



SERVICE USE BY FAMILY CAREGIVERS IN JAPAN

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Abstract—This paper presents a conceptual framework for understanding how Japanese family caregivers make decisions about the use of formal services such as adult day care, short term hospital stays, and long-term institutionalization. Using grounded theory methodology, 26 Japanese daughters or daughters-in-law who were caring for an elderly demented parent or parent-in-law were interviewed. From these data, an overall process of “navigating among endorsed options” evolved. This process was set in motion when caregivers reached the limit of their tolerance, a point at which they felt they could not continue caregiving under the given arrangement. Caregivers then began to assess three issues which determined whether or not they used formal services: the availability of services; their authority level within the family; and whether or not they could justify their tolerance limit. The availability of a service was determined by the quality of the service, the distance to the service, the sanctions that would incur as a result of using the service, information about the service, and the quantity of the service. The caregivers’ authority within the family varied depending on such factors as how much the caregiver was accepted by her married family or the type of family business. This authority level determined whether and how the caregivers could approach other family members in order to obtain their consent to use formal services. Finally, whether the caregivers could justify their tolerance limit depended on the internalization of the societal norm regarding family caregiving, attachment to the care recipient, and the caregiver’s belief on how care should be given. Justification of their limit included re-prioritizing the needs of family members, acting in defiance of societal norm, and redefining reality. Each of the three issues was assessed in relation to the others with the final decision to use or not use formal services based on the balance of forces. © 1998 Elsevier Science Ltd. All rights reserved

Key words—family caregiving, dementia, service use, Japan, daughter caregivers

INTRODUCTION

Mother’s gone for her first short-stay; tears in my eyes, standing by her empty bed.
 (Asahi newspaper poetry, November 24, 1997)

The increase in the aged population is a universal phenomenon that has stimulated a great deal of discussion about how best to support those elders with certain disabilities, such as dementia, and their families. This issue is of particular concern in Japan, where the number of elderly persons is increasing much faster than in any other country.

To meet evolving needs, various formal services have been developed in Japan as well as in other countries, including day care, in-home services provided by nurses or home health aids, short stay respite programs, and institutional long-term care. The development of these services, and the promotion of their quality and efficient use, is an important aspect of the role of health care professionals. Yet little is known about how family caregivers reach the decision to use formal services or what may hinder service use. Past research has yielded fragmented and often conflicting infor-

mation regarding factors influencing formal service use, such as institutionalization (McCoy and Edwards, 1981; Branch and Jette, 1982; Morycz, 1985; Colerick and George, 1986; Caserta *et al.*, 1987; Heyman *et al.*, 1987; Knopman *et al.*, 1988; Brodaty *et al.*, 1990; Greene and Ondrich, 1990; Hanley *et al.*, 1990; Pruchno *et al.*, 1990; Wallace, 1990; Miller and McFall, 1991; Retsinas, 1991; McFall and Miller, 1992; Wolinsky *et al.*, 1992, 1993; Collins *et al.*, 1994; Freedman *et al.*, 1994; Kasper *et al.*, 1994; Montgomery and Kosloski, 1994; Wright, 1994; Tsuji *et al.*, 1995). Although it is generally agreed that decision-making regarding formal service use should be captured as a process rather than an event (Morycz, 1985; Colerick and George, 1986; Greene and Ondrich, 1990; Pruchno *et al.*, 1990; Miller and McFall, 1991; Wolinsky *et al.*, 1992; Collins *et al.*, 1994), this process has not been fully elucidated. Further, little attention has been given to how culture influences this decision-making process. Research in Japan on the use of formal services is also limited (Asada, 1991; Ueda *et al.*, 1993; Takeda *et al.*, 1994; Yamamoto and Sugishita, 1998) and preliminary. Much of the past research emphasizes the need for further investigation related to service use, including the need to focus on the meaning of the caregiving role to the caregiver (Pruchno *et al.*, 1990), and the suggestion

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that qualitative methods may prove to be a valuable approach in further investigation (Caserta *et al.*, 1987).

Based on the literature review, a qualitative exploratory study using grounded theory methodology was conducted. Interviews were carried out in Japan with 26 Japanese females who were taking care of their elderly parent (or parent-in-law) with dementia. These data were analyzed to explain the overall experience of caregiving. The purpose of the current paper is to explicate the dynamics of the decision-making process of these family caregivers regarding formal service use.

BACKGROUND: CAREGIVING FOR ELDERLY PARENTS IN JAPAN

Three cultural factors are important as background to an understanding of decision-making in the Japanese family. First, the family in Japan is characterized by its patrilineal genealogy; that is, a vertically composite form of nuclear families, one from each generation (Lebra, 1984; p. 20). In this family structure, care of the aged has been traditionally considered to be the fixed responsibility of the succeeding generation. This moral tradition used to be financially reinforced through primogeniture, an inheritance pattern involving the transfer of the principal family assets to the successor son upon the death of his father. Although a new inheritance law abolished primogeniture after World War II, the influence of the traditional moral imperative still seems to have a strong impact in the minds of those involved. Thus, in 1992, 33.4% of bedridden elderly persons who were not in institutions were cared for by the female spouses of male children (Japanese Ministry of Health and Welfare, 1995). Yet data indicate that this cultural tradition is undergoing a change that will significantly influence family caregiving of the elderly in Japan. The number of households that included three generations decreased from 19.2% in 1970 to 12.5% in 1995 (Japanese Health and Welfare Statistics Association, 1997).

A second cultural feature that is significant is that each member of a Japanese family has his/her role in the household and contributes to the family according to their delegated status, duties, and abilities. The care of the sick and elderly has traditionally been a role expectation for women (Iwao, 1993). When a woman married, she was considered to have left her maiden family and entered the lineal family of her husband. She was placed under the direct control and supervision of her husband and, more especially, her mother-in-law. She was expected to maintain a high degree of respect for, and subordination to, her husband's parents, and to work diligently to fulfill her domestic responsibilities, one of which is the caregiving of the parents-in-law. Under this traditional cultural norm, the

first son's wife is expected to fulfill all the hands-on caregiving responsibilities for her parents-in-law, including assistance with eating or changing diapers, until the parents are hospitalized because of some medical condition. At the time of marriage, especially when a woman is to marry the first son of the family, most women expect to provide care to their parents-in-law (Yamamoto and Wallhagen, 1997). However, this traditional role expectation may increasingly cause conflict because of the increasing number of women working outside the home. In 1975, the number of employed women was approximately 12 million in Japan; this number rose to 20 million in 1993 (Japanese Prime Minister's Office, 1993).

Finally, traditionally in Japan, members within a group, such as family, are expected to subordinate their personal satisfactions and goals to those of the group (Hendry, 1981). The individual is consistently conceptualized as a part of a larger whole (Lebra, 1976). Under such a collectivistic view, the primary goal of each individual is to enact an established role within the family, so the household functions smoothly and in an integrated manner. Decision-making in Japan can be understood in this context; that is, any decisions should be made in such a way that the harmony within the family and the collective goal of the family can be maintained. In other words, decisions are reached collectively under the strong leadership of the patriarch.

