Providing Social Support to Family Caregivers
- An Essential Part of The Japanese Care Manager's Role

Satsuki Murofushi

Master's Thesis in Social Work

School of Social Work

Lund University

Autumn 2013

Supervisor: Per Gunnar Edebalk
Assessors: Katarina Jacobsson and
Max Koch

Abstract

Author: Satsuki Murofushi

Title: Providing Social Support to Family Caregivers. –An Essential Part of the Japanese Care Manager's Role

Supervisor: Per Gunnar Edebalk

Assessors: Katarina Jacobsson and Max Koch

The overall objective of this study was to investigate the social support provided by care managers to family caregivers of elderly adults receiving community based care under the Japanese Long-Term Care Insurance scheme. The study has explored such support from the perspective of the care manager, and in relation to the overall role of the care manager. As such, the following research questions have been employed: (i) what reasons do care managers have for providing social support to family caregivers, (ii) what kind of social support do care managers provide to family caregivers and how does it relate to the care managers' work assignments, and (iii) what is influencing the social support provided by care managers to family caregivers. The research questions were approached from the perspective of care managers through a qualitative approach, using semi-structured interviews as a research method. In total, interviews with nine care managers were held between December 2012 and March 2013, in the prefectures of Tokyo, Chiba, Kanagawa and Yokohama. The empirical material was analyzed within a framework of interactionist role theory. The analysis suggests that the activity of providing social support to family caregivers has become incorporated into the care manager role. Reasons for providing social support can be understood as a way for care managers to strive to create a situation, that allows family caregivers to continue providing informal care to their elderly family member within the community. The study identified seven different categories of social support. Three of these categories (supporting family caregivers with LTCI services; giving information and advice; creating a supportive environment) can be seen as social support that is provided partly through the care managers' formal work assignments. The remaining four categories (making referrals; being there; spending time talking; comfort and encouragement) can be said to fall outside of the care managers' formal work assignments. The social support provided by care managers are partly influenced by the developer behind the LTCI scheme (the Japanese government) and the companies the care managers work for, since they partly define the care manager role. The care managers' way of supporting family caregivers was also influenced by what they wished to accomplish by providing support as well as the care managers' preconceptions and/or opinions about what kind of relationship they should have with family caregivers, how family caregivers should be supported in certain situations and what kind of support that was important.

Key words: social support; Japanese care manager, long-term care insurance scheme, family caregiver, interactionist role theory, informal care, community based care

Table of Content

1. **Introduction** 1
1.1 Description of Problem 3
1.1.1 Objective of Study and Research Questions 5
1.2 Limitations of Study 6
1.3 Definitions 6
1.3.1 Social Support 6
1.3.2 Care Manager 6
1.3.3 Informal Caregiving/Caregiver and Family Caregiving/Caregiver 7
1.3.4 Elderly 7
1.4 Outline of Study 7

2 **Previous Research** 17
2.1 Social Support Provided from the Perspective of the Provider 17
2.2 The Effects of Social Support Provided to Informal caregivers 18
2.2.1 The Effects of Different Types of Social Support on Informal Caregivers 19
2.2.2 The Effects of Social Support in Relation to the Characteristics of the Family Caregivers and/or the Care-Recipient 20

3 **Background** 8
3.1 Traditional Japanese Family System 8
3.2 Decline in Traditional Source of Care 9
3.3 The Japanese Family Today and Family Caregiving 10
3.4 Before the Long-Term Care Insurance Scheme 11
3.4.1 Previous Attempts of Providing Care 11
3.5 The Long-Term Care Insurance 13
3.6 The Care Manager 15
3.6.1 Qualification and Work Experience of the Japanese Care Manager 15
3.6.2 Working Conditions of the Care Manager 16

4 **Methodology** 22
4.1 A Note on Validity and Reliability 22
4.2 Research Approach 22
4.2.1 Preconceptions 23
4.3 Choosing a Method 24
4.3.1 Interviews as a Research Method 25
4.3.2 Conducting Interviews with the Help of an Interpreter 26
4.4 Preparations of the Actual Interviews 27
4.4.1 Approaching the Care Managers 27
4.4.2 Information Letter, Consent Forms and Business Cards 28
4.4.3 Preparing for the Interviews with the Interpreter 29
4.5 Conducting the Interviews 29
4.5.1 Different Styles of Interpreting 31
4.6 Processing the Empirical Material 33
4.6.1 Presentation of the Empirical Material 34
4.7 Ethical Considerations 35

5 **Theoretical Framework** 36
5.1 Outline of Interactionist Role Theory 36
5.2 Classification of Role-Taking Behavior 38
5.3 Different Types of Roles 39
5.3.1 Formal-Roles and Working-Roles 40

6 **Presentation and Analysis of Empirical Material** 41
6.1 Provision of Social Support as Part of the Care Manager Role 41

6.1.1 The Care Managers' Formal-role in Relation to the Provision of Social Support 41
6.1.2 The Care Managers' Working-role in Relation to Provision of Social Support 43
6.2 Social Support Provided by Care Managers to Family Caregivers 46
6.2.1 Supporting Family Caregivers Through Their Formal Work Assignments .. 46
6.2.2 Other Forms of Support Evolves 50
6.3 What Influences The Provision Of Support? 52
6.3.1 Provision of Social Support Influenced by Legitimate Role Definers 53
6.3.2 Provision of Social Support Influenced by the Standpoint Adopted by the Care Managers 56
7 Discussion 61
Reference: 65
Appendix A: Interview Guide 74
Appendix B: Information Letter - English Version 76
Appendix C: Information Letter - Japanese Version 77
Appendix D: Consent Form - English Version 78
Appendix E: Consent Form – Japanese Version 79

Acknowledgments

Writing this thesis would not have been possible without the help and support of several people and I would therefore like to take the opportunity to acknowledge and thank them for all of their kind assistance.

I would especially like to thank the nine care managers, interviewed for the purpose of this thesis, who found time for me in their busy schedules. Meeting you and learning more about the work you do has truly been an inspiration.

A special thank you to Takashi Amano who was kind enough to help me to set up the majority of interviews and who provided valuable insight into Japanese research conduct.

I would also like to thank Alice who interpreted during the interviews with the care managers. Thank you for all of the numerous hours spent on trains going to and coming back from interviews as well as for all the interesting discussions and thoughts you shared.

I also would like to thank my supervisor Per Gunnar Edebalk, from the School of Social Work at Lund University, for suggestions, feedback and being flexible with your time.

Also a special thanks to André who has supported me throughout the whole process of writing this thesis, by taking time to discuss issues related to the thesis.

1. Introduction

The traditional Japanese family system is often described and understood from the perspective of Confucianism[1] (see Hashizume, 2000; Nishi et al., 2010; Hayashi, 2011), where the family is seen as the one solely responsible for providing care for their family members (Arai, 2001). More specifically, women, especially daughters or daughters-in-law, due to the predetermined roles that permeates the traditional Japanese family system, have functioned as the primary caregivers for older family members (Yamamoto & Wallhagen, 1998). However, this system has undergone some changes during the last couple of decades, due to an increase in women who have entered the labor-market (Matsuda & Yamamoto, 2001) but also a decrease in multi-generational households, which has made informal care giving for older family members less available than before (Murashima et al., 2003). Furthermore, according to Tamiya, Chen and Sugisawa (2009) who refer to a report from the Japanese Ministry of Health and Welfare from 1998, the views on children's responsibilities to care for elderly relatives have also changed. Nishi et al. (2010) argues that in spite of these changes, one of the most common sources of care for the aging population still consists of the informal care provided by adult children and/or their spouses.

The above mentioned changes in the Japanese society combined with a rapidly growing elderly population[2] (Ministry of Internal Affairs and Communication, 2012a), have in turn led to the traditional system of informal caregiving no longer was viewed as adequate for taking care of the frail elderly of the society (Matsuda & Yamamoto, 2001). In order to promote ”socialization of care” the Japanese government in April 2000 implemented the Long-Term Care Insurance scheme (henceforth referred to as the LTCI scheme) under the slogan ”From Care by Family to Care by Society” for the frail elderly (Eto, 2001). The aim of implementing the LTCI scheme was to establish

[1]Confucianism is a belief system that originated from China and is based on teachings on Kong Fuzi, who was active during the 6th century BC. Kong Fuzis goal was to create a society of social harmony. Kong Fuzi argued that this only could be achieved if people behaved in a proper way when interacting with each other. What is being perceived, as a proper way of behaving had to do with the social role and title of the person in question. Guidelines for how certain social roles and titles should relate to each other was outlined in what is being referred to as the “The five great relationships”, which describes the relationship between, fathers-sons, elder brother-younger brother, husband-wife, senior friend-junior friend and ruler-subject (Mitchell Fuentes, 2009).

[2] In 2010 the elderly population (65 years or over) accounted for 29.29 million people, as much as 23.1 % of the whole population, making Japan the country with the highest percentages of elderly population in the world (Ministry of Internal Affairs and Communication, 2012a).

a system that would promote independent living for the elderly, allowing them to continue living in their own communities as long as possible. With this goal the Japanese government also recognized the importance of the role family caregivers play as essential for the care within the community (Yamada, Hagihara & Nobutomo, 2009). The new insurance scheme covering both institutional and community based care for aged people (Arai, 2001) were primarily introduced as a ”mechanism to ease the burden of families looking after their frail elderly” (Tsuno and Homma, 2009, p. 10).

Providing informal care to elderly family members may place a burden on caregivers, affecting their psychological and physical well-being in a negative way (Hosaka & Sugiyama, 1999) and it has been argued that the *caregiver burden*[3], experienced by those caring for their impaired elderly at home, is a worldwide concern (Asahara et al., 2001). Research conducted within the Japanese context investigating the relationship between family caregiving and the psychological and physical well-being of family caregiver is scarce (Abe, Kashiwagi & Tsuneto, 2003; Nishi et al., 2010). However, the few studies available on the topic have shown results similar to international research[4]. For instance, Washio and Arai (1999) concluded that 53.3 % of the family caregivers in their study were shown to be depressed. While Arai, Nagatsuka and Hirai (2008) found that Health Related Quality of Life[5] (HRQOL) for family caregivers was lower than for non-family caregivers. As for the caregiving burden’s impact on family caregiver’s physical well-being, Hori, Hoshino and Suzuki (2010) found that the prevalence of high blood pressure of caregivers was significantly higher than in the control group. Furthermore, strength- and musculoskeletal symptoms were also significantly higher in the group of female family caregivers.

---

[3] The term caregiver burden is used when describing the impact (mental, social, financial and/or physical) of providing care for a person in need of care due to illness or who suffers functional impairments. Measuring caregivers burden, can be done in different ways, most commonly however is to ask caregivers to fill out a multi-item scale (Fauth, 2008).

[4] International research has found that there is a significant relationship between caregiver burden and psychological and physical well-being of family caregivers (see Arai et al. 1997; Gallicchi, et al. 2002; Pinquart & Sörensen, 2003).

[5] Health Related Quality of Life is a measurement used in research to assess the health of the population being studied. The concept of health is here not merely viewed as the absence of a decease, which could be measured with the help of objective measurements. Instead, the concept of health is viewed to be a state of well-being not only on a physical level, but also on a mental and social level (Singh & Dixit, 2010).

One of the goals with the LTCI scheme was to ease the burden experienced by family caregivers and this has led scholars to investigate whether the implementation of the LTCI scheme in fact has been successful in that aspect. The results from this area of research can however be described as contradictory (Yamada, Hagihara & Nobutomo, 2009). Yamada, Hagihara and Nobutomo (2009) refers to research conducted by Fuan and Sekita, and by Oura et al. who found that the reported care burden of the family caregivers who participated in their study was less than before the implementation of the LTCI scheme. Similarly, Kumamoto, Arai and Zarit (2006) also concluded that the services provided within the LTCI scheme had been successful in reducing the care burden for family members participating in their study. In contrast, Arai et al. (2002) and Arai and Kumamoto (2004) found no decrease in caregivers' burden, although there was a significant decrease in hours spent on caregiving and a significant increase in the number of services provided since the implementation of LTCI scheme. In addition, Oura et al. (2005) found that the caregiver burden for family caregivers was lower after the implementation of LTCI, but that the incidence of depression was higher among the caregivers.

1.1 Description of Problem

With the new insurance scheme a new occupation, within the context of Japanese elderly care, was introduced - the care manager (Tsuno and Homma 2009). The role of the care manager, as stated in the LTCI Act (1997:123) is to use their special skills and knowledge to support the service users, in this case the elderly adult in need of care, as well as inform them about and help them to access the services available in their community. These responsibilities are materialized through the process in which the care plan is being created, implemented and evaluated (Momose, Asahara & Murashima, 2003). The role of the care manager under the LTCI scheme has also been described as "pivotal", since their work with planning, implementing and evaluating the care provided is seen as a way to ensure that the quality of care is high, thus enabling the elderly adult to continue to live independently in their own homes for as long as possible (Matsuda & Yamamoto, 2001). In addition to these responsibilities, there are also a few authors who have suggested that the care manager´s role also should be understood as a source of social support for family caregivers taking care of their elderly who is receiving services through the LTCI scheme (Kuroda et al. 2007; Yamada, Hagihara, & Nobutomo 2008; 2009). Whether

provision of support to family caregivers can be said to be part of the care manager´s work assignments or how it actually relates to the overall role of the care manager, is not entirely clear. This is because it is neither articulated as one of the care manager's responsibilities in the LTCI Act (1997:123) and is rarely included in the descriptions of the care manager role (see Matsuda & Yamamoto 2001; Kusuda 2011; Campbell & Ikegami 2003; Momose, Asahara & Murashima, 2003).

Regardless of whether provision of social support can be said to be part of the care manager role or not, the existence of a few studies, by Kuroda et al. (2007) and Yamada, Hagihara and Yamamoto (2008; 2009), does however suggest that care managers, while planning, implementing and evaluating the care provided to the elderly, also provide social support to their family caregivers. Important conclusions that can be drawn from this research is that care managers intentionally provide social support to family caregivers and that this support may have an effect (both positive and negative) on the family caregivers (Kuroda et al., 2007; Yamada, Hagihara & Yamamoto, 2008; 2009). The result from the research gives us a better understanding of the social support provided by care managers to family caregivers, but there are still many questions that go unanswered. For example, it is still unclear for what reasons the care managers have come to support family caregivers. The fact that care managers intentionally provide social support to family caregivers seems particularly peculiar if we consider that the actual client of the care manager is the elderly adult together with the fact that the provision of social support to family caregivers cannot be perceived as a part of the care manager's responsibilities as described in the LTCI Act (1997:123). Another aspect that remains unclear relates to what kind of social support the care managers provide to family caregivers and how it relates to the care managers work assignments. In Kuroda et al. (2007) study, the social support was defined by the researchers as something that the care managers provide by simply planning, implementing and evaluating the care, while Yamada, Hagihara and Yamamoto (2008; 2009) in their studies specifically defined several different types of social support. Some of these types of social support, which was placed in the subcategories *social talk*, *information giving* and *reassurance*, correspond or relate to the planning, implementing and evaluation of the care, while other types of social support such as *talked about television and news* or *talked about hobbies*, seems to have no connection to the care managers actual work assignments. Last but not least, the research conducted by Kuroda et al, (2007) and Yamada, Hagihara and

Yamamoto (2008; 2009) investigate the social support provided by care managers to family caregivers from the perspective of the family caregivers, thus failing to provide us with any insight into what might influence the provided social support.

Is seems evident that, even though the Japanese society has moved from a system where caring from the elderly was perceived to be the primary responsibility of the family towards a system where it instead rests upon society, family caregivers and the informal care that they provide still plays a major role. Furthermore, even if there had been hope that the LTCI scheme in itself would ease the burden experienced by family caregivers, there is evidence that suggests the scheme has not been as successful in that area as had been anticipated. Since one of the goals of the LTCI scheme is to promote the independent living of elderly within the community, it seems essential that care managers under the LTCI scheme provide family caregivers with the support that will allow them to continue providing care as long as possible. Gaining knowledge into the areas that have been neglected by previous research would therefore be essential if we want to improve the care managers' ability to better support family caregivers in the future.

In order to approach these questions it will be argued that the social support provided by care managers has to be investigated in relation to the overall conception of the care manager's role, since the conception of the role in turn can be understood as something that defines the work conducted by the care manager. This further means that the social support needs to be investigated from the perspective of care manager rather than from the perspective of family caregivers.

1.1.1 Objective of Study and Research Questions

The overall objective of this study is to investigate the social support provided by care managers to family caregivers of elderly adults receiving community based care under the Japanese LTCI scheme. The study will explore such support from the perspective of the care manager, and in relation to the overall role of the care manager. As such, the following research questions will be employed:

- What reasons do care managers have for providing social support to family caregivers?
- What kind of social support do care managers provide to family caregivers and how does it relate to the care manager's work assignments?

- What is influencing the social support provided by care managers to family caregivers?

1.2 Limitations of Study

There are several limitations within this study which arise from the fact that the social support provided by care managers to family caregivers is investigated from only one perspective – the care managers'. Choosing this approach was deemed as necessary in order to fulfill the overall objective of the study but it also means that other areas have been neglected. Approaching the subject form the care managers' perspective more specifically mean that it is the care managers' perception of social support that is investigated. It is therefore necessary to point out that what the care managers perceive as social support not necessary is interpreted as the same by the family caregivers receiving it. Another limitation of this study is that it is not possible to determine how the social support provided by care managers actually affects family caregivers since the findings of this study solely will be based on the accounts made by care managers. This means that the different types of social support provided by care managers might have no affect, a positive affect or at the worst case a negative affect on family caregivers.

1.3 Definitions

1.3.1 Social Support

The term social support has been defined in numerous ways and each definition brings with it certain limitation (Shumaker & Brownell, 1984). This thesis uses the definition originally formulated by Shumaker and Brownell's (1984, p. 13) who defines social support as "an exchange of resources between at least two individuals perceived by the provider or the receiver to be intended to enhance the well-being of the recipient". This definition is deemed fruitful for purpose of this thesis, since the social support is investigated from the care managers' perspective and this definition not only allow the receiver but also the provider of social support to define what social support is.

1.3.2 Care Manager

The term care manager (sometimes also referred to as case manager) is an occupational title that does not solely exist within the Japanese LTCI scheme. It is also found in other countries and contexts (Blomberg, Edebalk & Tada, 2006).

However, within the frames of this thesis, the use of the term care manager refers to the care manager active under the Japanese LTCI scheme. These care managers are required to go through and pass a formal training program (ibid.). Hence, working as a care manager within the LTCI scheme requires special qualification.

1.3.3 Informal Caregiving/Caregiver and Family Caregiving/Caregiver

Dulin and Hill (2008) argue that it is difficult, in a specific way, to define the term informal caregiving, since the meaning differs depending on the context where the activity takes place. This thesis uses the aforementioned authors' definition where informal caregiving is defined as a "family member, loved one, neighbor, or significant other who provides direct assistance to a person (a care recipient) who, due to disability, is unable to be functionally independent without such assistance" (Dulin & Hill, 2008). With this definition, direct assistance provided by volunteer and/or organizations is excluded. The term family caregiving or family caregivers can in relation to this definition be understood as narrower and the significant difference between the definitions of the two terms is that family caregiving/caregivers exclude people that are not related to the care-recipient by blood or marriage (ibid).

