Session B-1 Family Care 2

Contested Family: Masculinity, Sex Discrimination and Emotion

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1. Introduction [1]

In Nepal, females hold 25.73 percent houses as chief of the family (CBS 2011) [2]. In the recent history of Nepal, the rural-urban migration is increasing, however, only 17 percent peoples reside in the urban areas and its annual growth rate is 3.62 percent. [3] With growing rural-urban migration, the family structure is changing from extended to joint, and joint to nuclear. Thus, the traditional meaning of care is changing gradually, we can find in any joint or nuclear family that the main head of the families are mostly male members because of their masculinity and thus decision making, authority, responsibility are directly or indirectly in their hand and because of this power, which is provided to them by social and cultural practices following from generation to this modern period sex discrimination practices can be seen occurring women are perceived and treated physically weak, foolish, trouble maker compared to men.

Therefore the perception of superiority in men can be seen and this results in different behavior and emotion from women in the same circumstances and in a situation of time. Thus, when the different thinking process of man and women occur in the same situation than understanding, behaving pattern, emotion, a way of caring also differs. Thus, it creates gaps between emotion, care and feelings of man and women and this gap invites the conflict within man and women. Hence, in this research also the husband and the wife thinking process are different because the husband is overruled by the feeling of masculinity and doesn't wants' to understand or hear women (wife and daughter) thinking and perspective.

Therefore, the husband doesn't listen to regarding the meaning of "care". He defines care as a supporting female member through economically and providing them with all materialistic comfort. Whereas female member defines care as a getting equal opportunity, decision making power, respect Hence, this understanding of care by male members and female member of this family is different to each other. This gap and differences in the meaning and understanding of care brings conflict and violence in the family and a situation turns up to the level of committing suicide. Thus the global definition of care which we perceive and do to each other has not same definition for all. The meaning of care is defined individually according to the size, structure, behavior and perception of the family members towards to each other.

2. Research family [4] at a Glance

This nuclear family is the residence of Lalitpur district, Kusunti area, living here for more than

30 years and is my neighbor. The respondent “father” age 45 originally belongs from the village area “charikot”. Later, at his age of 41 he joined the private college and completed higher education and is engaged in real estate business. Whereas “mother” age 43 respondents belongs from the village “kavrepalanchok”and from the age of 14 she started living in Kathmandu doing a job and supporting her family and after getting arrange marriage she quit the job by accepting husband's request for not working. At the age of 38 she felt the need of education because she became embarrassed when she was not able to sign in the children’s report card and in the bank's cheque book. So, she joined school and completed up to grade four. In order to look after her children and house, she couldn’t continue her study. All the three children’s where born and brought up in the city area. Father feeling the importance of education has placed all three children’s in a good school and college in the city area. Thus, elder daughter age, 23 is studying masters. Younger daughter, age 21 is studying in grade 12 and a son age 18 also in grade 12.

3. Research Methodology and Methods

Since the nature of the study is fluid and mercurial, the article has employed grounded theory (methodology) approach (Corbin and Strauss 2008) to interpret care in the "contentious conception" between male and female within a biological family. Even though, theoretically and morally "family" has been imagined as a 'care institution' but in practice within the Nepali biological family varied values exist to take care of male and female (Rana et.al. 2002, Aziz 2001). But, academically it should be understood how these varied values evolved in Nepal analyzing Nepali society, history and culture similar to the Japanese academic tradition (Shizuko 2013). However, discriminatory practices within male and female employing various social and cultural markers have been leading activism, social movements and revolutions across different points of time in Nepal (Karki 2006, 2010).

However, in private space, [5] beyond theological conception, the definition of the ‘care’ has been always been problematic, and any study focusing on care must acknowledge the overlapping meanings and conceptualisations associated with the notion. Very generally speaking, the notion 'care' has been conceptualized as 'presence of emotional bond between help seeker and help provider' (Harris & White 2013). Here, I argue care would be described as activities where all sorts of social and cultural boundary would be broken out to help others in a dignified manner with a mutually respectful emotional bond.

Here, the study is very close to Weber’ general causal logic theory (Kalberg 2005). The infusion of the two or multiple nodes may generate new logic and space for meaning of care formation. The ‘care salience’ in a personal developmental sense is, undoubtedly, quite essential in the care dynamics. Unlike psychological methods to measure care, in this article the notion of ‘care’ of an activist has been measured using the causal conceptions of material fulfillment, disrespect, dignity, mutuality etc. as respondents identified their reference worldviews.

Thus, to discover the meaning of care I carried out five in-depth interviews from July 15 to September 5, 2014 and in October 5th with a modern Nepali nuclear Hindu family in Lalitpur municipality 10, in Lalitpur district. The family holds two males (father and son) and three females (mother and two daughters) members. To interpret the deeply lying meaning of care in different contexts between male and female, and bread provider and bread receiver, I took several in-depth interviews in different time post-suicide-attempt by youngest daughter. Several memos I developed from the interview with youngest daughter and father who always ignored her. Relatively, fewer interviews I took with the rest family members because the suicide attempt was happened after a violent incident occurred between the father and daughter.

I developed various diagrams from these memos and from these memos the body of the article has developed. In another language, I have followed the techniques of Corbin and Strauss (2008), ground level response to the middle level concept and the middle level concept to high level themes.

4. Life Cases and Research Question

Following cases reflect the contentious meaning of care in a family.

Case 1

Having an arrogant personality, limited friend circle and is uninterested to study, always seeking attention, becomes happy whenever anyone supports and praise her therefore is ready to do anything for them. Where as in absence of it feels “hela”(unequal distribution of love and care) to her and has attempt suicide several times because she don’t find the usefulness of living life in disrespect, isolation, demotivation and in distrust. Therefore, women and man always have different kind of emotional feelings, nature and role in the society and when this difference is not understood and accepted by each other than the feeling of “hello” occurs which leads to conflict within the family and continuous conflict leads to frustration and thus it takes a person to the level of committing suicide.

Case 2

Bad family life experience, betrayal from own father, rude behavior from the stepmother and spending lonely, hard and struggle life from childhood to teenager age, had made the father very rude and misbehaving character, as well as has developed the concept of money is everything and can buy actual happiness and care, which he didn’t get in the absence of money. His step mother marrying his father and his involvement in real estate professions, which deals with various types of females, leaves the impression that working females can get characterless very fast for materialistic desire. So he is very authoritative towards female members of his family, does restriction and takes every decision for them. Lastly, concept of son will look in old age and daughters will go to the other's house, after getting married creates an unequal distribution of care in son and daughter.

Case 3

"Dependent to husband fully reduces the self respect as well as love and care from husband" wife stated". After marriage, we don't have the freedom to live in "self interest" every minute has to be dedicated to husband and his children only. Therefore, the female being illiterate and dependent on male motivates male to be more authoritative and controlling towards female members. Thus, provides only basic needs and materialistic wants as a care for them and fails to understand the real care which is giving respect, decision making power or in a one word no individual freedom is given.

Case 4

Eighteen years old son has developed the sense of proudness and masculinity in him. Thus he acts, behave in an authoritative manner. Therefore, this proudness acts changes into discrimination shape to his sisters. Understanding the concept that the son has to look after parents in their old age, within now he starts playing a role as a protector for his family member which he denotes as a career.

Case 5

Suffering from isolation, gender discrimination, distrust leads to fight for self identity, and for existence within the family. The elder daughter develops the hatred and competitor feeling towards the man. Accordingly, getting Materialistic support only brings momentum happiness which doesn't last in front of real care. And the real car, she never gets from her father and always craves for it. Therefore, have always given best effort in order to get it, but couldn't succeed and as a result becomes more emotionally far from the father's companion.