Despite the norm of family caregiving, various formal services began to be implemented as the needs of the elderly for assistance were more broadly recognized. A more Westernized view of family and caregiving among contemporary Japanese, as well as the modernization of the life style (i.e., increase of nuclear families), may have caused the increased need for formal services. In 1990, a special 10-year plan to improve the support systems for these elderly people and their families, termed the Gold Plan, was initiated. The Gold Plan included the introduction of home care support centres and day care centres as well as the development of long-term care facilities. The Ministry of Health and Welfare plans to increase these services by approximately tenfold between 1990 and 2000 (Japanese Ministry of Health and Welfare, 1995). Yet while this plan provided for services for the general population of older adults, support services for families whose elderly parents are demented are still limited. Ideally, these services should also be available for elderly persons with dementia and their families; but in reality, behavioral problems exhibited by many older adults with dementia often exclude them from such services as day care and short stay respite programs, and the number of services remains far below what is needed in Japanese society. As a result, the elderly and their families who are in need of help are added to a long waiting

list and do not receive assistance for an extended period of time.

PARTICIPANTS OF RESEARCH AND RESEARCH METHODS

The caregivers interviewed in the current research were all daughters or daughters-in-law of an elderly person with dementia. The research focused on filial caregiving because of the expected difference between spouse versus child caregivers in the caregiving trajectory, and the meaning and perception of caregiving (Montgomery and Kosloski, 1994). The interviewees were living in several cities, towns and villages in Yamaguchi prefecture and Tokyo in Japan. Yamaguchi prefecture is located in the west end of mainland Japan. Its main industry is refinery and other heavy industries in towns alongside the Inland Sea, with some agricultural villages toward the mountains and some fishing villages alongside the Japan Sea. Metropolitan Tokyo is the urban centre of Japan and the interviewees were from suburban cities (so-called bed towns) and downtown districts where many small home industries are located.

The interviewees were recruited through several senior service organizations. Those organizations included (1) two senior service centres which offer various respite services (i.e., day care, bath services, short stay respite programs, long-term institutionalization); (2) a public health centre in which a caregiver family group is sponsored; (3) two home care support centres through which home health aides and visiting nursing are provided; and (4) a private hospital for the elderly in which a day care, long-term care, and short- and long-term hospital stays. Caregivers were introduced to the first author by the staff members (nurses, social workers, or a psychiatrist) who worked at these organizations. The interviews were held between June and September of 1993.

After obtaining informed consent, interviews were conducted with 26 daughters ($n = 13$) or daughters-in-law ($n = 13$) caregivers, ranging in age from 32 to 63 years old. The interviewees and their spouses had a variety of occupations (e.g., agriculture, banker, college professor, retired) and marital statuses (e.g., single, married with dependent/adult children, widowed). At the time of the interview, the elderly parents with dementia, ranging in age from 63 to 99 years old, were living with the caregivers ($n = 18$), independently ($n = 5$), or in an elderly hospital ($n = 3$). At the time of the interview, caregivers had varied histories of prior use (or cessation of use) of formal services (e.g., home helper, bath service, day care, short stay).

The whole process of research (data collection and analysis) followed the grounded theory approach developed by Glaser and Strauss (1967) and explained by Glaser (1978) and Strauss and

Corbin (1990). A major strategy for data collection in this approach is theoretical sampling, whereby interviewee selection is guided by the on-going analysis. For example, the strength of the cultural norm of caregiving was considered an important condition for the overall process of caregiving. Thus, while caregivers were initially recruited from an urban area, they were subsequently recruited in rural, agricultural villages where traditional cultural norms were considered to be stronger. Further analysis, however, revealed that family business, rather than where the caregivers lived, was more influential on the level of traditional cultural norm, so we compared caregivers from agricultural families or traditional family industries, and those from modern office worker families. Thus, data were accumulated strategically.

Interviews lasted one to four hours (average = 2) and were audio tape-recorded and transcribed word for word for data analysis. Interviews were conducted using a non-structured approach with follow-up probe questions so that the caregivers could give their own view of the caregiving experience. In the grounded theory approach, the on-going analysis directs the subsequent interview questions. Therefore, probing questions were added and changed throughout the data collection.

The interviews began with a general question: "Would you tell me what happened and what you and your family have done since you first noticed there was something wrong with your parent(-in-law)?" During the course of the interview caregivers often discussed how they came to use formal services for the respite purpose. Because there was variation among caregivers in how they came to use formal services, specific questions about this process were added. For example, caregivers were asked, "Do you feel you need approval of other family members when you start using any formal services?"

Data analysis using the grounded theory approach involves comparing and contrasting among multiple events, meanings, and perspectives by constructing multiple codes and categories "to help the researcher to break through assumptions and to uncover specific dimensions" (Strauss and Corbin, 1990; p. 84). For example, in our analysis, caregiving of a parent was compared with that of a parent-in-law, and factors that differentiated these two groups were coded and eventually made into concepts and categories, such as authority or family boundary.

Major concepts pertaining to the research phenomena are identified in this manner through coding, memoing, and sorting of codes and memos. The development and elaboration of concepts using the grounded theory approach is similar to working on a jig-saw puzzle. Multiple codes are sorted and grouped to develop a concept and its properties. Over time, some concepts were replaced by or

grouped within new concepts that represented those data more adequately. This evolution of concepts occurred continuously during data analysis. For example, the category of "availability of services" was initially several separate concepts: quality of a service, information about a service, distance to a service. These latter concepts were grouped as properties within the concept of "formal service criteria". Then the word "availability" was identified as capturing the overall phenomenon.

The ongoing analysis also determined the focus and direction of research. For example, because the answers to the question "how did you come to use this service?" or "why didn't you use the service you desired?" were considered very important, the phenomenon of "formal service use" became one of the central themes of the analysis. Eventually the analysis resulted in the conceptualization outlined in the current article.

The analysis was conducted originally in Japanese and gradually shifted to English as it progressed. Major categories and concepts were developed originally in Japanese and then translated into English. Close communication was kept with American researchers who are knowledgeable about Japan and Japanese, in order to assess the validity of major translations. In order to promote the understanding of the American researcher (M. W.) regarding the cultural background of Japanese and their caregiving, the first eight interviews were translated word for word. After that, only the parts used in the analysis were translated. To assess the validity of the analysis, close contact was kept with the first author (N. Y.) and those who introduced the caregivers to her: social workers, public health nurses, and a psychiatrist. They reviewed the progress of analysis and gave comments to the first author as experts of the family caregiving for the elderly with dementia. Two Japanese experts of grounded theory approach also reviewed the analysis.

FINDINGS

The pervasive and strongly held societal norm of filial caregiving (Yamamoto and Wallhagen, 1997) makes Japanese caregivers reluctant to use any formal services for respite purposes. Because of this norm, any formal service use, with institutionalization being the most extreme example, is stigmatized in Japanese society. Thus, it is only after the caregivers reach the point of their tolerance limit that they start thinking about possible formal service use. Caregivers carefully navigate their way among options endorsed by the situation at any given time. This process is explicated below followed by a discussion of its implications for health care professionals involved in providing services to older persons with dementia and their families.

