

THE THEORETICAL BASIS FOR STUDY TO DEVELOP AND EVALUATE THE JAPANESE FAMILY CAREGIVING

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Introduction

Every developed country is dealing with issues related to care for older persons. Japan is no exception. As a matter of fact, Japanese society is the most rapidly aging population in the world. In 1965, 6.3% of the people in Japan were over age 65. The aged population doubled (12.6%) in 1991 and will double again (25.2%) by 2020 (Health and Welfare Statistics Association, 1992). Thus, care for older persons has been attracting considerable social attention in Japan.

The number of publications and media reports related to elder care in Japan has been increasing. Research on family caregiving for older persons is also increasing, however, the majority of research publications in this area have been demographic surveys and case studies. These studies have provided important information regarding the issues of family caregiving for older persons in Japan, however, there has been little research focused on identifying concepts related to family caregiving, or showing how the concepts are related. Even though some studies that examine concepts related to family caregiving, these studies focused on only the negative aspects of family caregiving, often called caregiver burden or stress. Therefore, to understanding comprehensively the phenomenon related to family caregiving in Japan, developing measures to examine negative aspects as well as positive aspects of family caregiving situations and the relationships among these concepts is essential.

The author conducted a study to develop and evaluate the Japanese Family Caregiving Inventory (JFCI). This is the papers describing the theoretical basis for the study and review of the family caregiving literature reported in the United States and Japan based on the concepts included in the JFCI.

The Theoretical Basis for the Study

Stress and coping theory (Lazarus & Folkman, 1984; Stephens, et al., 1990), exchange theory (Burgess & Huston, 1979; Cook, 1987; Gergen, et al., 1980), and role theory (Biddle & Thomas, 1966; Burr, et al., 1979) have been the frameworks most commonly used to study family caregiving in the United States. In Japan, stress and coping theory has been used in research on family caregiving (Niina, et al., 1989; Sugisawa, et al., 1992). From these theories, role theory was chosen as a framework for this study for several reasons. Stress and coping theory focuses on the individual, in contrast to role theory and

exchange theory which focus on interactions between an individual and other persons. Caregiving situations are minimally dyadic and very complex; focusing only on the individual provides a limited perspective. In addition, stress and coping theory views caregiving as a stressful, and therefore negative experience in contrast to role theory and exchange theory, which views caregiving as both positive and negative experiences.

Exchange theory explains caregiving as activities that a person performs to pay back previous debts. This theory has been used to examine relationships between adult children caregivers and their impaired elderly parents in the United States (e.g., Ingersoll-Dayton & Antonucci, 1988; Walker, et al., 1992). In Japan, daughters-in-law, in particular the first son's wife, are still the main caregivers and their caregiving role is prescribed by cultural norms (Nakajima, et al., 1982; Noguchi, 1988; Takasaki, et al., 1987). Exchange theory does not apply in the same way as it has been applied to caregiving by researchers in the United States. Even though exchange theory has been applied to examine general relationships among Japanese people, such as their custom of gift giving, the concept of exchange does not currently apply to most caregiving situations because the assumption of the caregiving role, first by the daughter-in-law if there is one and then by the daughter, is a cultural expectation.

In contrast, role theory is a useful framework for studying caregiving in Japanese culture. The Japanese culture is often described as a role dominated culture. Lebra (1976) referred to the individual as having the character of "a set of intra-individual overlaps occurring around a cluster of roles that he plays" (p.250). She suggested that the individual is associated more with "role-cluster personality" than with "basic personality," and this is especially significant in Japan. In Japanese culture, it is very important to know what the appropriate role to be taken is, how to learn aspects of the role, how and when to play the role, and to have the ability to perform the role. For example, a daughter-in-law will take her position in the three-generation household when she marries the first son. She will also take on the role of caregiver for her mother-in-law because of the cultural norms.

