1982). Loneliness: Its relationship to the educational experience of international nursing students in the United States. Western Journal of Nursing Research, 4(3), 301-315.

Kidd, P. & Morrison, E. F. (1988). The progression of knowledge in nursing: A search for meaning. Image, 20(4), 222-224.

Kidder, L. H. (1992). Requirements for being "Japanese": Stories of returnees. International Journal of Intercultural Relations, 16, 383-393.

Kiefer, C. W. (1987). Care of the aged in Japan. In E. Norbeck & M. Lock (Eds.), Health, illness, and medical care in Japan (pp. 89-109). Honolulu: University of Hawaii Press.

Kirmayer, L. J. (1988). Mind and body as metaphors: Hidden values in biomedicine. In M. Lock & D. Gordon (Eds.), Biomedicine examined (pp. 57-94). The Netherlands: Kluwer Academic Publishers.

Kleinman, A. (1988). The illness narratives: Suffering, healing, and the human condition. New York: Basic Books.

Kleinman, A., Eisenberg, L., & Good, B. (1978). Culture, illness and care: Clinical lessons from anthropologic and cross-cultural research. Annals of Internal Medicine, 88, 251-258.

Kojima, M. (1987). Nursing education in Japan and its future trends. International Nursing Review, 34(4), 94-101.

Komrad, M. S. (1983). A defence of medical paternalism: Maximizing patients' autonomy. Journal of Medical Ethics, 9, 38-44.

Kondora, L. L. (1993). A Heideggerian hermeneutical analysis of survivors of incest. Image, 25(1), 11-16.

Kono, K. (1989). Occupational health nursing: Present situation and how to develop in the future. Journal of Human Ergology, 11(suppl.), 197-209.

Larossa, R., Bennett, L. A., & Gelles, R. J. (1981). Ethical dilemmas in qualitative family research. Journal of Marriage and the Family, 43, 303-313.

Lear, M. W. (1993, January 24). Doctors entangled by the truth. The Oregonian, pp. R1, R4.

Lebra, T. S. (1976). Japanese patterns of behavior. Honolulu: University of Hawaii Press.

Leininger, M. M. (1991). Culture, care, diversity and universality: A theory of nursing. New York: NLN.

Leonard, V. W. (1989). A Heideggerian phenomenologic perspective on the concept of the person. Advances in Nursing Science, 11(4), 40-55.

Lincoln, Y. S. & Guba, E. G. (1985). Naturalistic inquiry. Beverly Hills: Sage.

Lock, M. (1984). Licorice in leviathan: The medicalization of care for the Japanese elderly. Culture, Medicine and Psychiatry, 8(2), 121-139.

Lock M. (1985). The impact of the Chinese medical model on Japan or, how the younger brother comes of age. Social Science and Medicine, 21(8), 945-950.

Lock M. (1986). Plea for acceptance: School refusal syndrome in Japan. Social Science Medicine, 23(2), 99-102.

Lock, M., & Gordon, D. (Eds.) (1988). Biomedicine examined. The Netherlands: Kluwer Academic Publisher.

Long, S. O. (1984). The sociocultural context of nursing in Japan. Culture, Medicine, and Psychiatry, 8, 141-163.

Long, S. O. (1986). Roles, careers and femininity in biomedicine: women physicians and nurses in Japan. Social Science and Medicine, 22(1), 81-90.

Long, S. O. (1987). Health care providers: Technology, policy, and professional dominance. In E. Norbeck & M. Lock (Eds.), Health, illness and medical care in Japan (pp.66-87). Honolulu: University of Hawaii Press.

Loustau, A. (1986). Diversity and challenge in our student body. Journal of Nursing Education, 25(3), 93.

Marmot, M. G., & Smith, G. D. (1989). Why are the Japanese living longer? British Medical Journal, 299, 1547-1551.

McCloskey, J. C., & Grace, H. K. (Eds.). (1990). Current issues in nursing (3rd ed.). St. Louis: Mosby.