Reaching the sense of tolerance limit

The sense of tolerance limit is the feeling that one cannot continue to take care any more in the same caregiving situation. At the point of tolerance limit, caregivers feel on the edge, close to being broken, because of the amount of difficulty that they are experiencing in providing care:

She (care recipient) wanted to go out with me, and she followed me everywhere, even inside the house. It was a two-story building where we lived, and when I was on the first floor, she was also on the first floor. When I went upstairs, she came with me. Everyday she followed me all day long, speaking ill of my father. It was so depressing, and it came to the point where I started to feel SO OFF, and to wonder what would become of me (Kaoru, #11; all the names used in this article are aliases).

The sense of tolerance limit may come on as an intolerable sense of frustration or as an intense depression, to the level of desperation. Chieko (#22), a 32-year-old caregiver who has been taking care of her mother-in-law with dementia since the time of her marriage, describes her desperation:

I came to realize that I myself was suffering from something like depression, or psychosomatic disorder. Because, well, I began to say something incoherent, or I started to drink more. Well, how should I put it, even if I told my siblings, they didn't understand me. But when I thought about Mother, my heart palpitated or I had difficulty in breathing. I couldn't get it out of my head that I had to take care of her, and that nobody understood me... But I have to live on... I cannot let go of any of them; my children, my mother, and my work... When I thought about various things, I really felt suffocated, and I began to think about only bad things. In order to escape from this situation, what should I do. It sounds horrible, but I started to contemplate double suicide. I could not discard such a thought as somebody else's concern... If I push Mother in the bath, if I push her only once, then Mother would fall and become bedridden, and then the things may move more smoothly. In summary, I came to think about the unthinkable.

As the caregivers reach this sense of tolerance limit, they begin to take various actions to get away from the sense of limit. Formal service use is one of these actions. The following is an example of how these actions are discussed in the interview:

The situation has been so awful these days and I was almost breaking down... If she continued to stay with us, I thought I would break down, too. So I was going to have a meeting among siblings and discuss the financial matter of institutionalization, like, splitting the cost among us... Although I feel sorry for her (about institutionalization), I was reaching my limit. I thought I would break down unless she went to a facility. The other day in the meantime, I called R (senior service centre) and was told they had an opening for a short stay because someone had canceled. It was perfect timing, and she stayed there for one week... I felt relieved, just a bit, but..., you know, I'm still stressed. (Interviewer) "Have you already talked with your siblings about hospitalization?" No, not concretely, I haven't yet gotten recommendations for available hospitals. We haven't come to that step yet. Yesterday, I asked my sister to visit the doctor with me. I met her at the hospital, and together we asked questions and heard his explanations. We are still at this level. The doctor said most elderly hospitals are far away from here. Also, he said a

patient like my mother will rarely be accepted by those (elderly) hospitals, and that even if she is accepted, she will be sent home soon. Probably she would be sent home. Soon. Those who are bedbound will be accepted, but in my mother's case, no hospitals will probably be available. When I talked with S (social worker), I told her I would talk with the doctor first. But nowadays the situation is getting worse, and my sister at one time said we had better hospitalize her, otherwise I would collapse. So we went to visit the doctor together so that we can discuss this matter with him (Tomoko, #5).

As the analysis progressed, three distinctive topics emerged as issues the caregivers consider in determining possible formal service use: availability of services, the caregiver's authority level within the family, and justifiability of one's tolerance limit. The caregivers elaborated on these complex issues extensively in the interviews.

Availability of Services

The availability of services is a relative concept in the sense that each caregiver, in any given situation, has a unique set of criteria for availability. These criteria determine whether or not they perceive that a specific service is available. Therefore, availability is not uniform to all caregivers, even where two caregivers are living in the same area where formal services are offered equally. Availability is also different in a single caregiver at different times. There are five criteria to determine the availability of a service: quality, distance, sanction, information, and quantity.

Quality. Quality of a service is always the most important criterion in determining if the caregiver can utilize the service. Caregivers tend to use only formal services that offer quality care. Mayu's (#9) reflection on how she chooses services highlights this property:

R (elderly home) is such a nice place, very warm atmosphere. I really wonder how they can be so nice and warm. So I use R or other services offered by the city, but I never use the so-called elderly hospitals; you know there are some at the mountainside. I would never, never send Grandma* to such facilities. I would never use such a facility even if it is free. Rather than using such a facility, I will continue to take care of her at home.

If the quality of care is not good enough, they feel sorry for the care recipients and prefer to continue to take care without using the service. Akiko (#1), after experiencing night time wandering of her mother-in-law for some while, reached her tolerance limit and began to search for a place to institutionalize her. However:

We went to see several hospitals. I visited such facilities for the first time in my life, and... some were restrained on the bed, some were screaming. We went to see those wards. Then (sigh and laugh), I could not make up my mind. We submitted the documents for hospitalization before we came back, but... I felt sorry for Grandma.

*Grandma refers to the caregiver's mother(-in-law).

Sending her there... So, although we submitted the application there...

After this experience Akiko decided not to institutionalize her mother-in-law.

The criterion of quality gradually changes. The greater the desperation in the caregiver's tolerance limit and the more clearly the caregiver justifies her tolerance limit (which we discuss later), the lower the criterion of quality. Mayumi (#18), when she first reached her tolerance limit, visited a social service office at a Japanese Red Cross hospital:

Someone at the office said, "Shall I call N hospital?" But at that time I was not thinking that much. (Interviewer) "the person at the office meant hospitalization?" Yes, but you know, I didn't know if I should hospitalize her or not. It was so sudden. But she called anyway, at that time. However, I was thinking N hospital? "What do you mean?" I mean, I had heard a lot about the hospital. Like, they lock in the patients. I had heard that the patients are locked in at N hospital.

However later on Mayumi decided to use this hospital when she became more desperate. Similarly, the level of authority within the family, which is discussed later, also influences the criterion of quality. The lower the authority, the higher the quality of services the caregivers require as a substitute for negotiating with other family members regarding the formal service use.

Quality varies among services and districts. In some rural areas, long-term care facilities may offer little respite for the caregivers, because they (often covertly) require that family members visit the facility almost daily to ensure quality care.

Distance. Distance is another criterion that determines the availability of the service. Caregivers usually prefer facilities near their homes. Hatsue (#17) would like to use a service closer to her living environment:

I have no choice when I cannot take care of her at home any more... (Interviewer) "You mean you are thinking of hospitalizing her?" I mean, sending her here (N hospital) would be OK. Or, a new elderly home will be opened in H (home town) soon. If I have to send her here in the future, you know the elderly home is closer to our house. If it is available, I would like to put her in a facility closer to our home.

The city limit is often considered a boundary because many services for elderly people are offered by the city government. However, anyone can qualify for most services offered by private hospitals, and the greater the desperation in the caregiver's tolerance limit, the further the acceptable distance. Some caregivers interviewed use short stay or long-term care facilities that are located even beyond the prefecture boundary.