These cases reveal that care includes two meanings within a single family from gender perspectives. First, male members define care as a fulfillment of basic, societal, educational need as well as the fulfillment of all materialistic wants. Showing emotional support, motivation, encouragement to female members by male member is taken as going beyond the role of "real man" which is not accepted by the masculinity definition of males. Second, whereas female member define care as a getting respect, trust, empathy, emotional support, decisions making power, freedom to do anything which they desire for. Therefore fulfilling basic and materialistic wants is the duty of male members because being masculine. So, it doesn't fulfill the meaning of real care. Hence, I argue that fulfillment of basic to materialistic want and giving respect, freedom, equality, motivation, empathy to female member by male is a real care.

4-1. Emotional Support

When an individual feels lonely, helpless, depressed, and confused as well as is happy, excited, and curious in any situation of circumstances and case he/she desires, emotional attention and support

from their own ones, their presence and listening will make them feel better and motivates them in both happy and in sad situations.

And in the absence of it, it will take them to the level of committing suicide. Hence emotional support for the female has got very much importance in their day to day life. The case of younger daughter describes the meaning more clearly which is as follows

> From my childhood, I never get attention and respect from my father, I failed thus; my father beats me instead of motivating me to study. I was even weak in studies and I still remember when I failed in class seven, I have to repeat my class, at that time I was scolded and beaten by belt from my father. I always expected love and care from my father, wish he had helped me to study and to do my homework's but whenever I asked him to help me in study he used to say, if I sit teaching you than who will go to work and pay your school fee? My friend's father also works but they have time for their children. Therefore, I used to feel so sad and used to think why he just can't give me a few minutes? 'When my brother failed in exam my father didn't scold him, neither beat him, but instead told him that if he passed the exam he will give him a cycle .I was so much disappointed with his discrimination done in same case'. Whenever, I used to go outside to roam with my friends, my father scold me, but when my brother used to go he didn't say a word. He allowed my brother to go to visit different places at evening time with his friend and whenever I tried to go he used to scold me saying "you are daughter so don't go outside in evening time only bad girls roam outside at evening time" {chori manche vayera bayluka bayluka ghumnay haina bigreko kayti matra ghumcha}.

4-2. Respectful Motivation

An individual always desires for motivation from their family member to carry daily activity to biggest work of their life. Therefore insulting, untruthful untrustable suggestion to carry out those works will demotivate a person to work. Hence, respecting individual ideas, though it may seem to achieve positive, encouragement and suggestion should be given as a respectful motivation. As following cases express

> My father always used to be happy whenever I stayed home but sometimes when I used to go at get together and birthday party and become late just at 6 pm , he used to create scandal at home shouting me, with by bad words as if I have done big crime. I couldn't bear his unreasonable shouting at me. Thus, I used to argue with him and he used to get angry with me and later on, in anger he started beating me up very badly. I feel so bad, disrespect without any reason and mistake, why I am always punished?

Consequently, being frustrated I started cutting my hand in order to punish myself that I am a girl and used to feel If I was a boy and have reached home lately than I wouldn't have got scolded and beating. And on one occasion I went to see a movie with my friends and got home late and as usual, my father scolded me saying that I went with a guy so I am late. I tried to convince him that I was with my friend, but he didn't believe my words and start saying abusive words, instant in anger I shout at him with bad languages, as a result dad became more aggressive and threw a chair at me. Even I couldn't bear the pain so I also hit with him by makeup kits ,both were becoming more aggressive and was hitting each other with anything which was available in the room at that time .My mom and sister tried their best to control the situation and fight, but dad even beat them up in his anger and was shouting women are not worthy in doing anything they are trouble makers only" {yo ayemai manche haru kayhi kam lagdaina khali dukha ko karan hun }" neither you can study properly nor you have good behaviors you are waste to this society . {na padera khana sakches na bani bayhora nai gatilo cha samaj ko lage boj ho ta}" his this kind of words were killing me day by day, I used to think neither I drink nor smoke, or have a boy friend than also why my father doesn't trust me, disrespect me and make me feel that to be a girl is like a cruise 'paap'. He always said that the female doesn't have brains they are powerless and always creates a problem with being over smart and is not capable of doing anything like man are capable to do and after hearing all this, I used to counter instead of disrespecting and demotivating why don't u motivate me to become better than males?

4-3. Equal Respect

Without discriminating gender, freedom to choose, speak, opportunities to present ideas, suggestion, and rights for decision making from basic household activity to societal level by female members is termed as equal rights known as a care. Subsequent case of wife is very relevant to equal respect as she expresses

"Before marriage, I was independent women I used to work, earns myself and used to support my family, but post-marriage, my husband didn't allow me to work and I have to be totally interdependent to him". I don't have anything to do except looking after husband and children .I have given birth to two daughter already and when I was pregnant for third time, my husband started giving me mental tortured that if I didn't give birth to a son, than this time he will marry another women to have a son. He wants' son because it brings prestige in society and support to his family, which girl birth won't give. My husband is very aggressive in nature, he doesn't listen to anyone, he always

feels and thinks he is only right and especially women can't be right because they are foolish, weak by nature. He doesn't understand the meaning of love and care, giving food, money is not love and care, but helping me in 'kitchen-rearing' children, respecting my emotion, interest, decision, my parents, relative and being happy in my happiness is actual love and care. The desire definition of love and care I fail to make him understand and be unsuccessful to get it from him till now. To look after three children are very hard for me, he only provides money that's not care, he never seats and spend time with children, whenever I told to do so he used to state, if I start spending time with them who will earn money? And when children's do mistake or fails the exam, he used to scold and beat them up. So, he has only negative impression in a child's mind and thus children have more negative feelings to their father. I tried my level best to make them understand about their distinct behavior, different thinking pattern and way of loving, caring for each other is different but couldn't succeed. "To take children's for a checkup, shopping, school, I have to do all by myself, as a husband and father he should have showed me care by helping with these activities, which he never did. Thus, I always felt ignored by my husband."I get freedom to look and care my children, but didn't get freedom to decide what they should eat, wear, which school they go, at that moment I feel so much discriminated and disrespected and used to think that if I was a father than I could have get authority to decide anything for my family. I always feel that I shouldn't have given birth to daughters because they will also get through all this phase which I am going through.

4-4. Material Support

Individual life in this modern society is miserable, in the absence of materialistic support. Absence of it will make the person neglected by the society. Nobody will look at your emotion (helpless condition) and provides a care for a person if they don't have materialistic support. So, in order to care a family member, material support is first priority and most important thing to run a family life. The following case of father interview supports this statement which is as follows

I didn't get the opportunity to go to school; my parents were very bad to me so, at the age of seven they brought me to Kathmandu in order to work in a hotel as a dish washer. Though my family was rich, my father in order to bring stepmother, he even pushed out my mother from home. "I have spent my childhood and adolescent age working and staying alone, and with my all hard work I have earned enough property to take care of my family". "I have given them an education, clothes, enough food to eat .So; they don't have to face any problem like I have faced in my life. 'No relatives were there for me,

when I need them most. All people are selfish in this world. I always felt and have seen that women are the reason for every problem from home to workplace. Their over smartness and bitchy “chada bayhwara” nature creates problems’. So, I want women to behave polite and not to speak in the male’s matter or work. “Women are weak from nature, they don’t have strong thinking power and physical strength like male have. So, I don’t allow my daughter and my wife to go outside from home because they will not be to tackle social problems, crime and incident which usually occurs in the society”. ‘I care for them so I take decisions for them and thus made my own rule and regulation to prevent from any bad incident which takes outside the home’. I have seen outside world and which is very bad, in every step of life there is danger and people are ever ready to stab you from back. ‘So in order to protect from those evil I rarely allow my wife, daughter to go outside and to bring any relatives or their friends at home. So, they are provided with everything they wanted, I have provided all the materialistic things which is needed to live in this modern life.

