The 6th Next-Generation Global Workshop

"Revisiting the Intimate and Public Spheres and the East-West Encounter" Postceedings

Inamori Center Bldg., Kyoto University -January 11 - 12

KUASU
KYOTO UNIVERSITY ASIAN STUDIES UNIT
京都大学アジア研究教育ユニット

PROGRAM

The 6th Next-Generation Global Workshop
Revisiting the Intimate and Public Spheres and the East-West Encounter

at Inamori Center Bldg., Kyoto University, Japan

DAY 1: January 11 (Sat), 2014

9:00 - 9:30	Registration
9:30 - 9:50	Opening Remarks: Prof. OCHIAI Emiko (KUASU Director, Kyoto University) Prof. AKAMATSU Akihiko (Exective Vice-President, Kyoto University)

Room: I	Session 1: Family
	Chair: SHIRASAKI Mamoru (Kyoto University)
9:50 - 10:20	TRAN Giang Linh (Institute for Social Development Studies) Why Are Sons Preferred in Viet Nam?: Cultural Ideologies, Socio-economic arrangements and Normative Pressures
10:20 - 10:50	SPECKER SULLIVAN Laura (Kyoto University, University of Hawaii) Comparative Foundations of Informed Consent in the United States and Japan
10:50 - 11:20	TURUNEN Jani (Stockholm University) Living in Two Homes: Shared Physical Custody of Children after Parental Union Disruption
11:20 - 12:00	Comments and Discussions Commentator: Prof. Michiyo YONENO-REYES
12:00 - 13:20	**Lunch Break** **(Meeting of Japanese Studies Scholars @ Room II)**
	Session 2: Community
	Chair: INUI Junko (Kyoto University)
13:20 - 13:50	KHAREL Sambriddhi (Nepa School of Social Sciences and Humanities) The Impact of Modernization on Dalit identities and Occupations among Three Dalit Communities in Kathmandu, Nepal
13:50 - 14:20	Aboobacker RAMEEZ (National University of Singapore) The integration of minority Malay immigrants into the core communities in Sri Lanka
14:20 - 14:50	ZHU Ruolei (National University of Singapore) Exclusion of the Forest-Dependent Poor: A Cross-Case Study on Forestry Communities in China
14:50 - 15:30	Comments and Discussions Commentator: Prof. ZHOU Weihong
15:30 - 15:45	**Break**
	Session 3: Gender and Sexuality
	Chair: IRIE Keiko (Kyoto University)
15:45 - 16:15	HO Diane Szu-Ying (National Taiwan University) Revisiting Gendered Division of Household Labor: Effects of Co-residence with Parents on Housework
16:15 - 16:45	BETA Annisa Ridzkynoor (National University of Singapore) How do Muslim women speak?: Hijaber Community and Visual Representations
16:45 - 17:15	HAMILTON Robert (Seoul National University) Reflexive Cosmopolitanism and Sexual Identity—A Study of Queer Identity & Sexuality in South Korea via Male Bisexuality
17:15 - 17:55	Comments and Discussions Commentator: Prof. Roland PFEFFERKORN
18:45-20:45	Welcome dinner ceremony

