Interventions for Elder Abuse and Neglect
With Frail Elders in Japan

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Although caregiver burden is not a direct cause of elder abuse and neglect, research in
Japan indicates that stressful caregiving relationships can lead to mistreatment and abuse
of frail elders by their families. At the present time, there is no formal notification system
for elder abuse in Japan. The purpose of this paper is to discuss crisis intervention
strategies that are implemented by social workers at Home Care Support Centers when
encountering cases of mistreatment, neglect, and abuse in family caregiving situations.
We present the demographic background of elders and their families and review findings
of elder abuse studies conducted by Japanese researchers. We then offer three cases to
illustrate intervention strategies employed by social workers who work at Home Care
Support Centers in an agricultural area in northeastern Japan, including (1) ongoing
monitoring, (2) arrangements for formal services, and (3) institutionalization. Cultural
issues unique to family caregiving situations are also discussed. [Brief Treatment and Crisis
Intervention 5:203–211 (2005)]

KEY WORDS: Japanese elders, elder abuse and neglect, family caregiving.

The task of caring for elders in traditional
Japanese society belonged solely to the family.
The rapid growth in the elderly population who
require care, however, has led to changes in
polices regarding the provision of formal
geriatric services. Although families continue
to provide the majority of care for frail elders,
during the last decade there has been an
increase in services, such as in-home health
care, to augment family caregiving. Local
governments in Japan are now mandated by
the national government to establish Home Care
Support Centers to assist families that provide
care for elders in their homes. Home-based
services such as visiting nurse care have led to
increased contact between professional care
providers and family caregivers. Whereas elder care in the past took place behind closed doors in the privacy of the family, professionals now have opportunities to observe elders who receive care from family members in their homes. As a result, professionals have become more aware of mistreatment, neglect, and/or abuse that occurs in family caregiving relationships (Soeda & Araki, 1999). Contact between home-based frail elders and social workers has further increased following the implementation of the national Long Term Care Insurance (LTCI) program in April 2000. Under this program, all elders must undergo a standardized assessment to determine eligibility of services covered under LTCI. The assessments, which are usually conducted by social workers in the home of the elders, have at times resulted in the discovery of elders who are neglected or abused by their family caregivers.

At the present time, there is no formal notification system for elder abuse in Japan. Furthermore, agencies that are charged with investigating abuse cases, such as the Adult Protection Services in the United States, do not exist. Social workers who encounter elders who are abused or neglected must, therefore, act and intervene on their own accord (Kato, 2001).

**Aging in Japanese Society**

Japan not only has the largest proportion of elders in the world (O’Leary, 1993), the Japanese also have the highest life expectancy. In 2000, the life expectancy for men was 76.4 years, and for women 86.4 years (Ministry of Health, Labour and Welfare, 2002). By 2025, the population of adults over 65 is expected to increase to 27% (Kono, 2000). Furthermore, as in the United States, the “old old” (75+), who are five times more likely to be bedridden compared with the “young old” (65–74), are increasing at a dramatic rate (O’Leary, 1993). Elders 80 years and older in Japan are expected to double in the next 20 years.

Japan is unique among other aging nations such as the United States in terms of the time span of the increase in the aging population. In a short period of 25 years, the proportion of adults over 65 doubled from 7% to 14% in Japan, whereas it is estimated that it will take the United States 70 years for the aging population to reach 14% (United Nations, 1990). The rapid increase in the aging population has had negative consequences for Japanese elders as well as for their families because the nation has not been able to provide adequate and appropriate services to meet the rapidly increasing needs of the aging population. For example, Japanese elders have higher numbers of physical impairments and lower functioning of activities of daily living and instrumental activities of daily living than do elders in the United States (Imai, 1998). This can, in part, be attributed to the lack of physical rehabilitation services in Japan (Imai, 1998).

Although recent policies known as the Gold Plan, New Gold Plan, and Gold Plan 21 have mandated increases in formal care such as skilled nursing facilities, day care centers, and in-home health care, the need for these services far outweighs the number of those that exist (Campbell & Ikegami, 2000).

