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Releasing From the Oppression: Caregiving for the Elderly Parent of Japanese Working Women

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Abstract

Caregiving in Japan is defined as predominately a woman's responsibility. However, caregiving has been largely understudied as a lived experience or within a cultural frame of reference. In an estimated 50% of Japanese households, women are currently caregivers of one or more family members. However, the relative absence of information on their experiences has held back the development of programs and services to support their caregiving. In this article, I present results of a grounded-theory study that explores the experiences of Japanese working women caregivers as they care for the elderly family member in their home. I interviewed eleven women caregivers including six daughters and five daughters-in-law. I generated a substantive grounded theory, resulting in the identification of the core concept of "releasing self" which included three dimensions: laughing away, self-belief, and losing enthusiasm for the elderly and elderly care.

Keywords

caregiving; culture; family nursing; gender; grounded theory; Japan, Japanese people; lived experience; women's health, midlife

Over the past few decades, studies into the role of women in Japanese family caregiving have been focused primarily on the conflict of managing child-raising and working, and a relatively small number of studies have addressed the subject of elderly care (Honma & Nakagawa, 2002; Watai, Nishikito, & Murashima, 2006). My purpose in this study was to explore the experiences of Japanese working women caregivers in a society where women increasingly recognize the importance of self-realization and are also aware of socio-economical and political changes.

For the past 30 years in Japan, four major changes have occurred in the lifestyle of middle-aged Japanese women and family caregiving. The first change is Japan's growing population of elderly people who need long-term care. In 2000, the number of frail elderly who needed long-term care was 2.2 million. The same number had increased to 4.1 million by 2005. The second change is in the length of time that an elderly person requires caregiving is increasing. (Health and Welfare Statistics Association, 2005; Japanese Ministry of Health, Labor and Welfare, 2007a).

In 1995, 53% of bedridden elderly, (people 65 years of age and over) had been bedridden for more than three years, and the average time between becoming bedridden and death was around 8.5 months (Japanese Ministry of Health and Welfare, 1998). In 2006, the period of time for an elderly requiring caregiving was estimated at seven to eight years, based on the healthy life expectancy of Japanese, as reported by the World Health Organization (Cabinet Office, 2006).

The third change is the influence of Western ideas of individualism propagated through the mass media. In contrast, the socio-cultural norms of Japan continue to place a huge expectation on Japanese women to take on the major caregiving responsibility for their frail elderly parents or parents-in-law. Traditionally, the typical life course of middle-aged Japanese women involved them working outside of the home for the prosperity of the household, as long as the elders were in good health. Once a family member become sick and needed daily assistance, women were expected to leave their job and dedicate themselves to housework and the care of the family member. For an elderly parent or parent-in-law, women were expected to take on the caregiving role for the remainder of the elderly person's life. The eldest daughter or the wife of an eldest son was charged to take the responsibility of caring for the elderly parent based on the patriarchal family system. This patriarchal family system was legally abolished after World War II; however, the system still persists in practical terms. These socio-cultural aspects have been reported elsewhere (Hashizume, 1998, 2000).

A consumer boom and an increased demand for higher education for children occurred in Japan during the 1980s. These two factors contributed toward a higher employment rate among women (Lock, 1993;

Smith, 1987; Sodei, 1995). At this time, Japan showed one of the world's lowest birthrates. Japan's birthrate has decreased constantly over the years, – standing at 1.32 in 2006 (Health and Welfare Statistics Association, 2007a). This factor has also increased a woman's chances of re-employment. Furthermore, “maternity and childcare leave” have been a legal provision since 1986 and Japanese women often resume working after taking the leave. Many nuclear families choose to live close to older relatives to share childcare responsibility, which helps women continue working (Japanese Ministry of Health, Labor and Welfare, 2006a). In 1990, the number of women employees (excluding agriculture and forestry workers) stood at more than 18 million – 37.9% of the country's workforce. In 2006, the same figure stood at more than 22 million, which constituted 41.6% of the country's workforce (Japanese Ministry of Health, Labor and Welfare, 2006b). Until 1970, the number of married-women employees was less than unmarried-women employees. In 1970, the 41.4% of women employees were married and 48.3% were unmarried (the remaining 10.3% were widowed or divorced women). By 1975 the number of married women employees had increased to 51.3%. Since then this figure has continued to exceed 50%. In 2006, the percentage of married women employees stood at 56.5% of the total women workforce and only 32.3% were unmarried (the remaining 10.7% were widowed or divorced women) (Japanese Ministry of Health, Labor and Welfare, 2006b).

Middle-aged Japanese women are increasingly highly educated and employed as full-time workers. Many of them have begun to view work as a path to self-realization and have continued in their careers (Hashizume, 2000; Japanese Ministry of Health, Labor and Welfare, 2006b). In 1970, 60.6% of women employees and newly graduated women were only high school graduates. By 1992, this figure had decreased to 50%; 30.6% of women employees were now junior college graduates and 17.3% were university graduates. This trend in reaching higher education continued, and by the late 1990's, the percentage of employees educated to those three academic backgrounds had evened out – each becoming around 30% (Japanese Ministry of Health, Labor and Welfare, 2006b). In 2006, the percentage of women employees who were employed full-time was 78.1% – a figure that has continued to increase. In addition, the average length of service of the woman employee has increased. It was 6.1 years in 1980, lengthening to more than 7.0 years in 1986, and by 2006 standing at 8.8 years (Japanese Ministry of Health, Labor and Welfare, 2006b).