5. Conclusion

All the female members in this study always expected for an emotional help, motivation, support, respect, equality and power to decide for what they want to wear, buy, and visit and to do which they didn’t get. Because of the main head of the family who always take the authority from small decision making to big one. Many small to big incident which occur in this 3 females life are similar to each other. Hence produces the same meaning of care which they fail to get from expected that one person i.e. {Younger daughter seeking emotional support from his father when she failed in her exam ,wanted, expected her father to be a teacher and to taught her so that she can pass her exam } as well as elder daughter wanting her father to arrive in school for father’s day celebration which didn’t happen and feeling of being orphan took place in her heart and {wife getting beaten by husband after 6 months of marriage because she have a conversation with a male neighbor}. Demotivating in every work, unsupportiveness, distrust in every idea that they presented to do make this all three female members to have negative feeling towards him. As well as this gap creates two levels of definition of care from them in the same family.

Without valid proof and reason, doubting wife and daughter and scolding them with abusive words, started making feel this three female members that "They are curse to be get birth as women because by birth, they were presented as physically weak as well as not having a good sense of humor" and when the main head of the family started treating in same way, they feel disrespect, loss of their own position, identity in their own house.

When a wife needed emotional support from her husband, she only gets materialistic support. She had to have handle all the child rearing process, household responsibility all alone, but couldn’t

get any decision making power not even to take decision like to choose a school for her children ,dresses ,toys for them.

As well as when younger daughter brought her friend at home and who was not allowed to appear because her father simply don't like because of her lower caste group, when she brought her in house than extreme violence occur with father, where she reaches to commit suicide also.

All three female members always search and seek for the support when they were feeling unsuccessful, alone in their life, but instead of support at such time they got scolded, beating, demotivation from the male member .Their expected behavior or care from male member was never fulfilled as they desired for. Slowly, this unfulfillment of desire started changing into frustration and thus frustration started converting into conflict. Hence, this three female always wanted to have a care which includes emotional support, express love, and respect, equality, which they fail to get and thus term it as absence of care.

And both the male members of this study have same thinking pattern or we can see the influence of father thought, behavior is adapted by son. So, they behave in the same way. Both have the feeling of superiority because of being male. So, is controlling all the female members of the house having a sense of authority as well as responsibility to care family. Thus, they make decision, rules and regulation for the female member's. The biggest care for the family is to give food, education, and shelter and to provide the entire materialistic thing needed to run life. Thus, male members feel giving enough care is by fulfilling all above responsibility.

Therefore, I conclude that role of a male and female member, their cultural norms, values, and prejudice thinking pattern, gender difference, biological structure, and life experience divide the meaning of care in individual as well as in a collective way within a same family.

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Notes

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[2] Female-headed households increased by 10.86 percent compared to 2001 census to 2011 census (CBS 2011).

[3] Here urban areas include metropolises, sub-metropolises and municipalities (CBS 2011).

[4] In this paper family includes only 'biological family'.

[5] Private space includes household affairs.

Changing Elder Care in Taiwan Families: The Role of Gender Culture

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1. Introduction: The incorporation of migrant care workers and filial piety in the family

With the ever-increasing elderly population and the decline of three-generation households, elder care is becoming a pressing issue in Taiwan. In 1992, the government implemented a policy that allowed households with state-approved care need to hire foreign care workers; since then, the total number of foreign care workers in Taiwan has grown rapidly. As of 2013, there were nearly 200,000 foreign care workers in Taiwan (70% from Indonesia) and over 90% were working in households as opposed to institutional care facilities (Wang, 2006; Chen, 2008; Chiu, 2009; Ministry of the Interior, 2011; Ministry of Labor, 2014). In a society where filial piety is still highly valued, hiring foreign care workers may seem like an unorthodox arrangement for elder care. This study focuses on how adult children coordinate carework with foreign care workers and among themselves, thus uncovering the changing social mechanisms of practicing filial piety in Taiwan.

Traditionally in Taiwan, sons are expected to care for the elderly parents. Three-generation patriarchal cohabitation is considered an ideal living arrangement, where authority, power, and wealth are distributed patrilineally within the family (Barker, 1979; Fei, 1985; Hsiao, 1991). Once daughters are married, they no longer belong to their original family and should devote themselves to their husband's family (Zhan & Montgomery, 2003). Sons, until they divide their family fortune, should share their filial responsibilities equally (Hsieh, 1985).

The social structure has changed enormously in the last century, from an agricultural to an industrial economy, in addition to undergoing rapid urbanization. At the same time, the society's microstructure (i.e., familial and interpersonal relationships) has also changed. Thus, numerous studies have considered whether younger generations still believe in filial piety and how they practice their filial responsibilities. Previous research has demonstrated that even though the social context has changed, people still believe in traditional Taiwanese values and prefer adopting new social mechanisms to fulfill their expectations (Chuang, 1972; Li, 1982; Chen, 1994; Yeah, 1995, 1997a, 1997b).

During the 1960s and 1970s, the market economy provided several income-earning opportunities for the adult children in families, and many of them preferred to live in the city. To fulfill filial piety, despite having moved away from parents' homes, the practice of rotating elder care among sons, or *lun-hun-tou* (literally, taking turns cooking), became a common arrangement. *Lun-hun-tou* means that the parents take turns living with each of their adult, married sons. Thus, filial responsibilities can be shared among the sons as equally as possible. *Lun-hun-tou* as a care

arrangement provided evidence that the value of filial piety persisted in a changing society (Hsieh, 1985).

Although the sons bear the filial responsibilities in this arrangement, the daughters-in-law do the actual caring for their husbands' aging parents (Hu, 2004). The work is not viewed in an egalitarian manner; rather, the prevalent understanding of filial care connotes a servant's role (Liu, 1998), and carework is usually undervalued and perceived as women's work (Cancian & Oliker, 2000). Hence, under the influence of Han filial culture, the care responsibilities have already been transferred from the son to his wife. But, a further transfer of these responsibilities to someone outside the family, through the market economy, was a new development facilitated by the supply of foreign workers (Lan, 2006). Glenn (1992) observed that most of the live-in migrant care workers were female, and that the segregated migrant labor market further reinforced the devaluation of caregiving.

Recent studies have shown that younger generations can still meet the requirements of filial piety by hiring a care worker. Lan (2002) used the term "subcontracting filial piety" to characterize the immigrant Chinese families in the U.S. who, instead of performing the actual caregiving themselves, hired people from outside the family to care for their aging parents. Thus, the new social configuration was implanted on foreign soil to maintain the ideal filial care (Lan, 2002). Families in Taiwan can also accept hiring care worker as a way to fulfill filial piety. Liang (2010) found that Taiwanese families who hired a care worker still cared deeply about the elders and usually shared some of the caregiving responsibilities with the hired person.

2. Methods

The data presented in this study are taken from an ongoing research project involving fieldwork with 10 families employing migrant care workers. The data were collected from July to November 2014. All the families live in urban settings, seven in Zhongli and three in Taipei; all the migrant care workers are from Indonesia. Five of the 10 families have employed migrant care workers for less than four years; the others have employed a worker for more than seven years. Almost all the care recipients (the elders) are aged over 80 years, and six are over 85 years; three are male and seven are female; nine are widows or widowers; and one elder man still lives with his wife, who is aged 83 years. Three elders live alone with their migrant care workers, including one elder lady with no son; six elders live with their sons; and one elder with no son lives with her daughter.

Table 1 provides more detailed information about my informants.

Family	City	Elders' Age range	Elders' Gender	Experience of the Family in Employing Migrant Care Workers	Elders' Living Arrangement
Wu	Zhongli	90–95	Male	1 year	Living with unmarried son
Hsu	Zhongli	85–90	Female	2 years	Living with married daughter
Wang	Zhongli	80–85	Female	Over 10 years	Living alone with her care worker
Huang	Zhongli	85–90	Female	Over 10 years	Living alone with her care worker
Hsieh	Zhongli	85–90	Male	7 years	Living with married son
Su	Zhongli	75–80	Female	3 years	Living with married son
Lin	Zhongli	85–90	Female	8 years	Living alone with her care worker
Yeah	Taipei	80–85	Male	1 year	Living with spouse and unmarried son
Chen	Taipei	85–90	Female	7 years	Living with unmarried son
Chang	Taipei	80–85	Female	1 year	Living with unmarried son

[Table 1: Details about the Informants]

I located these families through snowball sampling via personal referrals, and I have visited each of them nearly 5–10 times, during different hours of the day. On each visit I stayed with a family for 1.5–3 hours, to get firsthand knowledge about how they organized their daily lives, including activities outside the home, such as trips to parks, hospitals, barbershops, and temples. During my visits, I interviewed the elders' care workers using Chinese. During the interview, the care workers were encouraged to express themselves using Chinese and some Indonesian vocabularies. I used the translation software to translate Indonesian vocabularies into Chinese to better understand their

response. I also interviewed a total of 15 elders' sons and daughters: in four families I interviewed both the elder's son and daughter and in one family I also interviewed the daughter-in-law who lives with the elder. Fourteen of the informants consented on taping our conversation. To protect the informants' privacy, all names used in this study are pseudonyms.