Room: II	Session 4: Welfare and Redistribution
	Chair: INOMATA Yusuke (Kyoto University)
9:50 - 10:20	FUKUDA Jun (Kyoto University) Does the Transition from a Defined Benefit Plan to a Defined Contribution Plan Decrease Employee Numbers?
10:20 - 10:50	SHEN Ke (Fudan University) China's Age of Abundance: When Will it Run Out?
10:50 - 11:20	XU Yao (Kyoto University) Social Assistance in Urban China: From Dual-structure to Integration
11:20 - 12:00	Comments and Discussions Commentator: Prof. Jen-Der LUE
12:00 - 13:20	**Lunch Break** **(Meeting of Japanese Studies Scholars @ Room II)**
	Session 5: Designing Modernity
	Chair: FUKUDA Jun (Kyoto University)
13:20 - 13:50	Marco ZAPPA (Ca' Foscari Univ of Venice) Development as a *brand*: Japanese ODA to Asia and the Case of Vietnam in a Histric Perspective
13:50 - 14:20	WANG Tianhe (Kyoto University) The Environmental Taxation in China: Theory and Practice—The Debate over the Land Use Tax from Environmental View
14:20 - 14:50	YAMASHITA Tsuguta (Kyoto University) Alienation from Architecture?: A sociological investigation on the modernisation of architecture
14:50 - 15:30	Comments and Discussions: Commentator: Prof. Pekka KORHONEN and Prof. HOU Yangfang
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	Session 6: Literature and Culture
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9:30 - 10:00	CHEN Ying-Fang (National Chung Cheng Univ/Univ of Southampto), Chung-Yang YEH (University of Southampton) The Political Economy of Female Employment in Taiwan: The Employer' Perspective
10:00 - 10:30	Chin-Siang ANG (Univ Putra Malaysia) The Transformation of the Private Sphere
10:30 - 11:00	TANGCHITNUSORN Kanokwan (Chulalongkorn University) International Retirement Migration of Retirees from Developed Countries: Decision-Making Process and Impacts on Destinations
11:00 - 11:30	MORITA Makiko (Aalborg University) Understanding Care Giving and Care Taking Experiences throughout the Life Course —Focusing on Older Couples in Denmark
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12:10 - 12:30	**Address from Prof. KOYAMA Shizuko @ Room I**
12:30 - 12:45	**Group Photo @ Room I**
12:45 - 13:45	**Lunch Break**
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13:45 - 14:15	GROVER Shalini (University of Delhi) Post Colonial Labour Relations with Western Expatriates:Domestic Workers as Ayahs, Maids, and Nannies in India's Globalizing Economy
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14:45 - 15:15	SUTINYAMANEE Vasavat (Chulalongkorn University) Factor determining Migration among Hill tribe People in Northern Thailand
15:15 –15:45	ODASSO Laura (University of Strasbourg) Intermarriages: love and law in European countries
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10:00 - 10:30	CUBELIC Simon (Heidelberg University) Between Hegemony and Dialogue: The Formation of Legal Knowledge in Early Colonial Bengal
10:30 - 11:00	LIN Wan-Ping (National Taiwan University) Becoming West: the Discursive Practices in the Making of Chinese School in International Relations Theory
11:00 - 11:30	TEO Lee Ken (Natuional University of Singapore) Universal Ideal and Justice in the Social Philosophy of Syed Hussein Alatas
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12:45 - 13:45	**Lunch Break**
	Session 10: Philosophy
	Chair: NAKAJIMA Mitsuhiro (Kyoto University)
13:45 - 14:15	Filippo CASATI (University of St Andrews) , FUJIKAWA Naoya (Kyoto University) Heidegger's Nothingness and Nishida's Absolute Nothingness
14:15 - 14:45	IIZUKA Hajime (Kyoto University) K. C. Bhattacharyya's Subject as Knowable without Thinking
14:45 - 15:15	HAYASHI Itsuki (University of Hawaii at Manoa) Buddhist Emergentism: Conventional Reality in Vasubandhu and Dharmakīrti
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SESSION 1 :

Family

Why are sons preferred in Viet Nam?: Cultural ideologies, socio-economic arrangements and normative pressures

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Abstract

The sex ratio at birth (SRB) reflects the number of male birth to 100 female births. The rise in SRB in Viet Nam has occurred later than other countries within the region, but has accelerated quickly only for a short period. While in 2000 the SRB was still at normal levels and was estimated to be 106.2 male births per 100 female births, according to the 2009 Census, it had increased to 110.6. Research has shown that a tradition of son preference, among a variety of other factors, plays an important role in this SRB imbalance in Viet Nam.

This paper aims to explore what are the key factors associated with strong son preference in Viet Nam. This paper bases on a qualitative research conducted in 2010 in four provinces/cities of Viet Nam which all have an elevated SRB and represent four different regions of Viet Nam, namely Ha Noi, Hung Yen (the Red River Delta), Quang Ngai (in the Central), and Can Tho (Mekong River Delta). In-depth interviews were conducted with a total of 123 parents and grandparents whose last child/grandchild was born between 2006 and 2009, half of them are sonless.

The research findings have shown that the forces that compel people in Viet Nam to prefer sons to daughters are complex: at issue are *cultural ideologies* – particularly the idea that family lines are continued through males only and that ancestor worship should be practiced by men if possible; *socio-economic arrangements* – particularly patrilocal residence patterns in which the elderly couples live together with their son, and the ensuring inheritance patterns in which sons inherit the largest share of parents' assets; and powerful *normative pressures* which push people, especially women, to strive for sons in order to gain acceptance and recognition in families and communities.