The fourth major change in the lifestyle of middle-aged Japanese women and family caregiving has been the establishment of national initiatives for promoting home-based elderly care and a gender equality in society. The Japanese Ministry of Health, Labor and Welfare developed “The Gold Plan 21” and “the long-term care insurance system (*kaigo-hoken-seido* in Japanese).” These aim to promote the health and welfare of

elderly citizens and support family caregiving for the elderly (Health and Welfare Statistics Association, 2007b). “The Gold Plan 21” was established in 1999 after the conclusion of two former initiatives: “The Gold Plan” in 1990 and its revised version in 1994. The aim of “the Gold Plan 21” is to promote an active life and dignity for the elderly, and to establish qualified care services and home-based care programs. In 2000, “the long-term care insurance system” was established as a social insurance system, which aims to promote home-based care for the frail elderly or dementia sufferers who would have formerly had to undergo costly, long-term hospitalization (Health and Welfare Statistics Association, 2007c). Additionally, since the middle of 1980, policies regarding medical treatment fees for the elderly have been reformed several times, which has encouraged elderly patients to undergo early discharge from hospital (Health and Welfare Statistics Association, 2007d). The policies have been geared toward the promotion of self-care for the elderly and also the recognition of the responsibilities of family caregivers (Cabinet Office, 2006; Health and Welfare Statistics Association, 2007b; Japanese Ministry of Health and Welfare, 1998).

In 1986, the government established “The Law of Equal Opportunities and Treatment between Men and Women in Employment”, “The Law regarding Family Care Leave” in 1991, and “The Basic Law on Gender Equality” in 1999. These three laws aim to assure equal opportunities for women workers in areas such as overtime work. These laws also promote the welfare of workers by facilitating the coexistence of work and family life, including care for the elderly (Cabinet Secretariat, 2008). In 2002, 73.2% of workplaces, with 30 or more employees, provided family care leave to employees. That figure increased to 81.4% in 2005 (Japanese Ministry of Health, Labor and Welfare, 2006b). Since 1999, the Japanese Ministry of Health, Labor and Welfare has started to officially recognize companies that actively adopt these laws, referring to them as “family friendly companies”. Such companies numbered 38 in 1999—a number that had encouragingly increased to 227 by 2006 (Japanese Ministry of Health, Labor and Welfare, 2006c). From 2004 to 2005, 0.08% of the total number of women employees took family care leave (Japanese Ministry of Health, Labor and Welfare, 2006b). Compared with the numbers of employees who took maternity and child-care leave, the number of employees who took family care leave for elderly care was extremely small. This law figure shows that family care leave has hardly been utilized (The Japan Institute for Labor Policy and Training, 2006).

National initiatives and laws, and the “family friendly companies” branding system are designed to promote home-based elderly care enforced by women workers by aiming to concurrence of work and family life, and including elderly care. In reality, however, more people are seeking in-facility based elderly care, and increasing numbers of elderly people are on waiting lists to receive such services. Therefore, there remains the

issue of escalating caregiving costs (Abe, 2006; Health and Welfare Statistics Association, 2007c).

Government policy and a lack of in-facility resources have a salient impact on the life course of working women – forcing them to take on home-based elderly care. At the same time, the economic depression that began in the 1990s has threatened to impact the welfare of workers. For example, the number of companies that qualified as “family friendly companies” fell by 5% in 2002 (Ono, 2002). In addition to this reduction of independent efforts from companies for the welfare of their workers, government policy suggests that, of the elderly people who currently receive in-facility long-term care services, a percentage are actually fit for home-based care. Governmental policy has established a planned reduction of the number of sickbed in-facility long-term care services (Health and Welfare Statistics Association, 2007c). Under these circumstances, many working women are expected to devote significant time and energy to care for the older generation, and in some situations, they are expected to leave employment when the elderly person requires assistance in daily life (Hashizume, 1998, 2000; Kasuga, 2004; Okifuji, 1984). In 2006, throughout Japan, more than 90,000 employees left work to undertake elderly care, of whom 90% were women (Japanese Ministry of Health, Labor and Welfare, 2007b).

The Ministry of Internal Affairs and Communications conducted surveys on the time use of working couples in 1996 and 2006. The result showed that the time used by husbands for housework was shorter than for wives, and the results showed little improvement between 1996 and 2006. In 1996, the mean total time per day used for housework and family care was 33 minutes for husbands, in contrast to four hours and 22 minutes for wives (Ministry of Internal Affairs and Communications, 1996). In 2006, it was 46 minutes for husbands, but three hours and 39 minutes for wives. Irrespective of whether or not the wife worked, the time used by husbands for housework was shorter than for wives. Furthermore, the surveys showed that the time used for leisure was shorter in wives than in husbands, because the wives tended to give their free time to carry out housework and family care (Ministry of Internal Affairs and Communications, 2006). During the decade between the two surveys, the government initiated efforts to raise awareness of the importance of task sharing among family members by re-evaluating the gender role norm. However, the results of the surveys show that the prevalence of gender equality has been slow to be realized (Kashima, 2003). It has been suggested that gender equality is particularly difficult to promote in Japan, compared with other advanced Asian countries such as Korea, the Philippines, Singapore and Malaysia (Cabinet office, 2007; Kashima, 2003). Some have assumed that many Japanese women have to have already abandoned the idea of gender equality (Kashima, 2003).

In summary, the actual conditions of life for modern Japanese working women are subject to various socio-economical or political changes that encourage women's self-realization. At the same time, working women face tremendous expectations to assume the caregiving role for the entire family and the elderly. Unknown is whether this dichotomous situation affects or threatens the well-being of Japanese working women caregivers, forcing them into a life of "sacrifice and devotion" (Lock, 1993, p.54; Ueno, Oukuma, Ousawa, Jinno, & Soeda, 2008).

To illustrate this point: stories of elder abuse directed from family members have recently been revealed, raising serious concern about the unexplored area of caregiving. The stories resulted in the introduction of the Law for the Prevention of Elder Abuse introduced in 2006. According to the survey of Institute for Health Economics and Policy, approximately 20% of abusers were daughter-in-laws (Institute for Health Economics and Policy, 2004). Among the top five reasons for the abuse of an elderly care-receiver by the caregiver was derived from the indifferent attitude to elderly care displayed by the husband or other family members and relatives (Institute for Health Economics and Policy, 2004). Kato (2008) analyzed the reasons women caregivers committed homicide of the elderly parent care-receivers. She concluded that the traditional gender role norm had not changed, resulting in the oppressed condition of the caregiver. She further suggested that both the role of caregiving and the oppression of the caregiver were largely ignored by other family members (Kato, 2008).