Concepts for the Japanese Family Caregiving Inventory

The conceptualization of family caregiving based on role theory used by Archbold and colleagues (Archbold & Stewart, 1991; Archbold, et al., 1990, 1986) was used to guide the study. Their concepts are mainly derived from role theory and focus on not only the negative consequences of caregiving but also the positive consequences of caregiving. Their measures have been found to be reliable and have evidence to support validity, having been tested with caregivers of several different older populations. Because concepts and items for their measures were derived largely from qualitative data gathered from caregivers, the possibility of clinical application of their measures is high.

The concepts selected from Archbold and colleagues' conceptual framework of family caregiving fall into three broad categories: antecedents of caregiving, the nature of the caregiving role assumed, and responses to caregiving. Archbold and Stewart (1986) developed a questionnaire called the Family Caregiving Inventory (FCI) to measure these

concepts. Caregiving studies conducted in the United States and Japan were reviewed based on the main caregiving concepts that were included in the FCI. Those concepts are the amount of care (the amount and type of direct and managed caregiving tasks done by the caregiver for the care receiver), mutuality (the positive quality of the relationship between a caregiver and a care receiver), predictability of the caregiving situation (regularity and routineness of caregiving activities), preparedness for caregiving (feeling prepared to provide care), rewards of caregiving (positive aspects of caregiving), caregiver role strain (felt difficulties in fulfilling the caregiving role), and amount of negative life style change (amount of change in the caregiver's daily life because of caregiving).

1) Amount of Care

The amount of care consists of all the caregiving activities which caregivers actually perform in helping their care receivers. Some researchers (Montgomery, et al., 1985a; Moritz, et al., 1989) focus mainly on assistance with activities of daily living (ADL) and instrumental activities of daily living (IADL), in spite of results indicating that caregiving tasks usually go beyond ADL and IADL assistance. Others (Albert, 1991; Archbold, 1980; Archbold, et al., 1986; Bowers, 1987; Oberst, et al., 1989) include not only ADL and IADL, but also other caregiving activities, such as medical/nursing treatments, monitoring and reporting, emotional support, behavior management, activities to meet possible needs of a care receiver, managed caregiving, and additional household tasks.

Archbold and colleagues (Archbold, et al., 1986) defined the nature of the caregiving role as "the amount and type of direct and managed caregiving tasks performed by the caregiver for the care receiver" (p.6). Their measure is comprehensive and includes: 1) personal care; 2) protection; 3) management of behavior problems; 4) medically-related tasks; 5) housekeeping; 6) transportation; 7) financial, legal, and health decision making; and 8) little extras. Results of several survey studies in Japan indicated how much help care receivers needed (Department of Welfare, Tokyo Metropolitan Government, 1980; Matsumoto & Onakado, 1990; Matsumoto, et al., 1985; Nakajima, et al., 1982; National Organization of Local Welfare Commissioners, 1987), but did not study how much help caregivers actually provided. Despite the lack of measures of help provided, the concept of amount of care does appear relevant to caregiving in Japan.

2) Mutuality

Several studies have indicated that the quality of the relationship between a caregiver and a care receiver is an important aspect of caregiving. Some studies (Archbold, et al., 1986; Hirschfeld, 1978) have used mutuality as a concept to describe the positive quality of the relationship and others have used different concepts such as affection (Horowitz & Shindelman, 1983), social ties (Okun, et al., 1990), psychological attachment (Cantor & Hirshorn, 1989), marital closeness (Motenko, 1989), emotional investment in the relationship (Pruchno & Resch, 1989), and intimacy (Walker, et al., 1992).

Hirschfeld (1978) defined mutuality as the quality of the dyadic relationship. She considered mutuality as "the major parameter for families managing life with senile brain

disease" (p.77). She also described two important components of mutuality, "the caregiver's ability to find gratification in relationship with the impaired person and meaning from caregiving situation" and "the caregiver's ability to perceive the impaired person as reciprocating by virtue of his or her existence" (p.77). Archbold and colleagues (Archbold, et al., 1986) also identified the concept of mutuality as representing the positive quality of the relationship between a caregiver and a care receiver.