Key words: *son preference, sex ratio at birth, Viet Nam*

1. Introduction

The sex ratio at birth (SRB) reflects the number of male birth to 100 female births. The rise in SRB in Viet Nam has occurred later than other countries within the region, but has accelerated quickly only for a short period of time (UNFPA, 2009, 2010). While in 2000 the SRB was still at normal levels and was estimated to be 106.2 male births per 100 female births, according to the 2009 Census, it had increased to 110.6. In some provinces, the SRB was even close to 128 (GSO, 2011; UNFPA, 2010). Research has shown that a tradition of son preference, among a variety of other factors, plays an important role in this SRB imbalance in Viet Nam (Danièle et al., 2002; Guilimoto, 2012; UNFPA, 2010).

As the experiences of other countries with high SRB such as China, India and South Korea, the SRB imbalance, particularly the deficit of women, would lead to many severe social consequences, including increased pressures for women to marry at younger age, a rising demand for sex work, an increasing number of human trafficking and rape victims, as well as marriage squeeze for men. Obviously, girls and women have to suffer more from this imbalance.

This paper adresses the very important question "Why are sons preferred in Viet Nam?", in other words, what are the key factors associated with strong son preference in Viet Nam.

2. The study

This paper bases on a qualitative research conducted in 2010 in four provinces/cities of Viet Nam which all have an elevated SRB and represent four different regions of Viet Nam, namely Ha Noi, Hung Yen (the Red River Delta), Quang Ngai (in the Central), and Can Tho (Mekong River Delta). In-depth interviews were conducted with a total of 123 parents and grandparents whose last child/grandchild was born between 2006 and 2009, half of them are sonless.

Prior to fieldwork, detailed question guides for individual interviews were developed. Before the fieldwork, the team of six interviewers was trained over two days on research objectives, methodology and research tools. On average, each interview lasted 1 hour and 20 minutes. All the interviews were recorded and then transcribed. The data were analyzed using NVIVO – a software program for qualitative data analysis.

3. Key findings

Why do sons tend to be preferred to daughters in Viet Nam? To answer this question, the following presentation of results is divided into three sections; the first focusing on cultural, the second on socio-economic, and the third on normative factors. In everyday lives, these three sets of issues are closely intertwined, yet for analytical purposes they are treated separately in this paper.

3-1. Son preference: Cultural aspects

In countries around the world, ideas and practices of kinship form the core of cultural life, yet different societies have widely different ways of organizing kinship. Anthropologists distinguish between patrilineal (*phụ hệ*), matrilineal (*mẫu hệ*) and bilineal (*lưỡng hệ*) kinship systems. In patrilineal systems, descent is reckoned through males: the patriline is a line of descent from a male ancestor to a descendant (either male or female) which is continued only through sons. In a patrilineal descent system, people consider themselves as belonging to their father's patriline and inheritance usually follows the male line. In a matrilineal system, descent is reckoned through mothers and in a bilineal system through both mothers and fathers. In Viet Nam, numerous different kinship systems exist: among some ethnic minorities, such as the Ede and the Cham, kinship is defined as matrilineal. Among the ethnic majority Kinh who comprise 86 percent of Viet Nam's population, kinship is commonly described as patrilineal and patrilocal, yet with some bilateral traits (Hy Van Luong, 1989; Pham Van Bich, 1999). The next section discusses the importance of sons as described by research participants, placing these attitudes in the context of kinship practices and ideals.

3-2. Continuing the family line

When asked what they found was the single most important reason for the desire for a son, most interviewees – regardless of their occupation, education, lineage, geographic area, and socio-political status – pointed to the need to carry on the family line (*nối dõi tông đường)*. Only sons, people claimed, can carry on their father's name and continue the lineage (*dòng họ*). The idea that only males can continue the family line was found in all research sites, yet it seemed to be expressed with particular fervor by people in Hung Yen and with less force in Can Tho. A 33-year old Hung Yen man, for instance, said, 'The most basic thing that a son can do is to reproduce humans in order to carry on the family line (*dòng tộc*) so that it is maintained forever. This is most crucial.' A 36-year old man from Quang Ngai expressed the same idea, saying, 'The purpose of having a son is to maintain the continuity of a family line. People want their sons to carry on the family name and maintain the family line (*nòi giống*). Having no son means that you lose your roots (*mất gốc*).'