3. Findings

The preliminary findings show that even after hiring migrant care workers to care for their elders, the younger generation does not totally relinquish the care work. Sons and daughters take on different roles in caring for the elder parents and manage the migrant care workers to ensure that their parents are well cared for; however, this does not imply that the daughters have equal authority as their brothers. In addition, the previously significant role of daughters-in-law is declining.

3-1. Living Arrangements and the Sons' Responsibilities

My preliminary findings indicate that six of the elders live with a son, which seems to correspond with the traditional expectation. But, the elders with more than one son currently live with only one of them; the practice of *lun-hun-tao* seems to have ceased. As Mr. Chen, the eldest son of Ms. Chen, who is almost 90 years of age, states:

> I have heard of that kind of arrangement before. But moving around is exhausting! I don't think my mother would like to move around constantly. Our mother can hardly walk on her own. She needs to stay in a familiar place. If we make our mom constantly move around, it would seem as if we sons don't want to take care of her. …Besides, now we have hired a live-in care worker. It's not rational to make my mom move from one place to another. The care worker is doing a good job.

Apparently, the responsibility is not shared equally among family members once a care worker is hired. Those children whose parents live with them take on more responsibilities as the parents' health conditions deteriorate. However, during the interviews with the adult sons, the ethic of sharing filial responsibilities remains. Most of my informants said that if their elder parent could not afford their medical bill or hire a migrant care worker, they would share the expense equally among those who can afford it. While 3 of the families' adult children split the bill, most of the care recipients' children use their elderly parents' savings to hire the migrant care worker. They say that once the parents pass away, they will inherit the family fortune, so using their parents' money to hire the care worker is reasonable. Either the adult children share the expenditure or using the elder parents' saving to cover the bill, in most of the cases the cohabiting son would not be the solo financial barer. Notably, several daughters said that if their parents had no savings, they would be more than happy to pay some

of their parents' bills. "After all, we are the generation of working women. If my parents need my financial support, I can't see why I shouldn't do it," said Ms. Hsu. Linda, who is in her eighties, has six daughters, four of whom deposit 10,000 NT dollars monthly into a joint account to cover their mother's expenses. Ms. Wu, one of the four contributing daughters, explained, "My other two sisters don't make that much money. I am fine with it."

Some of the informants said that living with the elder parent does provide additional pressure; for example, they are the ones responsible for assisting when their parents suddenly need medical attention. Yet, they said that the presence of a care worker does provide some kind of compensatory assistance for them. By this, they were referring not only to the physical work and emotional support that the care worker undertakes but also the household chores that the care worker performs. Even though it is against the law, most of the families asked the care worker to do some household chores, such as doing the laundry, mopping the floor, and taking the garbage out; most of the families were fully aware that such requests were illegal. Some informants told me that since their household chores were being performed by the care worker, they were actually benefiting from having their parents living with them. For the adult children, this arrangement seems to be the justification that somehow they still share equal responsibilities.

When the elders live with their married sons, the daughters-in-law still play an important role in caregiving, such as by preparing meals or by taking over the daily carework when the migrant care worker has a day off. Some elders who live with their unmarried sons rely on their care worker to take care of them, even though those elders may have other married sons (and therefore daughters-in-law) available to them. This kind of living arrangement may indicate that the role of daughters-in-law in elder care is not as significant as in the past.

3-2. The Transferred Carework at Home

Once the migrant care worker arrives, she takes over most of the daily care responsibilities. The care worker may take the elder for a walk, make sure that the elder has taken his/her medicine, cook proper meals, assist the elder in taking a bath, change diapers, and sometimes take the elder on trips outside the home, such as to a temple or barbershop. The physical care performed by each care worker varies, depending on the recipient's health condition. The care workers told me that it did not take them much time to take over the duties and learn how to use the medical devices, such as the nasogastric tube.

In fact, care workers not only perform physical work but also provide emotional support for the care recipients, and sometimes even for the family members (Liang, 2010). Mr. Yeah, who is now in his fifties, has an 84-year-old father who has been extremely moody and restless recently. Mr. Yeah said, "Amy [the foreign care worker] knew how to calm my father. She has developed certain tricks. … I think she is better than my mother and me." Mr. Hsieh, who is nearly 50 years of age and whose

father suffered a stroke about 10 years ago, said:

> It was always nerve-wracking every night, because my father wanted to go to bed, but my wife and I wanted him to stay awake until 8 or 9 in the evening. So that he would not wake everybody up in the middle of the night. My father was yelling and kicking. He was always upset. Emma [the care worker] gradually learned how to keep my father awake and she calmed him down. It was a relief for us.

Most of the adult children asked their care worker to stay close to their elder parent all day. All the care worker informants sleep in the same room as the care recipients at night; one of them even sleeps in the same bed as her care recipient. The reason why the adult children hired a migrant care worker is mostly that they cannot stay with their parents 24/7, but they want somebody to be there for their parents around the clock. This is not just to assist the elders in navigating their daily life activities, but also to keep them safe, such as by preventing them from falling accidentally, or to have somebody available to react at once should the elder suddenly need immediate medical care.

Most of the adult sons and daughters-in-law whose elder parents live with them said that even though they did not have to care for their parents directly, they were still responsible for managing the care workers. Some said that they had to train the care worker in caring for the elder and assure that the care worker adhered to their parent's schedule. They said that though the care worker was like a family member, it was still just a job for her. As Mr. Chang said, "One of the merits of living with my mother is that I can make sure my mother is well taken care of. If the care worker did something inappropriate I could correct her immediately. …I have to deal with the care worker's agency, buy the supplies, and schedule her hospital visits."

The use of fictive kinship terms is prevalent (Lan, 2006; Constable, 2007). Most of the adult children of the elders, who are aged 50–60 years, said that they treated the care workers like their own daughters, since the workers are roughly the same age as their children (20–30 years). The choice of kinship terms indicates what Ayalon's research (2009) demonstrated that the employers were using the term to signify that they were not abusive or bad employers. The employers also hoped to encourage their care worker to care for the elder as she would for her own family members, hence assuring a high quality of care. The care workers also called their care recipients "*a-gun*" or "*a-ma*" (meaning grandfather or grandmother in Chinese). Those who have been taking care of the same elder for many years described their relationship as "very genuine." Rachel, who has been taking care of the same elderly lady for seven years said, "*A-ma* treats me like one of her grandchildren. I feel like she's my grandmother in Taiwan. I want to take good care of her."

Despite this analogy with family members, the pressure on care workers is still obvious. They work around the clock and must stay alert all the time. Every care worker interviewed stated that she

has not gotten one good night of sleep ever since she started working for the family, because the elder always needs assistance several times during the night. The elder may have a coughing spell, need to use the toilet, or simply be unable to sleep and want someone's company. Most care workers also complained about back pain, because they have to move their elder in and out of the wheelchair and bathtub.

The analogy with a family member may help the care workers to become more fully incorporated into their host families, but it also makes them more vulnerable to exploitation; employers tend to assume that, if the care worker truly loves the care recipient, she will do anything that the elder needs (Lan, 2006).