Horowitz and Shindelman (1983) defined affection as "the quality of the caregiver-older relative relationship as perceived by the caregiver. It is the degree to which the latter has positive feelings towards the older person and experiences their relationship as close and enjoyable" (p. 9). The higher level of affection indicated caregivers' felt close to, enjoyed spending time with, and had been able to confide in their care receivers. Okun and colleagues (1990) studied the concept of social ties, which referred to the amount of positive and negative social interactions and the degree of enjoyment with the interaction. Walker and colleagues (1992) used the concept of intimacy to examine good relationships between care receiving mothers and their caregiving daughters. Motenko (1989) used the concept of marital closeness, and Pruchno and Resch (1989) used the concept of emotional investment in the relationship in their studies of the relationships between wife caregivers and their care receiving husbands. In their theoretical and critique paper, Cantor and Hirshorn (1989) suggested that the psychological attachments which bond people to each other are the most elemental level of motivating factors for caregiving. They included concepts of love, hate, affection, intimacy, nurturance, and the positive and negative aspects of dependency in psychological attachment.

In Japan, Shimizu (1989) acknowledged the importance of studying relationships between caregivers and care receivers and other family members. However, he did not include the concept in his study because of a methodological difficulty that he did not explain in detail. Based on findings about help-seeking behavior in Japanese older persons, Inoue (1983) suggested that it is important to study relationships between caregivers and care receivers. The results indicated that older persons considered the quality of the past and present relationships with that person in deciding what kind of help they could seek from another person.

Oi and colleagues (1984) were interested in the quality of relationships between caregivers and care receivers as a contextual factor for psychotic manifestations in bedfast elderly persons. Nakajima and colleagues (1982) examined the relationship between a caregiver and a care receiver by asking whether caregivers thought their relationship with the care receivers were good. Even though researchers have acknowledged the importance of studying the quality of the relationship between caregivers and care receivers, this concept is not well developed in Japan.

3) Preparedness for Caregiving

The purpose of many interventions for caregivers is to increase their knowledge about disease and caregiving situations, and skills in providing care and managing their own stress (Glosser & Wexler, 1985; Greene & Monahan, 1989; Haley, et al., 1987; Kahan, et al., 1985; Toseland, et al., 1989). An assumption underlying these interventions is that

a person can better deal with a problem if he or she has enough knowledge about the situation and has skills in care provision and coping. The results from such intervention studies have been varied, but overall, receiving and sharing information and learning stress management skills have produced positive effects for caregivers.

Role theory emphasizes anticipatory socialization--learning a role prior to entering it. It is assumed that learning about norms, values, and appropriate behavior in the new role before performing it makes the transition into that role easier (Burr, et al., 1979). This learning process is referred to as anticipatory socialization. Harvath and colleagues (Harvath, et al., 1986), however, have questioned anticipatory socialization based on their findings that caregivers learned most parts of the caregiving role while in the role.

Instead of anticipatory socialization, Archbold, Stewart and colleagues "focused on caregivers' appraisal of how well-prepared they are, no matter when they learned the role" (Archbold, et al., 1992, p.329). They (Stewart, et al., 1993) used a concept of role acquisition that refers to "the way in which family caregivers learn about various aspects of the role of caregiver" (p.219). Theoretically, even though family caregivers learn their caregiver role "both prior to and during role occupation" (p.220), their study results suggested that "acquisition of the caregiver role occurs primarily after entering into the role" (p.220). Thus, they defined the concept of preparedness as "how well prepared the caregiver believes he or she is for the tasks and stress of the caregiving role" (Archbold, et al., 1990, p.328).