1.3.4 Elderly

The person receiving care provided through the LTCI scheme is in the literature regarding the LTCI scheme referred to in different ways. Terminology that is commonly used is impaired elderly, frail elderly, disabled elderly or insurance beneficiary (see for example Tsutsui & Muramatsu, 2005; Oura, et al. 2007; Tsuno & Homma, 2009; Kuroda et al, 2007). In this thesis the term elderly will be used when referring to the person receiving care provided through the LTCI scheme. The main reason for doing so is because this is the terminology often used by the care managers interviewed for this study. It should however be noted that referring to the person receiving care provided through the LTCI scheme as elderly might not always, in each individual case, be entirely correct since people between the age of 40 to 64 who suffers from an age-related disease also can be deemed eligibly to receive services provided through the LTCI scheme.

1.4 Outline of Study

The function of *chapter two* is to provide the reader with a background to the area of study. This includes a description of how the LTCI scheme developed as well as a description of the care manager occupation under the LTCI scheme. In *chapter three*,

a presentation of previous research will be provided. This research first and foremost relates to the social support provided by Japanese care managers to family caregivers within the frames of the LTCI scheme. Additional research finding has also been incorporated into the presentation to provide a more comprehensive view of the current knowledge relating to social support. *Chapter four* consists of a presentation and discussion of how the study was carried out in regards to the planning, collecting and analyzing of the empirical material. In *chapter five,* the theoretical framework that builds on interactionist role theory is outlined together with concept that was deemed as useful for analyzing the empirical material. The *sixth chapter* contains a presentation of the analyzed empirical material. This presentation is arranged in three sub-chapters each of which addresses the three research questions. *Chapter seven* consists of a conclusion where the research findings are reconnected to the research questions and the overall objective of the thesis. The chapter is rounded up by a final discussion regarding the care managers' ability to support family caregivers providing informal care to their elderly family members.

2 Background

2.1 Traditional Japanese Family System

The traditional Japanese family system rests upon the ideology of *ie*[6], which translates to family, home or house. However, the meaning of the word signifies much more than its English counterpart (Sugimoto, 2010). This system emerged during the Edo[7] period (Kumagai & Kayser, 1996) and was manifested in an official arrangement where individuals had to register themselves in a family register and conform to a multi-generational household (Asahara, Momose & Murashima, 2002). It is often described as a vertical and hierarchical/patriarchal system (see Kumagai & Keyser, 1996; Sugimoto, 2010) where the term vertical refers to the structure of the household, consisting of several generations of nuclear families, each represented by the first son of the previous generation and his wife (Lebra 1984). For women this traditional system meant that they would leave their biological families at the time of marriage and enter into the their husband's household (Wallhagen & Yamamoto-Mitani, 2006).

[6] The ideology of ie is strongly influenced by Confucianism, adopted by the Japanese as a moral code (Kumagai & Keyser, 1996).
[7] The Edo period refers to a period in Japanese history that lasted from 1600 to 1868 (Edmonds et al., 2012).

Referring to this household system as hierarchical/patriarchal has to do with the fact that each household had an officially appointed head (Sugimoto, 2010). Influenced by the Confucian hierarchical views "where age took precedence over youth and men over women" (Carroll, 2006, p. 111), the head of the household had power to decide in the majority of the household matters, rights that was manifested in the Civil Code. Within this system each member had pre-assigned roles, from which they were expected to contribute to the family accordingly (Kumagai & Keyser, 1996). The task of caring for elderly household members was considered to be the task of the succeeding generation, especially the daughter-in-law were expected to care for her husband's parents (Yamamoto & Wallhagen, 1998). Hence, the traditional Japanese family system, with its multi-generational households along with the norms and values penetrating it, provided a support network for the elderly members in need of care (Kumagai & Keyser, 1996).

2.2 Decline in Traditional Source of Care

In 1947 the new Civil Code was enacted, abolishing the ie system, giving husbands and wives equal rights within the family. The family unit was now limited to include only husband, wife and children, separating the family of a married son and his parents, each considered a family unit in it self (Kumagai & Keyser, 1996). The enactment of the new Civil Code together with changes taken place during the postwar era, such as changes in the labor market, demographic shifts and social change had implications for the traditional Japanese family system, altering the function and structure of the family (Kumagai & Keyser, 1996; Izuhara, 2006). This made the type of informal care, traditionally provided within the family, less available (Campbell & Ikegami, 2003; Rebick & Takenaka, 2006). In order to understand the structure and function of the Japanese family today, it is vital to look at some of the changes that have taken place during the postwar era.

One characteristic of the traditional family system was the multi-generational households. The percentage of multi-generational household has since the abolishment of this official arrangement decreased. In 1975, 16.9 % of all households were multi-generational households and in 2007 that number had decreased to 8.4 percent (Ministry of Health, Labor & Welfare, 2012a). However, this does not mean that the great majority of the elderly population lives separate from their children. In

fact in 2007, 43.6 % of people aged 65 or over either live together with their child or together with their child and their spouse.

When talking about a decline of traditional sources for informal care, women's participation in the labor market is often brought forward as a contributing factor and women's participation in the labor market in Japan is something that has consistently increased. In 2007, 41.5 % of the whole workforce constitutes of women and almost half of all women between the age of 16 and 65 years old undertake some kind of paid labor[8] (Ministry of Internal Affairs and Communication, 2012b). Surveys measuring attitudes among the population has also shown a change in views when it comes to women's participation in the labor market. In regards to women's participation in the labor market after entering marriage or after entering marriage and having their first child, women are no longer, to the same extent[9], expected to leave their job and devote themselves to taking care of the household or/and child rearing (Kono, Takahashi & Hara, 2010).

A rapid aging population will post a challenge to any developing country (Hamada & Raut, 2007). This is particularly true for Japan who is one of the fastest aging societies but also have the highest percentage of population aged 65 or over in the world (Ministry of Internal Affairs and Communication, 2012a). In 1950, 4.9 % of the population was 65 years or older, a figure that had increased to 23.1 % in 2010 and is predicted to reach 39.6 % in the year 2050. Reasons for this dramatic demographic change is the decline in birth rates along with an increase in the general life expectancy of the population (Ministry of Internal Affairs and Communication, 2012a). The consequences of these demographic changes is that there is a decrease in the number of young people who will be able to care for the elderly, which in turn will effect the nation's social welfare (Rebick & Takenaka, 2006)

2.3 The Japanese Family Today and Family Caregiving

The traditional Japanese family system, including a natural element of informal care for elderly family members (Kumagai & Keyser, 1996) has undergone some changes

---

[8] The employment status of Japanese women compared to Japanese men is however more unstable, where 59 % of employed women compared to 19 % of employed men are temporary or part-time workers (Kono, Takahashi & Hara, 2010).

[9] In 2008, 48 % of the people responding to the survey were of the opinion that there should be a balance between home life and employment and that woman, as far a possible, should continue working after marrying and having their first child. This is a significant increase since 1973 when only 20 % of people asked agreed with the above statement (Kono, Takahashi & Hara, 2010).

during the postwar era. However Karan (2004, p.175) states that even though there have been changes in values and social norms as well as in households' formation, these changes have been slow compared ”with the rapidity of underlying socioeconomic and demographic changes”. Furthermore, some observers have concluded that the principle of gender equality, that was introduced in the postwar Civil Code, never have been realized and that the ideology of ie is still present in Japan today, effecting the Japanese family constellation (Kumagai & Keyser, 1996; Sugimoto, 2010), putting expectations on the oldest son and his wife to care for their elderly parents (Oberländer, 2004).

Looking at the characteristics of the main caregiver of persons aged 65 years and above requiring care, 72.9 % of all main caregivers, in 2007, were women (Ministry of Health, Labour & Welfare, 2012b). Furthermore, in 2007, 60 % of the people who required care lived together with their main caregivers. Within this group, the largest group of main caregivers consisted of spouses, followed by children and then spouse of children (Ministry of Health, Labor & Welfare, 2012c).

2.4 Before the Long-Term Care Insurance Scheme

The National Diet passed the LTCI Law in 1997 (Talcott, 2002) and it was implemented in April 2000 (Matsuda & Yamamoto, 2001). The decision to implement such a large-scale program in a time when Japan in general had been calling for cutbacks and restrains in other welfare programs has been described by Campbell and Ikegami (2000) as an anomaly and Campbell (2002) argues that factors such as demographic change and a decline in traditional sources of care cannot alone explain the development and implementation of the LTCI scheme. To fully understand how this type of scheme came about, one also needs to look at the Japanese government's previous attempts of handling issues that accompanies an aging population. A brief account of the attempts leading up to the development and implementation of the LTCI scheme in 2000 will therefore follow.

2.4.1 Previous Attempts of Providing Care

The foundation for creating a social security system was established alongside the enactment of the new Japanese Constitution, after the end of the Second World War (Arai, 2002) and towards the end of the 1940s the importance of social welfare had been recognized and made into a national goal. This new realization was manifested

through the implementation of different programs directed towards the elderly populations such as the Public Assistant Law, Universal Health Insurance and a Public Pension scheme that was established during the 1950s and 1960s (Commonwealth of Australia, 2001).

During this period the first modern program offering elderly people services such as homecare and nursing homes, was established. However, in order to access these services, applicants were means-tested and elderly people with access to informal care by family caregivers were usually not considered eligible (Campbell and Ikegami, 2000). In 1973, the Medical Care program was implemented, which made medical care virtually free for bedridden elderly people. The establishment of this kind of medical program in a society with an underdeveloped long-term care infrastructure and where access to long-term care only was available to a limited group of people, created a situation where many elderly started to used the Medical Care program as a substitute for long-term care services, receiving care in hospital settings without having any real medical needs (Crume, 1997; Campbell & Ikegami, 2000). This trend (Crume, 1997), together with the demographic changes raised concern, in which the issue of providing care to the elderly population was starting to be viewed as a problem (Ishii-Kuntz, 1999) leading the Japanese government to re-evaluate their programs for the aged population in the late 1970s (Crume, 1997).

To deal with this issue, the ruling Democratic Party came up with the Gold Plan in 1989, which "aimed at broadening the reach of public service for the frail elderly beyond the poor or the people that had no access to family care" (Campbell, 2002, p. 167). This contributed to an expansion of already existing services such as institutional beds, home helpers and adult day-care centers, as well as creating new programs such home-care coordination centers and sheltered housing (Campbell, 2002). Campbell (2000) states that the political significance of the Gold Plan was that the care for frail elderly was being viewed as a major political issue for the first time and that the government took on the responsibility to provide all elderly with the care that they need and not just elderly with financial difficulties or elderly without families.

The Gold Plan did result in a rapid expansion of long-term care services, but the public demand as well as demands from the municipal governments exceeded the growing supply of long-term care services in the beginning of the 1990s. The demands resulted in raised ambitions, that was manifested in the New Gold Plan in

1994 (Campbell & Ikegami, 2000) The expansion of services together with the view that all elderly should be entitled to service regardless of their economical situation or availability of family caregiving, did however create problems, due to the fact that there was no appropriate infrastructure in place to successfully implement it.[10]Due to the obstacles faced, Japan decided to go for a social insurance scheme similar to that of Germany (Campbell & Ikegami, 2000).

2.5 The Long-Term Care Insurance

The LTCI scheme was enacted in April 2000 and put in charge of the scheme were the municipal governments,[11] since they were already responsible for the planning and administration of social welfare (Campbell, 2002). 50 % of the revenues of the insurance are paid with general taxes, both local and national, and the remaining 50 % come from premiums paid by the insured (Matsuda & Yamamoto, 2001).

The beneficiaries, who are outlined in article 9 of the LTCI Act (1997:123), are divided into two groups. The first group, includes people 65 years old and over, and the second group, includes people between the age of 40 to 64 years old. Both of these groups can, after being considered eligible, use the services provided within the insurance scheme. The second group, however, will only be considered eligible if the need for assistance or care is caused by age related decease (Talcott, 2002).

In order to access the services provided through the LTCI scheme, the insured elderly or their family apply through the municipal government. To begin with, the applicant is asked to fill out a standardized questionnaire (Matsuda & Yamamoto, 2001). This standardized questionnaire is then together with a written report from the applicant's doctor analyzed by a computer program which provides a preliminary assessment of the applicant eligibility and level of care need (Shinjuku-ku, 2012).

[10] The issues facing the Japanese government were the financing of the services and the procedures for determining eligibility for receiving services. The services provided were mainly financed by taxes, both local and national. Even though user fees were charged, these were inconsistently applied and the total amount only constituted a small proportion of the actual costs. Furthermore, the system used to assess eligibility was only design to cater to a limited population, providing small-scale services (Campbell & Ikegami, 2000).

[11] The Japanese administration system is divided into three different levels. At a national level is the central government that is responsible for the establishment of the laws and principles. In the case of elderly care the Ministry of Health, Labour and Welfare represent the central government. The policies set forward by the central government are implemented through the local governments, consisting of prefectural- and municipal governments. There are 47 prefectures in Japan comprising in total 3300 municipalities. The responsibility of the prefectural governments is to co-ordinate the activities of the municipality governments (Matsuda & Yamamoto, 2001).

The analyzed results together with a report from the applicants' home doctor, as well as a descriptive statement made by the applicant is then reviewed by a committee consisting of five appointed health care professionals (Matsuda & Yamamoto, 2001). After reviewing the material, the committee has the authority to overrule the recommendation made by the computer program (Talcott, 2002). The decision made by the committee in regard of the applicants eligibility and level of care need is given to the applicant within 30 days[12] (Matsuda & Yamamoto, 2001). The process that determines the eligibility and level of care need of the applicant is designed to be objective in the way, that the assessment is solely based upon the physical and mental disabilities of the applicant. Hence, factors such as the applicant's income, assets and availability of informal care are not taken into consideration (Ikegami & Campbell, 2002).

There are six different levels of assistance or care need that the applicant can be placed in, depending on the severity of their condition. Each level is in turn represented by a monetary amount, which the applicant is allowed to spend on services (Matsuda & Yamamoto, 2001). The first of these levels is referred to as *support required* while the remaining five levels are referred to *care level one, care level two* and so forth (Ministry of Health, Labour & Welfare, 2013). The applicant also pay a co-payment fee of 10 % of the total amount of services that they utilize (Blomberg, Edebalk & Tada, 2006).

When an applicant has been determined as eligible and assigned to one of the above-mentioned levels, him or her, with the assistance of a care manager select the kind of service they find suitable (Matsuda & Yamamoto, 2001). The opportunity to self determine what services would be best was something that did not exist before the implementation of LTCI (Talcott, 2002). The services that the insured can choose from can be divided into two categories: home care and facility care, each offering a series of services both of a social and medical nature[13] (Talcott, 2002). The different

---

[12] Any appeals are directed to the re-evaluators committee at the prefecture level (Matsuda & Yamamoto, 2001).

[13] The home care services includes: home nursing visits, home treatment management and guidance (by doctor), day service (at day care center), out-patient rehabilitation (at medical facility), respite care, group therapy for senile dementia, nursing care services in for-profit nursing homes, leasing and/or purchasing of care related furniture and implements, home renovation (small-scale standardized improvement) and support for home care. The facility care services includes, long-term care welfare facilities (special nursing home for the elderly), long-term care health facilities (geriatric health care facilities) and long-term care medical facilities (acute-care beds, beds for treatment of senile dementia, designated long-term care hospitals) (Talcott, 2002).

services can be provided directly by the municipal government or other service providers such as non-profit organization or by private business, which is also a change from before, where all services had to be provided directly by government's service providers (Talcott, 2002).

2.6 The Care Manager

As previously described, the eligibility for receiving care under the LTCI scheme is decided with the help of a computer program and a committee (Matsuda & Yamamoto, 2001; Talcott, 2002). Hence, the care manager does not take part in the process of determining whether or not and to what extent an applicant would be able to receive care (Blomberg, Edebalk & Tada, 2006). The role of the care manager, as stated by the LTCI Act (1997:123) under the LTCI system, is to use their special skills and knowledge to support the service users, in this case the impaired elderly, as well as inform them about and help them to access the services available in their community. These responsibilities are materialized through the process in which the care plan is being created, implemented and evaluated, which will be described more thoroughly below (Asahara, Momose, Murashima, 2003).

The main aspect of the care managers' work is to create a care plan, together with the elderly, and/or his or her family (Blomberg, Edebalk & Tada, 2006). During an initial meeting between the care manager and the elderly person the care needs and service available are discussed, and a care plan based on that discussion is drafted. The care managers then bring the drafted care plan to a care plan conference, where it is discussed in the presence of care providers. Finally, the care plan is then given to the elderly to be approved and signed. Once that has been done, the care manager contacts the service providers and coordinates the different services (Ikegami, 2004). After the care plan has been implemented it is the care manager's responsibility to follow up and evaluate how the care plan is responding to the needs of the elderly (Blomberg, Edebalk & Tada, 2006). The care plan is therefore monitored periodically (Omote, Saeki & Sakai, 2007) and amended if needed (Matsuda & Yamamoto, 2001).

2.6.1 Qualification and Work Experience of the Japanese Care Manager

In order to qualify as a care manager, the care manager is required to have five years of working experience in the fields of health and care. Furthermore, the care managers also have to pass a written exam, that focus on the LTCI scheme, basic knowledge

about health, health care and social services, as well as a course where the main focus is on composing a care plan (Blomberg, Edebalk & Tada, 2006). The educational background and the work experience of the Japanese care manager could not be described as homogeneous. In fact in 2004 around 340.000 people had been trained and certified to work as care managers. The three most common professional backgrounds within this group constituted of registered nurses, certified care workers and social workers. However, other professional backgrounds such as dentists, dental hygienist, midwifes, pharmacists, speech-language-hearing therapist and dietitian were found among the group of care managers that had been certified up to that point in time. The wide diversity can partly be explained by the fact that there was a high demand of care managers when LTCI was about to be implemented (Kikuchi et al., 2006).

Discussions concerning the care managers' qualification and abilities to perform their responsibilities under the LTCI scheme are something that has been brought up by different scholars. For example, Masuda and Yamamoto (2001) argue that care managers lack both the proper knowledge and a sense of responsibility to adequately perform their ascribed tasks. Furthermore, Kikuchi et al. (2006) argues that the training and previous work experiences cannot be viewed as sufficient.

2.6.2 Working Conditions of the Care Manager

The care managers get paid monthly by the insurer for every case he or she handles[14] (Kikuchi et al., 2006). The workload of the care managers has in previous literature been described as high. Blomberg, Edebalk and Tada (2006) refer to an unpublished report by Tada, who states that average workload of care managers is about 40 clients; whilst around 25 percent of care managers manage a workload of 50 to 60 clients. The workload was also something that was addressed during the interviews held with care managers for the purpose of this study. I was then informed that a cap on the amount of clients a care manager was allowed to have had been introduced. This meant that the care managers were not allowed to handle more than 35 cases (where the elderly had been assigned to care level one or above) and an additional eight cases (where the elderly had been assigned to the *support required* category). Many care

[14] This fee for each case was in 2006 8.500 YEN (Kikuchi et al., 2006) which was equal to 72 USD. This monthly fee can however be reduced, if the care managers fail to fulfill certain chores, such as visiting the service user on a monthly basis, establish a care plan or communicate and discuss the needs of the service user with the service provider (Asahara, Momose, Murashima, (2003).

managers do not solely work as care managers, in fact, it is not unusual that they are employees of organization providing elderly care (Campbell & Ikegami, 2003). According to Kojima, Ito and Sayama (2001) this can partly be explained by the fact that the reimbursement that the care managers receive for each client is considered quite low. Working as a care manager for an organization that provides care has further been questioned by Asahara, Momose and Murashima (2003) who argues that this situation can be problematic in the sense that there might not be enough time for care managers to fully devote themselves to the care management process.