3-3. Ways of Performing Family Care

Although hiring foreign workers helps the family with daily care, the children have not relinquished from carework totally. Many of the adult children informants stressed that preparing meals remained an important aspect; they regularly check in on their elderly parents, keeping them company and making sure that everything is alright.

Informants emphasized that in view of their elders' chronic diseases, such as diabetes, family members needed to monitor carefully the elders' diet. Moreover, preparing food is considered a way to show love in the family. *Fan-yong* (奉養), an expression for filial responsibility in Chinese, implies caring for elders' daily lives and providing them with sufficient food, in a respectful way (Ministry of Education, 2007). Many of the informants considered *fan-yong* and filial responsibility to be similar. In short, the cultural context with regard to providing elders with food is more profound than simply making sure the elders have enough to eat. The younger generation is expected to prepare food and drink for their elders with respect and love. Many adult daughters volunteered to teach the care worker to cook Chinese cuisine as a way to show their concern for their elderly parents. In some families, the family members still cook for the elder every day, even after the care worker's arrival.

One elderly man, nearly 90 years of age, who lives with his son and daughter-in-law can barely chew solid food, so he has porridge and a small portion of mashed solid food as his daily diet. His food must be prepared separately from the rest of the family's meals. The daughter-in-law, Mrs. Hsieh, stews the porridge every day and carefully chooses ingredients that the elder man likes, such as fish and special herbs. She still prepares his meals every day despite the presence of a migrant care worker. Mrs. Hsieh said, "I think preparing food for the elder is very important. I don't feel comfortable letting the migrant worker cook for my father-in-law." Even in families where care workers provide the elder's daily meals, the adult children still prepare special dishes for the elders on weekends or special family occasions.

Most of the adult children who do not live with their parents still visit them regularly. Liza Wang, age 87 years and living alone with her care worker in an old house, has two sons and two

daughters. The two sons live on the opposite side of the city and visit her once a week. Her younger daughter, Rebecca Wang, comes to share lunch with Liza five days a week and purchases daily supplies for her and the care worker, even though she is not the employer of the care worker. Rebecca said, "I visit my mother almost every day, because I live nearby. When I visit my mother, I check on things. … For example, I bought her a new pair of shoes yesterday, because the old ones have already worn out." What Rebecca meant by "checking on things" probably includes making sure that the care worker is taking appropriate care of her mother. Rebecca's older brother stated, "I know Rebecca goes home and checks on my mother almost every day. It makes me feel secure. Even though my mother lives alone with the care worker, I won't worry that the care worker treats my mother badly." It is reasonable to assume that when the daughters drop by their elder parent's place, they are also checking on the care worker's performance.

Some other adult children visit their parents regularly to perform specific care duties. Ms. Huang is almost 90 years of age, and her son Peter Chen visits her every weekend. Peter said:

> I take my mother out every weekend. My mom used to go everywhere on her own, but now if I don't come and take her, there's no way that she can leave this neighborhood in her condition. You know how elders keep repeating stories? I used to get very impatient about the repeated stories; I didn't feel like we were having a real conversation. But now I come home and listen to them. I realize that she needs someone to share her old memories.

Like Peter, many of the adult children mentioned that they visited their parents to support them emotionally. These visits could be described as emotional carework. Still, some adult children purposely visit their parents to do physical carework as well, such as massaging an elder parent with Parkinson's disease.

3-4. The Active Daughter and the Unbalanced Dynamics between Siblings

These examples of providing family care to elders show that adult children have not withdrawn from this role responsibility altogether. However, it is female members' duty to tend to these tasks. Whereas my study found that daughters-in-law are less significant in fulfilling a caring role than expected, daughters are still very firm supporters of their elderly parents.

"A married daughter is like splashed water," says an old Chinese proverb, implying that once daughters get married, they are not part of the original family anymore. In my fieldwork, however, I found married daughters playing an important role, especially in those families where the parent lives alone with a care worker. The daughters help integrate the care worker into the family and constantly drop by to check on their parent. In addition, when the care worker has a day off or returns to Indonesia

for a vacation, the daughters often become the primary caregiver for the elderly parent.

Daughters train the care workers. Ms. Li is in her sixties and has one brother; their mother has been diagnosed with Alzheimer's disease for two years. Ms. Li said that during the first weeks after hiring the care worker, she went to her mother's place almost every day to train the new employee. She explained:

> The first couple of weeks were the hardest. I showed her how I do everything, including how to clean the toilet, how to mop the floor, and when to take out the garbage. Besides, I cooked the meals for her and my mother. I taught her how to cook the dishes my mother likes. And, I also taught her how much vegetables and protein my mother needs each day so that she can help to control my mother's diet.

Ms. Li is not the exception. Ms. Wu also asked her sister, who was her father's primary caregiver before they hired the migrant care worker, to show the migrant care worker how to bathe her father and cook Taiwanese cuisine. As already noted, daughters may also visit the elderly parent's to provide care when the hired care worker has a day off. Monica Chen, who is in her fifties, said, "Every other Sunday is the holiday for our care worker. I go to my brother's place before 8 and take care of my mother, like cooking for her, bathing her, that kind of thing. I leave around 8:00 p.m. when the care worker is back home." When the care worker needs a longer vacation, such as to return to Indonesia for several weeks, some families hire a Taiwanese care worker, but some families' adult daughters move in with the elder parent or have the elder parent move in with them temporarily. Ms. Lin, for example, is almost 90 years of age and has no son. When her care worker went back to Indonesia for a month, she took turns living with her adult daughters' families. Similarly, Abigail Chen, Monica's sister, took her mother to her own home when the care worker went back to Indonesia for two weeks. She said:

> I didn't think too much about it. My mother needs her children to care for her, and I was available at that time so I volunteered. I took my mother to my place and she stayed with me for two weeks. I asked my mother to do some exercise, and to sew some buttons. It's not because I need her to do so, but I hoped that asking her to do this kind of thing would slow the deterioration of her cognitive abilities. …This is the kind of stuff that you can hardly ask the care worker to do.

Daughters who take over the caregiving when the care worker is unavailable expect themselves to provide a higher quality of care for their parents. This kind of care arrangement is somewhat unorthodox for a society wherein a patriarchal family structure is embedded. It is typical in families

where the elder's son is separated or widowed or where the elder has no son, since no daughter-in-law is available. But, it is notable that the elder's other married sons do not take over the care responsibilities. The situation that Abigail Chen shared shows that the younger generation may be more open to a different arrangement.

Although adult daughters participate in caring for elderly parents, this does not mean that they share equal power with adult sons when it comes to making medical decisions for the parents. Daughters may train the care worker and may care for their elderly parents, but in my fieldwork experience, sons are still responsible for the elders' medical arrangements and decisions. It is almost always the sons who take the parents to the hospital and to visit doctors specializing in the treatment of chronic diseases. Sons generally acknowledged that they are making most of their parents' medical decisions. As Mr. Huang said, "I guess sons still have more responsibilities in this kind of matter." Mrs. Wu is in her sixties and has two brothers; her mother moved in with her three years ago. She said:

> When it came to major medical decisions, I just called my brothers and asked them to make the decision. When my mother fell on the floor and the ER doctor told us that she needed a joint replacement for her hip. I called my older brother and he decided that we should transfer her to another hospital. It's not as if we couldn't have the surgery in the original hospital, but I didn't want to argue this issue with him.

The fact that most of the elders' medical decisions are made by their sons shows that, even though adult sons and daughters seem to share filial responsibilities, the sons are still expected to take the lead in times of major decisions. The medical decisions are presumed to be very important, because the adult children whom I interviewed believed these decisions would significantly affect their parents' quality of life and even their life expectancy. Daughters' caregiving is more about day-to-day care arrangements.