The Vietnamese terms for 'family line' (*dòng giống, nòi giống*) in themselves point to the primacy of males in this kinship model; '*giống*' can be translated as 'seed' or 'stock'. It is through the male 'seed' that the line is continued from ancestors to future descendants; a son therefore ties the individual to those who went before and to those who will come, placing each person within a larger community of people. To be a 'filial' son to his parents, interviewees said, a man must have a son who will carry on his father's line and name. Some son-less men in the study described feeling guilty towards their parents and ancestors for not producing the heir who would continue their lineage. Not having a son, they said, made it impossible for them to live up to their responsibility towards their

parents. A 28-year old man from Hung Yen, for instance, explained his wish to have a son in these words, 'I want to have a son to satisfy my parents' son preference. My parents really want to have a grandson and as a son, of course I have to try my best to produce a son to please them.'

Some of the elderly people interviewed explained that in traditional Vietnamese culture, the lack of a son to continue the family line was interpreted in terms of karmic misfortune: if a family was blessed with many sons, this would be taken as an indication of its high moral virtue (*phúc đức*), whereas a lack of sons was interpreted as a sign that the family had misbehaved morally and was being punished by higher powers. Today, such ideas still exist, they said, and this tends to aggravate the pain of not having a son.

Due to his importance for the continuation of the family line, some interviewees asserted that even a 'bad' son is still more valuable than a daughter. A 38-year old woman from Hung Yen, for instance, said: 'No matter how bad he is, a son is still a son. If he ruins his family or even beats or kills his parents, he is still a son. In such cases, having a son is still better than having a daughter.'

3-2-1. Ancestor worship

Because sons continue the family line, they also carry responsibility for the family altar *(bàn thờ tổ tiên)* where ancestors are worshipped. In most Kinh households, this altar is placed at the heart of the home. Decorated with photographs or drawings of deceased family elders, it is the site where incense is burnt, where offerings of fruit and flowers are presented to ancestors, where the respect, love, care and gratitude of living family members for their deceased parents and grandparents are expressed. In most cases, respondents said, the ancestors that are commemorated and addressed at this altar are those of the husband in the house, while the wife's ancestors are commemorated by her brother at the altar of his 'family line.' If there is more than one son in a family, it is the eldest son who bears the primary responsibility for his parents' souls after their death, and for the souls of his father's parents and grandparents. Such care is vitally important: without it, the souls of the deceased will lead a miserable and hungry life in 'the other world.'

With responsibility for ancestor worship comes also the responsibility for ancestral graves *(phần mộ tổ tiên).* One research participant, a 32-year old man from Quang Ngai, was the only son in his family. During the wars, his family lost many men, and he and his father are now the last living males in the entire lineage. For decades, it has been his father's responsibility to tend to more than seventy lineage graves, burning incense on anniversary days and on other special occasions. His father constantly reminds him that it is his obligation to care for the ancestral graves in the future – and to produce a son who can take over this task after him. This interviewee now has two daughters and still hopes to have a son who can fulfill his father's expectations, taking care of ancestor worship and family graves.

3-3. Son preference: Socio-economic aspects

In anthropological terms, 'patrilocal' (*ở nhà chồng*) refers to a kinship system in which a married couple resides with the husband's family, while in a 'matrilocal' (*ở nhà vợ*) kinship system the couple resides with the family of the wife. Majority of Vietnamese people reside patrilocally. Upon marriage, in other words, a woman is expected to live with her husband's family, while it is relatively unusual that a husband lives with his wife's family. Such patterns of residence, research participants suggested, play an important role when people in Viet Nam desire sons: because residence is patrilocal, most parents expect that when they get old and dependent on others for support and survival, it is primarily their son and daughter-in-law who will care for them.

3-3-1. Old-age support: social protection offered by sons and daughters

In Viet Nam, according to the 2008 VLSS, nearly 70% elderly persons (aged 60 and over) co-reside with their adult children (UNFPA, 2011). It is most common for elderly people to live with a son: the percentage of elderly living with a son is about 50% higher than the percentage living with a daughter (Barbieri, 2009). In the present study, informants across all research sites emphasized that sons are vitally important for parents as providers of old-age support. In a society where elderly people's subsistence depends mainly on the family, many interviewees expected to be able to 'lean on' their children in their old age. As a Vietnamese saying goes: 'a child relies on his father, an old man relies on his children' (*trẻ cậy cha, già cậy con*). Without a son, therefore, parents' prospects for their old age can be highly precarious, and particularly so if they are among the poorest members of the population.