3 Previous Research

3.1 Social Support Provided from the Perspective of the Provider

Characteristic for research that investigate different aspects of social support is that the investigation proceeds from the perspective of the receiver of social support rather than from the provider (Hupchey, 1998) and research concerning the social support provided by care managers to family caregivers is not an exception. Even though there is no previous research that specifically set out to investigates the social support provided by care manager to family caregivers from the perspective of the care manager, there is research conducted by Omote, Saeki and Sakai from 2007 that touches upon this subject. In their study, Omote, Saeki and Sakai (2007, p. 569) interviewed 21 female care managers in order to investigate "the difficulties perceived by care managers in Japan when managing care in cases of abuse of elderly people in the home". An interesting aspect of their findings, which tells us something about how the care managers perceive themselves and the work that they carry out in relation to the elderly and their family caregiver, is one of the strategies the care managers used in order to prevent or minimize the abuse of the elderly. This specific strategy meant that the care manager would provide services directed towards the elderly with the aim of easing the caregiving burden experienced by family caregiver. The social support provided here could be seen as indirect support, and even though the aim was to reduce the caregiving burden of the caregiver, the greater goal was to prevent or reduce the abuse experienced by the elderly.

Since there seems to be a lack of Japanese research specifically looking at the support provided to family caregivers by care managers from the perspective of care

manager, research by Dobrof et al. (2006) has also been included. In their study of a hospital based support program for family caregivers, Dobrof et al. assess the concerns presented by family caregivers who contacted or were contacted by the social worker of the support program. Furthermore, how the social workers intervened and the results of this intervention, was also investigated within the frame of the study. The assessment showed that family caregivers were facing an array of challenges, emotional as well as issues with resource. The interventions provided by the social workers addressed the different challenges faced by family caregivers, but the study also showed that the social workers tended to engage family caregivers into discussions of their situation and how they were coping, even though difficulties with coping were not always presented as a concern by the family caregiver in their initial contact. The social workers themselves viewed the support they provided within the framework of the support program as more than support in the form of information and referrals.

3.2 The Effects of Social Support Provided to Informal caregivers

Kuroda et al. (2007) points out that there is a lack of knowledge about the function of the support provided by care managers to family caregivers under the LTCI scheme. In their study the researchers investigates the relationship between the social support provided by care managers to family caregivers. In order to do so the researchers conducted two structured interviews with family caregivers set 12 months apart. At the initial interview, information about the family caregiver[15] and the elderly[16] was assessed. During the second interview information about the functional changes of the elderly and family caregivers' HRQOL was measured. The analysis showed that the family caregivers' satisfaction with their care manager had a positive effect on the family caregivers' physical and mental QOL. Similarly, Musil et al. (2003) investigated the effects of support provided by care recipients' primary care provider to informal caregivers during a period of 24 months. The researchers found that more support received had an effect on the reward derived from the caregiving experience, which in turn affected the caregivers' appraisal of their own health. However, results

[15] Satisfaction level with care manager, demographic variables, HRQOL, coping ability, number of family members and depressive state.
[16] Demographic variables, abilities to do the activities of daily life, depressive state, number of services utilization by community long-term care services per month, dementia assessment.

from physical examinations of the caregivers did not significantly correlate with the amount of support provided by the care-recipients primary care provider.

In the above-presented article by Kurado et al (2007), being satisfied with your care manager is assumed to be the same as receiving social support from the care manager. Hence, the study does not distinguish between different types of support and the effect it might have on the family caregiver. However, the different types of social support provided by care managers and its effect on family caregivers is something that has been investigated by Yamada, Hagihara and Nobutomo (2008; 2009). The data, which these two studies were based on, was collected in 2005. The method used, consisted of a self-administered questionnaire[17] that was distributed to family caregivers of elderly, receiving services under the LTCI scheme. The questionnaire among other thing listed different types of support that care managers might provide to family caregivers. A list that had been put together with the help of actual care managers. The findings of these two studies, together with other relating research, will be presented below. The presentation will begin with research that have looked at how different types of support effect family caregivers. It will then move on to research that has investigated the effect of support provided in relation to characteristics of the caregiver and the care-recipient.

3.2.1 The Effects of Different Types of Social Support on Informal Caregivers

In their first published article, Yamada, Hagihara and Nobutmoto (2008) examine how different types of support provided by care managers to family caregivers affected the family caregivers' care burden and depression. By using the self-administrative questionnaire, things like the family caregivers' perceived burden, depression, type and the amount of support provided by care managers were assessed. In regards to the support provided by care managers, the questionnaire included 11 items[18] of support, divided into two sub-categories, labeled *social talk* and *information giving.* The analysis showed that *social talk* provided by care managers

[17] The questionnaire was distributed to 923 family caregivers out of which 618 was returned to the researchers. The results presented in the article from 2008, are based on 371 of these questionnaires since 247 of them was excluded from the analysis. The results presented in the article from 2009 are based on 347 of these questionnaires since 271 of them were excluded from the analysis.

[18] The 11 items of social support included talked about television and news; talked about hobbies; talked about community topics; talked about caregiver's good memories from long ago; talked about caregivers' health and everyday life; spent time without talking: talked about complaints regarding family member; talked about caregiver's opinions or requests for care services; obtained information about care services; obtained information about caregiving techniques; and talked about caregiver's opinions or requests regarding other care providers.

had a positive direct effect on the care burden experienced by family caregiver, but not on depression. Support in the form of *information giving,* on the other hand, was not found to have any direct effect on family caregivers' burden or depression.

The effects of different types of social support provided to family caregivers have also been investigated by Okamoto and Harasawa (2008) who instead examined how social support provided to Japanese family caregivers by other family members affected the family caregivers' self-related health and depressive symptoms. The researcher found that emotional support[19] provided to family caregivers significantly related to the caregivers' self-rated health. Instrumental support[20], however, did not show to have an effect on the caregivers' self-rated health. Furthermore, the results also showed that less support from family members had a significant relationship with higher degrees of depressive symptoms.

In relation to international research, the findings from the Japan, presented above, can be said to be both consistent and inconsistent. In Savard et al. study from 2006, the informal caregivers who received support categorized as information and advice or emotional support were found to be more satisfied with support services. Furthermore, Cumming et al. (2008) investigated the effects of social support on informal caregivers of stroke survivors in the form of emotional/informational as one category and found that it reduced the caregivers' anxiety. International research has also shown that provision of information to family caregivers by other family members is a predictor of depression when the information provided makes the caregiver feel pressured or when the information is provided in a way that is viewed as inappropriate by the family caregiver (MaloneBeach & Zarit, 1995)

3.2.2 The Effects of Social Support in Relation to the Characteristics of the Family Caregivers and/or the Care-Recipient

Another interesting aspect of the findings presented in Yamada, Hagihara and Nobutomo articles from 2008 and from 2009 was that the characteristics of the elderly and family caregivers to some extent influenced how the provided support affected family caregivers. In their article from 2008, the researchers discovered that *social talk* was found to have a buffering effect on the level of care need on depression. This

[19] Emotional support in this study is related to esteem, understanding and help in decision-making provided to family caregivers by other family members (Okamoto & Harasawa, 2008).

[20] Okamoto and Harasawa states that instrumental support can be manifested in many ways but exemplifies it by saying that it for example consists of practical help and financial support (Okamoto & Harasawa, 2008).

meant that depression among family caregivers increased significantly in accordance to a higher level of care need of the elderly, when the support in the form of *social talk* was perceived as low by the family caregiver. Social support labeled as *information giving*, instead had a negative effect on the level of care need on depression. This meant that the degree of depression, among family caregivers taking care of an elderly with higher levels of care needs, significantly increased when the *information giving* by the care manager was being perceived as high.

In their article from 2009, Yamada, Hagihara and Nobutomo again investigated how the support provided by care manager to family caregivers affected family caregivers. This time the researchers did not only look at support in the form of *social talk* and *information giving* but the social support category of *reassurance* was added. Furthermore, the family caregivers were also categorized in accordance to gender and living arrangement in order to determine if these factors influenced how the support provided affected family caregivers. The analysis showed that *information giving* had a direct negative effect on the care burden experienced by male caregivers co-residing with the elderly. Furthermore, interaction between *information giving* provided by care managers and the *memory and behavior problems* of the elderly also had a negative effect on female caregivers' (co-residing with the elderly) attitudes towards social activities. The social support in the form of *social talk,* had a direct positive effect on the care burden experienced by female caregivers co-residing with the elderly. However, when *social talk* interacted with *memory and behavior problems* the analysis revealed that this was a predicament of higher caregiver burden for females co-residing with the elderly.

The findings presented above are similar to findings by Van Mierlo et al. (2012) who investigated the effectiveness of different psychosocial interventions[21] by analyzing the results of articles published between 1990-2008. The review of the 26 articles showed that different characteristics such as the severity and type of dementia of the care-recipient or gender of the informal caregiver did associate more frequently with positive effects of different psychosocial interventions.

Also worth mentioning is that previous research has found that characteristics of the relationship between the person providing support and the informal caregiver

[21] The term psychosocial interventions were in the study defined as "all non-pharmacological interventions that intend to support caregivers of people with dementia in accomplishing their caregiver task and improving their quality of life" (Van Mierlo et al 2012, p. 2).

receiving it has an influence on the type of support being provided. Miller and Guo (2000) found that gender had a significant effect on the provision of emotional support. Where female helpers compared to male helpers were nearly twice as likely to provide emotional support. Furthermore, formal service providers and the adult children of informal caregivers were more likely to provide practical assistance.

4 Methodology

4.1 A Note on Validity and Reliability

When the quality of a study is discussed terms such as validity and reliability are often used. How these terms are applied depends on whether the research conducted adheres to qualitative or a quantitative research approach, but the essence of these concepts is that the researcher critically reviews their findings and the process through which they are derived (Jacobsen, 2007). This study, which uses a qualitative method, will employ the terms internal validity and reliability. Internal validity relates to discussions about whether the study succeeds in measuring what it sets out to measure. Reliability on the other hand has to do with how the research was carried out and how it potentially has affected the research findings (ibid.). Aspects of the current study that relates to issues of internal validity and reliability will be discussed in relation to the different stages of the study. The term external validity is used to refer to issues about whether results from an investigation can be generalized to a larger population. However, the focus of qualitative research in general and this study in particular is not to determine the scope or frequency of the researched phenomena. Rather, the aim is to create a better and in-depth understanding of the research phenomena (ibid), which is the support, provided by care managers to family caregivers.

4.2 Research Approach

The overall objective of this study is to investigate the social support provided by care managers to family caregivers of elderly adults receiving community based care under the Japanese LTCI scheme. The study will explore such support from the perspective of the care manager, and in relation to the overall role of the care manager.

The purpose of approaching the subject from the perspective of the care managers is to gain insights into the circumstance under which the social support is provided, from which a better understanding of the social support in itself can arise.

This further means that this study seek to gain knowledge about the social support by exploring the *life-world* of the care managers and the meaning they ascribe to it, an approach that coincide with the hermeneutic research approach (see Hartman, 2004).

Knowledge in the hermeneutic approach is seen as something that is attained when the researcher's understanding of the research subject's life-world coincide with the research subject's understanding of their life-world. Something Gadamer described as *fusions of horizons* (Hartman, 2004). Hence, the research conducted within the frames of this thesis will strive to reach an understanding of the life-world of the care managers that correspond to the care managers' own understanding of their life-world. How such an understanding can occur is also something that is stipulated within the hermeneutic approach (ibid.) and this will be presented in more details, in discussions related to how the empirical material was collected and processed.

4.2.1 Preconceptions

Before looking more closely at how the study was carried out, there is a need to clarify how knowledge is actually perceived within the hermeneutic traditions. Within this tradition the researcher is very much a part of the process through which knowledge is generated since the researcher continuously, with help of his or her preconception, interprets and re-interprets the behavior displayed by the research subject in order to form an understanding of their life-world. These interpretations always take place in a social- and historical context and the knowledge is therefore always relative in relation to that specific context (ibid.). The acknowledgment that the researcher's interpretations of the empirical material depart from his or her preconceptions is therefore an integrated part of the hermeneutic research approach (Hartman, 2004). These can be understood as fears, expectations, opinions, values etc. (Sjöblom, 1994) something obtained by simply living in a society (Aspers, 2007). Preconceptions within the hermeneutic approach are not negative, rather they are seen as something essential, since they enable us to interpret and understand a phenomenon (Allwood & Erikson 1999). It is, however, important to manage ones preconceptions, by making oneself aware of them. Accounting for one's preconception will enable the researcher to more clearly see how they have affected his or hers interpretation of the collected material and by doing so also question if there are other possible interpretations (Sjöström, 1994).

My knowledge about Japanese elderly care in general and the LTCI scheme in particular, were in the beginning of the research process limited to what had been read on the topic in a different articles. An interest in how elderly people were cared for in the Japanese society in general and how it differed from the Swedish context had however arisen a couple of years earlier, due to some events happening in my Japanese side of the family. Growing up in Sweden, where the society carries the main responsibility for caring for the aged population, this situation sparked an interest, which eventually lead me to look more closely at the role of the Japanese care manager. The fact that I come from a society where family caregiving is more uncommon than in the Japanese context, as well as having seen how family caregiving can affect the situation for a whole family, further means that I during the research process have had to critically review the interpretations made, in order to stay open to all aspects of family caregiving. Having restricted knowledge about the LTCI scheme and Japanese culture, at the onset of this study can be viewed as something that might have restricted my ability to better sort out relevant information from less relevant information. It is however also possible that the degree of unfamiliarly with the area of research has been helpful in order to see and explore aspect that otherwise would have been taken for granted.

4.3 Choosing a Method

The hermeneutic approach provides the researcher with guidelines in terms of what knowledge is and how it is produced. However, the character of these guidelines is, according to Hartman (2004) too vague and can therefore not adequately guide the researcher in his or her practical work. The practical guidance needed has therefore been provided by the employment of a qualitative method (Hartman, 2004). Employing a qualitative approach, in relation to the overall objective, also seemed suitable since it aims to discuss, observe and analyze how the research subject thinks, reasons and acts. However, using a qualitative approach is not entirely unproblematic. For example, by engaging with the research subject through interaction, the researcher becomes a tool for his own research, inevitable affecting the research process and the empirical material collected through it (Aspers, 2007).

The empirical material for this thesis was collected through qualitative interviews with nine care managers. This specific method has been described as an appropriate method when the researcher aims to describe the research phenomena

from the perspective of the interviewees and their life-world (Esaission et al., 2007) since he or she through the interviews is able to gain insights into the experiences, feelings and attitudes of the respondents (May, 2001).

Choosing interviews as a research method does not necessarily mean that there was no other viable alternatives. Suitable alternatives could for example have been participant observation or vignettes. Employing participant observations would have been beneficiary since it allows the researcher to explore the world from the perspective of the care manager and discover the norms, values and patterns for interpretation and communication that controls their existence (Henriksson & Månsson, 1996). By using vignettes it would have been possible to further explore the actions of the care managers that take place in a context (Barter & Renold, 1999).

It could be argued that the above-presented alternatives in some aspect could have been equally suitable or even more suitable than employing interviews as a method in order to investigate the purpose for the current thesis. However, these methods were dismissed since it, in regards to using participant observation, would be difficult to gain access to the field and because both of these methods would require the extensive use of an interpreter, something that would exceed the budget for this study. It should here be mentioned that an interpreter was used during the research process and that discussions related to this will be held further on.

4.3.1 Interviews as a Research Method

This study employs semi-structured interview, which is often placed between the structured- and unstructured interviews. The semi-structured interview was deemed as a suitable choice, since this way of conducting interviews allows the researcher, to change the sequence and the formulation of question asked (Robson, 2002) as well as enabling the respondents to respond to the questions with their own words (May, 2001). Using a semi-structured approach meant that an interview guide[22] was created as part of the preparations before carrying out the actual interviews (Robson, 2002) and that it was designed in a way that reconnected to the objective of the study and its research questions (Esaiasson et al., 2007). The interviewed care managers will be referred to as respondents, rather than informants, since they are interviewed because of their involvement in the research phenomena (Holme & Solvagn, 2005).

[22] Appendix A

4.3.2 Conducting Interviews with the Help of an Interpreter

The interviews conducted with the care managers were carried out with the help of an interpreter. Aspects of using an interpreter will for the most part be discussed continuously in relation to the different steps of the research process described in this chapter. However, before doing so, there is a need to clarify the role of the interpreter within this study since this might vary in relation to different research traditions (Berg & Tyyskä, 2011). In the positivistic tradition, the interpreter's participation in the research process is often made invisible because they are viewed as merely a tool through which research can be conducted. Employing this mechanical view also means that the interpreter often is seen as a potential threat to the result of the study (Berg & Tyyskä, 2011). A contrasting view, that lays more in line with how the participation of the interpreter in this study has been viewed, are provided by scholars such as Temple (2002), Edwards (1998) and Larkin, De Casterle and Schotsmans (2007). Temple (2002) for example, states that the interpreter should be viewed as an active producer of knowledge. Similarly, Edwards (1998) also argues that the interpreter can be used as a source for information about the social setting. Furthermore, Larkin, De Casterle and Schotsmans (2007) argue that the interpreter should be included and consulted in all the steps in the research process. Adhering to this view means that the interpreter used for this study has been viewed as a resource that has been included and consulted during several aspects of the research process.

4.3.2.1 Selecting an Interpreter

The person employed to do the interpretations, was a non-professional trained interpreter[23] who I had become acquainted with while living in Japan. Reasons for employing this interpreter were several, but the most important was that she was able to communicate fluently in both English and Japanese, something that was seen as essential in order for the interpretations to become as rich and detailed as possible. However, the fact that the interpreter speaks the same language as the research respondents does not necessarily mean that he or she represents or share their culture (Temple, 2002). The interpreter who was ethnically Japanese, had lived in Japan for a while as a child, but spent the majority of her life living in America. This meant that

[23] In the beginning of the research process, the ambition was to use a professionally trained interpreter, but after doing some research into the costs of different interpreter services the decision to use a non-professional trained interpreter was made.

she had come to identify as being American rather than being Japanese. The interpreter was, despite of this, still familiar with and had knowledge about Japanese cultural. This further meant that the interpreter's function in the research process falls closely to Edward's (1998) description of how an interpreter can be used as a source of information about the social setting.

4.4 Preparations of the Actual Interviews

In relation to the purpose of the current thesis, only care managers working with elderly receiving community-based services through the LTCI scheme were approached to participate. The respondents were approached in a variety of way, which will be discussed below. The interviews were held over a period of 3 months, from December in 2012 to March in 2013. The length of the interviews varied, lasting from 40 minutes to 120 minutes, with an average of 80 minutes per interview[24]. All of the interviews were held at the offices or workplaces of the interviewed care managers, located in Tokyo, Kanagawa, Chiba or Yokohama prefecture. In total, interviews with nine care managers were conducted all of which worked for different companies who provided different kind of services directed towards the elderly population. Eight of the nine care managers had an occupational background in formal caregiving, while one of the care managers had worked as a volunteer coordinator. Six of the interviewed care managers worked fulltime as a care manager, while the remaining three care managers also had other occupational roles within the same company. This further meant that the workload between the interviewed care managers varied. While one care manager had three clients others had a caseload of 35 clients (care level 1-5) + 8 clients (support required). The time spent working as a care managers also varied from 1,5 years to 10 years. However, the average length of working as a care manager among the respondents was 6,8 years.