Sanction. The third criterion is sanction. If the sanction is high, the caregivers prefer not to use it. A long-term care facility is often unavailable because of social sanction or stigma. Finance is another type of sanction. This becomes an issue especially when the caregivers consider the use of

elderly hospitals. Although the minimum cost for hospitalization is reimbursed through the national health plan, additional fees that vary from hospital to hospital are charged. Fees for elderly homes are charged on a sliding scale system depending on the income of the elderly and their families.

Sanction by the care recipients may make some services unavailable. If the care recipient dislikes a service, sanction can be too high for the service to be perceived as available to the caregiver. Many care recipients refuse to be institutionalized, partly due to the firm traditional belief that elderly parents should be cared for at home and therefore it brings shame to be institutionalized. Rumi's (#4) mother-in-law is clear on this point: "When Grandma was healthy and did not need help, even at that time, she would often say, I will never stay in a hospital".

However satisfactory the quality of a service may be, use of a service can have effects on the care recipient. Such effects can be deemed unacceptable and the caregiver may not continue to use the service. Mayu (#9) describes the use of a 28-day stay respite setting:

We (caregivers) reluctantly place the elderly person in the 28-day stay program, only when there is no other way. They (care recipients) come back with some souvenirs. I mean by souvenir, they come back with something they didn't have before. They were among many people, (and staying there triggers the new habits and tendencies). For example, she (care recipient) comes back with very arrogant attitude, even if she was not like that before. She may come back with diapers, even if she didn't have one before. Or, because she walks so much there, she may injure somewhere. The longer I leave her in some place, the more souvenirs she brings back home with her... I myself suffer from this afterwards.

However, again, as the caregivers become more desperate and justify their tolerance limit, they are willing to accept larger sanctions.

Information. The criterion of information is another critical determinant for assessing availability of formal services. If the caregiver has insufficient information on formal services, even if they exist, they are not available to them. For example, Reiko (#21) believed there were no services that accept elderly persons suffering from incontinence, so she did not even attempt to search for such a facility for a long time. Needed information not only concerns the existence of specific services, but also their availability in terms of other criteria (quality, distance, sanction, and quantity). If a caregiver receives information that a specific facility is low quality, the facility then becomes "unavailable" for the caregiver. The amount of influence this information has on the caregiver's decision depends on its source. The suggestions of social workers or nurses can be very influential. Suggestions from the physicians are followed without question. Advice from non-professionals is also considered, although the degree of influence is weaker. Information on

the quality of specific services is abundant among lay people in neighborhoods, and rumors regarding services have significant influence on the caregiver's decision-making.

Some information comes from stereotypes held by the general public about certain services which may not be true. For example, many caregivers believe that care recipients are restrained to beds in any formal facility, and as a result, they disregard institutionalization as an option:

There is such a hospital also in H, but I heard they tie down the patients in the bed and never allow the patients to move. It was just a rumor, I have never been there and seen it, so I am not sure. But I heard so. Then, you know, even if we are stressed, we would never send Mother to such a facility (Hatsue, #17).

This incorrect image of formal services is sometimes changed through visiting the facilities. On the other hand, a first time visit to a facility in poor condition can be a horrifying experience, thus labeling institutionalization as unavailable (Akiko, #1; ref. p. 689).

A caregiver's knowledge of a service can be based on previous experience, although this is rather rare. Mayu (#9) used to take care of her bed-bound father-in-law before she begins to take care of her mother-in-law. Because of the previous experience with her father-in-law, she knows a specific facility is high quality. On the other hand, a previous negative experience can block the caregiver's desire to use the same facility again.

Many caregivers actively seek information regarding respite services by visiting several elderly hospitals or public health nurses, or buying books. Active seeking of information on possible formal services is often stimulated by caregivers reaching their tolerance limit. On the other hand, some come to know about available services passively; such as running into an acquaintance who happens to be the Director of Nursing at an elderly hospital, or being told about services through staff of the facility they are currently using. This passive seeking of information, if the acceptable service becomes available, can lead to the use of the formal service even if the caregiver is not very desperate. In fact, there are several cases where the formal services are used without reaching tolerance limit when the care recipients are recruited for newly developed services for the elderly. This appears to be an exceptional phenomenon in contemporary Japanese society where many services for the elderly are being developed rapidly.

Quantity. The last criterion is quantity of formal services. The criterion of quantity is different from the other criteria in the sense that it is not influenced by the level of tolerance limit of the caregiver. A formal service is often unavailable due to the length of waiting lists. There are three cases among the interviewees in which their elderly care recipient is currently placed on the waiting list for

an elderly home. However, desperate caregivers may appeal to the staff of formal services to view their circumstance as extreme (e.g., injury of the caregiver) and allow them first consideration. Quantity of services for the elderly varies in Japan in different areas. Sachie (#24) says:

I heard F city offers day care much more often. You can rarely use day care here. (Interviewer) "not yet, I guess". We can use it only twice in every three months. That's it. They can use it two or three times a week in F city.

Even if certain services are physically available, problem behaviors of the care recipient, such as wandering, aggressive behaviors, or incontinence, can cause the facilities to refuse entry of the care recipient. Health attributes of the care recipients also keep them from taking advantage of the services. For example, Rumi's (#4) mother-in-law was refused by a short stay service because of an infection (hepatitis B). The age of the care recipient can also influence availability of services; many facilities are available exclusively to those over 65 years of age. Chieko (#22)'s mother-in-law is 63 years old: "Since Mother has Alzheimer's (not being bed-bound) and is under 65 years old, she can't get anything (services or financial assistance)".

Authority Level within the Family and Negotiation

Authority in this research means the power any one person or group has over oneself or others, and this is another issue the caregivers consider upon determining formal service use. Assessment of authority has particular importance in Japan where the hierarchy of a group is given more attention than in Western countries (Nakane, 1970). The authority relationship between the caregiver and other family members (excluding the care recipient) is examined here. One's authority is a relative perception that derives from the integration of four issues:

- (1) how much authority the caregiver believes she is granted;
- (2) how much authority the caregiver believes is granted to other family members;
- (3) how much authority the caregiver perceives the other family members believe they possess; and
- (4) how much authority the caregiver perceives the other family members believe is granted to the caregiver.

The authority level of the caregiver is a significant determinant of which negotiation style she uses with other family members regarding formal service use, and it also directly influences whether the caregiver can use formal services. For example, Chieko's (#22) low authority level in the past did not allow her to persuade other family members and she could not use any formal services at the time:

You know, the time comes when you reach the sense of limit. I used to insist to my husband, "it is really hard on me". Then he would say, "I know, I know, but what do you want me to do? There is nothing we can do about it".

Our talk always ends this way. This has been repeated over and over. Eventually I realized that I just had to tolerate the situation; I could only accept it and persevere.

On the other hand, when the authority level is very high, use of formal service occurs without any consideration of other family members' power:

(Interviewer) "When caregiving becomes more difficult, do you think you will ask for help from your siblings?" No, they have their own family, so I don't think we will ask for help. "Any discussion about institutionalization?" Probably no. I guess we'll tell them afterwards. I mean, we'll say "we have institutionalized Grandma" afterwards (Aiko, #16).