The responsibilities of sons and daughters-in-law lie not only in economic support for their parents when they cannot work anymore, but also in care giving and covering of health care costs when parents are old and ill. Because daughters will move to their husband's household after marriage, interviewees said, they are 'other people's children' or 'ducks' that are destined to fly away from their parents. Therefore, having daughters means having no caregiver for the parents when they get old.' A 33-year old father of two daughters from Can Tho, for instance, said, 'Families that have only daughters cannot lean on them in old age. Daughters can only care for parents' diet, but sons can take care of everything.'

But if sons are so important for old age security, what then happens if a couple has no sons? During interviews, the research team invited people to tell stories about individuals in their community who had no sons. What, people were asked, happens to elderly couples in this situation? One might have expected that this question would elicit narratives of miserable old people living in loneliness and destitution – yet this was not the case. In contrast, interviewees in all sites told stories of elderly

people who lived fine lives supported by their daughters. Parents who do not have sons, people claimed, rarely become destitute and lonely in their old age – instead, they are taken are of by their daughters. In this research, many interviewees even emphasized that not only are adult daughters capable of residing with and caring for elderly parents – they also perform these tasks better than sons. Daughters, interviewees said, are often emotionally closer to their parents. Moreover, being more careful and considerate, they often care better for elderly parents than sons do, especially if the parents get ill.

But although daughters were generally described as being more caring and reliable than sons, patrilocal living arrangements placed limits on the care that daughters can provide: living with the family of her husband, a woman's primary responsibility, interviewees said, is to care for *his* parents, not her own. Caring for her natal parents too therefore places a doubled burden on the woman, and is only possible with her husband's consent. A 27-year old woman from Hung Yen said:

> In my village, daughters sometimes take care of not only their parents-in-law, but also their natal mother, since the father already died. They give thoughtful care to their mothers without any difficulty. (Q: How do neighbours talk about them?) All praise them a lot. Even sons-in-law accept this situation since I guess they were aware of this before marriage.

In sum, although interviewees praised and appreciated daughters, they also maintained that in most cases, sons do provide more 'certain' old-age security. Due to the custom of patrilocal residence, women are expected to 'follow' their husbands and give priority to taking care of his family; one cannot be sure, therefore, that an adult daughter will be in a position where she can offer her natal parents financial support and old-age care. Although a daughter may be able to offer some day-to-day support, it is the son who carries the main responsibility for parents in their old age. This responsibility, interviewees said, makes it logical and reasonable that sons inherit more than daughters of their parents' property.

3-3-2. Inheritance

Patrilineal kinship systems often involve patrilineal inheritance, that is, not only names and responsibilities for ancestors, but also land and property are passed on through the male line from fathers to sons. In the past, people said, if a husband and wife had no son, they were likely to find an heir *(người thừa tự)* in another branch of the patriline. Most often the son of the husband's brother would become the heir, inheriting the couple's property, including their land and taking responsibility for worshipping his deceased uncle and aunt. The main purpose of this arrangement was to care for the parents' souls while also making sure that their property did not fall into the hands of another lineage. Some elderly female interviewees told the researchers about how they themselves, as

daughters in a family with no sons, had experienced such property transfer: their parents' assets had been given to a male cousin, while they themselves had inherited practically nothing. They had found this very unfair, but had been powerless to change the situation.

In present-day Viet Nam, however, interviewees said, this form of inheritance is rare. If a couple has no sons, it is more likely that parents will transfer their assets to one of their daughters. Among the people in our sample who had no sons, only one person said she intended to find an heir within the patriline; everyone else said they planned to divide inheritance among their daughters. Many interviewees in the sample had children of both sexes. The majority of these individuals said that they planned to give both sons and daughters a share of the inheritance – but not an equal share. Because they expected to live with their son in their old age, and because he would also be taking care of ancestor worship, most interviewees planned to give their son a larger portion of the inheritance than their daughter.

In some cases, interviewees said that they did not plan to distinguish between boys and girls in inheritance. This intention was expressed more often by people in the southern research sites than in the northern ones. This finding can be explained by the fact that in the South people are more open to the possibility that parents may live with any of their children, mostly the last child, whereas in the North most people seem to take for granted that parents will live with their son, mostly the eldest son.