4.4.1 Approaching the Care Managers

The care managers participating in the current study were approached in several ways. Two of the interviewed care managers were contacted through two acquaintances. One of these acquaintances, which worked as a manager for an institutional facility for the elderly was able to arrange an interview with a care manager working for the same company. The second acquaintance arranged an interview with the care manager of her elderly relative. One of the interviewed care managers was also

[24] The length of the interviews partly increased because an interpreter was used.

approached with the assistance of a care manager that previously had been interviewed.

The remaining six interviews were arranged with the assistance of another researcher who was currently working on a research project through which he had established contact with several companies employing care managers. He was therefore able to use his pre-existing connection to arrange four interviews. The same researcher was also able to arrange two additional interviews with the help of a relative of his who had connections with care managers due to her current work at a municipal government.

A consequence of having to employ the help of different contacts is that I in many aspects have not had insights into how and for what reasons the specific care managers was approached. It is possible that representatives of the companies employing care managers choose to approach care mangers that they viewed as more suitable. It is for example notable that a majority of the respondents had worked as care managers for more than seven years or that most of them had worked as formal caregivers. This may have affected the study's internal validity, since it is possible that the result of the study could have differed if respondents had more varying occupational backgrounds or if the length of working as a care manager would have been more diverse.

Interviews with nine care managers were conducted. The amount of interviews was not determined beforehand; instead the number of interviews was guided by the principle of saturation. Which meant that the sufficient amount of interviews have been conducted when the researcher does not feel that he or she does not get any new information out of the respondents (Repstad, 1999).

4.4.2 Information Letter, Consent Forms and Business Cards

Before the care managers were approached, an information letter[25] containing, a short presentation of myself, the research subject and an outline of what the participation in the study would mean was drafted. This introduction letter was originally written in English and then translated to Japanese [26] by the above-mentioned researcher who helped to set up the six out of the nine interviews.

After consultation with the same researcher a decision to use consent forms was made, since this, according to the researcher was seen as part of Japanese

[25] Appendix B
[26] Appendix C

research customs. The consent form[27] was originally drafted in English and then translated into Japanese[28] by the same researcher.

Another step taken in order to prepare for the interviews was to have a business card printed for myself. Having a business card, which could be handed to the care managers at the time of the interview, was deemed as important since the exchange of business cards in formal settings is an integrated part of Japanese customs through which a good first impression is conveyed (Coulter et al., 2011).

4.4.3 Preparing for the Interviews with the Interpreter

Part of the preparations made before the interviews with the care managers was to arrange a meeting with the interpreter. The meeting aimed to prepare the interpreter in a way that would enable her to fully understand what was being said during the interviews, something that would contribute to better and more nuanced interpretations. The preparations included going through the questions in the interview guide to make sure that she had a good understanding of the meaning of the questions and in turn could come up with a suitable translation. An effort to provide and discuss other relevant information relating to the study was also made. This included general information about the LTCI scheme, the role of the care manager and the objective of the study. Another aspect that was discussed was how we, as interpreter and researcher, would relate to each other during the interviews in order to avoid unnecessary confusion. This, among other things included how the interpretation would be carried out, which will be further discussed below. The interpreter was also encouraged to seek clarification from both care managers and/or researcher during the interview if she found any of the question or answers confusing or vague.

4.5 Conducting the Interviews

Since the care managers, who participated in this study were approached in variety of ways and by different people it has been difficult to ensure that all the care managers before the actual interview had received the same information. While some of the care managers were provided with the actual information letter others were only provided with that information orally. In response to this inconsistency each care manger was therefore handed the printed introduction letter at the time of the actual interview. The

[27] Appendix D
[28] Appendix E

care managers were also provided with a consent form for them to sign.

Before the interview started the interpreter was also asked to inform the care managers that her ability to communicate by using more polite Japanese[29] might not always be sufficient. This decision was made beforehand, in order safeguard the study's reliability by avoiding a situation where the care managers would come to view the interpreter use of more informal Japanese as sign of disrespect or impoliteness, which might have lead them to be less forthcoming in answering questions.

Additionally, the care managers were also given information about the conditions of their participation and also asked for permission to record the interview. A disadvantage of recording interviews is that it may have an inhibiting effect on the respondents (Repstad, 1999). It is possible that the interviewed care managers would have felt more at ease during the interview if it had not been recorded. However, using a recording devise was deemed as necessary in order to have the recorded material translated as meticulously as possible.

The interviews were carried out with the guidance of the interview guide, which had been designed to connect to the study's objective and research question. Using a semi-structured interview method meant that orders of question would vary from each interview situation. However, the interviews were always introduced with general questions about the care manager's background and work, since there is a risk that an interview runs in to a halt if the research starts off the interview with complex and complicated questions (Jacobsen, 2007).

The interviews were carried out at the care managers' office or work place. Conducting interviews in an environment that is familiar to the respondent can according to Jacobsen (2007) both have advantages and disadvantages, which has implications for the study's reliability. In general the care managers seemed comfortable during the interviews which might have been affected by the fact that they were familiar with setting in which the interviews were carried out. Conducting

[29] The Japanese language is characterized by its extensive use of honorific forms (Japanese, 2013) influencing many linguistics components such as verbs, pronouns, nouns and adjectives (Nakamura, 2001). When engaging in conversation with others, individuals construct their sentences in a way that indicates their social status in relation to each other as well as the individuals they speak about (Japanese, 2013). This for example means that the same verb have different forms and that these needs to be applied differently depending on who an individual is speaking with and if the individual is talking about himself, the other person or a third person.

the interviews at the care managers' office or work place usually also meant that they could be carried out without any disturbance or interference. However, there were a few occasions where it is possible that the care managers were affected by the fact that there were other people present in the room. Examples of such situations were when two interviews with two separate care managers were carried out in the presence of the care managers' manager or when a manager of an interviewed care manager decided to sit in for a few minutes. It is possible that these situations inhibited the care managers' ability to freely express themselves.

4.5.1 Different Styles of Interpreting

During the interviews with the care managers, a consecutive style of interpreting was employed. Consecutive style means that only one person at a time speaks, while an interpreter employing a simultaneous style, interprets at the same time as the respondent and researcher are asking or answering questions (Westermeyer, 1990). An advantage of simultaneous style of interpreting is that the respondent and the researcher express themselves more, and that the material becomes richer (Hornberger et al., 1996). Despite of this, a decision to employ a consecutive style was made. A decision that was partly based on the fact that a consecutive style has been brought forward, by Baker who is being referred to by Wallin and Ahlström (2006), as a more suitable style for interpretation when it comes to the type of one-on-one interviews employed in this study, because it might distract the respondent, as well as the researcher. Furthermore, the fact that the interpreter used for this study was neither a professional trained interpreter nor a person with extensive experience of interpreting, also made the style of consecutive interpreting seem like a more viable choice, since using simultaneous style interpreting in a successful way requires more training from the interpreter (Westermeyer, 1990).

Employing a consecutive style of interpreting during the interview with the care managers proved to have both advantages and disadvantages, which arose from the fact that a lot of time was spent on interpreting the care managers' response to questions, time during the care managers had to wait. Sometimes the wait seemed to make the care managers impatient while it at other times provided the care managers with a break during which they had time to further consider what they had just said, leading them to provide additional information or insights. The wait between the time when the care managers were answering a question and the time when their answer

was being translated to me might also have had an affect on the interview situation, since the dispatch made it impossible to directly respond to what the care managers where saying, by using indicators such as nodding. An effort was therefore made to, as much as possible, to have eye contact with the care managers during the time they were answering question as well as during the time when the answer was translated back to me.

Using a consecutive style of interpreting also meant that the actual interpretation sometimes became shorter and less nuanced that the original answer provided by the care managers, which have had different implication on the interviews and the collected material. Not being able to fully part-take in the care managers' original answers during the interviews did limit my possibility to further explore important leads which could have led to a richer answers and deeper insights. Not having direct access to the care managers' answers also meant that some of the questions that were asked had partly been answered previously. Having had the initial meeting with interpreter, during which the interview guide and research purpose had been discussed, showed to be useful in these situations since her knowledge about the research purpose gave her a sense as to what was relevant in relation to the answers given by the care managers. The interpreter's familiarity with the questions in the interview guide also meant that she was able to rephrase questions so that the care managers did not have to repeat something they previously had answered. After the interviews a short discussion with the interpreter was held during which some of the responses to the questions provided by the care managers were addressed. The purpose of these discussions was to seek clarification to any uncertainties. This occasionally meant that my original understanding or interpretation of what has been said during the interview enhanced and or slightly shifted. During these discussions other aspects relating to the interpretation were also discussed. The interpreter, for example, at one occasion, brought up the difficulties of translating from Japanese, which is known to be a language where opinions and thoughts are expressed in an indirect and subtle way, to English that she saw as more direct and straightforward. This meant that the interpreter sometimes struggled with finding a balance between trying to interpret as close to what the care managers actually were saying, while at the same time trying to convey the meaning of what was being said by the care managers. This is an issue also addressed by Larson (1998) who argues that every language has distinct features and that the interpreters therefore are not always able to

translate in a “word-for-word” kind of manner without losing the meaning of what is being said. Larson therefore conclude that conveying meaning must have priority in order to safeguard the study’s validity.

4.6 Processing the Empirical Material

The process of planning and collecting the empirical material for this study, as described above, coincided with an inductive research strategy in that the process was not directed by a predetermined theory (Sohlberg, 2006). The research subject has instead, in accordance to qualitative research methodology (Jacobsen, 2007), been approached with openness to the unexpected (Sohlberg, 2006). However, the activity of processing the empirical material instead bear features of an abductive research strategy, which means that a deeper understanding of the empirical material has been created with the help of different theoretical concepts (ibid.). The following section gives a more in depth account for how this has been accomplished.

Shortly after the interviews were conducted the recording of the English interpretations was transcribed. Going through the transcribed material, different parts of the responses made by the care managers were highlighted as particularly relevant to the study’s objective and questions. In order to get a more nuanced picture, the interpreter was then asked to translate these parts of the interviews. The interpreter was given the instruction to translate as close to what the care managers was saying without loosing the meaning of what was being said. She was furthermore given permission to edit the translation by removing words of repetition.

The translated material was then organized in a manner that corresponds to some of the main features of what is referred to as a content analysis. This meant that different themes and categories that captured and highlighted different aspects of the empirical material were created and then illustrated with the help of different quotes taken from the translated material (Jacobsen, 2007). In accordance with an abductive strategy, the different themes and categories created were also continuously examined from the perspective of different theoretical concepts in order to gain an in depth understanding (Sohlberg, 2006). This meant that some of the themes and categories originally created would merge or new sub-categories would emerge. The final result of this study can therefore best be understood as results derived from an analysis that has pended between an examination of the concrete empirical findings and a theoretical understanding.

Employing a hermeneutic research approach means that the researcher seek to interpret meaningful phenomena, but a text or human action can be interpreted in more than one way (Gilje & Grime, 1995) and an important aspect of analyzing the collected material therefore has to do with on what grounds interpretations and conclusions are made. Grounds for interpretations have been guided by what is referred by Gilje and Grime (1995) as the *actor criteria*[30] and the *holistic criteria*[31], two criteria's that I view as reconcilable with the hermeneutic approach. The holistic criteria focus on the text (Gilje & Grime, 1995), which is represented by the transcription and translation of the interviews. Adhering to the holistic criteria means that interpretations of parts of an interview have been viewed as viable when they harmonize with the interpretation of the interview as a whole (ibid.). This coincides with what is often referred to as the hermeneutic circle, where an understanding of the research subject arise when an interpretation of a phenomena is done in relation to its context and vice versa (Sjöström, 1994). Adhering to the actor's criteria means that the interpretations of the empirical material also have been guided in a way that reconcile with what has come to be viewed as the actors' or in this case the care managers' own intention or objectives for carrying out a certain action. Hence, the care manager's own interpretation is given a privileged role and interpretations of their actions can therefore not be done independently of them (Gilje & Grime, 1995). The actor's criteria also bears resemblance with Gadamer's term fusion of horizons which means that knowledge is obtained when the researcher's understanding of the research subjects life-world coincide with the research subjects understanding of their life-world (Hartman, 2004).

4.6.1 Presentation of the Empirical Material

Part of the translations, have been used in the presentation of the empirical material in terms of citations with the purpose of highlighting different aspects. In order to make it more comprehensive for the reader, some quotes have been edited in different ways. When a few words have been eliminated from a quotation, these words have been replaced with […]. In the case where one or more sentences have been removed, these sentence/sentences have been replaced with [---]. Furthermore, since the quotes often only represents a small part of a longer statement, it is sometimes difficult to tell, from the quotes alone, what the care manager is referring to because key words have

[30] Author's translation.
[31] Author's translation.

been omitted. In order to make it more comprehensive, the omitted words were inserted into the quotes. Inserted words have been placed in brackets [ ].

4.7 Ethical Considerations

This study has been carried out in accordance to the four ethical principals articulated by the Swedish Research Council. Some of the aspects relating to these principles have already, at least to some extent been discussed under the heading - Conducting the Interviews. As previously mentioned, to ensure that all the care managers had received the same information in regards to the research objective of the current study and an outline of what the participation in the study would mean, before the formal interview commenced, each participant was provided with a printed version of the introduction letter containing the above mentioned information. Some of the care managers took time to carefully read the letter while others seemed less interested and/or concerned about its content and an effort was therefore made to inform all the care managers orally that their participation was voluntary and that they could terminate the interview whenever and for whatever reason they wanted. The care manager were also asked to formally agree to their participation by signing a consent form for reasons previously discussed under the heading – “Information letter, consent forms and business cards”. Providing information about the research objective of the study through the introduction letter as well as obtaining consent from the care managers are actions that adhere to the first two principles set by the Swedish Research Council (Vetenskapsrådet, 2002).

Another important principle articulated by the Swedish Research Council is the principal of confidentiality, meaning that the respondents interviewed for a study, in the presentation of the empirical material, in different ways are made anonymous (ibid.). Anonymity for the care manager interviewed for this study has been secured by providing the care managers with fictive names as well as by excluding the names of the company that the care manager worked for or the names of the city or municipal in which they worked.

Adhering to the fourth principal set by the Swedish Research Council means that the information, gathered through the interviews held by the care managers, would only be used for the purpose of research and not for any commercial or other non-scientific purpose (ibid.).

5 Theoretical Framework

Role theory will be used in this thesis in order to reach a better understanding of the social support provided by care managers to family caregivers. What is referred to as role theory have grown out of several different theoretical perspectives[32], which has had consequences for how roles are understood (Biddle, 1986). This thesis will employ interactionist role theory, which is built on the premises of symbolic interactionism (Callero, 2008).

In this thesis social support is defined as "an exchange of resources between at least two individuals perceived by the provider or the receiver to be intended to enhance the well-being of the recipient" (Shumaker & Brownell, 1984, p. 13). A conclusion that can be derived from this definition is that social support can be seen as something that arises from the interaction between people. Using interactionist role theory as an analytic frame, therefore seem particularly relevant since its departing point, is the interaction that takes place among individual and groups of individual and the patterns that these social interaction form. Hence, roles and the certain behaviors that belong to them initially and recurrently are seen to arise from interactions (Turner, 2002).

5.1 Outline of Interactionist Role Theory

Turner (2002, p. 234) defines a *role* as "a comprehensive pattern for behavior and attitude that is linked to an identity, is socially identified more or less clearly as an entity, and is subject to being played recognizably by different individuals".

The existence of one role depends on the existence of other roles, and roles therefore exist in either pairs or sets (Turner, 2002). A *role-pair* could be the care manager's-family caregiver's role or the elderly's-care manager's role. A *role-set* instead consists of several roles, which is described by Merton (1957, p. 111) as a "complement of role-relationships in which persons are involved by virtue of occupying a particular social status". This means that every role exist in a role-set together with other roles to which the role is connected by different role-relationships (Merton, 1957). For instance, a role-set could include roles such as the care manager, the family caregiver and the elderly.

In articles about role theory, people engaging in interaction have been referred

[32] Functionalism, structuralism, organizational psychology, cognitive social psychology and symbolic interactionism (Biddle, 1986).

to in different ways[33]. This thesis will consistently use the terms *focal-role* and *alter-role* in order to make it more comprehensive for the reader. The term focal-role should be understood as the role through which the investigation departs, in other words, the care manager's role. Alter-roles can be understood as the different roles that the focal-role interacts with and relates to. Furthermore, the term *actor* will be used when referring a person incubating a specific role.

The interaction taking place between actors is a significant part of interactionist role theory and it is viewed as a process that includes what is referred to by Turner (2002) as *role-playing*, *role-taking* and *role-making*. Role-playing is the "overt enactment of what one conceives to be one's appropriate role in a given situation" (Turner, 1956, p. 317). Role-taking means that an actor of a focal-role, when interacting with an alter-role, imaginary constructs the role of the alter and that he, on the basis of that construction, choose his own actions. The importance of the concept of role-taking is that it stipulates that the actions or behavior displayed by the alter-role, with whom the focal-role is interacting with, is interpreted and understood in relation to the role imputed to that alter-role by the actor of the focal-role. This means that similar action displayed by two actors can be assigned different meaning depending on how the alter-role is constructed by the actor of the focal-role and that an actors response to an act is always more than a response to an isolated act (Turner, 2002). The term role-making is especially important for interactionist role theory and was originally coined by Ralph Turner (Callero, 2008) who argues that people act as if there were roles even though the consistency and concreteness of the role only exists in a varying degree (Turner, 1962). This further means that actors incubating specific roles not only play them but also create and modify the role (role-making), when they now and then attempt "to make aspects of the role explicit" (Turner, 1962, p. 22).

The fact that a role is seen as something that is created and modified through the interaction process does not mean that role-making occurs uncontrollably and Turner (2002, p. 235) in fact states that, "the prevalence of role-making is balanced by the tendency for the broad outline of roles and sometimes quite specific role elements to become normative". This normativity is partly created through the relationships linking focal-roles to alter-roles, since changes in behavior displayed by an actor of a

[33] Ralph Turner, in his chapter entitled "Role Theory" for example uses the terms "focal-alter roles" and "self-other roles" interchangeably (Turner, 2002).

focal-role will force change of behavior in the alter-role. Change in behavior will often be met with resistance from the alter-role, especially in cases when the alter-role is depending on the focal-role to display specific patterns of behavior. Normativity also steams from the fact that the continuum of social relationships of different kinds to some extent is dependent on a certain degree of predictability (Turner, 2002).

5.2 Classification of Role-Taking Behavior

As previously mentioned, role-taking can be understood as the process in which an actor of a focal-role, when interacting with an alter-role, imaginary constructs the role of the alter and that he, on the basis of that construction, choose his own actions (Turner, 2002). The term *standpoint* will further help us to differentiate between different kinds of *role-taking behavior*[34] and Turner (1956, p. 321) argues that the actor, when taking the role of alter, imaginarily constructs the alter-role and that these constructions can proceed from one out of three possible *standpoints*. The three standpoints that Turner presents will in the following be referred to as *alter's standpoint, third-party standpoint* and *standpoint of the interactive effect*[35]. These different standpoints will affect the actors of a focal-role in different ways, but this does not mean that the standpoint adopted by the actor cannot change throughout the course of an interaction (Turner, 1956).

Role-taking behavior that proceeds from the alter's standpoint, happens when the actor within the process of role-taking adopts the standpoint of the alter-role, meaning that the actor allows the attitudes of the inferred alter-role to become his own (ibid.). Turner (1956, p. 319) refers to this type of *role-taking* process as an "automatic determiner of behavior", since it automatically provides the actor of the focal-role with directives for behavior.