McDonald-Scott, P., Machizawa, S., & Satoh, H. (1992). Diagnostic disclosure: A tale of two cultures. Psychological Medicine, 22, 147-157.

Meleis, A. I. (1985). Theoretical nursing: Development and progress. New York: Lippincott.

Meleis, A. F. (1987). Editorial: International nursing research for knowledge development. Western Journal of Nursing Research, 9(3), 285-287.

Merleau-Ponty, M. (1968). The visible and the invisible. (Lingis, Trans.). Evanston, Il: Northwestern University Press. (Original work published 1964).

Miller, D. F., & Harwell, D. (1983). International students at an American university: Health problems and status. Journal of School Health, 53(1), 45-49.

Minami, H. (1985). East meets west: Some ethical considerations. International Journal of Nursing Studies, 4(22), 311-318.

Minami, H. (1982). The construction and validation of a measure of *amae* network. Dissertation Abstracts International, 43, 3923B.

Mooneyhan, E. L., McElmurray, B. J., Sofranko, M. S., & Campos, A. B. (1986). International dimensions of nursing and health care in baccalaureate and higher degree nursing programs in the United States. Journal of Professional Nursing, 2, 82-90.

Morse, J. M., Solberg, S. M., Neander, W. L., Bottorff, J. L., & Johnson, J. L. (1990). Concepts of caring and caring as a concept. Advances in Nursing Science, 13(1), 1-14.

Munhall, P. L. (1988). Ethical considerations in qualitative research. Western Journal of Nursing Research, 10(2), 150-162.

Murray, S. O. (1991). Ethnic differences in interpretive conventions and the reproduction of inequality in everyday life. Symbolic Interaction, 14(2), 187-204.

Najmaie, H. M., & Modjeski, J. (1990). Application of world class service to world class nursing. Journal of Continuing Education in Nursing, 21(2), 53-55.

Navarro, V. (1986). A critique of the ideological and political positions of the Willy Brandt report and the WHO Alma Ata Declaration. In Crisis, health and medicine: A social critique (pp. 212-232). New York and London: Tavistock.

Norbeck, E., & Lock, M. (Eds.). (1987). Health, illness, and medical care in Japan. Honolulu: University of Hawaii Press.

Novack, D. H., Plummer, R., Smith, R. L., Ochitill, H., Morrow, G. R., & Bennett, J. M. (1979). Changes in physician's attitudes toward telling the cancer patient. Journal of the American Medical Association, 241, 897-900.

Nursing in Japan. (1993). Tokyo: Japanese Nursing Association.

Oberg, K. (1979). Culture shock and the problem of adjustment in new cultural environments. In L. F. Luce & E. C. Smith (Eds.), Toward internationalism (pp. 43-45). Cambridge, MA: Newbury House.

Ohno, Y. (1985). Health development in Japan: Determinants, implications and perspectives. World Health Statistics Quarterly, 38, 176-192.

Ohnuki-Tierney, E. (1984). Illness and culture in contemporary Japan: An anthropological view. Cambridge: Cambridge University Press.

Oken, D. (1961). What to tell cancer patients: A study of medical attitudes. Journal of the American Medical Association, 175(13), 1120-1128.

Paige, R. M. (1990). International students: Cross-cultural psychological perspectives. In R. W. Brislin (Ed.), Applied cross-cultural psychology (pp. 161-185). Newbury Park, CA: Sage Publications.

Pepin, J. I. (1992). Family caring and caring in nursing. Image, 24(2), 127-131.

Reischauer, E. O. (1977). The Japanese. Tokyo: Tuttle Co.

Sandelowski, M. (1986). The problem of rigor in qualitative research. Advances in Nursing Science, 8(3), 27-37.

Schaef, A. W. (1981). Womens' reality. San Francisco: Harper and Row.

Schlenker, B. R. (1986). Self-identification: Toward an integration of the private and public self. In R. Baumeister (Ed.), Public self and private self. New York: Springer-Verlag.

Schon, D. A. (1983). The reflective practitioner: How professionals think in action. New York: Basic Books.

Seidel, J. (1988). The ethnograph (v. 3.0). [Computer program].