In short, many interviewees emphasized that with increasing wealth, sons seem to become increasingly important: only sons, many people hold, ensure continuation of the family line and the perpetuation of the family's work. Although most people expressed a moral commitment to let daughters inherit too, the pattern of patrilineal inheritance seemed to remain strong. This cultural and socio-economic importance attached to sons was strongly reinforced by community norms: not only were sons seen as important 'in themselves' for cultural and socio-economic reasons – they were also important to ensure that the parents (and to some degree grandparents) were recognized as valuable persons in the eyes of others.

3-4. In the eyes of others: Family pressures and community norms

Collecting data for this research, the research team went to communities across Viet Nam, visiting and talking to people in both urban and rural areas. Whether they lived in a city, a town or a rural village, all interviewees expressed acute concern about 'the things people say': childbearing, the interviews showed, is not just a 'private' matter that concerns the individual woman, man, or couple, but a collective issue in which both family and community members take a keen interest. Living in closely-knit communities, many interviewees felt highly exposed to things that others may say about them, and most people strove hard to establish a positive image of themselves in the eyes of others. To gain other people's respect and recognition, the ability to produce children of the desired character

and ‘quality’ turned out to be very important. Most interviewees said they aspired to have no more than two children – and so the expectations placed on these two children seemed to rise.

3-4-1. Producing a modern family: the internalization of family planning norms

In Viet Nam today, many informants said, the ideal nuclear family composition includes mother, father, one son, and one daughter. The desire to have both ‘sticky rice and ordinary rice’ (*có nếp có tẻ*) is a long-standing one in Viet Nam, but today this ideal has become harder to achieve. Before, people needed ‘at least’ one son and ‘at least’ one daughter. Today, they need *exactly* one son and *exactly* one daughter. Some interviewees defined this need for exactly one son and one daughter as a product of the government’s strict family planning policies that allow people to have no more than two children. In Hung Yen, a 37-year old father of two daughters and one son said:

> At present, the government allows us to have only one or two children. Therefore, the tendency in families with many daughters is that when there is a pregnancy, they will certainly go for an ultrasound. If it is a boy, they will keep it, if it is a girl, they will terminate it. Nowadays, many people do this.

In the communities, however, the vast majority of interviewees did not represent the two-child-family norm as a demand placed on them by state authorities. Rather, they set it forth as *their own* ideal: in order to care properly for one’s children, they asserted, one should have no more than two. A 34-year old father of two girls from Ha Noi, for instance, said:

> Frankly, in my own view, I would like to have only two children, not more. Having many children we cannot take good care of them. We should create good conditions for our children to study and live better. It is much harder to provide good care for a child at present time…Frankly, I think like many other people do. I would like my family have both a boy and a girl.

The family planning norms that have been communicated to Viet Nam’s citizens over the past two decades seem, in other words, to have been internalized by many people now. These norms, in combination with the availability of new reproductive technologies – mainly ultrasounds and abortions – are, according to many interviewees, the driving forces behind the current rise of sex ratio at birth in the country. People embrace the small size family norm, and they embrace new ‘scientific’ methods for family-building, and these two things together create a situation where many girls are missing. In

the words of a 33-year old man from Ha Noi, 'Given the current situation where people want only two children, it is certain that daughters will be rare later on.'

But while the small size family norm has been widely adopted by people, the ideal gender composition of the family described by interviewees differed from the 'model family' propagated by the state: whereas family planning campaigns have sought 'gender neutrality' and attempted to ignore the cultural differences between males and females, interviewees in all research sites emphasized that the children's sex *does* matter – and that for most couples, it is vitally important to have at least one son. The 'model family' they described included one son and one daughter – and ideally, many interviewees said, the son should be born first. People in Viet Nam used to claim that 'not even deep rice fields and female buffalos are as valuable as a first-born daughter' (*ruộng sâu trâu nái không bằng con gái đầu lòng*), yet today many couples clearly aspire to have first a boy, and then a girl. Having a son as one's first-born 'puts the mind at ease', according to interviewees in all research sites. When having a son first, people can avoid the tension, pressure and uncertainty that will suffuse their lives if their first-born is a daughter. Like many other research participants, a 32-year old antenatal care client from Quang Ngai said she found it 'safer' to have a son first:

> I think it is best to have a son as my first child and a daughter as my second child. Because it is safer when my first child is a son. (In what way is it safer?). For example, I don't have to worry about the sex of my second child. It would be OK if I have another son, and it would be best if I could have a daughter. In contrast, if my first child is a daughter, I will be very worried when I am expecting the second child. I will be worried that my husband will be very sad if the ultrasound images show that I am expecting a daughter. He may say "Oh, dear! A daughter again." He may feel sad and therefore may make a lot of complaints.