Engaging in role-taking does not necessarily mean that the actor will adopt the standpoint of the alter-role. If the standpoint of the alter-role is not adopted, the alter

[34] Turner (1956) also uses the term *reflexivness* to further differentiate between different role-taking behaviors. Reflexivness in contrast to non-reflexivness in role-taking can be understood as something that takes place when the actor of a focal-role uses the alter-roles as a mirror in which the alter-roles' evaluation and expectation of the actor's own role is reflected. Reflexivness in role-taking further means that the actor is self-conscious in that he is consider how he appears to alter-role and will view himself as an object of others' evaluation. I have in this study made the decision not to make a distinction of whether or not role-taking behavior should be seen as reflexive or not, since it was not found to be fruitful for analyzing the empirical material.

[35] In Turners article from 1956 the term *alter's standpoint* was originally referred to as *other's standpoint*, but has in this study been change in order to create some consistency.

remain as an object to the actor and guidance and directions for behavior will therefore be provided through a third-party standpoint or standpoint of the interactive effect. The third-party standpoint that is adopted by the actor can either be a personalized standpoint that belongs to a specific individual or group or it can be a depersonalized standpoint in the form of a norm. Through the third-party standpoint the actor is provided with a directive on how to act, and the relevant alter-role will become the starting-point for the implementation of that directive. The directive provide through the third-party standpoint can work in different ways. It may direct the actor of a focal-role as to what kind of image he or she wants other to associate him with, but it can also provide the actor with a directive of how to act towards the alter-role, a directive that can be subjected to change as the actor constructs the alter-role (ibid.).

Taking *the standpoint of the interactive effect* happens when the actor engages in role-taking in what is referred to by Turner (1956, p. 319) as an "adaptive context". The standpoint that will guide the actor's behavior in the adaptive context is best understood as the actor's own objective with the interaction with alter-roles. This means that the actor will adjust his behavior in accordance to what he or she interprets to be the most likely effect of his interaction with alter-roles. It is important to point out that this objective also can be shared by the alter-role, with whom the actor interacts (ibid.).

5.3 Different Types of Roles

According to Turner (2002) roles can be seen to be differentiated out of different principals, which means that behaviors and attitudes that a role consist of are selected from three possible principals, *functionality, representationally* and *tenability.* Relevant for the current study is the principal of *functionality*, where the differentiation is task-oriented in that the role is created around specific tasks that contribute to achieving a collective goal. Dividing up tasks, within an organization, will prevent chaos because there is a distinction between what tasks belong to what role.

In order to understand roles and how they are formed, there is also need to look at different types of roles. Turner's definition of role, presented above, includes four types of roles. One of these roles is the *position and status role,* which can be understood as a role that is connected to a position in a formally organized group

and/or organization. The fact that *position and status* roles are connected to a defined position has implications for the role in that it becomes formalized. Roles within an organization exist for the purpose of the organization, meaning that role processes must contribute to the overall goal of the organization. Furthermore, the specific role is defined by what Turner refers to as *legitimate role definers*. The legitimate role definer creates boundaries for a role by stipulating what an actor of the role may or may not do (ibid).

The interaction involving position and status roles, that are linked to a formal position in a groups and/or organization, is different from interaction taking place in informal groups, and Turner (1962) describes it as a more complex process, since there will be a compromise between role behavior prescribed by the organization and the role-taking and role-making process. However, Turner does conclude that the affect that the formal-role will have on the behavior of the actor playing it may vary (ibid).

5.3.1 Formal-Roles and Working-Roles

Turner (2002) states that there are always inconsistencies between the conception of a role and role behavior, and he argues that this is more common for positions and status roles, for two reasons. Firstly, the legitimate role definers are often positioned far away from the interaction that takes place between actors of focal-roles and alter-roles included in the focal-role's role-set. Secondly, the rigidity of the organization also hinders the formal conception of the role to quickly adapt to change. As a consequence, actors of position and status roles often develop what is referred to as a *working-role*, which is significantly different from the specification of the formal role. It is important to note that a working-role should not to be seen as the deviant behavior of an individual. The concept of the working-role is instead based on role incumbents' collective understanding of how the role should be performed. In addition, Turner (2002) stresses that it is possible that the working-role is constructed in a way that undermines the goal of the formal role, but it is more likely that working-roles instead function in a way that helps facilitate the overall aim of the organization. Another important aspect of formal roles are that they typically are vague an incomplete in regards to the functionality principle, meaning that the actor often is not provided with detailed information about how the role should be performed (2002). However, Turner (2002, p. 243) does argue that the actors of

formal-role "find better ways to perform their responsibilities than those specified in the formal role".

One aspect that contributes to the creations of working-roles is what is referred to as *intrarole conflict* (Turner, 2002). Intrarole conflict is a conflict experienced within a role, in contrast to *interrole conflict* which is a conflict experienced between roles (Brett Herman & Kuczynski Gyllstrom, 1977). Intrarole conflict may arise for different reasons, but one type of intrarole conflict arises when one and the same role encompasses several tasks, but a restriction of resources and time prevents the actor of the role to attend equally to all tasks. Therefore intrarole conflict will occur when the successful performance of one task hinders the actor successfully perform another task incorporated in his role (Turner, 2002).

6 Presentation and Analysis of Empirical Material

This chapter contains a presentation and analysis of the empirical material collected through the interviews held with nine care managers. The chapter consists of three sections, each of which addresses one of the three research questions. The first section *Provision of Social Support a part of the care manager role* will strive to answer the question of *what reasons do care managers have for providing social support to family caregivers*. In the second section addresses the question of *what kind of social support do care manager provide to family caregivers and how does it relate to the care manager's work assignments*. While the third and final question of *what is influencing the social support provided by care managers to family caregivers* is addressed in the final section of this chapter.

6.1 Provision of Social Support as Part of the Care Manager Role

6.1.1 The Care Managers' Formal-role in Relation to the Provision of Social Support

The beneficiary of the service provided through the LTCI scheme is the insured elderly, as outlined in Long-Term Care Insurance Act, article 9. This means that the elderly is the official client of the care manager since the care manager's work is to create a care plan matching the needs of the elderly (Matsuda & Yamamoto, 2001). The care mangers pointed out the fact that it was the elderly who were their official client during the interviews in different ways. For instance, Mr. Sasaki said, "[…] we are the elderly individual's care manager, not the family's." Furthermore, some of the

care managers also pointed out that supporting families was not part of or supported by the LTCI scheme itself. Ms. Yamamoto expressed this by saying, "The […] insurance policy does not include caring for those who are supporting the elderly." Similarly Mr. Yoshida also stated, "In today's care system supporting the family of the elderly is not incorporated. We are to support the [elderly] individual in this system."

The care manager as an occupation was introduced within the frames of the LTCI scheme and the main focus of the care manager work is to plan, organize and adjust the care in relation to the elderly's need. This will, taken together, ensure that the elderly receives high quality of care, which in turn will "enable them to continue to live independently in their own homes for as long as possible" (Matsuda & Yamamoto, 2001, p. 6). Enabling the elderly to continue living independently in their own homes is also one of the goals with the LTCI scheme (Yamada, Hagihara & Nobutomo 2009) and therefore the role of the care manager can be understood as an essential role that contributes to reaching that goal. Seen from an interactionist role theory perspective, the behaviors and attitudes associated with the care manager role, such as the planning, organizing and adjusting the care, can be understood as to have been differentiated from the functionality principle. Meaning that these behaviors and attitudes are centered on specific tasks, that contributes to the achievement of a collective goal (Turner, 2002), namely the goal of the LTCI scheme. With its formal connection to the LTCI scheme, the care manager role can also be described as a status and position role, that is, a role connected to a formal position in a group and/or organization. This connection will have an impact of the role conception of the status and position role, because what is to be viewed as acceptable and non-acceptable behavior for actors of the status and position role is stipulated by legitimate role definers (ibid). The care manager role is connected to a formal position in the overall organization of the LTCI scheme and it would therefore be possible to argue that a legitimate role definer of the care manager role can be understood as the developer behind the scheme, namely the Japanese government (Eto, 2001). The fact that several of the care managers during the interviews pointed out that their formal client was the insured elderly and that supporting family caregivers was not outlined in the LTCI scheme can be understood as an example of how the boundaries stipulated by the Japanese government impact the role conception of the care manager role, in that that the care manager must adhere to the regulation set out in the LTCI Act

(1997:123). Therefore, providing support to family caregivers cannot be understood as part of the care manager's formal role. The actual impact of the Japanese government, as a legitimate role definer, on the care managers' ability to provide support will be discussed further on.

6.1.2 The Care Managers' Working-role in Relation to Provision of Social Support

The accounts from the care managers, presented above, clearly illustrate that provision of support to family caregivers is not part of the formal care manager roles, since it is neither part of, or supported by the LTCI scheme itself.

However, when actually asked about whether or not they thought that providing support to family caregivers was part of the care manager's role, all of the care managers, although to a varying degree, agreed that it was. For example, Ms. Watanabe expressed this by saying: "Yes, not only do care managers help the elderly but helping family caregivers is a very important task as well", while Mr. Sasaki expressed it more in terms of a personal opinion by saying, "[...] in my personal opinion, supporting the family is an essential part of the job. Which is something I try to incorporate while working with families." On the other hand, Mr. Kato expressed it in a different way saying; "It depends on the situation", explaining that families sometimes do not want him to get involved. Some of the care managers also talked about their role as providers of support to family caregivers in terms of something essential or as a need. Ms. Ito expressed this by saying, "We have to or else things will fall apart. It can lead to families falling apart. If we don't acknowledge the caregiver and help them, things could turn into incidents one may find in newspapers." Mr. Yamaguchi provided a more thorough account and said:

> In order for the elderly to live, there need to be some form of family support or else things will not work out. Which makes the people involved very important when caring for the elderly. For instance, if the caregiver gets sick or tired from supporting the elderly that they can't assist the elderly anymore, then the elderly individual can't live at home. To create a good environment in the home of the elderly, it involves having the family caregiver happy, healthy, and motivated to help the elderly. Therefore in that sense, it is very important to keep in mind of the family caregiver.

While recognizing that the act of supporting family caregivers was not part of their formal role, the care managers still agreed that it was an important part of their work. This view can, from an interactionist role theory perspective, be understood as something that has developed within the care mangers' working-role, which

comprises role behaviors that are not consistent with the formal conception of the same role. The development of a working-role is common among status and position roles and arises partly because of the distance between legitimate role definers and the actual interaction that takes place between focal – and relevant alter-roles (Turner, 2002). Looking at the care manager role, this would be a distance between the Japanese government, who has been described as a legitimate role definer, and the interaction that takes place between the care managers, the elderly and their family caregivers. A distance that was highlighted by Mr. Yoshida and Mr. Sasaki:

> As a care manager, it is hard to work because support for families seems like an obvious need in order to have a good home environment. However maintaining a good environment in the home is hard when the system doesn't allow support to family caregivers. Family support should be a must but currently it is not part of the system.
>
> Mr. Yoshida

> The government is focusing on the elderly to become independent, which is a great goal. However, the different services and support of families is not up to date. There are some situations where the family is asking for something and these things may be rejected because under the law, it is not allowed. As a care manager, we want the government to be more realistic rather than idealistic that families are part of the elderly's living and that those situations must be considered when coming up with a program.
>
> Mr. Sasaki

The LTCI system was introduced under the slogan "From Care by Family to Care by Society" (Eto, 2001) and has also been described as a "mechanism to ease the burden of families looking after their frail elderly" (Tsuno and Homma, 2009, p. 10). The aim of the LTCI scheme was to establish a system that would promote independent living for the elderly, allowing them to continue living in their own communities and Yamada, Hagihara & Nobutomo (2009) writes that the government with this goal has come to recognize the importance of the role the family caregiver play as essential for the care within the community. Even if the importance of family caregivers has been recognized by the government, the design of the LTCI scheme does not allow family caregivers to benefit directly from the services provided through the LTCI scheme since the beneficiary of these services is the insured elderly, which is outlined in the LTCI Act (1997:123) article 9. From the interviews with the care managers, it became clear that the design of the LTCI system does not adequately respond to the actual needs of family caregivers and that this inadequacy in turn creates a situation where the responsibility of providing support to family caregivers partly falls upon the role

of the care manager.

The fact that the behavior of supporting family caregivers has been incorporated into the working-role of the care managers might seem contradictory, since these behaviors are not part of, and sometimes even restricted by, the formal conception of the care manager role. The inconsistences between behaviors and attitudes incorporated in a working-role and those prescribed to a formal-role do not necessarily mean that the behavior of the working-role will undermine the overall goal with the formal role. Turner (2002) in fact states that it is more common that the behavior incorporated in the working-role would help to facilitate the goal of the formal-role and this also seem to be the case when looking at the support provided by the care managers to family caregivers. Several of the care managers talked about their provision of support in terms of a need, something that they had to provide in order to fulfill their formal work obligations, which in turn aims to meet the overall objectives with the LTCI system.

Ways in which the care managers supported family caregivers varied and is something that will be addressed in more depth later on, but it should be mentioned that the care managers used LTCI services as a way to indirectly support family caregivers. This could mean that services like day care and short stay were incorporated into the care plan of the elderly, allowing family caregivers some time off. Using LTCI services to support family caregivers, although in an indirect way, can be seen as an example of how the behaviors in the working-role go against the behavior prescribed in the formal role. The fact that the care manager employ behaviors that deviate from the behavior prescribed to the formal-role should not be viewed as the individual care managers engaging in deviant behaviors. According to Turner (2002), the behaviors incorporated in the working-role are based on a collective understanding of how the role should be performed. This collective understanding was during the interviews highlighted by some of the care managers. Ms. Yamamoto who previously had talked about suggesting short stay as a way to support the elderly and their family, also added: “The system itself hasn't really changed but the mentality and practice of the system has. There have been new understandings that after a while, one way might be more effective than the other.” Similarly, Mr. Yamaguchi who had talked about the possibility to use day service to support family caregivers also said: “These are ideas that have become more acceptable recently to ease the burden of the family members.”

The contradictions between the care managers formal-role and the attitudes and behaviors included in the care manager working-role is perhaps best captured in the following account made by Mr. Suzuki, who said:

> […] from a specialist's point of view, helping the family of the elderly is not allowed. We are not specialized to help the family nor are we counselors. However in reality, there is a need for us to help support these families. After working as a care manager all these years it is evident that what our job description requires from us is impossible without the extra work supporting the families. There are many grey zones on this subject matter but all in all there is a demand for us to be there for the family. [---] I'm only interacting with these clients as a care manager, but if I could help whether directly or indirectly in any way that could lead the family to live a more comfortable life, I feel like I have truly accomplished my job.

6.2 Social Support Provided by Care Managers to Family Caregivers

In the previous section, the support provided by care managers to family caregivers of elderly adults receiving community based LTCI service was analyzed with help of the two terms formal-role and working-role. The conclusion made was that the behavior of and attitudes towards supporting family caregivers was something that had developed as part of the care manager's working-role. When speaking about support as part of the care manager role, many of the care managers talked about support in general terms without making any distinct differentiation between different ways in which they supported family caregivers. However, from the interviews held with the care managers it did become evident that care managers supported family caregivers in a variety of ways, which will be presented below.

6.2.1 Supporting Family Caregivers Through Their Formal Work Assignments

In descriptions of the formal care manager role, work assignments that relate to the planning, organization and evaluation of the service provided through the LTCI scheme are often included (see Matsuda & Yamamoto 2001; Kusuda 2011; Campbell & Ikegami 2003; Momose, Asahara & Murashima, 2003). Even though the care managers' formal client is the elderly, the interviews with the care managers show that they address both the elderly and their family caregivers in their work. This meant that the care managers, to some extent, used their formal work assignments to support family caregivers, even though in a modified way.

6.2.1.1 Supporting Family Caregivers with LTCI Services

One of the most evident ways in which the care managers supported family caregivers, through their formal work assignments, was by the different services

provided through the LTCI scheme. These services cannot be directed towards family caregivers, since the LTCI (1997:123) Act article 9 defines the elderly as the official beneficiary, but several of the care managers perceived these services as a possible way of supporting family caregivers indirectly.

Some of the care managers talked about supporting family caregivers through the LTCI services in a more general way. For instance, Mr. Kato stated: "There is a limit as to how much I can help in the welfare system but I try to solve the issues and demands by implementing different services". Several of the care managers also gave specific examples of the services that they could provide and in what way they thought these services would support family caregivers. Some of the care managers gave examples of how they could arrange bathing services for the elderly, which would mean that the family caregivers would not have to do this themselves. Mr. Suzuki talked about how this service could be provided within the frames of day-service and said, "[…] by using day-services three times a week the family does not have to worry about bathing the elderly. By using appropriate services, the family's workload is lightened thus helping the family."

Many of the care managers also talked about the provision of LTCI services as something that would give family caregivers some time to rest and recuperate. Ms. Ito spoke about the possibility of giving family caregivers some time by arranging for home-helpers to come and assist the family by changing diapers or feeding the elderly. Several of the care managers also mentioned services like short-stay or day-service as ways of giving family members some time to off from caregiving. For instance, Ms. Watanabe said: "I can suggest options such as short-stays in order to give the family time to rest." The ability to provide these services that were directed toward the elderly, but indirectly supported family caregivers, were in fact described by some of the care managers in terms of *loopholes*. Mr. Yamaguchi for example expressed it as followed, "Day-service is mainly used for the purpose of helping the elderly get out of the home, stay active, […] but it can also be helpful for the family members to get a quick break to focus on themselves as well. This may be indirect but there are loopholes like this that we can use services to help the family."

6.2.1.2 Giving Information and Advice

Providing information about available services and advice on what services that would be suitable in the specific case to the elderly is also one of the care managers

formal work assignments (Blomberg, Edebalk & Tada, 2006). The interviews with the care managers did reveal that they also used this as a way of supporting family caregivers. Hence, the care managers gave family caregivers information and advice regarding the services provided through the LTCI scheme and about caregiving to family caregivers.

Mr. Yamaguchi talked about the uncertainties under which family caregivers live and said, ”Family members are often anxious and insecure because they do not know how long they would have to care for the elderly. [---] In order to lighten the load, it is necessary for me to provide information as much as possible.” Mr. Suzuki was more elaborated when talking about supporting family caregivers by giving them information about services provided through the LTCI scheme and pointed out that it was important for him to give the information about the LTCI services in a way that helped family caregivers to envision how the different services might improve their situation.

Providing information or advice to family caregivers by drawing on knowledge acquire through their experience working as a care manager or as a formal caregiver was also something that was brought up by some of the care managers. For instance, Ms. Yamamoto said: “All I can do is listen and most likely, I may have an answer because I may have encountered similar situations in the past.” Mr. Suzuki instead talked about how he could use knowledge acquired through his years working as a formal caregiver and said, "There is direct help that I can provide with my occupational background. Such as how to change a diaper or using a wheel chair. By using the skills I've learned from the field, I can give advice to families. Which can lead to setting the family's mind at ease.“

Some care managers also talked about how they would support family caregivers by helping them to make decisions in situations where they themselves were not able. Ms. Yamamoto provided the following example, “For instance, the elderly started to feel weak all of a sudden and the family doesn’t know what to do. In this case, we as care managers need to take initiative and actively take control of the situation.”

6.2.1.3 Creating a Supportive Environment Around Family caregivers

Another work assignment that belongs to the formal-role of the care managers is the coordination of care that is, coordinating the service provided by different service

providers (Ikegami & Campbell, 2002). The purpose with coordinating the service is to ensure that the elderly receives high quality care (Matsuda & Yamamoto, 2001). However, the care managers also talk about coordinating the service providers in a way that created a supportive environment around family caregivers.