**Family Caregiving**

Although intergenerational households have been on the decrease, 49% of elders in Japan live with their adult children (Kono, 2000). In Niigata prefecture, where this study took place, the rate of co-residence among elders and their offspring is close to 60% (Japan Bureau of Statistics, 1995, as cited by Otomo, 2000). While studies in the United States indicate that 70% to 80% of frail elders are cared for by their family members
(Hooyman & Kiyak, 2002), an estimated 90% of older men and 94% of older women are cared for by their families in Japan (Imai, 1998). Many of the caregivers in Japan are elderly themselves. In some cases people in their late 60s and early 70s provide care for their parents in their 80s and 90s (Kono, 2000).

The rate of institutionalization of elders in Japan is 1.2% (Sugioka, 1999). While some researchers consider the low rate of institutionalized elders in Japan a result of a cultural emphasis on filial obligations, most Japanese researchers attribute it to the inadequate supply of long-term care facilities (Maeda, 2000). Studies indicate that by the year 2025, 50% of women in their 40s and 50s will have to assume responsibility for the care of an elderly patient in their home (Ogawa, 1989).

It is also important to note that receiving care from adult offspring can have a negative impact on the elders. For example, Japanese women over age 75 have the second highest suicide rate in the world (Watanabe, Hasegawa, & Yoshinaga, 1996). A higher percentage of suicides is found among women who live in three-generational households than among those who live with their spouses or alone. Researchers attribute this phenomenon to the conflicts or discomfort that women experience in being cared for by their children (Watanabe et al., 1996).

Caregiver burden/stress is not the primary cause of elder abuse (Wolf, 1996). However, caregiving relationships are among the most frequent contexts in which elder abuse takes place (Anetzberger, 2000). A number of factors in Japan place undue stress on family caregivers: increased longevity among frail elders who are bedridden, which has resulted in prolonged years of caregiving; the decrease in family size, which limits the number of available caregivers; and changes in societal values that place more emphasis on individualism, resulting in caregiving relationships in which elders are vulnerable to mistreatment and abuse.

**Elder Abuse and Neglect in Japan**

Research on elder abuse and mistreatment in Japan has been growing in the last decade (Soeda & Araki, 1999; Yamaguchi, 2001). Most of the data on elder abuse are based on surveys conducted among formal service providers such as in-home care workers, case managers, and social workers who work for Home Care Support Centers (Soeda & Araki, 1999; Tsumura, 2001). At least nine large-scale surveys have been conducted among formal service providers, yielding similar findings (Yamaguchi, 2001). One exception is the research by Ueda (2000), who surveyed family caregivers directly.

The results of the surveys indicate that elder victims in Japan share similar characteristics to those found in the National Elder Abuse Incidence Study (NEAIS) conducted in the United States (NEAIS Staff, 1998). As in the United States, female elders in Japan are abused at higher rates than males, and those 80 and older are more likely to be abused or neglected than younger elders. For example, in a survey conducted by Tatara (2001), 80% of the victims were 75 and older. Other elders at risk for abuse and neglect include those with physical and mental frailties, as well as elders who are hostile toward their caregivers. Higher rates of physical abuse have been found with elders who have dementia, whereas elders who are alert are at higher risk for verbal abuse by their caregivers (Takasaki, Taniguchi, Sasaki, & Toguchi, 1998).

A high proportion of perpetrators in Japan are women (Tatara, 2001). Perhaps this is because the surveys focus on family care in which a higher percentage of caregivers are women than men. As in the United States, adult
children have higher rates of perpetrating abuse than do spouses. One difference in Japan, however, is in the rate of abuse perpetrated by daughters-in-law, a category that is not included in the NEAIS (1998) report. The high rate of perpetration by daughters-in-law is attributable to the large number of daughters-in-law who are primary caregivers of their husbands’ parents.

The most common form of abuse in Japan according to the surveys is neglect, which is followed by either physical or psychological abuse (Yamaguchi, 2001). Sons were slightly more likely than daughters to perpetrate physical abuse (Tatara, 2001). Among daughters-in-law who perpetrated abuse, two thirds were involved in neglect, while one third inflicted physical abuse. Takasaki and colleagues (1998) report that the most frequent abuse was of older women by their son or their son’s wife.