Based on their previous studies, Archbold and Stewart (1991) placed preparedness as a part of the nature of caregiving role assumed in their conceptual framework. However, their ongoing longitudinal study of spousal caregiving to people with early-stage Parkinson's Disease suggests that even though two-thirds of spouses did not yet view themselves in the role of caregiving, they could answer questions about their preparedness to provide care (Archbold and Stewart, personal communication, 1994). Based on these findings, they have moved the concept of preparedness to the category of antecedents of caregiving in their conceptual framework (Archbold and Stewart, personal communication, 1995).

In caregiving studies, concepts similar to preparedness have been used, including mastery, competence, and self-efficacy. Pearlin and colleagues (1990) defined mastery as "the control that individuals feel they are able to exercise over forces importantly affecting their lives" (p.589) and competence as caregivers' self rating of "the adequacy of their performance as caregivers" (p.589). Lawton and colleagues (1989) also used the concept of mastery. They defined caregiving mastery as "a positive view of one's ability and ongoing behavior during the caregiving process" (p.62). Haley and colleagues (1987) used the concept of self-efficacy as a part of caregivers' subjective appraisals of caregiving stressors. They defined self-efficacy as confidence regarding how well caregivers were managing caregiving problems. Even though these concepts are very similar to the concept of preparedness, slight differences exist. The definition of mastery by Pearlin and colleagues includes "control", but "well-prepared" does not encompass the notion of "control". Their definition of competency includes "adequacy", suggesting that external criteria must be met, whereas "feeling well-prepared" does not require

meeting external criteria. The definition of mastery by Lawton and colleagues includes "positive view of ongoing behavior" that is not necessary preparedness, but could be "self-approval." The concept of self-efficacy used by Haley and colleagues is most similar to the concept of preparedness. However, "managing caregiving problems" in their definition reflects a narrower view of the caregiving role than the definition of preparedness, which refers to the "tasks...of the caregiving role", tasks may or may not be problems.

Although there are some educational and training sessions for caregivers to prepare for caregiving in Japan, no Japanese research on the concept of preparedness for caregiving or related concepts was located.

4) Predictability of the Caregiving Situation

Archbold and Stewart (personal communication, 1993) defined predictability of caregiving situations as the caregiver's perception of regularity of activities or the establishment of routines within the caregiving experience. Other researchers have used concepts similar to predictability, including controllability (Dimond & Jones, 1983; Heckhausen & Baltes, 1991; Kuhl, 1986; Rodin, 1986; Schulz, 1976) and uncertainty (Christman, 1990; Piper & Langer, 1986).

A difference between controllability and predictability is that having control over a situation also means that it is predictable. However, predictable situations are not necessarily controllable. If a situation is uncertain, it is also unpredictable and uncontrollable. Kuhl (1986) indicated that social norms related to aging encourage a more passive attitude toward life, and in some cultures or subcultures, this social pressure toward passivity may be strong enough to determine a person's behavior.

In the Japanese culture, one of the strongest factors determining a person's behavior is social expectation (Benedict, 1946). In a cross-cultural study comparing attitudes of women in the United States and Japan (Campbell & Brody, 1985), Japanese women were more likely than American women to feel that they have little control over the things that happen to them. At the same time, Japanese caregivers feel stress about unpredictability in their future (Takasaki, et al., 1987). These data indicate that predictability, more than controllability, may be an important concept for research with Japanese caregivers.

5) Rewards of Caregiving

Even though most studies related to caregiving for elderly persons have focused on the negative aspects and consequences of caregiving, some researchers have documented its positive aspects (Farran, et al., 1991; Hinrichsen, et al., 1992; Motenko, 1989; Walker et al., 1992).

Archbold and Stewart (personal communication, 1993) studied the positive consequences or benefits of caregiving for the caregiver, they call this concept rewards of caregiving. They identified three dimensions of rewards of caregiving: 1) rewards of meaning, 2) rewards of learning, and 3) financial rewards.