Mr. Yoshida pointed out that a care manager, in order to support family caregivers, needs to be good at using other recourses such as social workers and nurses and said, "By including everyone, we can form a good team in order for us to give the family the best experience of living in the home with the team-support." Mr. Suzuki also spoke about creating a supportive environment around family caregivers and described his own role in terms of a *mediator* who in different ways would communicate with the other members of the team, in order to support family caregivers. Mr. Suzuki gave two examples and said:

> When the family caregivers are concerned about how they can take care of the elderly family member with dementia, by assisting in getting the right treatment, communicating with the doctor, and providing information can also serve the family as well. [---] Sometimes, I also speak with the nurses to tell them about the emotional and psychological condition of the family caregivers so that we can get professional help and advice. By being the mediator in communication and assessing the situation or implementing other services, we can support the family caregivers.

6.2.1.4 The Formal Care Manager Roles Effect on the Care Managers Actual Behavior

In the above-presented sections, several examples of how the care managers used their formal work assignments to support family caregivers were provided. It could be argued that the way the care managers have come to use their formal work assignments does not fully correspond with how these were intended to be used, since supporting family caregivers is not part of the care managers' formal-role. Using their formal work assignments in this way can therefore be seen as belonging to the care managers' working-role. The formal-role of the care managers, which include behaviors prescribed by legitimate role definers, hinders the care managers to support family caregivers by incorporating LTCI services directed toward the family caregivers. The relation between the formal-role and the actual behavior of an actor of that role is discussed by Turner (1962) who concludes that the rules prescribed in the formal-role serve to invoke the appropriate behavior in the in actor, but the effect that these rules have on the actual behavior of an actor of a role may vary. The fact that the care mangers support family caregivers by using their formal work assignments

does suggest that behaviors prescribed in the formal-role of the care manager only restricts the actual behavior of the care manager to a relative degree.

6.2.2 Other Forms of Support Evolves

Supporting family caregivers by employing formal work assignments might not always be sufficient and the care managers' accounts also revealed other ways in which they provided support. The types of support that will be presented below varied, but a majority can be understood as different types of emotional support.

6.2.2.1 Making Referrals

Many of the care managers spoke about different resources such as consultation desk at municipal office, study sessions, support groups and counselors, all of which were organized outside of the framework of the LTCI scheme, by different actors. Mr. Suzuki talked about the range of different resources available to family caregivers outside the LTCI scheme and said:"[...] there are many family support gatherings, conferences, and study sessions, in which we can pass this information along to the families and help them be at ease". Similarly Mr. Suzuki also talked about making referrals to resources organized outside the LTCI scheme, but added, "However this isn't exactly our job but we try to offer as much information in order to aid the families." In contrast, some of the care managers instead talked about how it was important for them as care managers to be aware of resources organized outside the LTCI scheme. Mr. Yoshida expressed this by saying, "[...] so it's up to the care manager to rely on these places, which are available to them, but it's up to the families to use these resources." and also added, "They might not want the help, but it is something that we can suggest in passing even though it may not be a service that is provided through the insurance."

6.2.2.2 Being There

During the interviews the care managers gave several examples of how they in different ways supported family caregivers. The ways in which the care managers supported family caregivers varied, but a common theme was that the care managers in different ways tried to *be there* for the family caregivers. Mr. Suzuki talked about how some family caregivers tended to be more worried than others and said, "There are families, even though the [care] plan is perfect, they are still worried. People who are worried will call a lot, and the best I can do is to listen and assess their needs. Earlier I mentioned that I visit once a month but that just happens to be the minimum.

If there is a need for support, I will visit them once or twice a week.” Similarly, Mr. Yoshida talked about the importance of letting family caregivers, who was experiencing a difficult situation, know that he as a care manager would try to be there for them and said, “[...] being able to say that I am with them to solve these problems with them is crucial. To reassure the families that we care and have the desire to help them as much as we can is essential in forming the trust to do our job”. Mr. Sasaki gave another example of supporting family caregivers by being there and said, “Personally, if there is a new client who's considering day service, I try to go with the family to observe the facilities [...].

6.2.2.3 Spending Time Talking to Family Caregivers

Many of the care managers spoke about the importance of being a good listener in order to support family caregivers. Being a good listener was sometimes described as a tool through which the care manager could fully understand the family caregivers’ problems and subsequently come up with a solution. However, some of the care managers also stated that they listened to the family caregivers’ problems or worries and that this did not necessarily mean that they would provide a solution or come up with advice; hence the listening in itself was viewed as a form of support. The fact that being a good listener can both be viewed as a tool and as a way of providing support to family caregivers is illustrated by the following account made by Ms. Watanabe who said, "First off, listening carefully. Secondly, deciphering if the family want to find a solution to a problem or wanting to talk about it [---]. If it seems like the family needs to vent, I try to listen to them and talk to them face to face. By listening to them I can give support by cheering them up." Some of the care managers talked about the family caregivers’ need for an outlet through which they could be heard. For instance, Mr. Yamaguchi talked about himself, in his capacity of being a care manager, as someone suitable of listening family caregivers, and explained it as followed:

> There are not many people who understand the hardship in which people go through when caring for the elderly. Sometimes it's the daughter who is taking care of the elderly so even if there are others living there, they might not understand the stress and anxiety she might be experiencing. I on the other hand understand and see family members go through this everyday. When I come across family members who are struggling, I can listen to them while they vent […]. Sometimes it will take 30 minutes. Others, an hour to two hours. But the important thing is that I lend a listening ear during these times that they may feel comforted.

6.2.2.4 *Comfort and Encouragement*

From the accounts made by the care managers it also became clear that they provided support in the form of comfort and encouragement to family caregivers. For instance, Ms. Ito said, “I try to support them emotionally by listening and sharing words of comfort." How the care managers went about it varied. Ms. Watanabe said, “Even one-liner [...] such as, ‘you’ve been working hard.’ Or ‘I understand what you’re going through’ can relieve these family members." Mr. Tanaka also spoke about how he comfort and encourage family caregivers by letting them know that there were people in their neighborhood going through the same situation. Mr. Tanaka explained it as followed:

> We can't say names however, we can encourage them by saying that there are other families out there going through the same situations and hope the family can feel reassured. Japanese people especially like knowing about other households. So Japanese people tend to feel comforted knowing that other families near them are going through the same situations. [---] we can say, ‘hey, I know it’s tough and there are others struggling right along with you. I know you can do it. Let me help you.’ We can give words of encouragement and comfort by letting them know that they aren’t alone in this situation.

6.2.2.5 *Creating New Ways of Supporting Family Caregivers*

The provision of social support is not part of the care managers’ formal-role and the care managers are therefore not either provided with any direct guidance of how they should support family caregivers, something that was highlighted by some of the care managers during the interviews. Considering the examples above of how the care managers’ support family caregivers, it would be possible to argue that the these ways of providing support can be seen as something that has evolved through the interaction between care managers and family caregivers something that can further be understood if the nature of roles in general are considered. Turner (1962) argues that roles only exist to a varying degree of concreteness and that the uniqueness of every situation demands some kind of improvisation from the actor of a role. An actor of a role can therefore not only be viewed as someone who simply plays the role, they also create it, by engaging in role-making. Supporting family caregivers by making referrals and providing emotional support as illustrated in the examples above, can be seen as something that has evolved through the process of role-making.

6.3 What Influences The Provision Of Support?

Aspects of what influenced the social support provided by the care managers were during the interviews highlighted by the care managers in several ways. These aspects

will be presented under the two headings *Provision of social support influenced by legitimate role definers* and *Provision of social support influenced by the standpoint adopted by the care managers*.

6.3.1 Provision of Social Support Influenced by Legitimate Role Definers

The Japanese government, the developer behind the LTCI scheme (Eto, 2001), can be viewed as a legitimate role definer who stipulates or prescribes what is to be viewed as acceptable and non-acceptable behavior of actor of the care manager role. What is acceptable and non-acceptable behavior is prescribed in the LTCI Act (1997:123) that regulates the LTCI scheme. Through the interviews with the care managers it also became clear that the Japanese government was not the only legitimate role definer of the care manager role. In addition, the different companies that the care managers worked for also, to some extent, defined what should be viewed as appropriate an inappropriate behavior of an actor of the care manager role. Furthermore, the interviews with the care managers showed that these legitimate role definers also influenced the social support provided by the care managers to family caregivers, both directly and indirectly.

6.3.1.1 Japanese Government

As previously illustrated, one way in which the Japanese care managers supported family caregivers was by using the different LTCI services. The care managers' ability to use these services was however influenced by the Japanese government, as a legitimate role definer, since only services directed toward the elderly could be incorporated into the care plan. Hence, the care managers were not able to directly support family caregivers with the help of LTCI services, because the LTCI Act (1997:123) defines the elderly as the official beneficiary (article 9). This was addressed by some of the care managers. Mr. Yoshida talked about it in relation to using the service of home-helpers and said, "[...] if there are two people living in the same home. [---] The helpers can only clean the elderly's room. If there are communal spaces, such as the bathroom, under the care system it is not allowed. So in those terms, the system itself only supports the elderly individual."

The empirical material also showed that the Japanese government as a legitimate role definer also influences the care managers' ability to support family caregivers with financial limitation. The LTCI scheme is developed in a way that requires the insurance beneficiary to pay a 10 % co-payment fee for the LTCI services

incorporated in the care plan (Matsuda & Yamamoto, 2001). The services provided within the LTCI scheme are discounted, but using more services will automatically mean that the elderly and/or their family have to pay more. This meant that the care managers were limited in their ability to incorporate LTCI services in the care plan if the elderly and/or their family caregivers could not afford it. Hence, the care manager's ability to indirectly support family caregivers with limited finance was influenced because the care managers have to adhere to regulation in the LTCI Act. Situations like these were among others, highlighted by Mr. Yamaguchi, who spoke about the lack of money as something that made it more difficult for him to provide support. Mr. Yamaguchi concluded, "Coming up with a plan is more challenging with the financial limitation." This restriction, prescribed through the rules included in the care managers' formal role, does not necessarily mean that the care manager will refrain from providing support to family caregiver with financial limitations. For instance, Mr. Yamaguchi also talked about ways in which he could help families with difficult financial situations and said, "There are limitations but there are different services that can be helpful in these situations. Some are financial aid and some will exempt the payments. We will try as much as we can to help fill in the gaps to make it easier for the families."

6.3.1.2 The Care Managers' Companies

All of the care managers, participating in this study, worked for companies that provided different types of services directed towards elderly people. Working as a care manager for a company that provides these types of services rather than working independently is not uncommon for the Japanese care managers. In fact, most of them work for companies that provided different services to the elderly population (Blomberg, Edebalk & Tada, 2006). Working for a company also meant that the care manager role, to some extent, was defined by legitimate role definers, such as people in management positions within the company. These legitimate role definers influenced the social support provided both in a direct and indirect way.

One way in which the care managers' company could directly influence the support provided by care managers to family caregivers was highlighted through accounts made by Mr. Sasaki. Mr. Sasaki had earlier spoken about how he emotionally supports family caregivers by going with them and the elderly when visiting new service providers. Mr. Sasaki later talked about how he was able to

support family caregivers in this way because there are many grey zones when it comes to how a care manager may or may not support family caregivers. Mr. Sasaki pointed out that the care manager on an individual level can decide how to support family caregivers but also acknowledged that, “[...] there are some companies who refrain the care managers from providing these extra services.”

How the companies that the care manager worked for indirectly could come to influence the support provided was highlighted by some of the care managers. For example, Mr. Suzuki who previously stated that one way in which he could support family caregivers was to create a care plan that truly would match the need of the elderly, later talked about how the expectation on the care manager role, held by the company the care manager worked for, would influence the care manager ability to perform their work and said:

> [...] there are not many independent care managers. Most are within a different care facility. Therefore, the company has other responsibilities that need to be taken care of as well that may end up on our plate of responsibilities. Some care managers work for hospitals, day service facilities, and other places with different expectations and so on that will add a new load of expectations on these care managers. Sometimes money can also get involved, that the focus of the facility is to make money therefore the care manager cannot fully fulfill their job because the focus is on the money rather than the client. For instance, to save money, these care mangers may have to do some of the work around the hospital or help plan day service can be added to the workload. In these cases, even if we genuinely want to focus on making a care plan, we are not able to do so.

In the example above, it becomes evident that the expectations placed on the care manager by the care manager’s companies might add to the care manager’s workload. This in turn will mean that the care manager have less time for other work assignments. Time constraint or lack of time, was also brought up by Mr. Sasaki and Mr. Yamaguchi as an example of something that would influence their ability to support family caregivers. Mr. Yamaguchi who previously declared that he supports family caregivers by listening to their concerns and that the time he spent listening could range from 30 minutes to 2 hours also added, “I definitely feel that there isn't enough time in the world if I truly were to do my job at the fullest." Mr. Sasaki who also talked about supporting family caregivers by listening to them during his monthly visits also added, “Under the government, it is not our job to be a counselor but for me I do try to listen. There is a limitation on time so we can't be there for two or three hours but within the time given, I try to comfort and support these family members as much as possible.”

In these cases, time constraint was pointed out as something that would affect the care managers' work performance in relation to their ability to support family caregivers and this can, be understood as an intrarole conflict. An intrarole conflict arises because one role may encompass several tasks and restrictions of recourses and time will prevent an actor of a role to attend equally to each of these tasks. These kinds of intrarole conflict arise when the successful performance of one task hinders the actor ability to successfully perform another task, which is incorporated in his role (Turner, 2002). The expectation placed on the actor of the care manager role by the company they work for can be understood as something that creates a situation where the care managers, due to the different work assignments assigned to them, lack resources in the form of time to support family caregivers in the way they find necessary.

6.3.2 Provision of Social Support Influenced by the Standpoint Adopted by the Care Managers

In the previous sections, aspects were highlighted of how legitimate role definers of the care manager role influence the support provided by the care managers to family caregivers. However, how the formal-roles and the behavior prescribed to them affect the actual behavior of an actor of such role vary (Turner, 1962), and we have seen several examples of how the care mangers both create new behavior as well as modify behavior which is already prescribed in their formal-role. The interviews with the care managers further revealed that the provision of the social support also was influenced by the standpoint adopted by the care managers. This means that the type of support provided was influence by the care managers' preconception of what was important or what should be done in certain situations, but also by what the care managers actually hoped to accomplish by providing support to family caregivers.

6.3.2.1 Third-Party Standpoint

From the care managers' accounts it became clear that they were of the opinion that different family caregivers as well as different situations would require them to provide different types of support. However, this did not mean that the care managers also had preconceptions and opinions in regards to their relationship to family caregivers and how family caregivers should be supported, which in turn would influence how they would support family caregivers. This can further be understood as the care managers adopting a third-party standpoint that will direct their behavior

when interacting with family caregivers. Adoption of a third-party standpoint means that the actor of a focal-role have adopted a norm that will provide a directive for action and that alter-roles will become a starting-point for the implementation of that directive (Turner, 1956). Examples of ways in which the adoption of a third-party standpoint would influence the support provided by the care managers to family caregivers were provided through the accounts made by the care managers during the interviews.

Some care managers talked about their relationship with the family caregivers in terms of an ideal relationship, a relationship that was described as a partnership. Mr. Kato expressed it as followed, "The relationship between the care manger and the families are centered on the elderly. By having cooperation from the family as well I am able to further assist them. We try to work as partners." By referring to the relationship to family caregivers in terms of a partnership, the care managers can be understood as having adopted a third-party standpoint that prescribes what kind of image they want alter-roles to associate them with. Hence, the care managers have adopted a norm that says that their relationship to family caregivers should have the character of a partnership, meaning that they will try to direct their behavior towards the family caregivers so that an image of a partner will be portrayed. Striving to develop this kind of relationship indirectly influence the support provided since it gives the care managers direction of how they should and should not behave towards family caregivers. An illustration of such directions was perhaps best captured by an account made by Ms. Ito who stated, "In basic terms, we are equals. I am not there to boss them around. I am there to lend a helping hand and to listen to what they have to say. It is a relationship where we are equally invested in helping the elderly. I want to listen and comfort them by solving these things together."

The empirical material also showed that the care managers adopted other third-party standpoints that would influence the way they supported family caregivers. In fact the care managers' accounts showed that they would find themselves in situations where they would employ directives from a third-party standpoint that to a certain degree would go against the concept of being a partner. For instance, Mr. Kato and Ms. Watanabe talked about different skills and traits that they thought was important to master as a care manager in order to support family caregivers and Ms. Yamamoto said, "[...] to take charge to be decisive is very important." and Mr. Kato similarly said, "[...] make decisions is a helpful skill." Viewing skills such as being

decisive and taking charge as important can further be understood as a third-party standpoint that the care managers have adopted. Mr. Kato and Ms. Yamamoto talked about the importance of these skills in situations where the family caregivers themselves were not able to make decisions, situations that would require the care manager to step in and take charge. This third-party standpoint can be understood as providing the care manager with a directive when he or she interacts with family caregivers that are struggling or are unable to make a decision. The acknowledgement of the family caregivers inability to make decisions will enable the care manager to act in accordance to the exiting directive, that is, to support the family caregivers by helping them to make decisions.

The care managers' accounts showed that they employed several different strategies to support the family caregiver that they met through their work. This did not mean that the care managers did not have preconceptions of what type of support that might be more important than other types of support. Some of the care managers explicitly talked about what they saw as the most important way to support family caregivers. For instance, Mr. Sasaki stated, "I personally believe that […] it is important for us to emotionally support these people rather than the trivial things on the side." A concrete example of how this type of standpoint would influence the support provided by the care managers was given through the accounts made by Mr. Yamaguchi who spoke about how he actively was trying to creating an environment where the family caregivers would feel comfortable to share their concerns. Mr. Yamaguchi more specifically talked about how family caregivers in the beginning were hesitant to talk about their experiences because they did not want to take up his time, but how he over time had been able to change this. He described the situation as followed;

> [---]When I sit down with them and let them know that I'm willing to take the time to listen, it is easier for them to share their concerns. Little by little the conversation moves forward and they are willing to open up. There are so many people who believe that no one wants to listen to them or understand what they are going through that they hold it in. In the beginning, these people might have only talked 5-10 minutes but these days, it has extended to 30 minutes to an hour.

The situation described in the above statement can be understood as the care manager acting in accordance to the third-party standpoint, which proclaim that emotionally supporting family caregivers is important, since it is the care manager who actively

works to create an environment that allows the family caregivers to open up gradually, rather than the family caregivers who actively seeks it. Hence, viewing certain types of support as particularly important can also be seen as third-party standpoint that will influence the support provided by the care managers to the family caregivers.

6.3.2.2 Standpoint of Interactive effect

The previous section provided examples that illustrate how the support provided by the care managers can be influenced by the third-party standpoint adopted by the care managers. The fact that the care managers had preconception, did not always mean that they would let these guide their behavior. In fact, the interviews with the care managers suggest that they in many ways adjusted their behavior in relation to the specific situation and family caregiver, suggesting that the care managers' behavior, was guided by another type of standpoint.

Several of the care managers spoke about the importance of having different types of knowledge such as knowledge about available resource or caregiving, in order to support family caregivers. This did however not mean that the care managers provided the same type of support to all the family caregivers that they came in contact with through their work. In fact, most of the care managers instead talked about the importance of providing the right type of support in relation to the need or the specific situation in which the family caregivers found themselves. This meant that the way the care manager originally had supported the family caregivers might change over time, something that was highlighted by Mr. Yamaguchi who said:

> If the family is self-reliant and capable, I don't have to put as much effort being concerned for them. As time goes by, the condition of the elderly may change. When that happens, I have to put more time and adjust to them in order to stabilize the situation. When the conditions change, the routines for the family members change as well so they might need support in ways they didn't need in the past. In addition, these family members may need to gain certain knowledge they might have not needed in the past in order to care for the elderly. For instance, diapers, "How many kinds and how do you use them?" within these changes, there are new demands and concerns.