Shearer, R. A. (1989). Teaching foreign students. Journal of Nursing Education, 28(9), 427-428.

Snyder, M. (1985). Independent Nursing Interventions. Albany, NY: Delmar.

Statistics Bureau. (1990). Statistical Handbook of Japan, 1990. Tokyo: Japan Statistical Association.

Stein, L. I. (1967). The doctor-nurse game. Archives of General Psychiatry, 16, 699-703.

Stein, L. I., Watts, D. T., Howell, T. (1990). The doctor-nurse game revisited. The New England Journal of Medicine, 322(8), 546-549.

Steslicke, W. E. (1987). The Japanese state of health: A political-economic perspective. In E. Norbeck & M. Lock (Eds.), Health, illness, and medical care in Japan (pp. 24-65). Honolulu: University of Hawaii Press.

Stewart, E. (1987). American assumptions and values: Orientation to action. In E. C. Smith & L. F. Luce (Eds.), Toward internationalism (vol. 2) (pp. 51-72). Rowley, MA: Newbury House.

Stewart, L. (1988). Japanese and American management: Participative decision making. In L. A. Samovar & R. E. Porter (Eds.), Intercultural communication: A reader. Belmont, CA: Wadsworth.

Suzuki, S., Kirschling, J. M., & Inoue, I. (1993). Hospice care in Japan. The American Journal of Hospice & Palliative Care, 10(4), 35-40.

Swinbanks, D. (1989). Japanese doctor keep quiet. Nature, 339(8), 409.

Tanner, C., Benner, P., Chesla, C., & Gordon, D. (1993). The phenomenology of knowing the patient. Image: Journal of Nursing Scholarship, 25(4), 273-280.

Tanner, C., Kodadek, S., Haylor, M., & Wros, P. (in press). The nurse physician relationship: Negotiating clinical knowledge. In P. Benner, C. Tanner, & C. Chesla, (Eds.), Expertise in nursing practice. New York: Springer.

Taylor, C. (1977). Interpretation and the sciences of man. In F. R. Dallmayr & T. A. McCarthy (Eds.), Understanding and social inquiry (pp. 101-133). Notre Dame: University of Notre Dame.

Taylor, C. (1985a). Human agency and language: Philosophical papers I. Cambridge: Cambridge University Press.

Taylor, C. (1985b). Philosophy and the human sciences: Philosophical papers II. Cambridge: Cambridge University Press.

Thompson, J. L. (1985). Practical discourse in nursing: Going beyond empiricism and historicism. Advances in Nursing Science, 7(4), 59-71.

Tien, J. (1982). Surviving graduate nursing programs in the United States: A personal account of an Asian-American student. Journal of Nursing Education, 21, 42-44.

Uhl, J. E. (1993). International exchange--students and faculty. Journal of Professional Nursing, 9(1), 5.

Upvall, M. J. (1990). A model of uprooting for international students. Western Journal of nursing Research, 12(1), 95-107.

Van Manen, M. (1990). Researching lived experience: Human science for an action sensitive pedagogy. Ontario: Althouse Press.

Watson, J. (1988). Nursing: Human science and human care, a theory of nursing. New York: NLN.

Wenger, A. F. (1991). The role of context in culture-specific care. In P. Chinn, (Ed.), Anthology on Caring, New York: NLN, pp. 95-110.

Westermeyer, J., Neider, J., & Vang, T. F. (1984). Acculturation and mental health: A study of Hmong refugees at 1.5 and 3.5 years postmigration. Social Science and Medicine, 18(1), 87-93.

White, M. (1988). The Japanese overseas: Can they go home again? New York: The Free Press.

Whorf, B. (1956). Language, mind, and reality. In J. B. Carroll (Ed.), Language, thought and reality: Selected writings of Benjamin Lee Whorf (pp. 246-254). Cambridge, MA: The MIT Press.

Woodard, L. J., & Pamies, R. J. (1992). The disclosure of the diagnosis of cancer. Primary Care, 19(4), 657-663.