Considering the various conditions outlined above, what was clearly lacking was a study of the women caregivers' lived experience in caring for frail elderly parents or parent-in-laws. My purpose in this study was to explore the Japanese women caregiver's experiences in a society in which women increasingly recognize the importance of self-realization and are growingly aware of socio-economical and political changes.

Method

I employed grounded-theory methodology for collecting and analyzing the data. Grounded-theory methodology is rooted in symbolic interactionism. The methodology assumes a person, as a member of a social grouping, behaves in numerous social contexts in accordance with the meanings and values that are jointly owned by that social group (Glaser & Strauss, 1967; Strauss & Corbin, 1990). I assumed that the caregivers would construct certain meanings around their day-to-day experience of caregiving during dynamic exchanges with the elderly. I predicted that those meanings would be based on their interpretations of the caregiver's interactions with one another within a social context. I assumed that this is influenced by the sociocultural and

historical values of Japanese family caregiving and gender roles.

Definition of Terms

In this study, the word “the elderly”, “the elders”, “frail elderly”, and “the elderly parent or parent-in-law” denotes the elderly care-receivers who are 65 years of age or over. They are the natural parent of women caregivers or natural parent of the spouse of the caregiver. The word “women caregivers” and “caregivers” denote daughters or daughters-in-law of the elderly care-receivers.

Sample

After review and approval by the Human Subjects Committee, I recruited women caregivers who met the following study criteria. These were: (a) employed and married, (b) living together with the elderly parents or parents-in-law, (c) caring for the elderly family members who were house-bound or chair-bound as defined by the criteria of the Japanese Ministry of Health, Labor and Welfare, and (d) the elderly were able to interact verbally and were not diagnosed as having senile dementia. I designed these criteria to facilitate an exploration of a typical setting of family caregiving for the elderly who were not suffering from dementia, seriously frail or injured, and none of them were diagnosed with malignant tumors. Previous studies on Japanese family caregiving had mainly focused on those populations.

Study Participants and Protocol

From the sample, two of the daughters were not the eldest daughters of the care-receiving parent. All of the daughters-in-law were wives of the eldest son of the care-receiving parent. Most of them were full-time workers. Their spouses were also employed or self-employed. The women caregivers ranged in age from 39 to 52 years of age. Seven of them were living with school age children. Children of the other caregivers were above school age or had entered adulthood. The elderly parents or parents-in-law in the sample ranged in age from 70 to 85 years of age. Every elderly care-receiver, except one, was a widow or widower. All of the elderly used home care service once a week or every two weeks. The length of caregiving varied, with a range of eight months to 15 years.

I recruited the women caregivers from six different home care agencies in local and middle metropolitan districts of a single prefecture in Japan. The districts included both rural and industrial areas. I selected those districts, as for open sampling, to explore the various values, attitudes and opinions of the caregivers concerning traditional gender role norms within changing society. In the process of open sampling, I held interviews with women caregivers of various backgrounds. These were: occupation, age of the caregiver’s children, age of the elderly, blood relation to the elderly and whether the elderly had cognitive decline, and I

guided the subsequent interviews and analysis based on the data. For axial sampling, I focused on the following three conditions and tried to indicate differences and changes in context, action or interaction, and consequences: (a) how strongly the caregiver was aware of and valued the traditional gender role norm, (b) whether husbands and the elderly parent were cooperative and willingly shared the task responsibility or practiced self-care, and (c) whether the quality of the relationship between the caregivers and the elderly tended to worsen over time. For discriminate sampling, I tried to determine how well the working women caregivers released their feelings of oppression. Finally, I intended to take the analysis to the point of theoretical saturation (Strauss & Corbin, 1990).

As prescribed by grounded-theory methodology, I initially asked caregivers broad-band, open-ended questions. The goal was to give them an opportunity to offer a broad description of their caregiving experiences. The interview questions centered around four themes: (a) gaining a general overview of their caregiving experience, (b) changes in quality and quantity of caregiving and insights into elderly caregiving that occurred during the caregiving experience, (c) meanings applied to caregiving that caregivers developed since taking on the role, and (d) the prospect of future caregiving. I audio-recorded the conversations, with the permission of the caregivers, and assigned each caregiver a code number to ensure confidentiality. The tapes were then transcribed and later destroyed. I analyzed the data concurrent with the interviews, using the “constant comparative method” (Glaser & Strauss, 1967; Strauss & Corbin, 1990). I then constructed a coding system to capture the meaning of the transcripts, using the process of open coding. Several codes were then grouped into categories that subsumed these codes. The elicited categories provided focus for subsequent interviews with new caregivers. The interview questions used toward the end of the study after data were analyzed were more focused. These were: (a) in what ways are you able to release the oppressed feelings? (b) what kinds of accomplishments are you able to obtain by being keeping up both your continuing employment and caregiving of the elderly parent? and (c) how do you view the life of contemporary working women caregivers? I linked categories and subcategories through the process of axial and selective coding (Strauss & Corbin, 1990).

As data analysis continued, six categories consistently emerged, and less new information was elicited. After the 11 interviews, I became confident that the data had reached a point of theoretical saturation.

I employed a process of peer debriefing and informal member checks to establish the trustworthiness of the data. Two Japanese nurse scientists, both experts in grounded theory methodology, took responsibility for the peer debriefing, and we met to discuss the interview data, analytic categories and interpretations. Regarding informal member checks, I provided the results to the caregivers as additional interview questions (Janesick,

1994; Lincoln & Guba, 1985).

Data were collected over a one-and-a-half year period; each caregiver was interviewed once. Interviews were conducted in the caregivers' homes or in a quiet room of the home care agency. The average duration of an interview was 95 minutes (SD 34.2, range 40 to 160). I conducted the interviews and I am a native Japanese speaker.