But, sons do not always have full decision-making power in everything; in some cases, the daughters united together to bargain over care arrangements with their male siblings. Mr. Yeah has been living in his mother and father's house since his father needed intensive care last year. He hired a migrant care worker this year. Mr. Yeah convinced his mother to send her husband to a nursing facility three months ago, because it became very difficult to care for him as his health and mental condition deteriorated. He said that even though his mother and the care worker took turns as caregivers, the father would wake up at 3:00 or 4:00 a.m. and demand his wife's attention all day. Mr. Yeah said that his mother, who is 83 years of age, was exhausted. Thus, Mr. Yeah thought it would be in his father's best interest to move to a facility where he could get professional help and care. But, after residing there for two months, the father returned home. Mr. Yeah said:

> My sisters were very upset that we moved our father to the facility. They kept calling my mother and saying that it was really unfair for my father. They said that it was as if we had abandoned our father, and that it was not filial at all. Finally, my mother gave in and we moved my father back.

In Mr. Yeah's family, his sisters united and convinced their mother to change her mind, and in the end they changed the whole care arrangement for their father. In other families, especially when daughters outnumber sons, it is not uncommon for the sons to feel pressure from their sisters regarding the parents' care arrangements.

4. Conclusion

The people whom I interviewed still referred to all elder care arrangements as part of filial responsibilities. My findings, nevertheless, reveal changes in care arrangements and in the practice of filial piety in Taiwan. The commodification of elder care allows the younger generation to be emancipated from the round-the-clock caregiving. It is also clear that family dynamics change profoundly in the context of hiring a care worker. Households in the Han tradition used to be strictly patriarchal, with authority being passed down from father to son. Now, married daughters are participating in caring for their parents, even though they still do not have equal decision-making power with sons. Daughters normally take on direct care work and sometimes step up as the primary caregiver when the foreign care worker is unavailable. The sons are responsible for the living arrangements and making major medical decisions—in short, those aspects of care that are viewed as important or fundamental. The division of labor between daughters and sons not only differs in power position but also reflects cultural gender norms. The new care arrangement, in which families employ foreign care workers but still play a role in caregiving, clearly demonstrates that the intergenerational relationship is still guided by the logic of filial piety, but that as adult daughters join in caring for elder parents, the connotations of filial responsibilities are no longer limited to the sons.

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Finding "Commensurable" and "Communicable" Meanings in People with Dementia

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1. Introduction

This thesis attempts to pursue and envisage a concrete pathway in the system of a "mutual" recognition (="commensurability") between caregivers and residents (=people with dementia) by examining the group-care practice at Japanese S hospital and nursing home for people with dementia (=S hospital and nursing home) in a broader socio-political context in Japan. The value of the property and the cost of care at S hospital and nursing home are not special. What does make it stand out is, for example, when you enter one of the 'houses' at S hospital and nursing home you sometimes find the smell of coffee hanging in the air. S hospital and nursing home is a space where the 'daily-life sphere' is constructed.

While many sociologists have discussed the relationship between the health care professional and the patient at the point of its one-way asymmetry, some sociologists have tried to recommend alternative medical care or social welfare. The point of departure for this thesis lies in neither the unconditional affirmation of western modernized medical professional knowledge, nor in anti-western modernism, rather it is from a third way. In this thesis I show nothing but my appreciation of S hospital and nursing home's challenging group-care practice in which western modernized medical space and the 'daily-life sphere' are bridged to create a new relationship between caregivers and care-receivers. The fabrication of S hospital and nursing home which aims to perform norms and values in 'daily life' has led caregivers to initiate pattern-making practices to embrace and operate by a particular form of the 'contested sympathetic cognition' for people with dementia. Therefore, the 'daily-life sphere' is the sociological analytical term for projecting the reorganization of medical care and social welfare in western modernized areas and countries.

Although the 'contested sympathetic cognition' at S hospital and nursing home is caregivers' one-way cognition, we can admire the "commensurability" between caregivers and people with dementia. Certainly, what has been done by caregivers towards people with dementia at S hospital and nursing home has been forged by applying the one-way asymmetrical relation that has been revealed in the context of reflection and criticism of medicalization in western modernized areas and countries. However S hospital and nursing home's caregivers have succeeded in new positive relationships with people with dementia. In the past people with dementia have been considered to be incommensurable in a one-way relation with their caregivers. At times, they have been segregated, treated medically badly and deserted. On the other hand, people with dementia at S hospital and nursing home are expected to be "commensurable." This is in stark contrast to the way people with

dementia used to be treated. 'Daily life' fabrication and pattern-making practices in S hospital and nursing home provide the "commensurability" between caregivers and people with dementia to caregivers. Its seismic impact on caring can be upheld by the caregiver's individual construction of the "commensurability" between caregivers and people with dementia in the 'daily life sphere.'

2. Cognitive Structural Analysis of Group-Care Practice

2-1. The 'Medical Cognition' of Dementia and Anti Medical Care Practice

The primary factor that has forced people with dementia to be secluded, to be poorly cared for medically or to be abandoned is western modernized medical professional knowledge. People with dementia have been imposed with isolated, medically ill treated or neglected lives because of the diagnostic accounts of their brain atrophy or porencephalia. When we call this type of cognition 'medical cognition,' the strongly influential 'medical cognition' has worked in western modernized areas and countries to make the motion of separation and restraint for people with dementia valuable. Due to the medical technical development of brain visualization in the 1980s, the 'medical cognition' was reinforced and the utterances and actions of people with dementia were deemed problematic. Under the 'medical cognition,' demented symptoms seem to be unchangeable and people with dementia are absolute patients. The 'medical cognition' has been endorsed within medicalization in western modernized areas and countries.

However, since the 1990s it has been recognized that demented symptoms can change in accordance with their situational surroundings and relations with carer(s). This has attracted attention in western modernized areas and countries. In some cases demented symptoms have died down without medicine. When we call the cognition of people who are attracted by the notion that demented symptoms can be changed in accordance with their situational surroundings and relations with carer(s) the 'linkage cognition,' within the 'linkage cognition' people with dementia are not always patients.

While it is true that the 'medical cognition' and the 'linkage cognition' have been argued as having an opposing relationship (Iguchi 2007), these two cognitions are not always opposite in care-practice. Carers who are eager to promote the social aspects of people with dementia tend to complain about medical thinking and its ill treatments. Cruel medical treatments like giving too much medicine and the use of physical restraint on people with dementia are strong incentives to improve caring. However, carers who complain about medical thinking and its care treatments, in fact complementally execute the 'medical cognition' and the 'linkage cognition' in practice.

2-2. Two Complementary Cognitions about People with Dementia

The 'medical cognition' and the 'linkage cognition' have a complementary connection in care practice. Iguchi Takashi has reflected on this (2005; 2007). Iguchi mentions that the 'medical

cognition' is one of the notional options to understand dementia or the meaning of people with dementia's utterances and actions. Iguchi explains both the 'medical cognition' and the 'linkage cognition' are among the variations of the 'linkage cognition' and are placed at opposite poles (2007). According to Iguchi the 'medical cognition' is sometimes helpful for a family caregiver to exempt oneself from considering what people with dementia do and say (2005; 2007). For example, family carers that are willing to accept family with dementia can tentatively think dementia causes their family to make strange utterances and actions. As long as a family caregiver has the will to accept what family with dementia do and say, the 'medical cognition' works to purse the one-way recognition of people with dementia without asking validity of interpretation about the meaning of people with dementia's utterances and actions.

2-3. The Formation of S Hospital and Nursing Home's Group-Care Practice

Basically S hospital and nursing home supports the 'linkage cognition,' but the 'linkage cognition' is modified in a complicated manner. Once the 'linkage cognition' is chosen in group-care practice, caregivers consequently give up the 'medical cognition' and the complementary relationship between the 'medical cognition' and the 'linkage cognition' seems to end. Iguchi obtained his analytical notion from caring as family business. To make the latent relationship between the 'medical cognition' and the 'linkage cognition' in group-care practice visible, I propose a new cognitive concept that is equivalent to the 'medical cognition,' and secondary to the 'linkage cognition.' To refine the new cognitive concept I use what Kisuyo Kasuga said in her study about group-care practice, as follows (2003): "Emotionally controlled labor seeks to feel sympathy with, accept and realize what people with dementia want." The notion that caring is an emotional work of labor is key to the discussion that tries to enhance the societal and economical position of care-giving labor. The institutionalization of medical care or social welfare for people with dementia carries on patient-centered caring that the 'linkage cognition' comes from. Kasuga picked up the practical training of a Japanese nursing home based on the 'linkage cognition' and disputed that excess emotional control and mental burdens impose on care workers. Kasuga continued to say that to show complete receptivity is to discern exactly what people with dementia want. However, in Kasuga's study, while showing sympathy is the same as giving receptivity, it remains unknown how we are to discover the exact wishes of people with dementia. Fundamentally, in general, understanding is not always the tool for receptivity and receptivity can be without understanding.