Wros, P. (1992). Behind the curtain: Nursing care of dying patients in critical care. Unpublished doctoral dissertation, Oregon Health Sciences University, Portland, OR.

APPENDIX A

The Context of Health Care in Japan

The Health Care Context of Japan

The health care context of Japan is presented here to familiarize the reader with aspects of the Japanese population's health status, Japan's health policies, and the process of reimbursement and the physician's role in this. In order to understand the situated practice of Japanese nurses, understanding these important facets of the Japanese health care context will be helpful.

Health Status

Changes in Japan's health status indicators have been dramatic in the years since the Second World War. For example, in 1947 the estimated life expectancy at birth for male and female Japanese infants were 50 years and 53.9 years respectively (Iglehart, 1988a). Now Japanese people enjoy the longest life expectancy in the world (Marmot & Smith, 1989). Other outcome indicators of health such as the infant mortality rate in Japan have also improved radically since after the Second World War. Japan's infant mortality rate is now the lowest in the world.

Infectious diseases, principally tuberculosis, were the major cause of death in Japan before and shortly after the Second World War World (Ohno, 1985). As early as 1919 Japan had a Tuberculosis Prevention Law and in 1936 a National Campaign for Tuberculosis Prevention was begun. The Campaign included compulsory inoculation, case finding and registry, and widespread use of anti-tuberculosis drugs.

Ohno (1985) maintains that changes in mortality are generally related, directly or indirectly, to changes in sociocultural, economic and biomedical developments.

More precisely Ohno (1985) argues "the rapid and substantial decline of mortality from all causes in Japan, particularly after the Second World War, has undoubtedly resulted from several factors including the expansion of medical services throughout the country, the introduction of new drugs, the development of new medical techniques, the application of antibiotics, and progress with immunization programs" (p. 178).

Other influences on mortality include compulsory education for nearly 100 percent Japan's children and the gradual attainment of higher educational levels (Ohno, 1985). In 1980 senior high enrollment had risen in Japan to 94.2 percent. Higher levels of education have affected health outcomes by enhancing understanding of lifestyle influences on health, a component of the school curriculum (e.g information on sanitation and nutrition), by reinforcing immunization programs, and by directly improving nutritional status for some Japanese children through the school lunch and milk programs (Ohno, 1985).

Kaplan, Haan, Syme, Minkler, and Winkleby (1987) in their paper, "Socioeconomic Status and Health," assert that across populations, regardless of whether the major causes of death and disability are from infectious or noninfectious disease and regardless of how socioeconomic position is measured, lower socioeconomic levels correspond with higher rates of morbidity and mortality. Likewise, Kawamura et al. (1985) declare that improvements in Japan's health status markers are inexorably tied to Japan's rapid economic growth.

Japan's Health Policies

In 1947, the Japanese Constitution was adopted. It guaranteed all citizens "the right to maintain minimum standards of wholesome and cultured living" and specifically declared the state responsible to "use its endeavors for the promotion and extension of social welfare and security, and of public health" (Iglehart, 1988a, p. 810). By 1961 despite the Japanese Medical Association's opposition to aspects of the program, the Japanese government made health insurance compulsory and universal (Long, 1987). This commitment to universal access to health care has been financed by two broad insurance categories, employee health insurance--which insures 75 million employees of private corporations and governmental agencies and their dependents--and community or national health insurance, which insures another 45 million people, either unemployed adults (including the elderly), employees of small businesses, the self-employed, or farmers (Iglehart, 1988a). All employers must either sponsor and partially finance an insurance plan or contribute to a publicly administered plan. The Japanese government pays administrative costs for all plans, none of which are for profit (Iglehart, 1988a). All insurance plans do not have equity of cost sharing or benefit coverage. Employee health insurance plans tend to be more comprehensive than community health plans which generally cover the populations with the most illness and health care expenditures (Iglehart, 1988a). Nevertheless, the universality of insurance does protect Japanese individuals from financial devastation caused by a serious illness (Iglehart, 1988a).