Results

Story Line

Through the ongoing process of data collection and analysis, a substantive grounded theory was generated with a core concept of "releasing self" as the central phenomenon. Working women caregivers recognized that, in modern Japan, adhering to the traditional gender role norm of taking sole responsibility for housework and caregiving was not compatible with the pursuit of their own careers and personal life. This was because of a demand to maintain stability in their current lives and also their own worries over personal financial security in their old age. In those women who valued their work and personal life, specific feelings of oppression were described, which led them to take particular actions to improve their situation. This process of attempting to improve their situation can be described as "releasing self," which explains how the socio-cultural and historical values of family caregiving and gender roles impact the everyday experience of Japanese employed women caregivers.

The theory that developed over the course of the interviewing and data analysis consists of six steps and 23 categories. Figure 1 is the diagrammatic model of "releasing self." This model illustrates the relationships between the different steps in the process of "releasing self", including the links between the different categories within the steps. The steps and categories are briefly described below, using quotes from the participants of this study.

INSERT FIGURE! ABOUT HERE

Step 1: Following the Norm Automatically

The first step is conceptualized as the causal condition for participating in providing elderly care. It describes the process of a working woman becoming a caregiver.

All the participants of this study described their daily schedule as being "fixed" and "tight." As elderly parents in the family began to need assistance in daily life, some of them were hospitalized for medical treatment. Women had to take on the additional task of caregiving for the elderly on top of an already busy daily routine of work, childcare and housework. This left the women struggling to manage all the demands on

their time. As long as the elderly were able to eat and use the toilet without assistance, women considered the task of caregiving similar to other forms of housework, such as doing the laundry or preparing meals. However, when the elderly person required considerable assistance until recovery, the women caregivers were overwhelmed by the enormity of the tasks. One caregiver shared, “There was no time to look back, and I just did it.”

Because of the extremely demanding schedule that the caregivers were subject to, they were seemingly unconscious of the underlying traditional gender role norms, which were in part responsible for placing this burden on their shoulders. In taking on the role as caregiver, it seems that the women were following the norm automatically. This step involved four categories, described below.

Doing it alone. Caregivers quietly performed and managed the task alone without assistance of other family members, so as to avoid disrupting the daily schedules of others. This unwillingness to disrupt others denotes the Japanese value of keeping harmony of the group (Hashizume, 1998, 2000; Kanemoto, 1987; Tierney, Minarik, & Tierney, 1994) and also the Japanese sense of independence (Kinoshita, 2000).

Doing the best. Caregivers prioritized the needs of their husbands and the elderly and valued their well-being so highly. Caregivers would do things for them that the others could have done by themselves. Caregivers tried to offer the “best care.” “Best care” relates to the amount of psychosocial care given. For example, they took the elderly out of the house and made time to engage them in conversations, which offered invaluable comfort and stimulation. Caregivers also considered taking the elderly for medical check-ups as giving the “best care”. This tendency to take the elderly for medical check-ups was largely because they regarded the frailty of the elderly as an illness that needed to be “fixed” by medical treatment (Freed, 1990; Hashizume, 1998; Munakata, 1986). As for medical treatment for the elderly, caregivers obediently followed any suggestions made by the physician, which is also a normative behavior for the Japanese (Hashizume, 1998; Haug, Akiyama, Tryban, & Sonoda, 1991; Tierney et al., 1994).

Valuing the elderly. As a mark of honor and respect for the elderly parent (Hashizume, 1998; Kiefer, 1990; Sodei, 1995), caregivers neither argued with the elderly nor pointed out their faults. They arranged neat and convenient living environments for the elderly. They provided meals for them to their preferred taste. This tendency was stronger in caregiving where the elderly person was more than eighty years of age and/or with mild cognitive decline. As one caregiver shared, “My mother is eighty-five and I am not sure if she’ll live any longer. So I take good care of her and prepare food however she likes it.” Another caregiver shared, “My mother has not been diagnosed as having senile dementia, but sometimes I cannot understand what she does. I

try to suit my understanding to her condition.” The caregivers also tried to protect the privacy of the elderly parent.

Enduring. Alongside adapting to the new circumstances of taking the responsibility of caregiving, caregivers also continued to work. They also prioritized their tasks of caregiving and housework over their own personal interests, thus limiting their personal time for rest or recreation. They performed all of their tasks without complaining. Those attitudes of “giving one’s very best” denote Japanese feminine identity (Reischauer, 1981; Smith, 1987), as illustrated by one caregiver:

When I started taking care of my mother-in-law, I was the only one to handle it. Both my husband and my daughter had jobs. My son and his wife have been living next to our house, but they have their own life. So, I did everything alone. I honored whatever she said and never opposed her. I took her to so many clinics and hospitals. There was no time for myself. Because of this difficulty, I lost ten pounds in three months.

Step 2: Reducing the Amount of Tasks

The second step provides the context or background of the substantive theory that evolved. This step involves two categories: “Entrusting” and “Focusing”. All the caregivers in this step described how sooner or later, they (women caregivers) discovered their limits of power and stamina to manage their numerous tasks alone. They found that it took a long time for the elderly to get well, and in some cases their frailty was immutable. This being the case, the amount of care required increased over time. These conditions forced the caregivers to reduce the amount of care given and reduce the amount of time given to housework. Those caregivers who were physically weak were highly likely to resign from their jobs. Here follows a description of the two categories of “Entrusting” and “Focusing”.

Entrusting. This category involves caregivers asking for help from professional care workers and also family members. Here “family members” specifically refers to daughters or daughters-in-law of the caregivers, women siblings or fathers, husbands or sons who willingly offered to help. The tasks most frequently entrusted to professionals were bathing and psychosocial care. Family members were most frequently entrusted with part of the housework, such as laundry, cleaning the house, grocery shopping and such. Dressing, bathing, and toileting (e.g., changing diapers, cleaning bed pans) were the least likely tasks to be entrusted to men family members. These tasks all involve coming into contact with a naked body, which is considered taboo for men (Ichimori et al., 2004). One caregiver stated,

My husband has been doing dishes willingly since I began to take care of his mother. But he does not change her diapers and I never ask him to do it. Although they are mother and son, I think THAT is my role.