The reasons behind elder abuse and neglect by family caregivers are similar to those found in the United States (Bulkwalter, Campbell, Gerdner, & Garand, 1996) and include (1) physical or mental disability on the part of the victim, (2) psychological or developmental disorders on the part of the perpetrator, (3) caregiver stress, and (4) a history of conflict between the victim and the perpetrator (Hagihara, 2001; Takasaki et al., 1998). Ueda (2000), who conducted a survey among caregivers, noted that one of the major factors that exacerbated caregiver stress was the lack of formal services.

Case Illustrations

As stated earlier, mandated reporting of elder abuse does not exist in Japan. Social workers who encounter elder abuse must therefore intervene by finding resources to support the caregiver, or separate the caregiver and elder by admitting the latter to a facility. The following three cases illustrate the types of interventions conducted by the social workers at Home Care Support Centers and highlight cultural issues that are unique to caregiving situations in Japan.

Case 1

Mrs. A, a 93-year-old widow, receives care from her daughter-in-law, who is 75 years old. Mrs. A lives with her son, daughter-in-law, adult grandson, and his wife. Mrs. A and her daughter-in-law have lived together for over 50 years, from the time the daughter-in-law married Mrs. A’s eldest son. Mrs. A has been bedridden for the past 5 years and has severe dementia. The daughter-in-law provides full care for Mrs. A, including changing diapers, feeding, and bathing. The daughter-in-law has heart disease and is under the regular care of a physician, who has told the daughter-in-law to stop providing care for Mrs. A because of the heavy burden it places on her physical condition. The daughter-in-law, however, insists on continuing to care for Mrs. A because she believes that it is her duty. Mrs. A is very dependent on her daughter-in-law and constantly calls for her when the daughter-in-law is out of her sight.

One year ago, Mrs. A started to place her hands in her diapers, and the daughter-in-law began to physically restrain Mrs. A by tying her arms to the bed. Mrs. A’s physician, who makes house calls, was aware of the restraints but did not tell the daughter-in-law not to use them. The social worker who visited Mrs. A to assess her for eligibility for LTCI felt that restraining Mrs. A for 24 hours a day was a form of mistreatment, and tried to intervene by getting in-home health care for Mrs. A. The social worker first discussed the matter with the daughter-in-law, who refused to get outside help, insisting that she had nothing else to do during the day except care for her mother-in-law. The social worker...
then approached Mrs. A’s son (the daughter-in-law’s husband) and grandson, but they were also reluctant to have an in-home care worker provide services in their home. Because formal services cannot be forced upon families who refuse help, the social worker has continued to make periodic home visits to maintain ties with the daughter-in-law and continue to observe Mrs. A’s condition. The long-term goal of the home visits is to get the family to eventually accept formal in-home care.

This case illustrates the way in which the primary caregiver, other family members, and the physician may not be aware that continuous use of restraints can be viewed as a form of mistreatment. In fact, a large number of caregivers as well as the general public in Japan are not aware that certain acts are considered abusive (Ueda, 2000). Unintentional mistreatment is frequently found among caregivers of frail elders who display problematic behaviors.

This case also presents the difficulty of intervening in a situation when the family does not agree to utilize outside help. The social worker believed that an in-home health care worker would be able to find alternatives to restraining Mrs. A. The family, however, refused his suggestions. Quite often, families are reluctant to utilize services because they view the practice as an invasion of their privacy.

Furthermore, Mrs. A’s daughter-in-law, who is 75, grew up in an era when family and gender roles were well defined. In fact, the daughter-in-law’s identity is linked to her fulfilling her roles as the wife of the eldest son. Caregiving is what gives meaning in life for the daughter-in-law. If the social worker pushes the daughter-in-law to utilize formal services too strongly, he risks invalidating her purpose in life. In addition, he could potentially undermine her status and power in the family, which comes from being the primary caregiver. Thus, given that the mistreatment is not life threatening, the intervention strategy in this case was to establish an ongoing relationship with the caregiver and monitor the elder’s condition.

Case 2

Mrs. B is 88 years old and is cared for by her 53-year-old daughter-in-law. Mrs. B and her daughter-in-law have lived together from the time the daughter-in-law married Mrs. B’s son. The relationship between Mrs. B and her daughter-in-law has been ridden with conflict from the very beginning. The daughter-in-law never felt welcomed into the home by Mrs. B and resents the way Mrs. B was always critical of her in the past. In fact, the daughter-in-law believes that her first pregnancy ended in a miscarriage because of the stress caused by Mrs. B’s abusive manner. The daughter-in-law also complains that she was hospitalized in the past for ulcers that developed as a result of her conflicts with Mrs. B.