Before 1973, elderly Japanese, many of whom were covered on community health plans, often paid 30 percent of their medical bills, out-of-pocket. But 1973 saw the enactment of an amendment to the 1963 Law for Welfare of the Aged (Kiefer, 1987). The 1973 amendment boosted hospital benefits for the aged and made most out-patient services free to those over 70 (Kiefer, 1987). Public costs to support the added coverage skyrocketed and community health insurance plans were hard pressed to remain solvent, some needing to be "bailed out" by national governmental funds. In 1982 Japan enacted the Health and Medical Services for the Aged law which spread the cost of health care responsibility for persons over 70 and bedridden persons over 65, between the national government, local authorities and insurers of various solvent health insurance systems (Hinohara, 1990; Kiefer, 1987). Furthermore the law imposed small cost-sharing requirements on the elderly (300 *yen* or about $3 per hospital day) and reduced hospitals' cost incentives for long term hospitalization of elderly persons by reimbursing on a diminishing scale--the longer the stay, the lower the reimbursement rate (Iglehart, 1988a; Kiefer, 1987).

Japan has been able to finance improvements in health care delivery with relatively little public or political outcry in part because of the concomitant rapid growth of its economy (Iglehart, 1988a). However, costs of providing health care for an increasingly aged population are rising exponentially. Kawamura et al. (1985) invoke a prediction cited by the Population Institute of Nihon University: unless changes in system of medical expenditures occurs, the medical insurance system as it

now exists will collapse by 2025.

Physicians and Reimbursement in Japan

Japan had a total of 9608 hospitals in 1985 and 283,390 clinics (Iglehart, 1988b). A facility with 20 beds or more is considered a hospital. Yet a clinic may also have beds for patients--as long as it contains less than 20. Eighty percent of Japan's hospitals in 1985 were "for-profit," privately owned, most of them by physician directors (Iglehart, 1988b). Public hospitals in Japan tend to be larger facilities than private, tend to have affiliations with Japan's medical schools, and tend to perform more acute/critical care interventions than the private hospitals and clinics (Iglehart, 1988b).

In 1988, Japan's physician ratio reached 1 physician per 609 people (Statistics Bureau, 1990). And, Japan graduates some 8000 new physicians per year (Iglehart, 1988b). Salaried physicians generally teach/practice in public/university hospitals whereas, private physicians usually own their own clinics/hospitals and are small business entrepreneurs.

The Japanese Medical Association (JMA) has historically been a strong advocate for the private clinic-based or private hospital physician, perhaps because historically private physicians were the powerful majority (Iglehart, 1988b). However now only about 36 percent of Japan's physicians own and operate clinics and private hospitals, while about 56 percent are public hospital based (Iglehart, 1988b). With this change has come a decrease in the influence of the JMA.

There is intense competition for patients among clinics and hospitals under Japan's free enterprise style medicine, where the entire population is covered by health insurance, and physicians (or the facilities they own) are reimbursed on a fee-for-service basis (Abe, 1985). In addition there is at times, an economic disincentive for clinic physicians to hospitalize a patient because hospitals have their own physicians; admitting privileges are "non-transferable," so the physician must relinquish the patient and reimbursement (Iglehart, 1988b). Physicians usually receive from patients or patient's families, un-taxed income in the form of a virtually required expression of gratitude (Iglehart, 1988b). These tax-free gifts are not estimated either in physicians wages or in health care expenditures.

In Japan, physicians' fees and hospital costs are not separated for reimbursement purposes (Iglehart, 1988b). Reimbursement is made to the hospital or clinic by the insurance carrier on a fee-for-service basis and charges are set by a nationally standardized point system (Abe, 1985; Iglehart, 1988b). The point-fee system, as it is called is based upon the idea that each medical service is assigned a certain number of points, each point being worth 10 *yen* (Abe, 1985; Iglehart, 1988b). Points are assigned based upon the degree of technical skill required to perform the minutely defined service or consultation and the cost of materials, such as drugs or laboratory tests (Iglehart, 1988b). Therefore, under the point-fee system, physicians are not rewarded for increased skill level in an area, and, for reimbursement purposes, the prestige of a facility is not considered. Individual

physicians have little control over point-fee prices which are set by a national ministry. On the other hand, physicians do have control over the numbers of patients they see, and the frequency with which they see them, both which tend to be high compared to the United States. For example, using statistics from a 1973 survey, Japanese physicians averaged 65 patients per day--an estimated one to three minutes per patient, while physicians in the United States averaged 17 patients per day (Lock, 1986). Additionally, Japanese physicians have discretion over the drugs and laboratory tests they might use in treatment (Abe, 1985).