In order to understand the family caregiver's need, several of the care managers brought up the importance of really listening to the concerns expressed by the family caregivers. Mr. Suzuki expressed it as followed, "In the end, it is essential to be a good listener. By listening well, I can learn more about their concerns, which will lead

to better preparation. We can form better plans and services around these people by knowing them better." Other care managers instead spoke about the importance of getting to know the family caregivers in order to support them in a way that would be helpful to them. For instance, Mr. Sasaki brought this up when talking about whether or not to support family caregivers by referring them to study sessions on dementia and said:

> Before bringing fliers and information on these meetings or study groups, you need to get to know the family better. It's harder to give this information to newer clients. One must be sensitive to the situation at all times. We cannot just go up and tell them, "hey your father or mother has dementia you need to get it checked out or get more information" is a hard point to get across. If you have some trust with the family and the family understands the situation with the elderly, we can individually assess how each family may receive the information we are about to give.

In the above, examples of how the care managers used different types of knowledge in order to support family caregivers has been provided. What type of knowledge the care managers use depends on how they understand the family caregivers' need. The fact that the care managers change how they support family caregivers in relation to what they interpret to be the need of family caregivers, might at first been interpreted as situation where the care managers have adopted the standpoint of the family caregivers (alter' standpoint) and therefore conform to what he or she interprets to be the family caregiver's expectation. However, it will instead be argued that it is more likely that the behavior displayed by the care manager in the interaction between the care manager and the family caregiver, is guided by the standpoint of the interactive effect. This means that the care manager adapts his or her behavior when interacting with the family caregivers in order to attain a certain objective. Evidence that suggests that the care managers' behavior is adjusted in order to reach a certain goal rather than simply conforming to what the care manager interpret to be the expectation of the family caregivers is found in the account made by Mr. Yamaguchi who talked about the support that he provides in terms of a means through which he could "stabilize the situation" or "make their lives easier". Similar reasons for providing support were also highlighted by other care managers. Ms. Ito and Ms. Watanabe gave similar reasons when they talked about how they sometimes would comply to the demands made by family caregivers in terms of what services to incorporate in the care plan,

even if the demands were not always coincided with the wishes of the elderly. Ms. Watanabe expressed it as followed:

> Depending on how demanding the family is, it may be easier to listen to the family in order to have a more stable environment in the home. Some of these demands may include, showers, meals, and other aid regarding the elderly. Even if the elderly isn't saying they need help, by providing the extra help, the family is content and may have less tension within the home.

Ms. Ito explained it similarly by saying:

> Sometimes, even though the elderly may not want to do a short stay, the family may insist on putting them in short stay [...]. In this situation, even though it goes without saying that our first priority is the elderly but support of caregivers are equally as important to have a healthy environment in the home. My job usually consists of elderly living in their homes however in some situations I can suggest them to do short stays in a facility to help the caregiver have time to rest.

The examples provided by Ms. Watanabe and Ms. Ito more clearly illustrate the objectives that guide the care managers behavior when interacting with the family caregivers and how their attempts to reach the objective might influence the support provided by the care managers to the family caregivers. Considering the above presented accounts, it will further be argued that the objective that care mangers strive to achieve through their interaction with the family caregivers, in more general terms, should be understood as the formal goal of the care manager role as well as the goal with the LTCI scheme, that is, enabling the elderly to continue living in their own home for as long as possible. This means that the care manager tries to adapt the type of support they provide to what they interpret as being the specific need of a family caregiver and that their overall objective with supporting the family caregiver in this way is to ensure that the family caregiver can continue to provide informal care to the elderly, so that the elderly can continue to live at home as long as possible.

7 Discussion

The overall objective of this study has been to investigate the social support provided by care managers to family caregivers of elderly adults receiving community based care under the Japanese LTCI scheme. The study has explored such support from the perspective of the care manager, and in relation to the overall role of the care manager. The following research questions have been employed (i) What reasons do care managers have for providing social support to family caregivers, (ii) What kind of social support do care managers provide to family caregivers and how does it relate to

the care manager's work assignments, and (iii) What is influencing the social support provided by care managers to family caregivers.

The analysis of the empirical material, collected through interviews with nine care managers suggests that the provision of social support, even though it cannot be said to be part of the care managers' formal role, has been incorporated in the care managers working-role. The accounts made by the care managers further indicates that they have come to see the provision of social support as something necessary in order to fulfill one of the goals with their formal-role as well as one of the overall goals with the LTCI scheme. That is, enabling the elderly to continue living in their home as long as possible.

This study also looked at what kind of social support care managers provided to family caregivers and how it related to the care manager's work assignments. The accounts made by the interviewed care managers showed that they provided a variety of different kinds of support. The different types of support were in this study classified into seven different categories. Three of these categories, namely: *supporting family caregivers with LTCI services*; *giving information and advice* and *creating a supportive environment around the family caregivers,* can further be understood as social support that the care managers partly provided through their formal work assignments comprising planning, implementation and evaluation of care. The four remaining types of social support that care managers provided was categorized as *making referrals; being there; spending time talking to the family caregiver* and *comfort and encouragement.* These four types of social support can be said to fall outside of the care manager's formal work assignments and can be understood as something that had evolved through the interaction, taking place between care managers and family caregivers.

This study also set out to identify what influence the social support provided by care managers to family caregivers and the analysis suggest that the support was partly influenced by legitimate role definers such as the Japanese government and the different service-providing companies that care managers worked for. The influence by the Japanese government as a legitimate role definer meant that care managers were not able to use LTCI services to directly support family caregivers and that their ability to support family caregivers with a strained financial situation was limited. The different companies that care managers worked for could also influence the support by prohibiting care managers to provide certain types of support, but also by adding

more work assignments to the care manager's workload, limiting the time care managers could spend on supporting family caregivers. The analysis also suggests that the provision of support was influenced by the standpoint that guided the care managers' behaviors. Third-party standpoints, adopted by care managers, influencing the provision of support, were different preconceptions, or opinions, of what kind of relationship they should have with family caregivers, how family caregivers should be supported in certain situations, and what kind of support that was important. The analysis also shows that care managers in many aspects adjust the way they support family caregivers in relation to each individual family caregiver. This suggests that the care managers' behavior is guided by the standpoint of the interactive affect and it is argued that the overall objective with adjusting the support in relation to each individual family caregiver, is to make sure that the specific family caregiver will be able to continue to provide informal care to the elderly as long as possible, thus enabling the elderly to continue living in their own home.

Looking at the development of the LTCI scheme, it could be argued that the different aims and motives for its establishment are somewhat contradictory. On the one hand, the scheme was launched under the slogan, "From the care of the family to the care of the society" (Eto, 2001), and described as a "mechanism to ease the burden of families looking after their frail elderly" (Tsuno and Homma, 2009, p. 10). On the other hand, the care that family caregivers provide for their elderly is still recognized as essential by the Japanese government in order to allow elderly to continue living in their communities as long as possible, an aim of the LTCI scheme in itself (Yamada, Hagihara & Nobutomo, 2009). Hence, while Japan has taken a significant step towards developing as system where society takes a greater responsibility for the provision of care to the elderly population, this system in itself partly rely on the availability of family members providing care for their elderly relatives.

While the LTCI scheme indirectly supports family caregivers through the different services provided to the elderly, the scheme itself is not designed to acknowledge or address other needs of support that family caregivers might have. The design of the LTCI scheme is particularly interesting in relation to the overall objective of this study, since it effects the work carried out by Japanese care managers. In order to fully fulfill there duties under the LTCI Act the care managers in many situations found it necessary to not only address the elderly individual, but also the family as a whole.

It has been suggested by other researchers investigating the social support provided by care managers that care managers should be provided with training in psychosocial needs assessment in order to better support family caregivers (Yamada, Hagihara & Nobotumo, 2009). While acknowledging that it can be beneficial to equip care mangers with tools in order to better support family caregivers I would argue, based on the findings of this study, that it is equally important to recognize the care managers' work with supporting family caregivers as essential and by doing so, making it part of their formal role. Doing so would hopefully create a foundation more conducive for meeting the actual needs for support of family caregivers. However, realizing that a drawback of this study is that it employs a qualitative method, and as such does not strive to generalize the research findings to the larger population of care managers within the LTCI scheme, it would be of interest to further investigate whether or not the conclusions made within the frames of this study are applicable to a larger population of care managers.

Reference:

Abe, K. Kashiwagi, T. & Tsuneto, S. (2003) Coping Strategies and its Effects on Depression Among Caregivers of Impaired Elders in Japan. *Aging & Mental Health*, Volume 7, Issue 3, pp. 207-211.

Arai, Yumiko; Kudo, Kei; Hosokawa, Toru; Washio, Masakazu; Miura, Hiroko; Hisamichi, Shigeru (1997) Reliability and Validity of the Japanese Version of the Zarit Caregiver Burden Interview. *Psychiatry and Clinical Neuroscience*, Volume 51, Issue 5, pp. 281-287.

Arai, Yumiko (2001) Japan's New Long-Term Care Insurance. *Lancet*, Volume 357, Issue 9269, p. 1713.

Arai, Makoto (2002) "The Aging Society and the Social Security System in Japan". In Conrad, Harald & Lützeler, Ralph (red.): *Aging and Social Policy: A German-Japanese Comparison*, München: Iudicium

Arai, Yumiko; Masui, Kaori; Sugiura, Midori; Washio, Masakazu (2002) Fewer Hours of Care Yet Undiminished Caregiver Burden with New Long-Term Care Insurance in Japan. *International Journal of Geriatric Psychiatry*, Volume 17, Issue 5, pp. 489-491.

Arai, Yumiko & Kumamoto, Keigo (2004) Caregiver Burden Not 'Worse' After New Public Long-Term Care (LTC) Insurance Scheme Took Over In Japan. *International Journal of Geriatric Psychiatry*, Volume 19, Issue 12, pp. 1205 – 1206.

Arai, Hirokazu; Nagatsuka, Miwa; Hirai, Kei (2008) The Relationship between Health-Related Quality of Life and Social Networks Among Japanese Family Caregivers for People with Disabilities. *BioPsychoSocial Medicine*, Volume 2, Issue 1, p. 17.

Asahara, Kiyomi; Momose, Yumiko; Murashima, Sachiyo; Okubo, Noriko; Magilvy, Joan K. (2001) The Relationship of Social Norms to Use of Services and Caregiver Burden in Japan. *Journal of Nursing Scholarship: an Official Publication of Sigma Theta Tau International Honor Society of Nursing / Sigma Theta Tau*, Volume 33, Issue 4, pp. 375 – 380.

Asahara, Kiyomi; Momose, Yumiko & Murashima, Sachiyo (2002) Family caregiving of the elderly and Long-Term Care Insurance in rural Japan. *International Journal of Nursing Practice,* Volume 8, Issue 8, pp. 167–172.

Asahara, Kiyomi; Momose, Yumiko & Murashima, Sachiyo (2003) Long-Term Care Insurance in Japan Its Frameworks, Issues and Roles. *Disease Management & Health Outcomes*, Volume 11, Issue 12, pp. 769-777.

Aspers, Patrik (2007) *Etnografiska metoder: Att förstå och förklara samtiden.* Malmö: Liber.

Barter, Christine & Renold, Emma (1999) The Use of Vignettes in Qualitative Research. *Social Research Update,* Issue 25, Guilford, England: University of Surrey.

Bergman, Rachel C; Tyyskä, Vappu (2011) A Critical Reflection on the Use of Translators/Interpreters in a Qualitative Cross- Language Research Project. *International Journal of Qualitative Methods*, Volume 10, Issue 2, pp. 178-190.

Biddle, Bruce J (1986) Development in Role Theory. *Annual Review of Sociology*, Volume 12, pp. 67-92.

Blomberg, Staffan, Edebalk, Per Gunnar & Tada Yoko (2006), Personliga ombud för äldre? Reflektioner med utgångspunkt från den japanska vård- och omsorgsförsäkringen för äldre. Working Paper 2006:11. Lund: Socialhögskolan.

Brett Herman, Jeanne & Kuczynski Gyllstrom, Karen (1977) Working Men and Women: Inter- and Intra-Role Conflict. *Psychology of Women Quarterly*, Volume 1, Issue 4, pp. 319-333.

Callero, Peter L. *(2008)* “Role Theory". In Darity, Jr., William A. (ed.) *International Encyclopedia of the Social Sciences, 2nd edition, Volume 7*. Detroit: Macmillan Reference. (Web. 10 Sep. 2012).

Campbell, John Creighton (2000) “Changing Meanings of Frail Old People and the Japanese Welfare State”. In Long, Susan (ed.): *Caring for the Elderly in Japan and the U.S.*. New York: Routledge.

Campbell, John Creighton & Ikegami, Naoki (2000) Long-Term Care Insurance Comes to Japan. *Health Affairs*, Volume 19, Issue 3, pp. 26-39.

Campbell, John Creighton (2002) “How Policies Differ: Long-Term Care Insurance in Japan and Germany”. In Conrad, Harald & Lützeler, Ralph (ed.): *Aging and Social Policy: A German-Japanese Comparison.* Munich: Iudicium

Campbell, John Creighton & Ikegami, Naoki (2003) Japan’s Radical Reform of Long-term Care. *Social Policy & Administration*, Volume 37, Issue 1, pp. 21-34.

Carroll, Tessa (2006) “Changing language, gender and family relations in Japan”. In Rebick, Marcus & Takenaka, Ayumi (ed.): *The Changing Japanese Family.* Abingdon; New York: Routledge.

Coulter, Sarah; Lee, John; Sheldon, Andrea; Meraz, Juan (2011) Doing Business in Japan. *Conflict Resolution & Negotiation Journal.* Issue 1, pp. 62-67.

Commonwealth of Australia (2001) *A Comparison of Aged Care in Australia & Japan.* (Australia and Japan Partnership). Canberra: Commonwealth of Australia.

Crume, Yoko (1997) *Publicly-Mandated Long Term Care Insurance Programs: Japan Chooses a Modified German model* (The Occasional Long Term Care Policy Paper Series, Paper 5) Durham: Duke University, Center For the Study of Aging and Human Development.

Cumming, Toby B; Cadilhac, Dominique A; Rubin, Gary; Crafti, Naomi; Pearce, Dora C (2008) Psychological Distress and Social Support in Informal Caregivers of Stroke Survivors. *Brain Impairment*, Volume 9, Issue 2, pp. 152-160.

Dobrof, Judith; Ebenstein, Helene; Dodd, Sarah-Jane; Epstein, Irwin (2006) Caregivers and Professionals Partnership Caregiver Resource Center: Assessing a Hospital Support Program for Family Caregivers. *Journal of Palliative Medicine*, Volume 9, Issue 1, pp. 196-205.

Dulin, Patrick & Hill, Robert D. (2008) "Caregiving". In Leong, F. (ed.) *Encyclopedia of Counseling, Volume 1, pp. 67-70.*Thousand Oaks, CA: SAGE. *SAGE Reference Online* (Web. 4 Jun. 2012).

Edmonds, Richard Louis et al. (2012) "Japan." In *Grove Art Online*. *Oxford Art Online* (Web. 6 Jun, 2012).

Esaiasson, Peter & Gilljam, Mikael & Oscarsson, Henrik & Wängnerud, Lena (2007) *Metodpraktikan: Konsten att studera, samhälle, individ och marknad,* Stockholm: Nordstedts Juridik.

Eto, Mikiko (2001) Public Involvement in Social Policy Reform. Seen from the Perspective of Japan's Elderly-Care Insurance Scheme. *Journal of Social Policy*, Volume 30, Issue 1, pp. 17-36.

Fauth, Elizabeth (2008)"Caregiver Burden". In Leong, F. (ed.) *Encyclopedia of Counseling, Volume 1, pp. 64-67.*Thousand Oaks, CA: SAGE. *SAGE Reference Online* (Web. 5 Jun. 2012).

Gallicchio, Lisa; Siddiqi, Nauman; Langenberg, Patricia; Baumgarten, Mona (2002) Gender Differences in Burden and Depression Among Informal Caregivers of Demented Elders in the Community. International Journal of Geriatric Psychiatry, Volume 17, Issue 2, pp. 154-163.

Gilje, Nils & Grimen, Harald (1995) *Samhällsvetenskapernas förutsättningar*. Göteborg: Diadalos.

Hamada, Koichi & Raut, Lakshmi K. (2007) "Ageing and elderly care in an open economy". In Hamada, Koichi & Kato, Hiromi (ed.): *Ageing and the Labor Market in Japan: Problems and Policies*. Cheltenham, UK; Northampton, MA: Edward Elgar.

Hartman, Jan (2004) *Vetenskapligt tänkande: från kunskapsteori till metodteori*. Lund: Studentlitteratur.

Hashizume, Yumi (2000) Gender Issues and Japanese Family-Centered Caregiving for Frail Elderly Parents or Parents-In-Law in Modern Japan: From the Sociocultural and Historical Perspectives. *Public Health Nursing*, Volume 17, Issue 1, pp. 25 – 31.

Hayashi, Mayumi (2011) *The Care of Older People in Japan: Myths and Realities of Family 'Care'* (History and Policy Paper June 2011) UK: Cambridge University and the University of London.

Henriksson, Benny & Månsson, Sven-Axel (1996) "Deltagande observationer". In Svensson, Per-Gunnar & Starrin, Bengt (ed.): *Kvalitative studier i teori och praktik*, Lund: Studentlitteratur.

Hosaka, Takashi & Sugiyama, Youko (1999) A Structured Intervention for Family Caregivers of Dementia Patients: A Pilot Study. *The Tokai Journal of Experimental and Clinical Medicine,* Volume 24, Issue 1, pp. 35-39.

Hori, Yoko; Hoshino, Junko & Suzuki, Kishiko (2010) Physical and Psychological Health Problems Among Japanese Family Caregivers. *Nagoya Journal of Medical Science*, Volume 73, Issue 3-4, pp. 107-115.

Hornberg, John; Gibson, Count; Wood, William; Dequeldre, Christian; Corso, Irene; Palla, Barbara & Bloch, Daniel (1996) Eliminating Language Barriers for Non-English-Speaking Patients. Medical Care, Volume 34, Issue 8, pp. 845-856.

Hupcey, Judith E. (1998) Clarifying the Social Support Theory-Research Linkage. *Journal of Advanced Nursing,* Volume 27, Issue 6, pp. 1231-1241.

Ikegami, Naoki & Campbell, John Creighton (2002) Choices, Policy Logics and Problems in the Design of Long-term Care Systems. *Social Policy & Administration*, Volume, 36, Issue 7, pp. 719-734.

Ikegami, Naoki (2004) Impact of Public Long-Term Care Insurance in Japan. *Geriatrics and Gerontology International,* Volume 4, Issue Supplement 1, pp. 146-148.

Ishii-Kuntz, Masako (1999) "Japan and Its Planning toward Family Caregiving". Lechner, Viola M & Neal, Margaret B (ed.): *Work and Caring for the Elderly: International Perspectives*. London: Routledge.

Izuhara, Misa (2006) "Changing families and policy responding to an ageing Japaneses society". In Rebick, Marcus & Takenaka, Ayumi (ed.): *The Changing Japanese Family*. London: Routledge.