Focusing. This category involves caregivers focusing on the tasks that have greater compatibility with the caregiver's other duties of work and housework, and also compatibility to personal preference. "Entrusting" part of the tasks to someone else allow caregivers to be "Focusing". This process was described by one caregiver,

Ten years have passed since I started taking care of my mother. I am also getting older and can not give her bath alone. But I try to talk with her as much as I can. I ask home care nurse to give her bath and give my time to talk to her.

Step 3: Attributing the Choice of New Coping Strategies to Change with the Times

The third step is identified as an intervening condition that effectively facilitates new interactional strategies. In this step, the actions of caregivers either followed or contradicted the current policies for promoting gender equality and for home care of the elderly. Caregivers recognized that meeting the needs of their husband and the elderly parent was incompatible with the continuance of the woman's own work and the valuing of her personal life. The awareness of this incompatibility stemmed not only from their own experience, but was also reinforced by the mass media. Caregivers were also influenced by home care nurses, who promoted the idea of "self-care" – reinforcing the importance of the caregiver's helping the elderly carry out self-care to prevent them from becoming bedridden.

Caregivers were also influenced by the practices of other women caregivers. Those women already found time to continue working and enjoy personal recreation by involving their husbands in the responsibilities of housework or caregiving. The women caregivers also realized how the fluctuation of Japanese economy impacted their lives by threatening their personal financial security and future employment opportunity. From these various sources, the caregivers discovered the traditional gender role norm to be outdated amid the various current political and economical changes. Thus, they chose "new coping strategies" to pursue an ideal of valuing their personal life and work, adopting the phrase: "change with the times." This step involved five categories.

Persuading and insisting. Some caregivers persuaded their husbands to share in caregiving

responsibilities and do what they could do to help. Likewise, they persuaded the elderly to get involved in self-care (on mutual terms), to reduce the amount of tasks for the caregiver. These actions correspond to the current policy of promoting self-care for the elderly and gender equality in society. Those husbands and the elderly who highly valued the traditional norm rejected calls for self-care or for the man's help in caregiving. In some cases, therefore, caregivers had to object to their dependent elderly or husband by insisting on individualism and equal opportunities regardless of age or sex. One caregiver shared, "Some elderly people dislike seeing men in the kitchen, but nowadays men and women are equal. When I am too tired, I ask my husband and my son to do housework." Another caregiver said, "My mother-in-law asks me to do things even though she can do it, but the home care nurse said it is important for her to do things herself. That helps me make time for myself. Now I encourage her to do so."

Caregivers also persuaded or insisted that women siblings who were living close, but had thus far provided little help to caregiving activities, to share some of the caregiving responsibility. Those siblings were limited to those who were a blood relation to the caregivers and the elderly parent, and who kept a good relationship with the caregiver. However, daughter-in-law caregivers did not persuade, nor insist, that in-law siblings (daughter of the elderly and her spouse) become involved. For daughter-in-law caregivers, those in-law siblings were recognized as being "outside of the family caregiving boundaries" as Willyard, Miller, Shoemaker, and Addison (2008) found (p. 1685). Unless they willingly offered to help, those outsiders were last resort or were finally asked to help in cases where the caregivers were physically unable to manage the caregiving because of sickness or impairment.

In accordance with current medical policies for the elderly, physicians often suggest an early discharge for elderly patients from the hospital. In Japan, it is culturally expected that people will comply with the suggestions of the physician. However, the caregivers noticed that an equal relationship between patient and members of the medical profession is needed concerning the advocacy of the patient— something that has been publicized recently (Japan Medical Association, 2000; Yoneyama, 2008). Thus, caregivers ceased to remain as obedient family representatives and insisted that physicians supply good treatment for the elderly. One caregiver shared, "I have asked the physician to visit my mother in our home months ago, but he hasn't visited her yet. I think she will be better if the physician gives her a drip infusion."

Continuing to work. The rise and fall of the Japanese economy during the 1980's and 1990's has had a great impact on individual consumption, affecting women's enjoyment of life. At the same time, these factors contributed to the collapse of the national pension plan and the reduction of the labor market for women

(Kashima, 2003; Morito, 2004; Sekikawa, 2004; Tachibanaki, 2006). Caregivers, however, tended to continue working, recognizing that the traditional Japanese life course of a woman is an outdated idea. This shift in thinking enabled them to pursue career opportunities, which also allowed them to budget for their retirement.

As one caregiver said,

The TV and the newspapers said that the national pension plan would collapse before we get old. If I lose my job now, no company would hire a middle-aged woman like me. So I want to continue working as long as I can. I want to save money for my retirement.

The caregivers who considered their work as a means of supplementing the income of their husband would rather resign their posts when they felt that the elderly needed more care. Those caregivers referred to the insufficient number of long-term in-facility care services. One caregiver shared,

When my father-in-law becomes frailer, I will quit my job. If there were enough nursing homes I would take him there and continue working. My job is just for money. If my husband got better pay, I'd rather stay home. The truth is I have to work for the money.

Valuing personal career. Women caregivers, who worked as professionals in their respective fields, saw their job as part of their self-realization. Some women described how their own mothers, who were working outside of the house, had to become a caregiver after their grandparent had become sick. They often stated the adage “times have changed” and commented on how they valued their career more than they valued following the traditional life course of a Japanese woman. One caregiver shared, “My mother abandoned her career to care for my grandmother. In her day, that was the path for women, but not anymore. Times have changed. My job is part of me.”

Considering institutional care as an alternative. To continue working, to follow careers and enjoy personal life, caregivers considered institutional care as a viable alternative to home care. Caregivers who lived with school age children tended to have this opinion as they found managing their workload heavier than caregivers who lived without school age children. One caregiver said,

People used to take care of the elderly at home, but nowadays, we have nursing homes. When my mother becomes too frail, I think I will take her to one. I have a job and children. I have to secure my own life, too.