The relationship between caregivers and care-receivers bears the character of reciprocity. Reciprocity is not fair trade. Because there happens to be pride-betting trade between caregivers and care-receivers, relationships in caring are always unfair (Goto 2005). Caregivers look down on care-receivers and look up to care-receivers. Care-receivers look down on caregivers and look up to care-receivers. It is not fixed but changeable. It is often the case that the more the care-receiver needs

the more the caregiver is moved in their mind.

To provide their fullest receptivity to people with dementia, S hospital and nursing home's caregivers, including nurses and doctors, artificially create the 'contested sympathetic cognition.' In order to achieve the "commensurability" between caregivers and care-receivers, S hospital and nursing home's caregivers treat the people with dementia as 'daily-life-conductors.' In the 'contested sympathetic cognition,' caregivers do not need to communicate with people with dementia as they do with the 'medical cognition.' On the contrary, despite their one-way approach caregivers at S hospital and nursing home can partially understand the meaning of people with dementia's utterances and actions under the 'contested sympathetic cognition.' Though the 'receptive cognition' cannot lead S hospital and nursing home's caregivers to understand the meaning of people with dementia's utterances and actions like the 'medical cognition,' it can prompt caregivers to display complete acceptance of people with dementia.

Formation of Cognitive Arrangement in Group-Care Practice and the Relations with its Prototype

The 'Linkage Cognition'	
Understanding：○ Acceptance：○ Communication=Com：○	
The 'Contested Sympathetic Cognition'	The 'Receptive Cognition' (=The 'Medical Cognition')
Understanding：○ Acceptance：○ Com：×	Understanding：× Acceptance：○ Com：×

(○： Positive ×： Negative)

Note: One-way approaches from caregivers are included within communication.

Thanks to the complementary relationship between the 'contested sympathetic cognition' and the 'receptive cognition' S hospital and nursing home's caregivers accomplish the "commensurability" between caregivers and people with dementia. This "commensurability" brings about better 'linkage cognition' among S hospital and nursing home's caregivers' minds.

I exemplify the detailed pathway to the "commensurability" between caregivers and people with dementia at S hospital and nursing home showing the data I have collected from December of 2007 to March of 2008. At the very beginning of my research, I was just a guest. After people with dementia identified me as a caregiver I intended to display myself as a caregiver. There were several chances for me to help people with dementia, for example, changing underwear, taking them to the bathroom, and spending the nights with them. Staff and caregivers at S hospital and nursing home were very helpful, and I was able to do vast research with their cooperation.

3. Construction of the 'Daily-Life Sphere' at S Hospital and Nursing Home

3-1. The Formation of S Hospital and Nursing Home's Group-Care Practice

In general, all the strange actions (="problematic actions") can be understood if presumable situation and context are able to be applied. At S hospital and nursing home, the patterned situation and context which are organized by 'daily-life conductor' stereotypes enables caregivers to easily distinguish strange actions of people with dementia from "ordinary" actions, and to react spontaneously. 'Daily-life conductor' stereotypes make "healthy" and "usual" people the regulations and values present at S hospital and nursing home. The 'daily-life sphere' is strongly influenced by present Japanese "common sense." Without events like group-exercises or group-activities, caregivers at S hospital and nursing home succeed in keeping and raising the stability of patterned situation and context.

Patterned situation and context are the resources of contested sympathetic cognition at S hospital and nursing home. Of course, caregivers at S hospital and nursing home do not realize that they are handling and reacting smoothly to the strange actions of people with dementia. It is not their intention but the result of group practice. Then, I explain how to construct 'daily-life' patterned situation and context from what caregivers at S hospital and nursing home allude to as their unique way of care; appointing small units, hearing care-receivers' life histories, and reproducing the old days.

3-2. Appointing Small Units as 'Daily-Life Sphere'

First of all, in regards to appointing small units, S hospital and nursing home consists of individual 'houses.' This type of care is called unit care in the field of social welfare. Unit care at S hospital and nursing home is sophisticated. Each 'house' has its own name and some 'houses' have mailboxes near the entrance. Each 'house' has its own family budget. At least once a day care-receivers arrange their meals and dishes together with caregivers in the kitchen. Care-receivers do not take any medicine for dementia. Due to bad conditions, most care-receivers have rejected other hospitals or nursing homes. Care-receivers are able to take part in domestic duties whenever they would like to.

Of notable difference here is that caregivers at S hospital and nursing home divide visibly and invisibly its space into several sections to conform to Japanese spatial partiality between public areas and private areas. Caregivers are acutely aware of being sensitive to this. In living and dining areas, caregivers are prohibited from managing dirty things like nappies because these are public areas. When a care-receiver appears in a public area wearing pajamas, caregivers ask the care-receiver to move to a private area to change their clothes.

Caregivers at S hospital and nursing home create a 'sphere of daily life' where present Japanese "common sense" prevails. At first glance, the norms and values of S hospital and nursing home's 'daily-life sphere' express that of "healthy" "ordinary" Japanese people as opposed to that of person-centered care. When a care-receiver rejects being shaved or manicured caregivers proceed with it. Caregivers rewash the dishes and chopsticks after care-receivers have finished washing them.

Consequently, seemingly caregiver-centered care is harmonized with person-centered care. The ‘daily-life sphere’ works to hide medical and institutional situation and context. In the ‘daily-life sphere,’ hygienic norms and values are embedded within the ‘daily-life’ customs. Caregivers believe that the ‘daily-life’ customs are indispensable to maintaining care-receivers’ safety and wellbeing. In the precedent cases, caregivers judged shaving or manicuring as important to care-receivers’ safety, and the dishes and chopsticks touched by unclean care-receivers’ hands as harmful to care-receivers’ health. Even if a quarrel or a tiny brawl occurs between care-receivers, malleable quality of the ‘daily-life sphere’ would be applied. So long as the ‘daily-life sphere’ is the place where people live together, some quarrels or tiny brawls may happen among residents who have different domestic and cultural backgrounds.

Whereas the ‘daily-life sphere’ is the base of the “commensurability” between caregivers and care-receivers at S hospital and nursing home, to improve the one-way ‘contested sympathetic cognition’ into “mutual” communication process it needs the complementary relationship between the ‘receptive cognition’ and the ‘contested sympathetic cognition.’ So far as the caregivers’ ‘contested sympathetic cognition’ solely requires stereotypical acceptance towards care-receivers nothing like “mutual” communication has happened between caregivers and care-receivers.

3-3. Hearing Care-Receivers’ Life Histories and Reproducing the Old Days

In order to attain “mutual” communication, caregivers at S hospital and nursing home listen to care-receivers’ life histories and help them reproduce the old days. Listening to care-receivers’ life histories is one of the original psychological therapies known as recollection therapy in the field of social welfare. According to this theory, elderly people are able to positively affirm their lives by sharing their life history. At S hospital and nursing home, caregivers utilize this theory to understand people with dementia as well. Caregivers at S hospital and nursing home trust the notion that people with dementia contain “previous” well-embodied memories. As to the peculiar behavior of a care-receiver collecting pieces of waste paper and rubbish, caregivers at S hospital and nursing home were able to explain that this was because Japanese society was very poor when the “elderly people” were young. When a crippled elderly lady stood to stretch her spine in an unusual form caregivers thought this was from wearing a ‘kimono’ (Japanese traditional wear).