Jacobsen, Dag Ingvar (2007) *Förståelse, beskrivning och förklaring: Introduktion till samhällsvetenskaplig metod för hälsovård och socialt arbete.* Lund: Studentlitteratur.

Japanese (2013) *Colombia Electronic Encyclopedia, 6th Edition,* p. 1, Literary Reference Center, EBSCOhost. (Web. 5 Jan, 2014)

Karan, Pradyumna P. (2004) *Japan in the 21st Century: Environment, Economy, and Society.* Lexington: University Press of Kentucky.

Kikuchi, Kazunori; Takahashi, Ryutaro; Sugihara, Yoko; Inagai, Yumi (2006) "Letters to Editor" Five-Year Experience with the Long-Term Care Insurance System in Japan. *Journal of the American Geriatrics Society,* Volume 54, Issue 6, pp. 1014 -1015.

Kojima, K; Ito, S; Kim, L; Sayama, M (2001) A New Social Care Insurance in Japan on 1 April 2000. *Japan-Hospitals: the Journal of the Japan Hospital Association*, Issue 20, pp. 21-25.

Kono, Kei; Takahashi, Koichi & Hara, Miwako (2010) The Survey of Japanese Value Orientations: Analysis of Trends over Thirty-Five Years. *NHK Broadcasting Studies*, 2010, No 10.

Kumagai, Fumie & Keyser, Donna J (1996) *Unmasking Japan today: the impact of traditional values on modern Japanese society*. Westport, Conn.: Praeger

Kumamoto, Keigo; Arai, Yumiko & Zarit, Steven H. (2006) Use of Home Care Services Effectively Reduces Feelings of Burden Among Family Caregivers of Disabled Elderly in Japan: Preliminary Results. *International Journal of Geriatric Psychiatry,* Volume 21, Issue 2, pp. 163 – 170.

Kuroda, Akiko; Tanaka, Katsutoshi; Kobayashi, Ryuji; Ito, Takeshi; Ushiki, Ayako; Nakamura, Ken (2007) Effect of Care Manager Support on Health-Related Quality of Life of Caregivers of Impaired Elderly: One-Year Longitudinal Study. *Industrial Health,* Volume 45, Issue 3, pp. 402-408.

Kusuda, Yasuyuki (2013) *Care manager and moral hazard in long-term care insurance system* (Nihon Fukushi Univerity Volume 46). Chita: Nihon Fukushi University, Department of Economics.

Larson, Mildred (1998) *Meaning-based translation: a guide to cross-language equivalence, 2and ed.* Lanham, Md.: University Press of America.

Lebra Sugiyama, Takie (1984) *Japanese Women: Constraint and Fulfillment.* Honolulu: University of Hawaii Press.

MaloneBeach, Eileen E; Zarit, Steven H (1995) Dimensions of Social Support and Social Conflict as Predictors of Caregiver Depression. International Psychogeriatrics, Volume 7, Issue 1, pp. 25-38.

Matsuda, Shinya & Yamamoto, Mieko (2001) Long-Term Care Insurance and Integrated Care for the Aged in Japan. *International Journal on Integrated Care,* Volume 1, Issue 3.

May, Tim (2001) *Samhällsvetenskaplig forskning.* Lund: Studentlitteratur.

Merton, Robert K (1957) The Role-Set: Problems in Sociological Theory. *The British Journal of Sociology,* Volume 8, Issue 2, pp. 106-120.

Miller, Baila & Guo, Shenyang (2000) Social Support for Spouse Caregivers of Persons With Dementia. *Journal of Gerontology: Social Sciences,* Volume 55, Issue 3, pp. 163–172.

Ministry of Internal Affairs and Communication (2012a) Official Webpage of Ministry of Internal Affairs and Communication. http://www.stat.go.jp/english/data/handbook/c02cont.htm (2012-02-01).

Ministry of Internal Affairs and Communication (2012b) Official Webpage of Ministry of Internal Affairs and Communication. www.stat.go.jp/english/data/shugyou/pdf/sum2007.pdf (2012-04-04).

Ministry of Health, Labour and Welfare (2012a) Official Webpage of Ministry of Health, Labour and Welfare. http://www.mhlw.go.jp/english/database/db-hss/dl/hs091216d.pdf (2012-04-04).

Ministry of Health, Labour and Welfare (2012b) Official Webpage of Ministry of Health, Labour and Welfare. http://www.mhlw.go.jp/english/database/db-hss/cslc-tables.html (2012-04-09).

Ministry of Health, Labour and Welfare (2012c) Official Webpage of Ministry of Health, Labour and Welfare. http://www.mhlw.go.jp/english/database/db-hss/dl/hs091216d.pdf (2012-04-06).

Ministry of Health, Labour and Welfare (2013) Official Webpage of Ministry of Health, Labour and Welfare http://www.mhlw.go.jp/english/topics/ elderly/care/2.html (2013-08-13).

Mitchell Fuentes, Catherine M. (2009) "Confucianism". In Birx, H. (ed.) *Encyclopedia of Time: Science, Philosophy, Theology, & Culture, pp. 209-213.*Thousand Oaks, CA: SAGE. *SAGE Reference Online*. (Web. 5 Jun. 2012)

Momose, Yumiko; Asahara, Kiyomi & Murashima, Sachiyo (2003) A Trial to Support Family Caregivers in Long-Term Care Insurance in Japan: Self-Help Groups in Small Communities. *Home Health Care Management Practice*, Volume 15, Issue 6, pp. 2003 15: 494-499.

Murashima, Sachiyo; Yokoyama, Azusa; Nagata, Satoko; Asahara, Kiyomi (2003) The Implementation of Long-Term Care Insurance in Japan: Focused on the Trend of Home Care. *Home Health Care Management & Practice,* Volume 15, Issue 5, pp. 407-415.

Musil, Carol M; Morris, Diana L; Warner, Camille B; Saeid, Hala (2003) Issues in Caregivers' Stress and Providers' Support. *Research on Aging,* Volume 25,

Issue 5, pp. 505-526.

Nakamura, Keiko (2001) “The Acquistion of Polite Language by Japanese Children”. In Nelson, Keith E; Aksu-Koc Ayhan and Johnson, Carolyn E. (ed.): *Children’s Language, Vol. 10.* New Jersey: Lawrence Erlbaum Assoc Inc.

Nishi, Akihiro; Tamiya, Nanako; Kashiwagi, Masayo; Takahashi, Hideto; Sato, Mikiya; Kawachi, Ichiro (2010) Mothers and Daughters-In-Law: a Prospective Study of Informal Care-Giving Arrangements and Survival in Japan. *BMC Geriatrics,* Volume 10, pp. 61-69.

Oberländer, Christian (2004) “Sociology of Aging”. In Kreiner, Josef; Mèohwald, Ulrich; Ölschleger, Hans Dieter (ed.): *Modern Japanese Society.* Leiden, Netherlands: Brill.

Okamoto, Kazushi; Harasawa, Yuko (2008) Emotional Support from Family Members and Subjective Health in Caregivers of the Frail Elderly at Home in Japan. *Archives of Gerontology and Geriatrics,* Volume 49, Issue 1, pp. 138-141.

Omote, Shizuko; Saeki, Kazuko & Sakai, Akemi (2007) Difficulties Experienced by Care Managers Who Are Care Workers Managing Elder Abuse Cases in the Japanese Long-Term Care Insurance System. *Health and Social Care in the Community*, Volume 15, Issue 6, pp. 569–576.

Oura, Asae; Washio, Masakazu; Izumi, Hisako; Mori, Mitsuru (2005) Burden Among Caregivers of the Frail Elderly and its Correlation with the Introduction of a Long-Term Care Insurance System for the Elderly in Fourth Year. *Japanese Journal Of Geriatrics*, Volume 42, Issue 4, pp. 411-416.

Oura, Asae; Washio, Masakazu; Arai, Yumiko; Ide, Saburo; Yamasaki, Ritsuko; Wada, Jun-ichi; Kuwahara, Yuichi; Mori, Mitsuru (2007) Depression Among Caregivers of the Frail Elderly in Japan Before and After the Introduction of the Public Long-Term Care Insurance System. *Zeitschrift für Gerontologie und Geriatrie*, Volume 40, Issue 2, pp. 112-118.

Pinquart, Martin & Sörensen, Silvia (2003) Differences Between Caregivers and Noncaregivers in Psychological Health and Physical Health: A Meta-Analysis. *Psychology and Aging*, Volume 18, Issue 2, pp. 250–267.

Rebick, Marcus & Takenaka, Ayumi (2006) “The changing Japanese family”. In Rebick, Marcus & Takenaka, Ayumi (ed.): *The Changing Japanese Family*. London: Routledge.

Repstad, Pål (1999) *Närhet och distans: kvalitativa metoder i samhällsvetenskap.* Lund: Studentlitteratur.

Robson, Colin (2002) *Real World Research,* Oxford: Blackwell Publishers.

Savard, Jacinthe; Leduc, Nicole; Lebel, Paule; Béland, François; Bergman, Howard (2006) Caregiver Satisfaction With Support Services: Influence of Different Types of Services. *Journal of Aging and Health*, Volume 18, Issue 1, pp. 3-27.

Shinjuku-ku (2012) Official Webpage of Shinjuku-ku. www.city.shinjuku.lg.jp/foreign/.../kaigo2012_e.pdf (2013-03-06).

Singh, Rajbala and Dixit, Shikha (2010) Health-Related Quality of Life and Health Management. *Journal of Health Management*, Volume 12, Issue 2, pp 153-172.

Shumaker, Sally A. & Brownell, Arlene (1984) Toward a Theory of Social Support: Closing Conceptual Gaps. J*ournal of Social Issues*, Volume 40, Issue 4, pp. 11-36.

Sjöström, Ulla (1994) ”Hermeneutik - att tolka utsagor och handlingar”. In Starrin, Bengt & Svensson, Per-Gunnar (ed.): *Kvalitativ metod och vetenskapsteori.* Lund: Studentlitteratur.

Sohlberg, Peter (2006) “Teorier och kunskapsbildning i socialt arbete”. In Blom, Björn; Morén, Stefan & Nygren, Lennart (ed.): *Kunskap i socialt arbete. Om villkor, processer och användning.* Stockholm: Natur och kultur.

Sugimoto, Yoshio (2010) *An Introduction to Japanese Society. 3rd Edition.* New York: Cambridge University Press.

Tamiya, Nanako; Chen, Li-Mei & Sugisawa, Hidehiro (2009) Caregiver’s Decisions on Placement of Family Members in Long-Term Care Facilities in Japan: Analysis of Caregiver Interviews. *Social behavior and Personality: an International Journal,* Volume 37, Issue 3, pp. 393-410.

Talcott, Paul (2002) “The Politics of Japan’s Long-Term Care Insurance System”. In Conrad, Harald & Lützeler, Ralph (ed.): *Aging and Social Policy: A German-Japanese Comparison*, Munich: IUDICIUM Verlag GmbH**.**

Trost, Jan (2010) *Kvalitativa intervjuer*, Lund: Studentlitteratur.

Tsutsui, Takako & Muramatsu (2005) Care-Needs Certification in the Long-Term Care Insurance System of Japan. *International Health Affairs*, Volume 53, Issue 3, pp. 522-527.

Tsuno, Norifumi & Homma, Akira (2009) Ageing in Asia—The Japan Experience. *Ageing International,* Volume 34, Issue 1-2, pp. 1-14.

Turner, Ralph H (1962), “Role taking: Process Versus Conformity”. In Rose, Arnold (ed.): *Human Behavior and Social Processes*, Boston: Houghton-Mifflin.

Turner, Ralph H (2002) “Role Theory”. In Turner, Jonathan H (ed.): *Handbook of Sociological Theory*, New York: Plenum Publishers.

Turner, Ralph H (1956) Role-Taking, Role Standpoint, and Reference-Group

Behavior. American Journal of Sociology, Volume 61, Issue 4, pp. 316-328.

Van Mierlo, Lisa D; Meiland, Franka J. M; Van der Roest, Henrie¨tte G; Dro¨es, Rose-Marie (2012) Personalised Caregiver Support: Effectiveness of Psychosocial Interventions in Subgroups of Caregivers of People with Dementia. *International Journal of Geriatric Psychiatry*, Volume 27, Issue 1, pp.1-14.

Vetenskapsrådet (2002) Forskningsetiska principer inom humanistisk-samhällsvetenskaplig forskning. Stockholm: Vetenskapsrådet.

Wallhagen, Margaret & Yamamota-Mitani, Noriko (2006) The Meaning of Family Caregiving in Japan and the United States: A Qualitative Comparative Study. *Journal of Transcultural Nursing*, Volume 17, Issue 1, pp. 65-73.

Wallin, Anne-Marie & Ahlström, Gerd (2006) Cross-Cultural Interview Studies Using Interpreters: Systematic Literature Review. *Journal of Advanced Nursing*, Volume 55, Issue 6, pp. 724-735.

Washio, Arai (1999) Depression Among Caregivers of the Disabled Elderly in Southern Japan. *Psychiatry and Clinical Neurosciences*, Volume 53, Issue 3, pp. 407-412.

Westermeyer, J. (1990) Working with an Interpreter in Psychiatric Assessment and Treatment. *Journal of Nervous and Mental Disorders*, Volume 178, Issue 12, pp.745–749.

Yamada, Miho; Hagihara, Akihito & Nobutomo, Koichi (2008) Coping Strategies, Care Manager Support and Mental Health Outcome Among Japanese Family Caregivers. *Health and Social Care in the Community*, Volume16, Issue 4, pp. 400–409.

Yamada, Miho; Hagihara, Akihito & Nobutomo, Koichi (2009) Family Caregivers and Care Manager Support under Long-Term Care Insurance in Rural Japan. *Psychology, Health & Medicine,* Volume 14, Issue 1, pp. 73-85.

Yamamoto, Noriko & Wallhagen, Margaret (1998) Service Use by Family Caregivers in Japan. *Social Science & Medicine,* Volume 47, Issue 5, pp. 677-691.

Appendix A: Interview Guide

General

Could you describe your educational background?
Could you describe your occupational background?
Why did you decide to become a care manager?
Could you describe the care manager-training program?

Could you describe your work as a care manager?

- Main tasks and responsibilities
- Full-time/part-time
- Type of organization
- Amount of clients
- How long have you worked as care manager
- Do you have any supervision?

Support to Family caregivers

It has been suggested that it is part of the care manager's work to support family caregivers and I am wondering what your thought on that is?

In what way do you support family caregivers?

Are there other ways or types of support that care managers can use to support family caregivers?

Training, Education and Occupational background

In your view, what skills are necessary for a care manager to have in order to provide adequate support to family caregivers?

Are there any skills that you feel that you lack?

Do you feel that the care manager's training program is helpful in your work with supporting family caregivers? And if so, in what way?

Do you feel that your educational background is helpful in your work with supporting family caregivers? And if so, in what way?

Do you feel that your previous occupational background is helpful in your work with supporting family caregiver? And if so, in what way?

Is there any training that you do not have, that you feel would have helped you in your work of providing support to family caregivers?

Family Caregivers

Could you describe the relationship between you as care manager and the family caregivers that you meet?

Are there different types of family caregivers? If so, in what way do they differ?

Do you think different caregivers need to be supported in different ways? Could you give some examples?

Other circumstance

Are there any difficulties in providing support to family caregivers? If so, what are they?

Is there something you would like to add?

Appendix B: Information Letter - English Version

Dear Sir or Madam.

My name is Satsuki Murofushi and I am a Swedish Social Work student, enrolled at the Masters Program of Social Work at Lund's University, Sweden.

I am currently writing my master's thesis about Japanese care managers and more specifically their work with supporting family caregivers of older adults in the community setting. I am therefore, looking for care managers that would be interested in participating in an interview.

The interview will last for about an hour and take place during the month of November and December. I will conduct the interview in Japanese with the help of an interpreter. The participation is of course voluntary and the interview can be terminated if and whenever the interviewee decides to.

The material collected through the interviews will be kept confidential and available only to me and my supervisor Per Gunnar Edebalk. When it is used in the thesis, the names of the participants will be changed and information that might reveal the identity of the participants will be removed.

November 2012
Master student in Social Work, Lund University
Satsuki Murofushi

Appendix C: Information Letter - Japanese Version

修士論文研究協力のお願い

拝　啓

　はじめまして。私、室伏五月と申します。スウェーデンのルンド大学大学院ソーシャルワーク修士課程で勉強しております。

　現在、日本のケアマネジャーが高齢者の家族介護者をどのように支援しているかに関する修士論文を執筆中しております。そのため、この研究にご協力いただけるケアマネジャーの方を募集しております。面接にて上記のテーマに関してお話を聞かせていただきたいと考えております。

　なお、面接は **11** 月〜**12** 月中に行いたいと考えております。時間は約 **1** 時間を予定しています。面接は私の通訳者を通して、ご参加いただける方おひとりずつ行わせていただきます。

　本研究への参加は任意です。また、ご協力いただける場合でもいつでも参加を中止することができます。面接を通じて収集された資料は、私と私の指導教官の **Gunnar Edebalk** のみが使用いたします。外部への情報流出が無いよう、機密を厳重に保持いたします。また、論文等で発表する際にも、参加者の名前など個人を特定できる情報は削除したうえで発表いたします。

　大変お忙しいところお手数をおかけいたしますが、ご協力のほど、何卒よろしくお願いいたします。

平成 24 年 11 月
ルンド大学大学院ソーシャルワーク修士課程
室伏　五月

Appendix D: Consent Form - English Version

A study of the support provided by care managers under the LTCI plan to family caregivers.

This study aims to investigate and understand support provided by care managers to family caregivers providing care for elderly relatives in the community. The study will materialize in the form of the Researcher's Master's thesis in Social Work. The study may also be presented at academic conferences as well as published in academic journals.

Researcher:
Satsuki Murofushi
Masters Student, School of Social Work, Lund University, Lund, Sweden.
090 1357 27 20
satsuki.murofushi@gmail.com

You have been invited to participate in this study due to your work as care manager.

Taking part in this study is voluntary and I can withdraw at any time, without stating a reason. Names of interviewees will be anonymised and the information collected through the interviews will be presented in a way that makes it impossible to identify the interviewee's real identity. The interviewee will receive an electronic copy of the Master's thesis upon request.

I understand that information from this interview may be used as data in the researchers Master's thesis and also in academic papers that may appear in academic journals and presented at academic conferences.

I agree to take part in this study.

____ Signature

____ Date

Appendix E: Consent Form – Japanese Version

研究参加同意書

研究名：
介護保険制度下で居宅介護支援専門員（ケアマネジャー）によって提供される家族への支援に関する研究

目的：
この研究は、地域に居住する高齢者を介護する家族に対して、ケアマネジャーが提供している支援に関し調査し、理解することを目的とする。研究の成果は、主に調査担当者のソーシャルワーク修士論文の執筆のために利用される。なお、修士論文の執筆後は、学会発表や学術誌への投稿論文の形で発表される可能性もある。

研究担当者：
Satsuki Murofushi
Lund University, Lund, Sweden
ソーシャルワーク修士課程

対象者の選定：
対象者は、介護支援専門員として現にケアマネジメント業務に従事する者を選定した。

同意文書：

本研究への参加は自発的なものであり、いつでも理由を告げることなく研究を中止することができます。また、参加者の名前は匿名化され、インタビューで得られた情報も個人が特定できない形でのみ発表されます。修士論文完成後、参加者の希望により本文を電子メールにて送信します。
私は、本研究のインタビューで得られたデータが、研究担当者の修士論文、学会発表、学術誌への投稿論文のみで発表されることを理解しています。

私は、本研究に参加することに同意します。
____ 署名

____ 日付