Farran and colleagues (1991) conducted a qualitative study to search for an explanation

of how caregivers might grow and find meaning through the caregiving experience. They critiqued the stress and coping paradigm, the most commonly used theoretical framework in caregiving research, because outcomes of caregiving within this theory have been viewed as negative. Farran and colleagues used existentialism, which suggests that a person finds meaning through suffering, as a theoretical framework for their study. They found that four themes characterized caregivers' responses to caregiving: 1) valuing positive aspects of relationships and caregiving; 2) making personal choices about life and caregiving; 3) searching for provisional meaning; and 4) searching for ultimate meaning.

Hinrichsen and colleagues (1992) conducted a content analysis of responses to open-ended questions with family caregivers and found three categories of rewards. Their rewards categories were: 1) relationship with the patient-includes improvement in the relationship with the patient, greater appreciation of the patient as a result of caregiving, and satisfaction in seeing the patient's improvement; 2) relationship with self-includes the caregiver's satisfaction over having fulfilled an obligation, feelings of growing as a person as a result of caregiving, and general satisfaction from helping another person, and; 3) relationship with others-includes improvement of relationships with other family members in the course of caregiving and satisfaction from interaction with the health care system.

Motenko (1989) examined the concept of gratification which they define as a caregiver's experience of moments of warmth, comfort, and pleasure through caregiving. She was specifically interested in the quality of the spousal relationship, such as whether a caregiver's marriage relationship is enjoyable, and whether a caregiver perceives any aspect of having the care receiver at home as pleasurable.

Walker and colleagues (1992) studied outcomes of caregiving for elderly mothers and their caregiving daughters based on exchange theory. They examined the data for both positive and negative outcomes of caregiving (i.e., benefits and costs) but found only negative outcomes in caregiving in daughters. As they stated, they might not have represented the domain of positive outcomes in their questions. They suggested a need for more work in conceptualizing and measuring benefits of caregiving.

In their questionnaire, Nakajima and colleagues (1982) asked Japanese caregivers whether they had experiences in which they learned something from their care receivers. Their question is related to the concept of rewards of learning. However, it is a single item and does not capture the complexity of the concept of rewards of learning.

Sugisawa and colleagues (1992) studied the relationships between the Japanese caregiver's life satisfaction and the care receiver's health status and characteristics of the caregiver (e.g., existence of a secondary caregiver, social support, economic status). They asked the caregiver whether he or she is happy in providing care for the elderly person. Their question is related to the concept of rewards of caregiving, however, it is an open-ended question and the findings from this question were not reported.

6) Caregiver Role Strain

Many researchers have studied the negative effects of caregiving on caregivers; how-

ever, they have used different names to describe it. Many of these researchers have used the term "burden" (Deimling & Bass, 1986; Fitting, et al., 1986; George & Gwyther, 1986; Kosberg, et al., 1990; Miller, et al., 1991; Montgomery, et al., 1985a, 1985b; Morycz, et al., 1987; Pearson, et al., 1988; Poulshock & Deimling, 1984; Pratt, et al., 1985; Vitaliano, et al., 1989, 1991; Zarit, et al., 1980, 1986, 1987), while others have used the term "strain" (Archbold, et al., 1986; Cantor, 1983; Mui, 1992; Robinson, 1983; Scharlach & Boyd, 1989), and "stress" (Deimling, et al., 1989; Green, et al., 1982; Lieberman & Kramer, 1991; Stephens, et al., 1991). Whatever these negative effects are called, they are often overlapping and usually include several factors such as physical and emotional responses, effects on family life, and difficulties in performing caregiving tasks. Clear definitions of each concept are needed because the similarity of meanings and difference of names can be confusing.