Factors that determine caregiver's authority level within the family

There are several factors that determine the authority level of the caregiver at any given time. These include: societal norm, family acceptance process, family boundary, and personality style. As the conditions of these factors change, the authority level of the caregiver changes. Most factors are recognized by the caregivers themselves. Moreover, the caregivers consciously try to earn higher authority based on knowledge of these factors.

Societal norm. The most important factor is the societal norm on the position of the caregiver in the family. The hierarchy of authority within a family with regard to caregiving is, by principle, as follows: if the spouse of the care recipient is alive, his/her authority claim is generally the highest within the family, especially when the spouse remains income-producing. Next is the husband of the caregiver, who is usually the care recipient's son. In the case of daughter caregivers, their authority is usually higher than that of their husbands with regard to caregiving. However, even when the caregiver's authority is relatively high, the opinions of her husband are respected. Daughter-in-law caregivers hold the lowest authority with regard to caregiving; many repeatedly say that they cannot speak up with regard to caregiving from the position of daughter-in-law.

The societal norm on the position of a daughter-in-law is held most strongly by the older generation. The generation gap on the view of this norm often causes family conflict in caregiving. Naoko (#7) is a daughter-in-law caregiver whose father (care recipient spouse) still holds power over their family wholesale business:

Normally, if both husband and wife are alive and healthy, one of them takes care of the other if either one gets sick... We are in that situation, so if Grandpa wants, he can take care of her. He is healthy, and if he really has sympathy toward Mother (his wife), he should quit his job and take care of her. I think that's best for Mother and I can help him. But in reality, I guess he wants to enjoy himself (laugh). When I told him what I thought, he got mad... He said, "I cannot do this, now, after all these years. I'm embarrassed even to walk together (with his wife)".

Family acceptance process. When the caregiver is a daughter-in-law, another factor in determining the caregiver's authority level is where she is in the family acceptance process. Family acceptance is a process by which a daughter-in-law is gradually accepted by the married family. The authority of daughter-in-law over domestic matters is the lowest when she married and came into the new family. Gradually, learning from her mother-in-law and fulfilling her role diligently, the daughter-in-law increases her authority to make decisions based on the family customs. When the mother-in-law loses her ability to function as the matriarch of the family, the daughter-in-law takes over the position and the family acceptance process completes. The authority level of the caregiver depends on where in this family acceptance process the caregiver is at the time of caregiving. For example, Chieko (#22) began to take care of her mother at the time of her marriage when she had the lowest authority level. As a result, she could not make any changes in the caregiving arrangement, even when her tolerance limit had reached a profound state and she was desperate.

Daughter-in-law caregivers play their expected role diligently and according to societal norm. It is only after a certain period of time that they begin to feel justified to speak, which is an indication of the progress in family acceptance process and the elevated authority level. Akiyo (#6) is a daughter-in-law caregiver in a family with a home industry where several siblings of her husband work together on a daily basis. At the beginning of caregiving, her authority was very low and she could not even throw away spoiled food her mother-in-law stored:

Grandma kept all the salmon meat together. When she broiled it, she did it all together and left it in the fridge. My sister(-in-law) showed it to me one day, "Look, I wonder what Grandma is going to do with all this spoiled salmon!" I said, "I can't throw it away in front of Grandma". She said, "don't worry, I can", and she did it for me.

Similarly, Akiyo could not speak up regarding her tolerance limit for a long time knowing the care recipient sons' intention to keep the care recipient at home. However, after some time, she began to have more to say regarding caregiving. Finally when she had another tolerance limit experience, she spoke up that she needed help. At that time Akiyo's sister-in-law began to assist her from time to time. Recently Akiyo has begun to feel it is intolerable to keep the care recipient at home and hopes to institutionalize her. However, her authority is not perceived high enough to directly discuss this matter with her husband and his siblings yet:

Two of her sons still have a strong attachment to Grandma. Mother-son relationship. They say harsh words to Grandma, like, "Oh, Grandma is speaking garbage again", but they are still doing fine with each other. So I can't say I don't want to take care of her at home any

more, right now. They all will say no to institutionalization, so I can't speak up yet.

Caregivers' assessment of their authority level changes over time in this way. Some caregivers are conscious of this principle and attempt to earn higher authority through diligent caregiving as well as attending to other family chores:

I feel we have to change (father-in-law's old style) even if gradually. I can't change drastically. Therefore, I think by doing my best Father would appreciate me, and I feel that I can say what I want as long as I do what I have to do... If I put up for 10 years more, it may be possible for me to rule the world (laugh). I can endure if I think this way. (Naoko, #7)

When the authority is earned by the caregiver, other family members often acknowledge this authority. However, if some family members do not share the view that the caregiver has earned greater authority, it can cause family conflict.

Family boundary. Family boundary is also a factor that influences the authority level of the caregiver. Family boundary is the extent to which a stem family, which consists of the patriarch and his wife, and the successor son and his wife, is influenced by other members in the extended family. When the family boundary is strong and the stem family is not influenced by other members of the extended family (e.g., traditional agricultural family), the authority level of the caregiver tends to be high. Conversely, when the family boundary is weak (e.g., traditional merchant family, modern nuclear family), the authority level of the caregiver tends to be low. Family boundary influences the authority level of the caregiver in the following way: if the stem family provides all the care and other members in the extended family do not spend the time and energy to assist with this care (strong family boundary), these members feel they are not entitled to claim authority in caregiving. This heightens the authority of the caregiver. On the other hand, if the caregiver is helped by other family members with caregiving (weak family boundary), the caregiver often feels that she cannot claim high authority.

Personality style. Another condition that determines the authority level perceived by the caregivers is the personality styles of both the caregivers and other family members. Some individuals tend to claim higher authority in any given situation than others. Therefore, if other family members have a personality style not conducive to claiming high authority, the relative authority perception of the caregiver can be high. On the other hand, if both the caregiver and other family members have personality styles that desire high authority, it often promotes family conflict.

Personality style is addressed because the caregivers interviewed, regardless of whether they were a daughter-in-law or a daughter, perceived their authority at different levels, and the variation can-

not be fully explained by the other factors discussed above. For example, Sachie (#24) is a daughter caregiver within a family with a relatively strong family boundary, yet she cannot use formal services because other distant relatives may disagree: "I imagine it would be very relieving if I can put her in an institution. But I can't. I cannot decide it by myself".

Styles of negotiation

Caregivers must (at most authority levels) obtain consent and endorsement from other family members in order to use formal services because disturbing family harmony must be avoided as much as possible. Thus, when caregivers desire to use a formal service, the first task for them is to negotiate. The choice of an appropriate negotiation style is essential in order to maintain the desired harmony. A different style of negotiation is used depending on who the caregiver is negotiating with, because authority is a relative perception and a caregiver feels a different level of authority with different members of the family. Authority level of the caregiver is a significant determinant of which negotiation style she uses with other family members regarding formal service use.

Indirect negotiation. In Japan, negotiations in general tend to be more indirect than direct. However, this is especially true when caregivers perceive their authority level as low.