Enjoying personal life. Besides valuing their own careers, caregivers tried to enjoy their personal lives by engaging in hobbies and pursuits to aid their physical and mental well-being. Until the end of World War II, the patriarchal family system demanded that women were subservient; having fun or enjoying a personal life was considered sinful for women (Hashizume, 1998; Minami, 1980; Smith, 1987; Sodei, 1995). However, the economic prosperity of the 1980's promoted a national leisure boom. The economic development and the political changes encouraged caregivers into gaining autonomy and seeking enjoyment in family life (Hashizume, 2000; Minami, 1980; Smith, 1987). Caregivers, whose children had finished schooling, tended to be the ones able to afford the time and money to pursue hobbies. One caregiver said, "The TV, newspapers, and magazines say there are so many attractive places to go. My children are grown-up and we have longer lives now. We should enjoy our life. I am saving money monthly with my friends for traveling." At the same time, caregivers also expressed concerns about whether they might be criticized if the condition of the elderly took a sudden turn for the worse while the caregiver was away from home. Should the elderly person pass away while the caregiver was elsewhere, it would leave an undesirable sense of not fulfilling responsibility, particularly for the Japanese woman. Caregivers expressed that they attached great importance to attending to the elderly person. They tried to be close to their side at the end of that person's life. One caregiver shared, "I never feel like going out for fun. What if something happens to my mother while I am away from home? Everybody would surely criticize me. All my labor would be in vain and that would be so embarrassing."

The three categories described above of "continuing to work," "valuing personal career" and "enjoying personal life" correspond to the current policy for promoting gender equality; however, these lead the caregiver to consider institutional care which is in direct contradiction to the current policy of promoting home care of the elderly.

Step 4: Feeling Oppressed

The fourth step was another intervening condition that constrained the previous step of interactional strategies. In Japan, normative behavior in the family and community is based on the following three values: (a) a respect for the elderly, (b) the patriarchal family relationship purporting man supremacy, and (c) a respect for harmony in the family and the community (Hashizume, 1998, 2000; Kanemoto, 1987; Tierney et al., 1994). Over time these have been internalized as moral directives among the people. The traditional gender role norm has been with this long history, and is still highly valued by the general public in many respects (Hashizume, 1998, 2000; Yamamoto & Wallhagen, 1998). This step describes how caregivers encountered an awareness of the value of the traditional gender role norm. Caregivers expressed feelings of being selfish or irresponsible if

they put their employment and personal life before valuing the traditional gender role norm. Often, those husbands, elderly people and neighbors (the community) who placed high value on the norm, criticized the caregivers either directly or indirectly. However, caregivers avoided arguing against them for the sake of maintaining harmony between the family and the neighbors.

This step, “Feeling Oppressed,” involved five categories. Three of them: “feeling sorry”, “feeling guilty”, and “feeling ashamed,” represent a caregiver’s negative feelings about herself. Those feelings arose from remorse for having gone against the norm. The other two categories: “feeling angry” and “feeling disgusted,” represent the attitudes of the caregivers directed against the caregiver’s unreasonable conditions.

Because caregivers were aware of the possible collapse of the national pension plan and feared the possible reduction of the labor market for women, they continued working out of necessity. Current employment allowed them to secure their future employment, support the current stable husbandry and make a budget for their retirement. Work was not just a means of self-realization but was rather a means to survive the uncertain situation of future financial security. Caregivers also knew how to reduce their daily tasks by sharing the household responsibilities with their spouse and by promoting self-care of the elderly. These strategies were indispensable for the caregivers to successfully manage the tasks of elderly care, housework and working. Among the general public, however, attitudes regarding the traditional norm had not changed. This exposes a lack of effort to reform attitudes toward, and awareness of, traditional gender norms within the general public. It has placed a very one-sided expectation on the role of caregivers on women – an unchanged state which proves ever more burdensome. Below is a descriptive outline of the five categories.

Feeling sorry. By asking other family members to share the responsibility of caregiving and housework, caregivers regarded this as bothersome to the others. Caregivers who valued the traditional norm higher also expressed having similar feelings toward professional care workers as well. One caregiver said,

I feel sorry for my husband and daughter as I think I am just using them for my own convenience. I feel sorry for the home care nurses, too. Although I can not do this alone, I should, after all, manage this all by myself.

Feeling guilty. Some caregivers regarded themselves as undervaluing the elderly person and the responsibility of caregiving if they prioritized their own life and work before the duty of caregiving. As one caregiver shared, “It is important to encourage my mother to do the things by herself, but I sometime feel guilty. Because I know she can not do it as she used to.”

Feeling ashamed. Some caregivers described a loss of pride in their role in the housework, as they reduced the heavy workload of household tasks. This led to feelings of shame because there is great pressure from the traditional culture for women to keep a tidy home. One caregiver expressed, “Because I am so busy with work and caring for my mother, my home is an untidy mess. That makes me feel ashamed.”

Feeling angry. A number of caregivers described how those husbands and elderly persons who highly valued the cultural norm, disagreed with the caregiver’s recognition of the “changing times.” They objected to the caregiver’s insistence on promoting self-care and task sharing. Caregivers also came under criticism from neighbors for not prioritizing caregiving responsibilities and continuing to work. The outdated attitudes, expressed by the elderly, the husbands and the neighbors, brought out feelings of anger in the caregivers as they were urged to follow such unreasonable conditions against their will. One caregiver said,

Once my husband overheard my neighbors talking about how I am still working even after my mother-in-law began to need assistance in her activities of daily life. He once asked me to stop working. I got so angry. I told him that I had to work for managing our husbandry and to ignore those outsiders.

Caregivers also felt anger toward the questionable policies of home-based elderly care. They recognized it promotes the early discharge of elderly patients without administering adequate medical treatment. One caregiver shared,

My mother-in-law was kicked out from the hospital just after three months. She could barely walk. On TV it said that rich and famous people or politicians can stay longer in a hospital and receive proper treatment. I was angry and told her [the elderly’s] physician that this is unfair.