3-4-2. Producing a son: pressures within the family

In this study, both men and women reported feeling pressured by family members to have a son – yet these pressures took different forms, often weighing more heavily on women. When they get married, women in Viet Nam often move to live in the household of their husband's parents. This places them in a vulnerable position within their husband's household: being new to this family, they have to prove their worth by behaving well and working hard, - and by producing the heir that will carry on this family's line. Giving birth to a son, therefore, secures a woman's position within her new family. Knowing this, a woman's natal parents will often feel happy and relieved if she gives birth to a son; they know that this helps her to be protected and recognized in her new family. This 65-year old woman from Hung Yen was very happy when both of her two daughters gave birth to sons. She

felt that she could now have peace of mind, knowing that her daughters would have a good status in their husbands' families. She felt proud to have delivered 'perfect' daughters who 'knew how to give birth':

> I wished that when my daughter got married she could deliver a son to continue her husband's family line. For me, it is fine to have granddaughters, but their family needs a grandson. So I wished that my daughter could have a son so that she would not be neglected by her family in-law. Frankly, I was so proud because my two daughters delivered two first-born sons. I was truly very proud.

A woman's value, interviewees in all sites suggested, depends on the kind of children she produces, and the child's sex is an important parameter of success. In Hung Yen, women's dependence on sons to gain acceptance within the patrilineal family seemed to be particularly strong. In many extended families, and particularly in Hung Yen, there seemed to be a competitive normative environment where the family's women – knowing that they were being assessed by others, and judged on their capacity to give birth – would compete against each other, each trying to gain a superior position vis-à-vis other women in the family through the children they were able to produce:

> I want to produce a son to keep up with my sisters and brothers. My older sister has a son and my younger sister has a son too; therefore, I must have a son to be equal to them. I must have a son so that my friends would not continue to say that I can't produce a son. (A woman aged 24 with two daughters in Hung Yen)

Some women in the sample said that they themselves hoped to have a son because they knew how important a son was to their husband and/or parents-in-law. A 35-year old woman from Quang Ngai, for instance, told the researchers that she had decided to have her third child – who turned out to be a son – because she felt sorry for her mother-in-law who did not yet have a grandson:

> My brother-in-law has three daughters and my mother-in-law very much wants to have a grandson. So I decided to have another child. (Did your mother-in-law encourage you to have another child?) No, she did not. It was up to us. Feeling sorry for my mother-in-law and thinking that we still had few children, I decided to have another child.

In some cases, in short, women said they strove for sons out of feelings of love, compassion and responsibility for their husband and his family. They wanted to live up to the expectations that were placed on them and to be good wives and daughters-in-law. In other cases, however, the situation within the family was more tense and conflict-ridden. Some women – particularly those living in Hung Yen - reported feeling threatened: by not having a son, they said, they exposed themselves to the risk of losing their husband to another woman. Being divorced or abandoned by their husbands would be not only morally problematic for the women, but also entail large financial risks. A 33-year old Hung Yen woman with two daughters told the researchers that lacking a son made her feel very anxious, as she had witnessed several men finding new wives if their first wife failed to produce a son:

> This actually happens in our village. Some people said, "See. Those men have up to four daughters, but they are still faithful to their wives." However, in fact, the men had illegal wives in other places where they go to work. Then later, they bring their mature sons back to their family. Evidently, men really prefer sons. We often tease each other, saying "If you can't produce a son, your husband will get married to another woman." But in many cases it is not just teasing, but fact. Therefore, if I know for sure that if I can produce a son this time, I will definitely get pregnant and give birth to him. However, no one can know that, so I am very worried.

In some cases, people reported, paternal grandparents put considerable pressure on young couples to produce another pregnancy in the hope of having a son. This was particularly likely to happen when there was a lack of sons in the extended family at large, as the entire family line was then at risk of discontinuation. A 38-year old woman from Hung Yen who was the mother of two girls and a boy told the researchers that before her son was born, she was constantly criticized by her mother-in-law for not giving birth to a son. Even though their housing conditions were very bad, her mother-in-law did not allow them to build a new house because they had only daughters:

> [When] my grandmother was still alive, she often complained. After giving birth to the second child, I would like to build a new house, but she did not allow that. She said, "You have only daughters, for what do you want to build a house?" She did not permit us to build the house because we live on her land.