Mrs. B had a stroke and became bedridden 4 years ago. The daughter-in-law did not want to look after Mrs. B. However, she did not feel that she could relinquish her responsibility, because of societal expectations and the watchful eyes of the neighbors, whom she feared would criticize and badmouth her for not fulfilling her duties as a daughter-in-law. The negative relationship between Mrs. B and the daughter-in-law intensified. Mrs. B became more demanding and critical of the daughter-in-law and complained to her daughters about the care she was receiving. Mrs. B’s daughters never offered to help the daughter-in-law or expressed appreciation for the work she was doing.

The social worker became involved with this case because the daughter-in-law came to the Home Care Support Center to find out about caregiving equipment such as commodes and special beds. The social worker also suggested in-home health care and day treatment. Mrs. B, however, refused to receive these services. The daughter-in-law became increasingly stressed,
making comments to the social worker such as “I can’t stand going near her,” “I don’t want to breathe the same air she breathes,” and “I can’t stand it when she calls out for me.”

Mrs. B then began to develop dementia. As Mrs. B’s dementia began to worsen, the daughter-in-law began to stop changing Mrs. B’s diapers regularly and stopped giving her semiweekly bed baths. The daughter-in-law, however, did not seem to be aware that her behaviors constituted neglect. Because, due to her dementia, Mrs. B could no longer reject outside services, the social worker made arrangements to lighten the daughter-in-law’s burden by making arrangements for in-home health care and respite care. She referred Mrs. B to day treatment services and arranged short stays at residential facilities for Mrs. B. As the burden of caregiving has lessened, the daughter-in-law has become less negative toward taking care of Mrs. B.

This case illustrates the dilemma that family caregivers face when they feel that they have to provide care because of social expectations. Whereas Mrs. A’s daughter-in-law finds personal fulfillment in caring for her mother-in-law, Mrs. B’s daughter-in-law experiences caregiving as simply a duty and obligation. Norms regarding filial obligation have been changing in Japanese society, and there are fewer expectations for daughters-in-law to care for their in-laws. Rural communities, however, tend to be more conservative than urban areas, and people tend to be more concerned about deviating from social norms. Unlike urban areas, which tend to have a transitory population, families in rural areas remain in the same house for generations and have intimate knowledge of their neighbors.

As in the United States, a history of conflicted relationships can result in elder abuse and mistreatment in Japan, especially in situations where caregiver burden is severe (Takasaki et al., 1998). In traditional intergenerational families, the mother-in-law has authority over household matters and wields power over her daughter-in-law. The balance in this relationship shifts when mothers-in-law become frail and dependent on care by their daughters-in-law. Long-term resentments on the part of the caregiver can lead to abusive behaviors even when there is no malicious intent.

Case 3

Mrs. C is a 78-year-old widow who lives with her 37-year-old son, who is single. Mrs. C has been bedridden for the past 3 years. The social worker first visited Mrs. C at the request of the municipal office that is in charge of the LTCI program. Mrs. C had been screened for eligibility but had not applied for any of the services for which she was eligible. The municipal office requested the social worker to find out why Mrs. C had not been using the services, since she was assessed as having severe self-care limitations. When the social worker made an unannounced home visit, he found Mrs. C in bed covered up in a blanket. He asked the son how his mother was doing, and the son reported that she was doing fine. The social worker visited 2 days later and found that things in the room had not changed since the previous visit. For example, the food bought at a take-out store remained as it was. He looked more carefully and found that Mrs. C’s bedding was soiled with urine and that there were bruises on Mrs. C’s cheeks and arms. Mrs. C also appeared dehydrated. When the social worker asked Mrs. C about her bruises, she said that it was a result of a fall. Although Mrs. C appeared bedridden, the son also told the social worker that she had been walking until a few days ago and concurred that she bruised herself when she fell. The social worker made immediate arrangements for a visiting nurse, who found that Mrs. C had severe bed sores. The social worker...
interviewed the neighbors and found out that Mrs. C had complained that her son used to hit her. The son has a mild developmental disorder, and the social worker judged that he was not capable of providing adequate care for his mother. In addition to making arrangements for visiting nurse care, the social worker made arrangements for Mrs. C to be moved to a skilled nursing facility.