Lock (1986) contends that physicians, because of the point-fee system, must spend a "relatively large portion of their work day dealing with paper work unrelated to patient care" (p. 101). Secondly, she argues, there is considerable incentive to perform some physical intervention on every patient the physician sees because other than in the case of hospital-based psychiatrists or counsellors, history taking, guidance, supportive therapy, or preventative education, are not reimbursed (Lock, 1986). Thirdly, Japanese physicians not only prescribe drugs but also sell them (Lock, 1985). And since the revenues of physicians are proportional to the quantities of items covered under material point-fees, and because with medications, the point-fees usually cover more than what the physician paid, it is hypothesized that the system of point-fee-for-service has resulted in the excessive prescription of drugs for Japanese patients (Abe, 1985; Iglehart, 1988a; Lock, 1984).

Japan's population is aging more rapidly than that of any other country

(Hinohara, 1990). In a cross-cultural comparison across six developed countries, U.S.A., West Germany, France, Italy, Japan, and Sweden, Japan has the highest number of hospital beds to total population, twice as many as the United States, and most of Japan's hospital beds are full (Hinohara, 1990). According to Hinohara (1990), one third of the hospital beds in Japan are occupied by people over 70. This is, in part, because Japan has few nursing homes and hospital stays are relatively long. The average Japanese hospital stay is 39 days, excluding tuberculosis and psychiatric hospitals which have longer average lengths of stay (Hinohara, 1990). Yet, 40.6 percent of in-patients stay in the hospital for more than 6 months while 44.7 percent of those in-patients over 65 stay over 6 months (Hinohara, 1990).

A private hospital room in Japan in 1988 cost about $30 per day (Goto, 1988). Among the reasons listed by Goto (1988) for the lower cost of hospitalization in Japan compared to the U.S., is low malpractice premiums. According to Goto (1988), it is rare for hospitals or physicians to be sued by patients in Japan. He alludes to the "fatalism of the Oriental mind" (p. 341). And, he suggests that because the "Oriental culture traditionally has a respect for authority figures...it is unusual for a Japanese to blame his or her physician for a bad outcome" (p. 341).

Important points to note about Japan's health care context are: (a) the rapid improvement of health status indicators such as infant mortality rates or life expectancy since the Second World War; (b) Japan's rapidly aging society; (c) Japan's constitution declares the state responsible to promote and extend social welfare,

security, and public health; (d) universal health insurance; (e) 80 percent of Japan's hospitals are privately owned and for profit; (f) hospitals and physicians are reimbursed through a government set point-fee system that tends to encourage physicians to perform some physical intervention in the form of treatment or tests, while counselling, history taking, and preventative teaching are not reimbursed; (g) Japanese physicians tend to see more patients per day for a shorter time than doctors in the U.S.; (h) litigation against physicians or hospitals is unusual; (i) the reimbursement system may encourage Japanese physicians to over prescribe medications for their patients; (j) there is a severe shortage of nurses in Japan but no shortage of physicians. All of these aspects of Japanese health care have implications for the context of nursing in Japan.

APPENDIX B

Guidelines for Transformational Stories

Guidelines for Recording Transformational Stories
adapted from Deborah Gordon and Patricia Benner's
Guideline for Recording Critical Incidents
from the AMICAE Project, 1984

You have been asked to describe transformational stories from your international education experience. These stories will be used as data in a study, the purpose of which is to describe the lived international educational experience of Japanese nurses in order to develop more tactful, resourceful understanding within academic settings in the United States.