The concept of burden has been widely used in caregiving research especially after Zarit and colleagues published their early work (1980). Zarit's framework is based on the stress and coping model of Lazarus and Folkman (1984). He developed the 29-item Burden Interview which measures discomfort caused by problematic caregiving situations (Zarit, et al., 1980). He assumed that this discomfort placed burden upon the caregiver. Some researchers (Montgomery, et al., 1985a; Poulshock & Deimling, 1984) criticize Zarit's measure because it did not distinguish between subjective and objective burden. They conceptually and instrumentally adapted parts of Zarit's work and studied both subjective and objective burden. George and Gwyther (1986) defined burden as the physical, psychological and emotional, social, and financial problems that can be experienced by caregivers. They conceptualized burden and well-being as two sides of the same coin and developed an instrument to measure well-being in order to examine caregiving burden. Even though Zarit acknowledges that researchers have operationalized burden differently, he stated that its common use is "the sense that care demands had overwhelmed the person's emotional, physical and financial resources for providing assistance" (p.13)

Both stress and strain are sometimes used interchangeably or unclearly with burden (Vitaliano, et al., 1989, 1991), and stress and strain are also sometimes used interchangeably (Abel, 1990). Stress tends to be used more as a general term to describe the negative effect of caregiving. Using the stress process as a conceptualization, Zarit (1990) differentiated dimensions that various researchers had measured and assigned their measures to the categories of stressors, appraisal, coping, and outcome. His categorization has clarified the measurement of concepts of stress.

Sometimes strain is used as a general term in the same way as stress; sometimes it is used in a more specific way. It is important to clarify which way the concept of strain is being used based on its definition and underpinning theory. For example, Selye (1976) used "stressor" to refer to the cause of being worn out and "stress" to the effect of being worn out. Then he stated that "stressor" and "stress" in biology and medicine respectively correspond to "stress" and "strain" in physics. Knapp (1988) suggested that researchers use Selye's definition of stress eliminate the use of strain in research on biological and psychological stress so that confusion would not occur.

In contrast to Selye's perspective, the concept of strain, as derived from role theory (i.e., role strain), is defined more specifically. The concept of role strain was developed and defined by Goode (1960) as the felt difficulty in fulfilling role obligations. Burr and colleagues (1979) explained Goode's definition of role strain as "the stress generated within a person when he/she either cannot comply or has difficulty complying with the expectations of the caregiving role or his/her set of roles" (P.57). They conceptualized role strain as a specific stress.

Archbold and Stewart conceptualized caregiver role strain based on Goode's work (Archbold, et al., 1986). They defined caregiver role strain as the caregiver's felt difficulty in performing the caregiver role (Archbold, et al., 1990). They developed nine measures of Caregiver Role Strain and adapted two measures, Increased Tension and Feelings of Being Manipulated, from Montgomery and Borgatta's measures (Archbold, et al., 1986, 1990). Their measures are: 1) Strain from Direct Care; 2) Strain from Managed Care; 3) Strain from Lack of Resources; 4) Strain from Worry; 5) Strain from Role Conflict; 6) Strain from Economic Burden; 7) Strain from Mismatched Expectation; 8) Strain from Increased Tension; 9) Strain from Feelings of Being Manipulated; 10) Strain from Communication Problems; and 11) Global Strain. Two measures, Strain from Direct Care and Strain from Managed Care, are associated with specific caregiving tasks and the others measure strain relate to the overall caregiving situation.

Several studies have been conducted to examine negative consequences of caregiving in Japan. However, their conceptual bases were not well described. Nakajima and colleagues (1982) studied members of a Japanese support group for caregivers of demented older persons. They reported that the two most difficult problems for caregivers were 1) absence of a person who could help to provide care and 2) lack of sleep. Archbold and Stewart included these two problems in their measure of the caregiver role strain from lack of resources.