Negotiating through silence

When a caregiver perceives her authority level as very low, she often cannot take any action to negotiate and keeps silent. These caregivers can only hope that other family members recognize the need for formal service use. As Akiyo (#6) says: "I am still waiting for others to say, sister, there is no other way, let's put her into the hospital. But I haven't heard that". This behavior is not strictly negotiation, but it is often seen in caregivers. Only when other family members with high authority appreciate the deteriorated condition of the care recipient and grant formal service use can the caregiver begin to take action to use it.

Negotiating by revealing

Caregivers with low authority sometimes appeal indirectly, demonstrating that some formal service use is necessary. The condition of the care recipient is shown in subtle ways for this purpose. This indirect method of communication is an attempt to drive other family members with higher authority to say, "it's time to institutionalize Mother". Akiyo's (#6) experience is an example:

I want them to look at how her daily life has become abnormal. For example, she takes off her clothes and becomes naked. I used to try very hard to put her clothes back on, but nowadays it is warmer so I am not worrying about her catching cold. They usually stop working

around 7 o'clock, then they come upstairs and change their clothes. If she was naked then, I used to put back the clothes on her, because I didn't want them see her naked. But now I would like them to see such a situation, so I let her do whatever she likes. Then her sons say, "what are you doing, Grandma? Have you taken off your clothes again?" So now they know about it.

Negotiating by borrowing authority

Another style of negotiation when the caregiver's authority level is low is to borrow authority from outer authority figures in order to persuade other family members to use formal services. The caregivers may not actively seek an outer authority figure for this purpose, but passively meeting someone with authority often results in formal service use. This person with authority can suggest formal service use to other family members for the caregiver. For example, Chieko (#22) told her husband that the social worker said it was time to think about hospitalization, hence she could institutionalize her mother-in-law.

Direct negotiation. Generally, as the caregivers' authority increases, their style of negotiation changes from an indirect to a direct form.

Confrontation

When the authority level of the caregiver is relatively high and is similar to that of other family members, the caregiver often directly discusses her views on possible formal service use with other family members. This is confrontation and consent seeking:

In February last year, she (care recipient) got much worse, I mean her condition. She wandered around at night or even during day time, and got lost every time she went out... At that time, because it was so hard for me, I just couldn't help telling that I was not sure if I could continue for another year. (Akiyo, #6)

At this level of authority, caregivers still seek consent of other family members, and if this is not received, the caregivers often let go of the idea of formal service use. In the case of a daughter-in-law, even if she is the only person in close contact with the care recipient, she will attempt to obtain consent from blood relatives of the care recipient living some distance away. Further, because of the general social norm about avoiding direct negotiation, it is possible that a caregiver with higher authority will still use indirect forms of negotiation.

Monopoly

Occasionally the caregivers' authority level is the highest within the family and they are free to use any formal services without consulting others. Caregiving in these situations is under the virtual monopoly of the caregiver. These caregivers often discuss possible formal service use with their spouses whose opinion is respected. However, the opinions of other members in the extended family may not be sought (Aiko, #16; ref. p. 691). An

environment affording a very high level of authority to the caregiver occurs when the family boundary is very strong and the position of caregiver has been established in the process of family acceptance. Aiko is from a traditional agricultural family and she has married for 29 years at the time of interview. In addition, even if a caregiver does not necessarily feel her authority level is high, she may negotiate in a direct way when she strongly justifies her tolerance limit, which is discussed below, or when a favorable service is available.

Justification of One's Tolerance Limit

Another issue that caregivers assess in their decision-making process is whether their tolerance limit has justification. That is, whether the caregiver can validate her tolerance limit to herself. When the caregivers come to sense their tolerance limit, they ask themselves, "should I tolerate this much difficulty?" There are times when the caregivers can say "no, I don't have to", justifying their tolerance limit as reasonable, while at other times they cannot help saying, "yes, I still must". This inner questioning is another component of the decision-making process regarding the use of formal services. For instance, Rumi (#4), with strong belief in the role of daughter-in-law, is not going to justify her tolerance limit till the death of her mother-in-law:

(Interviewer) Are you going to take care of her at home till her death? "Yes, I will. I know it is the duty of a daughter-in-law. Yeah". I wonder why you could do so much. I wonder how you would feel if your mother-in-law is institutionalized? "I think it would actually be a burden for me. I guess I would feel, oh, I institutionalized her! Shame on me".

Emi (#19) is wondering if she can justify her tolerance limit and use a short stay service but has not yet justified her limit:

Short stay is very helpful, but I am not going to use it now. I sometimes think about using it, but I feel sorry for her. She forgets about her experience there. I mean, I can't decide about short stay use yet. I can't say, it is OK if she doesn't like it. I am going to use it anyway because I am in bad shape (laugh). If I could decide to do that, I would feel a little relieved.

On the other hand, Mayumi (#18) had a strong conviction that she could justify her tolerance limit when she institutionalized her mother-in-law in an elderly hospital:

I was doing my best, visiting the (acute) hospital to take care of Grandma, although I was only by myself. I didn't want people to say, "Grandma was taken to the elderly hospital because her daughter-in-law didn't want to attend to her". I didn't want to hear people say so after all my efforts to this day. I was doing my best. I didn't want my relatives to say so... But at that time, I thought, no, no more. I didn't think I could take care of her at home. Even a professional helper could not attend to her. I didn't think I could. (Interviewer) "At that point, didn't you worry what your niece or sister-in-law would say about institutionalization?" No, there was no other way.

So I thought and called my sister-in-law and niece saying, I hospitalized her.

The central question assessed in determining whether the tolerance limit is justifiable or not is, "have I done enough to take care of the elderly parent(-in-law)?" In Japan, it is an underlying assumption by most family caregivers that they must take care of their elderly parents. Caregivers are freed from this inner imperative only when they have taken care of the parent enough to meet the normative requirement. Toshiko (#10), after having taken care of her father-in-law for several months, came to the strong sense of tolerance limit. At that time she could say to herself that she has done enough:

I take care of him to some extent. But if I feel this is the limit, then I cut off the caregiving... I think I have already done more than enough for my obligation. I think the four months of caregiving is enough for fulfilling my obligation.

An application for institutionalization of Toshiko's father-in-law had already been submitted to the municipal government and he is on the waiting list.

Factors that determine caregiver's justification of one's tolerance limit

How soon the caregivers can justify their tolerance limit varies among individuals for several reasons.

Value of care. Two major factors are the internalization of societal norms and the attachment of the caregiver to the care recipient. These two factors do not allow the caregivers to justify their tolerance limit because they give essential value to family caregiving (Yamamoto and Wallhagen, 1997). In principle, the traditional Confucian thought defines that the debt children (or children-in-law) owe their parents for their life-long caring and love is insurmountable, and that the children are required to pay back for the rest of the parents' lives. The sense of attachment also motivates the caregiver for further caregiving. Hideko (#23), a daughter caregiver, says:

I guess I liked Mother so much. I guess I adored her. So I didn't want to ask anyone else to take care of her for me, by any means. I couldn't entrust her to anyone else. I felt Mother was safe as long as I took care of her myself.