Feeling disgusted. In some cases, caregivers felt the sole responsibility for the task that remained on them. The burden remained on them no matter how hard they worked to persuade or insist on the acceptance of the “changing times” from the care-receiver and other family members. It brought out feelings of disgust in the caregivers. As one caregiver shared,

My father never listens to me, even though I ask him to do things because it is good for him. That disgusts me. I tell the story to friends, but everybody says, “There is no other way.” I cry, but nothing changes.

In contrast to this, those husbands and elderly who also recognized the “changing times” were cooperative and willingly shared the task responsibility or practiced self-care. In those cases, caregivers experienced comparatively few feelings of oppression, and were able to continue working, alongside caregiving and enjoying their own life.

Step 5: Releasing Self

In Step 5, caregivers worked to release their oppressed feelings. This step involved the three categories outlined below.

Laughing away. Frequently, caregivers went through a process of laughing away any negative feelings toward themselves. They also laughed away the feelings of resentment they harbored toward the elderly and husbands who disagreed with the caregiver’s efforts to promote self-care or task sharing. “Laughing away” is not a negative form of self-ridicule, nor is it ridiculing the husband or the elderly. Rather it describes the resilient action of the sense of humor. Humor makes an unchanged situation positive. One caregiver laughingly explained,

Even though I implore my husband about gender equality, he never gives his hands to housework. I sometime tease him and say, “How would you survive by yourself if I get sick and go into hospital?” He answers, “I will go out to eat.” He wouldn’t even give me the time of day.

Self-belief. The caregivers took several steps which helped them to perceive themselves and their actions positively. These also helped them to deal frankly with opposition from husbands and the elderly. Caregivers attributed their own behavior, in not following the traditional norm, to their individual temperaments. They also continued appealing to their husband and to the elderly to accept the “changing times,” by requesting them to share the responsibility and to do things for themselves. Faced with opposition from husbands and the elderly about the requests, caregivers reconciled themselves to continually pressing them about the matter. In such a way, caregivers were able to disregard and eventually overcome the opposition of husbands and the elderly.

As mentioned earlier, caregivers felt a certain amount of anger toward physicians who requested an early discharge for the elderly from hospital. To remedy this anger, caregivers channeled their energy into improving the level of caregiving by themselves. One caregiver shared, “I and my husband gave up asking the physician to give our mother-in-law additional treatment, and decided to make her better on our own.”

Losing enthusiasm for the elderly and care of the elderly. Those elderly care-receivers, who valued the

traditional norms highly, often refused the caregiver's request to become involved in forms of self-care. They tended to be very dependent on their caregivers. In those cases, caregivers who had had past experience attending to other cancer-suffering parents tended to regard the condition of their noncompliant dependent elderly as a "so-called illnesses." In this study, three such caregivers held their cancer-suffering parents in high esteem when compared with the noncompliant dependent elderly. They saw that "she/he gave their very best even struggling with cancer." This tendency was more pronounced in those caregivers who strove to persuade the elderly to become involved in self-care. Also, caregivers regarded the elder's request for dependence as being "child-like" behavior. This caused the caregiver to feel anger or even disgust toward the elderly and the task of caregiving. In such cases, the caregivers no longer viewed the care-receiver as an honorable elderly parent, rather just "another old person." Furthermore, caregivers saw the refusal of the elderly as being their way of venting anger over their immutable condition on the caregiver. In those cases, the quality of the relationship between the elderly person and the caregiver tended to worsen; this inevitably led the caregiver to lose enthusiasm for caregiving. In turn, a lack of enthusiasm led to caregivers decreasing the amount of psychosocial care they provided. One caregiver mentioned, "My mother-in-law had been using me like a servant, and she never followed what I said. I've washed my hands of her. Now I do the least I have to. I never feel like giving her a nice word."

Step 6: Making Accomplishments

This final step identifies the consequence of the caregiving process. By taking cognitive or behavioral actions to release themselves from the oppressed feelings that developed in the previous step, caregivers were able to manage the coexistence of working, family life and elderly care. Successfully managing these demands brought the caregivers a substantial sense of achievement and psychosocial reward. This step involved the following four categories.

Getting concrete evaluations. By continuing to work, caregivers were able to set financial goals by their earnings and made concrete achievements of work – seeing their wages as an accurate evaluation of their performance. This is an important factor for the caregivers, as their housework and caregiving are perhaps often taken for granted by their families and the care-receivers, which inevitably leads to the caregiver's feelings of being unappreciated. The concrete evaluations achieved at work countered those feelings. One caregiver stated, "I work harder and the payment gives me the sense that I am evaluated exactly."

Covering financial needs. Some caregivers described how their earnings covered husbandry, costs for leisure, and helped their retirement budget. The caregiver's earnings also supported the children; the two family

incomes had allowed them to cover all their financial needs. Additionally, caregivers often covered the cost of the elderly care with their salary.

Getting psychological fulfillment. Caregivers described how covering their financial needs, by means of their own earnings, brought them psychological fulfillment. Furthermore, achievements at the workplace, which brought praise from superiors or colleagues, allowed caregivers to feel the “joy of working”. That joy was also found in their daily interactions with coworkers.

In some cases, caregivers withdrew from their active psychosocial care and lost their enthusiasm for the elderly person and caregiving (as described in the previous step). In such cases, children of the caregivers (grandchildren of the elderly) often took some role in the care of the elderly and also consoled the weary caregivers. Those caregivers described feeling some psychological fulfillment from seeing that their children had inherited their caring nature. They also saw this as their child’s expression of gratitude toward the elderly parent – repaying them for being cared for by their grandparent during their childhood. One caregiver shared,

My mother-in-law has been dependent on me and her childish behavior always bothered me. Our relationship is pretty bad and my son knows it very well. He is grown-up now and has a nice word for me when I am irritated with her. He also takes care of her when I am too tired. My mother-in-law took care of him when he was little. I am glad to see that my son inherits that caring mind.