In this case, the social worker’s main intervention was to separate Mrs. C from her son. This was deemed necessary because the son was not capable of taking care of his mother and because of the likelihood that he was abusing her. Admission to a skilled nursing home was possible in this case because the facility had an opening. When beds are not available, the social worker has to resort to a special regulation in the welfare law, which stipulates that municipal governments can intervene and place patients in nursing homes in “extraordinary circumstances.”

Discussion

Table 1 illustrates three different types of intervention strategies that were described in the case illustrations. They include (1) ongoing monitoring, (2) arrangements for formal in-home health care, and (3) arrangement for visiting nurse care, as well as (4) institutionalization in a skilled nursing facility. The most common intervention strategy employed by social workers when they encounter abuse and neglect in family caregiving situations is the arrangement of formal services. Studies in the United States indicate that formal services do not have much effect on the well-being of caregivers (Tennstedt, 1999, as cited by Hooyman & Kiyak, 2002). However, in situations where mistreatment and abuse are involved, in-home services are effective in (1) providing appropriate care, (2) monitoring high-risk situations, (3) teaching caregiving skills to family members, (4) easing the burden of the caregivers, and (5) providing emotional support to the caregivers.

Some families, however, are reluctant to utilize outside help. In addition to invasion of privacy, receiving formal help can create more stress for families. Formal care can pose complications for families that are not used to engaging in contractual helping relationships. For example, families may not be able to assert their needs to formal service providers for fear of offending them. The emphasis on preserving harmony in interpersonal relationships in Japanese culture can inhibit families from voicing complaints to formal service providers because it can cause conflicts.
When families refuse to utilize formal care, an important part of working with family caregivers is to build ongoing relationships, which enable social workers to continue to observe and monitor elders in their home. Elders are at risk for mistreatment and abuse when their families become insular and socially isolated. Establishing trusting relationships with caregivers decreases risks for abuse and mistreatment. Social workers and other formal care providers must remain supportive and non-judgmental toward caregivers even in situations in which they are abusive. Furthermore, it is important to understand abuse and neglect from a systemic perspective. Assessments must be made based on understandings of (1) the elder victim, (2) the caregiver, (3) interaction between the elder and the caregiver, (4) past and current family dynamics, (5) receptiveness toward utilization of services, and (6) availability of appropriate services.

Two societal factors in Japan can facilitate early detection of abuse that occurs in family caregiving relationships. As mentioned earlier, social workers at Home Care Support Centers have close contact with elders and their families through the national LTCI program. Furthermore, community volunteers, known as Minsei-i’in, are appointed by the minister of Health, Labour and Welfare to monitor and support community members who require assistance. These volunteers perform a variety of functions, including providing assistance to families with frail elders (Asano & Saito, 1988), and often refer families with elders who are at risk for abuse to Home Care Support Centers. Early detection, however, does not always take place, because an official definition of elder abuse and neglect has not been established by the government.

The current intervention strategies used among social workers at Home Care Support Centers have inherent limitations. The lack of mandate to report abuse precludes a uniform system of intervention, and there is no systematic training of elder abuse prevention and intervention for social workers and other care providers in interventions. Lack of awareness of elder abuse among caregivers as well as the general public in Japan also renders elders vulnerable to abuse. A comprehensive program that includes public education regarding elder abuse, a national notification system, and training and education of caregiving skills for families is needed to minimize risks of elder abuse and treatment.

Conclusion

This paper discussed intervention strategies currently used by social workers at Home Care Support Centers in a rural area in Japan. Elder abuse is becoming increasingly recognized as a serious social problem in Japan, given the high rate of elders with chronic mental and physical disabilities and the stress and burden that caregiving poses on family members. It is important to view abuse and mistreatment by family members from a systemic perspective and not to blame the family members for the abuse. Ongoing relationships with caregivers and at-risk elders can be established only by understanding the predicaments of family caregiving situations caused by factors that are often beyond the control of the elder or the family members.

References

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