Suggestions for achieving symbiosis in the aging society: Interpersonal relationships and QOL of the Japanese elderly and family caregivers in a cultural context

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1. Japanese Aging

Japanese aging is the biggest and fastest in the world. We recognize that it draws people's attention in the current world. We would like to think how to keep the QOL (Quality of Life) of the elderly and their families. This matter is very much based on socio-cultural context. The context is reflected in their interpersonal relationships. There is a famous Japanese newspaper cartoon called Mrs. Sazae. It is also a series, TV animated series, which is also very popular. Mrs. Sazae is a heroine and a housewife. Three generations live together in one house with a garden. This is an old and good Japanese family and they hold a place dear to our hearts. It is sweet, but such families are actually getting fewer. Statistics in 1995 by the National Institute of Population and Social Security Research in Japan show it.

According to the data by International Value Conference office in 1980, the rate of living together with elderly in the Japan, USA, France, Singapore, India, and Korea is interesting. Japanese people hope to live together with elderly more than Western people but less than the other Asian people. Japan is located somewhere in between Eastern and Western thinking. However in Japan recently, the rate of living together is getting lower. Elderly households are increasing. As the pension system is becoming more fixed, the elderly become more independent. Some elderly choose to live separately but close to their kids' families. Such a lifestyle seems to be more western.

We will briefly mention some Japanese social situations related to the aging. Japan adopted more modernization with westernization after World War II. Democratic and individualistic ideas were spread. Industrialization and urbanization progressed. Population in cities increased and houses became smaller in cities. Psychological functions in the community became weaker. In the last 30 years the number of children is getting less and the number of nuclear families is increasing. In such a situation many elderly

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people have started to live alone or just as a couple.

Nevertheless, we should mention that values, norms and expectations from the old family system are very much alive in our mental dimension. This causes two gaps. One is the norm-reality gap. Another is a gap between the elderly and the young. Expectations from the elderly and social pressure based on social norm requires families to live together and take care of their elderly. Care roles tend to be apportioned to the eldest son and his wife. The main caregiver role is often assigned to the son’s wife. It must be different from the norm is western countries. The modern Japanese son’s wife is sometime perplexed by this role.

Change of the social support system for the elderly from private support to public support may not have been accomplished yet. It is a social problem to secure social support for the elderly. So, our westernizing society and the remaining eastern sense of values make us confused.

2. Social Support Networks of elderly and family caregivers

We conducted a survey about Japanese elderly and family caregivers. Figure 1 is the social support network of Japanese elderly who live in such a social situation. Family and relatives occupied more than half of their networks, which suggest a family centered network system. There are some differences between male and female. The men’s network has more job people and family. The women’s network has more neighbors and the network quality is better.

In order to know the influence of support from families living with their elderly, mental health is compared among group of singles, couples and families living with elderly (Figure 2). The mental health of single men is alarming. It is well known that Japanese businessmen work too hard. If support resources are
composed only of job related people and family, they may be vulnerable. It is recommended to develop private networks in the community.

Meanwhile, the social support networks of family caregivers are as follows, when elderly are under their care (Figure 3). Families seem to be overall and the biggest support resources, especially in regards to two kinds of practical supports. The public support system might not cover so much care work. Family
members might be the greater support resource than any other resources, and only when family members aren’t available, other resources start to compensate in meeting the needs. It’s the so called hierarchical compensation model of support resources. Friends are remarkable about companionship and professionals are a big resource of information support. It fits the task specific model, which means a certain resource supplies a certain support. Non-family members help caregivers from outside of care work itself.

As elderly care is stressful, we measured caregivers’ burden, and found that caregivers’ mental health is different depending on relation with caretakers (Figure 4). A spouse who has had a long relationship and is almost in the same life stage as the care receiver, showed better mental health than children of the care receiver or the son’s wife, who are still young and in the middle of their own life stages. Especially the son’s wife is presumed to feel more conflict in her care role, which is a vestige of the classic family system.

As shown above, social support of the elderly and the family still seems to be limited to inside the family. Therefore, a QOL dilemma occurs. If the QOL of the elderly is kept higher by kind family care, then the family QOL may become lower because of the heavy care job. And vice versa. If the family is free from care work, the elderly may not be happy. It is not easy to keep QOL for both the elderly and families at the same time.

3. Cognitive developmental stages

However, we have a question. Is family just a victim of care giving stress? In the United States, Knight (1991) said that African Americans showed less care giving stress because of family centered cultures. Then, in our cultural context, can we find some positive meaning for care giving?
Our old family system is based on Confucianism, but we pay attention to Buddhist ideas, which are also our philosophical background. We should recognize that life is fundamentally hard. If you aren’t swayed by distress, you can be free. Acceptance and satisfaction are considerable ideas. They might be similar to cognitive strategies to stress in the meaning of changing cognition about one’s situation. However it is not just a technique and it doesn’t mean simple avoidance or defeatism. Cognition is developed and adapted. We call it “adaptive acceptance”.

Our hypothesis is this. At first, people deny reality because of shock. Next, they express negative response as helplessness, anger and so on. And finally, they reach positive cognition as they learn that care of their elderly is their important job and devotion is their aim. They may develop a feeling of sufficiency. They think that care makes them understand life. And they want to make good use of their experience. Perhaps Adler’s 1975 cross-cultural adaptation theory used a similar idea.

Table 1 shows an experience rate of 9 stages. In the past, the latter stages showed lower experience rates. It suggests that stages occur in order. It fits the process model more than the pattern model, which assumed only personal differences. And yet the current stage doesn’t show the same distribution. As an encouraging factor of progress of the stages, we think relation with caretakers and degree of dementia is important, which may affect the quality of human relationships. We would like to know very much whether this phenomenon is observed in the same manner in other cultures and how much it is universal.

Hofstede (1991) made a map of 53 cultures. He found 4 factors of cultures and we use 2 of them here, masculinity and individualism. Japan was assessed as having strong masculinity, which explains our strong orientation to economic success, business and gender role norms. It reminds us that Japanese men take a much smaller care role in family and have poorer community life than women. About individualism, the United States’ score was the highest. Asian countries are assessed as collectivist. Japan was located between eastern and western countries in terms of individualism. On this figure, we recognize Japan’s
unique position. North European countries are located here. They might enhance their high−level social welfare system in a feminine culture, which tends to think a great deal of humanity. There is a big cultural distance between these countries and Japan on this figure. It may not be easy to import the system directly over this distance. It might be a cause of difficulty for expanding public support.

4. How to increase QOL

Then, for our question, “How to increase QOL?”, we suggest the following two points. At first, we seem to have no common solution across various cultures. Under each cultural context, we should understand problem occurrence mechanisms and promote the most adequate measures for the society. For example, we need some effort to make the elderly understand public support or to create some help system for the son’s wife.

On the other hand, methods in some cultures could include ideas not contained in other cultures. It is worthwhile to pay attention to some ideas from outside. We could learn something new and re−consider our own sense of value. For example, “adaptive acceptance” possibly sounds fresh and new to many people.

These two ideas, consideration inside and outside of a culture, which depend on culture awareness, are thought to be a basic way of thinking for cross−cultural health psychology. Through this perspective, we expect to find the better way for increasing our QOL in the future.

REFERENCES

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Note