Having feelings of achievement. Caregivers generally carried out elderly care and housework at a feasible level, which enabled them to manage it alongside their work and their personal life. Being involved in elderly care gave the caregivers a strong sense of fulfilling their duty. Those accomplishments worked to maintain the self-confidence of the caregivers and encouraged them to continue to take on their multiple tasks. Successfully combining work, housework and caregiving correlated with a higher morale within the caregivers. One caregiver shared this sentiment, which echoes that of others,

When I get paid, I feel I am evaluated exactly and that gives me energy for tomorrow. I work very hard in my office and do my best at home. I can switch myself from one task to another. That makes me feel great.

Discussion

The results of this study revealed that women working caregivers placed priority on caring for elderly parents and doing housework over their own careers and personal life. The importance of responsibility

of these tasks is deeply imprinted in the psyche of working women caregivers in Japan. The prioritizing of these responsibilities were reinforced in two ways, (a) through the influence of home care nurses, other working women caregivers and the mass media, both of which promoted self-care of the elderly, and (b) by their feelings of distrust of the questionable future of Japan's social security system.

The deeply embedded sense of the norm – to take care of the family and to relinquish self to the needs of the elderly parent or husband and to housework – resulted in the women caregivers feeling oppressed, and feeling guilt and shame toward themselves. Increasingly they found themselves feeling apologetic toward others. The traditional norm – to care of the family and to relinquish self – discouraged the working women caregivers in Japan to strive for gender equality, and put the onus on Japanese women to take major responsibility for caregiving and housework. This suggests furthermore, that the caregivers see themselves as being devalued and experience a sense of low self-esteem (Hashizume, 1998, 2000; Kanemoto, 1987; Yoshizumi, 1995).

Two types of oppression were evident in the interviews: “feelings of anger” and “feelings of disgust.” It is possible that the roots of these negative feelings stem from the women caregivers’ being pulled by the need to continue their outside employment, because of the potential instability of the social security system.

Women caregivers in this study were self-reliant and worked to achieve a balance between career and elderly care at home. See categories of “entrusting” and “focusing” (in Step 2) and “persuading and insisting” (in Step 3). Concurrently, results uncovered that some husbands and elderly parents held to traditional norms and resisted the caregiver’s requests to share in the caregiving tasks and to have the elderly be involved in their own self-care. Some caregivers were criticized by neighbors or families if they continued to work outside the home. Even as the women caregivers recognized the incompatibility of the norm with their present-day life, they were urged to follow these unreasonable conditions against their will. Faced by rejection or criticism, caregivers felt disgust (in Step 4). This pattern of anger, oppression, and non-responsiveness of the women caregivers’ family network also raises serious concern about the potential impact on the long-range health of the caregiver.

Seligman’s (1975) theory of helplessness is relevant to the current results; it predicts that situations in which the individual’s voluntary actions have no effect result in a person giving up; they learn to be helpless when they cannot change the situation or the outcomes. The consequences of this condition are that the person becomes motivationally and emotionally deficit (Seligman, 1975). In this study, women caregivers learned over

time that no matter what they did or what they requested family members did not and would not respond.

Some of the caregivers reported losing enthusiasm for future caregiving. (See the category of “losing enthusiasms for the elderly and care of the elderly” in Step 5.) Having learned helplessness, women caregivers withdrew from providing psychosocial care. Folkman and Lazarus’s (1990) theory on stress and coping is also relevant to this study’s results. The caregivers’ actions of withdrawing suggest a strategy to avoid conflict with the elderly. Furthermore, such aggravated relationships between caregivers and the elderly could possibly lead to forms of neglect. Results showed that women caregivers changed their view of the elderly from being the “honorable parent” to being “another old person” acting childish with their depended needs.

The results showed that women caregivers assume work as a means of surviving the uncertain situation of future financial security. (See the category of “continuing to work” in Step4.) Being conscious of the corruption of the national pension plan and the reduction of the women labor market, caregivers assumed the task of caregiving alongside an already crammed daily routine.

The study results raise serious question on whether many working women caregivers can afford the time to sustain a healthy lifestyle. Recall that that the family care leave for elder care was infrequently used compared with the numbers of employees who took maternity and child-care leave (The Japan Institute for Labor Policy and Training, 2006). This is likely because employed caregivers would want to maintain their current amount of household income. If they needed to take time for caregiving they chose to take paid holiday, instead of using the leave (The Japan Institute for Labor Policy and Training, 2006).

Caregiving of the elderly differs from child-raising, in that no one knows when it will come to an end. Taking long-term care leave possibly relates to fears of displacement or losing employment opportunity. The caregivers were aware of the current, difficult socio-economical conditions for middle-aged women workers. There was another reason for the small number of caregivers taking long-term care leave as they expressed fear about decreasing the manpower of their workplace should they take the leave. They knew no one would be hired immediately to replace them. Because of the Japanese attitudinal behavior of keeping harmony of the group (Hashizume, 1998, 2000), they were afraid of causing their coworkers any “inconvenience” (The Japan Institute for Labor Policy and Training, 2006).

The dichotomous situation of the Japanese working women caregivers was uncovered by exploring their lived experience: on the one hand, they strived for self-realization that was sustained by policies of gender equality. On the other hand, they were pulled by the traditional gender role norm that served as their moral directive as a caregiver. Concurrently, governmental efforts to raise awareness of the gender equality and of

task sharing among family members have been slow to be realized. Health care policies for long-term elderly care have focused on cost reductions. Unstable socio-economic conditions and fears for future husbandry accelerate women caregiver's need to shoulder those responsibilities without caring about their own healthy lifestyle. The value of keeping harmony and an unwillingness to disrupt others perplexed women caregivers not only in task sharing within family members but also for judgment of using formal services.

Future additional research is needed to examine culturally acceptable ways women caregivers can be assisted to better balance their multiple demands, maintain household harmony, and retain employment. The issues are culturally sensitive and require a participatory model of engaging the caregivers in generating their options, not merely imposing them.

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Bios

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Figure 1. Releasing Self