Reproducing the old days crystallizes the process of understanding people with dementia. On the one hand, caregivers put the private belongings that care-receivers used before entering S hospital and nursing home around each private area or public area, for example their own favorite dressing table, family Buddhist altars, rice bowls, chopsticks and shampoos. On the other hand, caregivers put the goods that “elderly people” used in their teens or twenties around public areas. You can find a ‘kuro-denwa’ (vintage Japanese black home telephone), the picture of Emperor and Empress Showa and a wall clock. Vintage chests of drawers were presented from the neighbors. In some houses

everybody could enjoy being seated on ‘engawa’ (veranda equipped along Japanese wooden houses) and ‘kotatsu’ (Japanese heater tables) on ‘tatami’ (straw mats).

Reproducing the old days powerfully empowers caregivers when two contradictory situations or contexts exist within the same care-receiver. For example, one moment O-san was crying out looking for her late husband claiming that he was missing, and the next moment she was whispering that she knew her husband had already passed away. To help with their interpretation about care-receivers’ intention and will, caregivers grow to understand by way of stereotypes like “elderly people,” “their younger age,” “males and females,” “Japanese” and “patients.” In O-san’s case, even the caregiver who was terribly confused about O-san’s condition at the beginning withdrew their conclusion that the best thing they could do for O-san was to communicate and keep in touch with O-san until she was familiar with her state of confusion. The reason why the caregiver had this change in conclusion was that three months later the caregiver heard other caregivers share that the demented symptom of O-san was witnessed just after O-san had lost her best partner. Referring to “females” and “elderly people” caregivers gave the valid interpretation that O-san tried to domesticate her “reality” by coming and going between past and present. The matter was not whether it was real or not, the matter was that caregivers can trust the possibility that there might be different accustoms and ways from days gone past that they can apply to the situation and context at S hospital and nursing home.

At S hospital and nursing home caregivers estimate that “previous” embedded memories of “elderly people” complete their “golden days.” When the elderly person is female, caregivers presume her “previous” embedded memory is her “sweet sixteen.” When the elderly person is male, caregivers suppose his “previous” embedded memory is “in the prime of life.” Theoretically nobody knows the exact age of “previous” embedded memories of “elderly people.” The reason why caregivers think this notion is trustworthy is that people who embrace any feeling of being lost or confused wish to maintain their pride. This argument comes from recollection therapy in the field of social welfare. To conclude, the findings from hearing care-receivers’ life histories are connected with medical stereotypical cognition for people with dementia.

3-4. Sharing Patterned Situation and Context among Caregivers

The effect on caregivers from hearing life histories gives both reference for the meaning behind peculiar remarks and behaviors of people with dementia, and reference for suitable manners for reinforcing the caregivers’ observations. As I already mentioned, caregivers’ first priority is the daily health and safety of care-receivers’ lives. Caregivers at S hospital and nursing home earnestly watch care-receivers’ (bodily) trifle differences to catch anything wrong with care-receivers’ (body). In other words, caregivers at S hospital and nursing home are watchful to distinguish anything unusual about care-receivers’ from their average patterned (bodily) condition.

This daily standardization does not contradict observational sight within caregivers' practice for hearing care-receivers' life histories within the 'daily-life sphere.' However these double observational frameworks allow the training and discipline to understand the intention and will of care-receivers, hidden just behind their utterances and behaviors. The caregivers' findings about care-receivers' lives are not unique due to group-care practice. Caregivers at S hospital and nursing home observe what care-receivers do and say in a watchful manner, and share their findings. They exchange information gathered while they chat while dining, cooking, cleaning and washing, and as they collect daily schedules, medical and physical records.

Therefore, caregivers at S hospital and nursing home desire to modify care-receivers' deviant character mobilizing standardized patterned 'daily-life' situation and context. With ease, they pick up care-receivers' deviant utterances and behaviors that are the reverse of the 'daily-life sphere' where "healthy" and "usual" people's regulations and values prevail. They are inclined to make excuses that people with dementia are keen to be proper, because 'the greatest common devisor' between caregivers and care-receivers is being the 'daily conductor' at S hospital and nursing home. This is the function of the 'contested sympathetic cognition.' When a male elderly person spoiled his pants, caregivers argued that the size of his underwear was wrong. The caregivers' interpretation was as follows. Because the male elderly person was upset about spoiling his pants, it made the situation and context worse. Caregivers are accustomed to responding as they would do with an "ordinary" Japanese person. Because of the function of the 'daily conductor,' it is not the care-receivers' pride but the caregivers' pride which is at stake. The male elderly person and caregivers were accomplices as the executors and observers of present Japanese "normal" regulations and values.

4. Caregivers' Reflection on Communicating with People with Dementia

The minimum condition of "mutual" communication between caregivers and care-receivers is that there must be the process for caregivers to observe care-receivers reacting with the awareness of caregivers' intention and will. Within the situation and context of S hospital and nursing home, the primary caregivers' intention and will determines artificially manufacturing the 'daily-life sphere' for care-receivers. Caregivers at S hospital and nursing home report that care-receivers react to caregivers' intention and will by talking about the artificiality of their care practice itself. This situation and context is the beginning of communication between caregivers and care-receivers.

The following two points sum up the artificiality of S hospital and nursing home's caring. The first point is the patterned situation and context of the 'daily-life sphere' where stereotypical average "healthy" and "ordinary" peoples' regulations and values function. The second point is the caregivers' one-way acceptance of people with dementia where the 'contested sympathetic cognition' and the 'receptive cognition' are well engaged to guarantee 'the greatest common devisor' between caregivers and care-receivers. In relation to the second point, caregivers identify the 'medical

cognition' that caregivers might abolish. The more deeply they reflect on how their 'contested sympathetic cognition' as well as their 'receptive cognition' are fundamentally nearly the same character as the 'medical cognition,' the more fiercely they grasp the "commensurability" between themselves and people with dementia.

A young caregiver at S hospital and nursing home reflected on her experience as follows. "I was scared of being engaged by N-san. When N-san talked to me, I greeted her and ran to G-san's room. Because I was so terribly sorry I couldn't concentrate on G-san, and just nodded and responded to G-san's friendly conversation saying 'Yes, yes, yes.' G-san said to me 'You just repeated "Yes, yes, yes."' As I felt sorry for G-san, G-san kindly said 'Being strained must be tiring, is it?' Tears fell from my eyes. Her words remain etched in my mind. I thought this is the experience of being healed by 'elderly people.'" In the above example, the relationship between caregivers and care-receivers is reversed. When a caregiver is conscious of this reversed relationship they become aware that the notion of "commensurability" between caregivers and care-receivers can truly exist. However, it is rare for caregivers to be able to admit their faults that preclude the notion to see people with dementia as a communication partner. This is when caregivers are able to internalize the "commensurability" between themselves and people with dementia.

5. Conclusion

This thesis precisely depicts the system of 'daily-life sphere' that realizes a "mutual" recognition between caregivers and care-receivers within a medical and welfare institution from the point of caregivers' structural cognitive arrangement. The 'daily-life sphere' at S hospital and nursing home completes not the asymmetric relations between patients and medical health care professionals but the "commensurable" and "communicable" relations between caregivers and care-receivers.

The analytical framework from caregivers' structural cognitive arrangement is completely different from that of the channel of communication between caregivers and care-receivers focusing on caregivers' and care-receivers' individual ability, mental condition and its relations. Nowadays the analytical framework for the channel of communication between caregivers and care-receivers is dominant in both academic studies on dementia or people with dementia and the institutionalization of medical care or social welfare.

In addition to this, while we cannot avoid pride-betting trade from caring, caring depends on carers' emotional sympathetic abilities. S hospital and nursing home's group-care practice does not necessarily entail this type of emotional sympathetic abilities on carers. S hospital and nursing home's group-care practice and the analytical framework from caregivers' structural cognitive arrangement would be suggestive of open caring to everybody.

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Note