A series of survey studies with impaired elderly persons and their family caregivers have been conducted by sociologists, psychologists, and psychiatrists (Maeda & Shimizu, 1984; Shimizu, 1981; Shimizu & Honma, 1978) in a metropolitan area of Tokyo. The first study focused on objective difficulties of caregiving and the second one focused on subjective difficulties of caregiving. In the third, researchers developed a 10-item scale to measure subjective difficulties of caregiving and ran factor analysis. They found two factors--a caregiver related factor (i.e., lack of manpower, conflict with a job, and economic burden) and a care receiver related factor (i.e., behavior problems and physical functional problems). Shimizu (1991) studied the concept of burnout among the Japanese family caregivers of older persons with dementia based on the stress-coping theory. He used the Maslach Burnout Inventory; however, further examination is needed before applying this measure with the concept to Japanese family caregivers because the investigators did not find evidence to support the reliability and validity of the instrument.

Nakatani and Tojo (1989) developed the Subjective Burden scale (SBS) which is a 12-item measure that examines subjective burden of caregiving for demented older persons. The SBS includes six dimensions: 1) anxiety; 2) fatigue; 3) relationships with other persons; 4) restrictions of social activities; 5) demand for freedom from caregiving; and 6)

lack of caregiving will. Based on their study, the sixth dimension, lack of caregiving will, was separated from the SBS and became a 2-item scale of willingness to continue caregiving (Sakata, 1989).

Another study (Niina, et al., 1989) was conducted to explore factors which influenced subjective burden in caregivers of demented older persons and to examine the relationship between subjective burden in caregiving and the stress response. Based on the Burden Interview (Zarit, et al., 1985) and the Caregiver Strain Index (Robinson, 1983), the researchers developed the Caregiving Burden Scale (CBS) to examine subjective burden in caregivers for demented older persons. The CBS includes nine dimensions: 1) burden from helping with activities of daily living (ADL); 2) managing dementia symptoms; 3) concern about the future; 4) caregiving related trouble with family and/or relatives; 5) restrictions in daily and/or social life; 6) physical health problems; 7) mental health problems; 8) financial burden; and 9) lack of social services. Later, they studied relationships between these dimension and social support, and suggested that emotional support could be a predictor of lower caregiving burden (Niina, et al., 1991).

All of the dimensions identified by Japanese researchers are included in the concepts of caregiver role strain used by Archbold and Stewart, except burden from "relationships with other persons" and "caregiving related trouble with family and/or relatives." The investigator identified a similar concept, caregiver role strain from relationships with other family members through content analysis of books by Japanese caregivers. This concept, that may be related to the Japanese culture, will be discussed elsewhere.

7) Amount of Negative Life Style Change

Archbold and colleagues (Archbold, et al., 1986) defined amount of negative life style change as the amount of change in the caregiver's daily activities required by the caregiving role. They used a measure developed by Montgomery and Borgatta (undated) to measure objective burden.

In Japan, results of several studies (Nakajima, et al., 1982; Niina, et al., 1989; Noguchi, 1988; Takasaki, et al., 1987) indicated that negative life style change is one of the important concepts related to family caregiving, and examined this concept as a part of difficulties in caregiving and/or caregiver burden. A limitation of these studies is that the definitions of the concepts are not clearly stated. Even though different researchers categorized their items under one concept, they used different terms to refer to the concept (e. g., difficulties of caregiving, subjective burden, caregiving influences on life). Further, a wide range of items (e. g., role conflict, economic burden, relationship difficulties, the negative life style change) were included under this one concept.

Archbold and Stewart conceptualized the concept of amount of negative life style change as one characteristic that accompanies assumption of the caregiving role. In contrast, Japanese researchers have conceptualize their concept as responses to caregiving. It can be argued either way--the change occurs because of caregiving or the change occurs along with caregiving.

Conclusions

The theoretical bases of the study developing the JFCI was described and studies of family caregiving reported in the United States and Japanese literature were reviewed. The review suggested that the family caregiving concepts identified by Archbold and Stewart in the United States are important to study in both countries, the United States and Japan, to expand understandings of family caregiving. However, using a concept cross-culturally requires concept verification in the target culture.

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