The actual level of debt and repayment perceived by the children, however, varies. If the child (or child-in-law) feels the debt very strongly, they cannot justify their tolerance limit easily, while if they do not feel much debt, their sense of repayment is completed relatively soon. Hiroko (#13) feels a strong sense of debt toward her mother-in-law: "I think I could raise my children because my mother(-in-law) helped me. I feel the debt and so I thought I would do my best to take care of her".

On the other hand, Yukiko's (#20) experience is an opposite example:

To be frank with you, I used to have such a strong grudge toward Mother... She was very strict to me, or she was self-centred... So, when she began to have this problem, I thought "why me?" after such a harsh experience.

What counts as fulfilling the debt also is not uniform among caregivers. The sense of the amount accomplished for the care recipients in relation to their debt does not directly reflect the duration of caregiving; rather, it reflects the level of the tolerance limit. The more desperate the caregivers become in their tolerance limit, the sooner they can justify it to themselves. The overwhelming sense of tolerance limit convinces them that they have done enough.

Belief regarding how care should be given. Another factor determining when the tolerance limit becomes justifiable is the caregiver's personal belief regarding how care should be given. Some caregivers give little thought as to how they communicate with or treat the care recipient; as long as they continue care at home, they feel they are giving enough. Other caregivers feel they can and should justify their tolerance limit when they can no longer maintain their compassion and warm feelings toward the care recipient. Chieko (#22) thought she should justify her tolerance limit to herself when she found she could no longer be compassionate toward her care recipient:

In the end I was wondering if I should continue to take care of her, suppressing my emotion, and bouncing back my troubled emotions on her. I was determined not to let it happen by any means, but I felt that such time has come.

The two other issues that are considered in decision-making, the availability of a service and the caregiver's authority within the family, also influence the justifiability. For example, Toshiko (#10) will not justify her limit to send her mother-in-law to an elderly hospital which has a vacancy, but she can justify her limit if her mother-in-law can stay in a favorable elderly home. The elderly home is full, so her mother-in-law is on the waiting list and still cared for at home. Similarly, with the high level of authority caregivers can justify their limit without experiencing too much agony. Akiko (#1), who has long history of caregiving, talks about her use of short stay without showing much desperation:

Recently I come to feel "I would like some time off", so I think I have some vacation using a short stay service here, probably a couple of times a year.

Because of the factors discussed above, there are many occasions when caregivers recognize their limit yet cannot justify it to themselves. In other words, only when one's tolerance limit is considered defensible can justification take place.

Components of justification

Justification of one's tolerance limit involves three components: prioritizing the well-being of the caregiver and other family members over that of the care recipient; a willingness to act in defiance of the societal norm; and redefining reality and setting up a boundary.

Re-prioritizing. When caregivers justify their tolerance limit, the well-being of the caregiver and/or other family members takes greater precedence, even at the cost of reduced attentiveness to the care recipient's well-being. Conflict of interest among family members is a persistent difficulty in the caregiving experience because the best interest of the care recipient is respected to a great extent. However, when caregivers justify their tolerance limit, they mentally accept a lower degree of attentiveness. This change is most dramatically exemplified when the physical life of the caregiver is perceived as threatened:

There was another woman who was taking care of her mother-in-law in my neighborhood. She suddenly got sick and passed away in one week... When I heard that story, even though I felt guilty for my mother(-in-law), I thought I didn't want to shorten my life because of caregiving. I thought, "I want to live at least till I am 70!" (Akiyo, #6)

Naoko (#7) also describes her re-prioritizing:

I feel sorry for Mother(-in-law), but she doesn't know any more. I feel sorry for her, but we have our own life to worry about. We have to think about our children's future. She began acting strange about the time of the first child's entrance exam, and exams for other kids are still to come.

Acting in defiance. The second phenomenon is acting in defiance of the societal norm of filial caregiving. The impact of this norm is so strong that even divorce and leaving the family, or being hospitalized because of health problems of the caregiver, is sometimes thought to be the only escape from the sense of tolerance limit, rather than abandoning the role of caregiver. In such a context of filial caregiving in Japan, justifying any tolerance limit involves the rejection of, and repulsion against, the societal norm. In other words, justification of their tolerance limit constitutes an abandonment of a certain self-ideal developed through internalization of the societal norm. Therefore, the caregivers recognize they should feel negatively, as is observed in the use of derogatory terms: "I thought it could not be helped even if something happened, and I thought I would go impudently" (Akiyo, #6). However, when they can justify their tolerance limit, they accept themselves as acting in defiance of the societal norm. Akiyo (#6) says:

I used to feel as if she were entrusted to me, and I worry much about attending to her (care recipient) all the more. I had to be attentive. But now that I have come this far, I have recently assumed a defiant attitude that it's OK if she would fall or whatever would happen to her.

Akiyo explained that after she has come to think this way she began to entrust caregiving to the resources other than herself.

Redefining reality. Justification of one's tolerance limit also often involves a redefinition of the caregiver's reality. This means the caregivers' perception of reality changes from needing to take care by any means and at any cost to an acceptance of limited caregiving. They still continue caregiving, but now they endorse the idea of limited care. Chieko (#22), after years of struggle to meet her family's expectation, concludes:

I came to realize that people around me, I mean the members of my husband's family, would take it for granted however much I devoted myself, and would require more and more of me. So I felt that I should draw a line to what extent I went.

The redefinition of reality reflects the caregiver's change in their beliefs in, and self-understanding of, their caregiver role: they can stop forcing themselves to be cast into the ideal figure of caregiver; devoted, tireless, and forever accepting. This leads to setting up a boundary in their caregiving, and they begin to try to take control over the situation, as seen in, for example, formal service use.

The redefinition of reality and the setting up of a boundary are seen more prominently among daughter-in-law caregivers than daughters because daughters-in-law have greater tendencies to abide by the societal norm regarding filial caregiving. Japanese daughters-in-law, throughout their life courses, strive to get approval and acceptance from other family members, and to some extent, they are more than willing to sacrifice themselves for the well-being and harmony of the family. For daughters-in-law, sacrifice is a means to achieve the ultimate goal of creating a harmonious and happy family, and in this sense, sacrifice has its reward and value. Therefore, the redefinition of reality to avoid sacrificing themselves completely is a significant turning point for these caregivers.

This process sometimes follows a critical realization by the caregiver that her self-sacrificing is not achieving its intended purpose. In caregiving, devoted daughters-in-law often liberally sacrifice themselves and still do not receive the expected reward of appreciation from other family members and/or a harmonious, happy family. When they recognize that there is no end to the family members' expectations, they decisively stop expecting to satisfy them. This recognition and acceptance leads to the redefinition of reality and the setting up of a boundary. Eventually, the caregivers stop worrying about offending other family members' feelings.

Decision of Formal Service Use

Careful examination of the above three issues, availability of services, authority level within the family, justifiability of one's tolerance limit, and the interaction among them leads caregivers to the final

decision of whether or not they use a formal service (Fig. 1). Only when the caregivers can meet the requirements of all of these issues can they start formal service use. In other words, the decision to use formal services is made when caregivers can justify the tolerance limit to themselves, negotiate successfully with other family members at their given level of authority, and perceive a service as available. Usually, the shortest service (e.g., bath service) is used first with long-term institutionalization considered only as a last resort. Day care is different from other services in the sense that it is in some occasions considered as an intervention for the elderly (i.e., to stimulate the elderly with activities). When day care is recognized as an intervention for the elderly rather than a respite for the family, this overall process of decision making may not be applicable. For example, Sachie (#24) quit her job in order to escort her mother to day care. Otherwise, caregivers gradually increase the extent to which they entrust the care of their elderly parent (or parent-in-law) to formal services, depending on the service availability. Extension occurs when they again experience the sense of tolerance limit and, after going through the decision-making process, again decide to use additional services.