The descriptions will focus on the reflected accountings of the international education experiences, both positive and negative, which you judge were transformative. The attached forms can be used to record your stories. You have been asked to both describe verbally and also to provide a brief written report of one or two stories that you consider descriptive of transformative aspects of your international experience. The story may describe an experience you had during your international education, may be a story from your current professional life that reflects upon your international experience, and/or may be a story that describes aspects of reentry into Japanese professional life. First, however some clarification of what is meant by "transformational story" is in order. A transformational story may include any of the following types of incidents.

A. What Constitutes a Transformative Story?

A situation in graduate school or in learning to live in the U.S. that significantly changed you as a person, you as a nurse, or somehow significantly changed your practice or professional life.

A situation occurring during your international educational experience in which you were shocked by differences in nursing practices/professional life from those with which you were familiar.

A situation where nursing practices/professional life in the U.S. were similar to those in Japan.

A situation in graduate school or in learning to live in the U.S. that went unusually well.

A situation in graduate school or in learning to live in the U.S. where there was a breakdown, a misunderstanding.

A situation in graduate school or in learning to live in the U.S. that captures what the international education experience is all about.

A situation in graduate school or in learning to live in the U.S. that was particularly demanding.

A situation that occurred during your reentry into Japanese professional life that stands out for you.

A situation from your present practice or professional life that you consider reflective of your international educational experience.

B. What to Include in Your Transformational Story

The context of the incident (e.g., the setting, time of day, who was present).

A detailed description of what happened.

Why the story is important, why you recall it.

What your concerns were at the time.

What you were thinking about as it was taking place.

What you were feeling during and after the incident described in your story.

What, if anything, you found most demanding about the situation.

C. In the space below and on the back of this page, please describe in detail one or two transformational stories.

D. Personal Data

Name: (optional) Date:

Education history: Year graduated from nursing school:

Year entered graduate school(s):

Year finished graduate school(s):

Name of graduate school(s):

Current position title:

Institution:

Amount of time in the U.S.:

Amount of time in practice before going to U.S.:

Title(s) before going to U.S.:

Amount of time in each position:

Institution(s):

Practice specialty/research interests before going to U.S.:

Practice specialty/research interests now:

Amount of time since your return from U.S.:

APPENDIX C

Consent Form

Oregon Health Sciences University
Consent Form

TITLE AND PRINCIPAL INVESTIGATOR
Ms. Dawn Doutrich, RN, BS, MS, is doing a descriptive study titled, "The International Educational Experience of Japanese Nurses."

PURPOSE
The purpose of the research is to describe the lived international educational experience of Japanese nurses who have obtained or are in the process of obtaining masters or doctoral degrees from schools of higher education in the United States and who have returned or are returning to professional life in Japan. These descriptions are sought in order to develop more tactful, resourceful understanding within academic settings in the United States. The descriptions will focus on the reflected accountings of the international education experiences, both positive and negative, which you judge were transformative.

PROCEDURES
If you agree to participate in the study, you will be interviewed up to three times over a period of six months. Each interview will take about one hour of your time, with the first interview just a little longer for consent and orienting information. The interviews will consist of episodes or stories from your international education experience, stories about your reentry into Japanese professional life, and/or stories from your current professional life that may reflect upon your international experiences. You will be specifically asked to describe in detail any incident from your international education experience that you believe significantly changed you or your nursing practice, either clinical or academic. And, you may be asked to describe (an) incident(s) from your current practice/professional life that reflect(s) transformation(s) that may have occurred during the international education experience. These interviews will be audiotaped and after transcriptions have been made the tapes will be destroyed.

RISKS AND DISCOMFORTS
There are no physical risks associated with your participation in this study. However you may experience annoyance, embarrassment, or feelings of discomfort in recalling some of your experiences.