On the other hand, caregivers do not use formal services when they cannot justify their tolerance limit to themselves, when successful negotiation with other family members is impossible, or when there are no available formal services. In this situation, they continue to take care in the same care arrangement, pushing up their tolerance limit.

The overall process of decision-making explained above is conceptualized as "navigating among endorsed options", a process in which the caregivers carefully monitor the situations that surround them and find the way that is safe for themselves while maintaining harmony within the family and society.

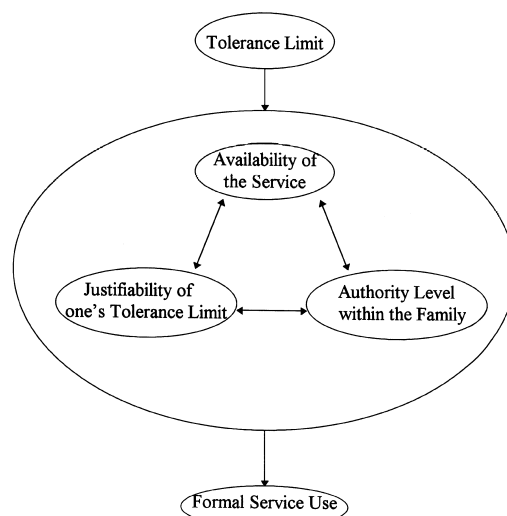


Fig. 1. Decision-making process of formal service use

DISCUSSION

The current research focused on how caregivers describe and explain their decision to use formal services for the respite purpose in Japan. Some past literature shows that caregiver factors, namely their demographic characteristics, needs, and appraisals, play important roles when caregivers decide to use formal services (Morycz, 1985; Colerick and George, 1986; Caserta *et al.*, 1987; Pruchno *et al.*, 1990; Miller and McFall, 1991; Retsinas, 1991; McFall and Miller, 1992; Wright, 1994; Tsuji *et al.*, 1995). Past literature also suggests that the decision to use formal services should be considered a process (Morycz, 1985; Colerick and George, 1986; Greene and Ondrich, 1990; Pruchno *et al.*, 1990; Miller and McFall, 1991; Wolinsky *et al.*, 1992; Collins *et al.*, 1994). The current research makes a contribution to the literature on this complex decision-making process through the use of a qualitative approach (grounded theory) that allows caregivers to provide their own explanations of how they decide to use formal services.

Two of the three issues, justifiability of one's tolerance limit and authority level within the family, are considered to be particularly prominent in Japanese society. Similar issues may be at work in other societies, although probably to a lesser extent. Justifiability of one's tolerance limit is assessed in light of the essential value of care which is based on the societal norm of filial caregiving and the attachment to the care recipient. This goes along with the discussion that the examination of caregiving appraisal should incorporate those aspects of care other than burden (Lawton *et al.*, 1989). The current research extends the discussion by Lawton *et al.* (1989) and shows that the analysis of non-negative caregiving appraisal of the caregivers is necessary not only for the examination of the caregiver psychological well-being but also for the examination of formal service use. Little attention has been paid in previous research to the issue of the caregiver's authority level within the family. Future research on formal service use may benefit from incorporating this concept in the research framework.

The current research also has implications for future health care practices. The main implication is that the role of health care professionals could be conceptualized as assisting caregivers as they navigate among endorsed options of care in a healthful way. Health care professionals should realize that any formal service would not be used effectively unless the caregivers can successfully deal with the three issues discussed in the current research. When there is the situation where the caregiver does not use formal services despite the obvious need of service use, careful assessment of the three issues might give a new insight for future care plan.

Health care professionals may have to assist caregivers in justifying their tolerance limit at a reasonable level. Tolerance in general, and especially tolerance of the difficult tasks in caregiving, is regarded as a virtue by Japanese women (Lebra, 1984). This makes the difficulties worth tolerating and, by virtue of this difficulty, caregiving becomes all the more meaningful. Under such a societal aesthetic, the assessment of difficulties in caregiving in itself may not be enough to examine the possibility of formal service use. Only when the difficulty exceeds the meaningfulness of the caregiving, and when the caregivers believe they have done enough to meet the requirement of the cultural aesthetic, will they justify their tolerance limit.

Also important is the assessment of the authority level of the caregiver within the family. This is especially the case in Japan, and health care professionals should take appropriate actions depending upon the authority level of the caregiver. For example, where the authority of family members other than the caregiver is very high, intervention might be oriented to empower the caregiver in terms of authority. Examples of intervention include having the caregiver borrow the authority of the health care professional, or reinforcing the caregiver's idea of her accomplishments in caregiving, in order to let her have a higher sense of authority. When there is an authority struggle among family members, the health care professional may assume an intermediary role, promoting a constructive discussion among family members. When there is no one who can make decisions within the family, the health care professional needs to take an active role to guide the family to effective decision-making.

Additionally, health care professionals must ensure accurate information on formal services is received by the caregivers and other family members, because they may have negative or outdated stereotypes of such services. On the other hand, some services are in fact unavailable in terms of their quality, distance, sanction, information, and quantity. Health care professionals are also held accountable to appeal to policy-makers for further improvement of formal services.

Another important implication is that the three issues that the caregivers assess upon determining formal service use influence one another. This supports past literature that suggests that we need to examine the interactions of various factors and not only the main effects (Kasper *et al.*, 1994). Noteworthy is the change in the criteria utilized to assess service availability based on changes in the justifiability of one's tolerance limit and the caregiver's authority level within the family. Therefore, even with no effective intervention possible for one issue, approaches to other issues may alter the balance and afford caregivers the ability to use formal services.

A major limitation of the current research is that caregivers were reflecting back on their experiences when they explained their decision to use or not to use formal services. Recall bias is thus inevitable. Similarly, an accurate examination of care recipient's condition during this decision-making was not possible. A longitudinal study that monitored the decision-making process as it unfolds would be valuable.

In order to implement further research on effective interventions for the elderly with dementia and their families, including achieving appropriate formal service use, Montgomery (1996) suggested that researchers develop a typology of caregiving contexts and then provide appropriate interventions for each typology. Development of a typology of formal service use by the caregiver has been attempted in the past (Noelker and Bass, 1989) but more research is called for. It may be beneficial, upon developing a caregiver typology, to take into account the issues discussed in the current research.

The decision-making process of service use by the family caregivers pictured in this paper is strongly influenced by the formal services offered within the society. On December 9, 1997, the House of Representatives of Japan passed a long-term care insurance bill that will drastically change the living environment of the elderly and their caregivers. What this new insurance system will bring to the experience of family caregiving in Japan is yet to be seen.

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