PARTICIPANT PROTECTION
Dr. Hiroko Minami, RN, DN.Sc., has agreed to act as the Japanese sponsor of this project. Ms. Yoko Nakayama, RN, M.A., and Ms. Iku Inoue, RN, M.S. have agreed to act as consultants. Dr. Minami and the two consultants may aid with certain parts of the analysis and thus may see some of the transcribed interviews. If you would prefer that your name not be associated with your interview, they will not be appraised of your name, but may be able to determine who you are from your story.

You may withdraw descriptions of particular stories and prevent them from being published. You may decline participation or withdraw from this study at any time without affecting your relationship with or treatment at the Oregon Health Sciences University.

CONFIDENTIALITY
You have a choice in whether or not you claim your stories. To indicate your choice you need to circle one of the two confidentiality options offered below.

Option 1
If you prefer to retain authorship of your transformational stories circle this option. Ms. Doutrich will acknowledge you and may print your name along with your narrative or story in her dissertation and/or professional publications. If you choose this option a research team composed of Japanese and U.S. consultants may perform segments of interpretive analysis on your transcript.

Option 2
If you prefer not to retain authorship circle this option. However. please understand that people may be able to determine who you are by the context of your story, even though your name and demographic information will be changed, and even though your responses will be strictly confidential. Neither your name nor your identity will be used for publication or publicity purposes. And, before publication you will be able to look at your interpreted stories and decide if you are satisfied with the confidentiality protection. If You are not satisfied you may withdraw a particular story or you may withdraw from the study.

Please be advised that members of Ms. Doutrich's dissertation committee may review transcripts. Dr. Christine Tanner. RN, Ph.D. of Oregon Health Sciences University, School of Nursing is the primary faculty advisor to this project.

BENEFITS
There is no direct benefit to you for participating in this study. In the future, other nurses may benefit from this study as nurse educators better understand the lived experience of international nursing scholars.

COSTS
There are no monetary costs to you as a participant.
Please circle the confidentiality option of your choice. Your signature below indicates you have read the foregoing and agree to participate in this study.

Date Signature Witness

APPENDIX D

Participants Who Chose to Be Named

Code List

A=Dr. Yoko Nakayama

B=Dr. Noriko Katada

C=Mr. Masashi Kawano

D=Ms. Junko Takano

E=Ms. Shizue Suzuki

F=Ms. Yuki Ashikaga

G=Ms. Emiko Endo

H=Dr. Iku Inoue

I=Mr. Shinobu Iwase

J=Dr. Yasuko Higuchi

APPENDIX E

Coding System for Ethnograph

CODE LIST

1) TYPE OF STORY
- SE-school episode
- COHOE-coming home episode
  - Americagaeri
- TE-teaching episode
  - teaching nursing--meaning in context
- PE-practice episode

2) CULTURAL ASSUMPTIONS (CULTAS)
- VALDIF
- DECISION MAKING (DM)
- ADVOC
- CULTJPN
  - LANGUAGE (LANG)
  - ENRYO
  - OMAKASE (OMAK)
  - CARE
  - AMAE
  - HIERARCHY (HIER)
  - OTHER
- CULTUSA
  - LOGIC
  - LANGUAGE (LANG)
  - INDEPENDENCE (INDEP)
  - ASSERT
  - RIGHTS
  - DISCLOSURE (DISCLO)

3) PRACKNOW (not trivialized by tips or hints) but for faculty and students

4) SELF
- VALUES
- CHANGE
- ISOLATION (ISOL)
- MS (mental status)
- SHOCK
- ESTEEM
- JUDGEMENT/DECISION MAKING/PROBLEM ID (JUDGE)

5) METAPHORS (double code) (META)

6) TRANSITION (TRANS)
- ACCULTURATION (ACCULT)
- REENTRY (REENT)
- CAREER DEMANDS (loss/gain) (CADE)

7) HEALTH CARE COMPARISONS (HCCOM)
- RNMD--relations
- DELIVERY DIFFERENCES (DELDIFF)
- PT--the meaning of patient in Japan/US
- PRACDIF

8) EDUCATION COMPARISONS
- TEACHER ROLE
  - ADVISOR
- STUDENT ROLE
- TEACHING/PRACTICE STRATEGIES (TEACH)