In Hung Yen, some informants reported that pressure from parents in-law or husbands could sometimes lead to conflicts and violence in the family, particularly if the wife refused to get pregnant again. The woman would be blamed for "not knowing how to give birth" and threatened with divorce:

> Without a son, conflicts occur frequently in the family; trivial problems are turned into serious ones; and husband and wives have quarrels, even fights with each other. Take my elder sister's family as an example. They have four daughters. Just because of son preference, there have been regular conflicts between her and her husband. They have even almost got divorced just because he insists on having a son. He forces my sister to produce a son because he is the only son in his family. (Man aged 27, two daughters, Hung Yen)

3-4-3. Community pressures

The research found that pressure to have a son came not only from the family, but also from the community at large. Some interviewees described such community pressure – which usually took the form of teasing or degrading remarks – as just as hurtful and hard to live with as pressures within the family. Because community pressure unfolded in public space, those exposed to it were humiliated and lost face in front of other people; whereas family pressure would usually take more discreet and 'private' forms. While women were particularly vulnerable to pressures within the family due to their insecure social position in their family-in-law, men seemed particularly vulnerable to community pressures. In popular opinion, to be successful in life (*thành đạt*) and to be fully masculine, a man must have at least one son (ISDS, 2007). Not having a son may therefore expose a man to ridicule and gossiping. A 22-year old man from Hung Yen confirmed this, saying, 'Since I had my son, it has been more relaxing to go out. With only daughters, I would be teased that I did not know how to produce a son.'

Both in the North and the South, interviewees reported that other people's teasing and jokes often generate heavy pressures on men. In the Red River Delta, this old saying is still sometimes used to ridicule those who have only daughters: 'the wife's father gets punched' (*bố vợ phải đấm*); meaning that men who have only daughters are not respected, not even by their son-in-law. Interviewees also reported that in family parties (*cỗ*), men who have only daughters are sometimes placed at the 'lower' tables *(ngồi mâm dưới)* where the more 'inferior' members of the family, such as women and children, are seated, while the most respected members of the family – such as grandfathers and senior uncles – are placed at the 'higher' tables. Even if this does not happen in reality, in workplaces and at drinking parties, it is common for men to tease son-less men, saying that they will be placed at the 'lower' tables of family parties. Such public humiliation was described by informants as very hurtful and as a very effective way in which pressure is placed on men to do all they can to have a son.

A son is a symbol of power. Families having sons, informants said, feel more confident in the local community, and lineages with many males have more power and prestige. Not having a son, therefore, tends to make people feel inferior and vulnerable. A 27-year old woman from Hung Yen felt heart-broken because people were ridiculing her husband. She told the researchers that she and

her husband experienced a huge pressure from both friends and family, and this made them both feel tense and worried:

> My husband was often provoked by his friends. This made him very sad. When visiting us or going out together, [his friends] said that he has no one to hold the stick [at his funeral] or that he does not know how to make a baby. My parents feel sad also. They told us that they want two grandsons, so we should try hard, by whatever means, so that they can have two grandsons. Besides, relatives and cousins, for instance, when sitting together at family feasts, provoked my husband, calling him this and that. So my husband and I feel very sad and very worried.

Such teasing among men was reported particularly in the North; however, men living in other regions also experienced such situations. Another man living in Quang Ngai, for instance, gave this example from their localities:

> When I go outside, many people tease me. They say things like "you are a lifetime maternal grandfather." (Male, 32 years old, having two daughters)

Pressures seemed to increase if a couple had two daughters. Sometimes people posed only curious questions, or made some remarks to show their concern – however, this would still increase the anxieties felt by the son-less:

> When we had our first child, people did not talk or comment much. But since the birth of our second child, the pressure has increased and people are talking more about it. (Male, 35 years old, having two daughters, Hung Yen)

In recent years, new idioms used to characterize son-less families have emerged. People sometimes mock son-less couples by saying that they have 'built a house for charity' or 'built a house of affection and gratitude' (*xây nhà tình nghĩa*), thereby implying that the family has accumulated property, but will 'lose' this property to another kin group by letting their daughter and son in-law inherit it. Such idioms, although meant for fun, were sometimes experienced as very hurtful. These idioms seemed to be more commonly used in the North than in the South, and especially in the Red River delta.

4. Conclusion

This paper has shown that the forces that compel people in Viet Nam to prefer sons to daughters are complex: at issue are *cultural ideologies* – particularly the idea that family lines are continued through males only and that ancestor worship should be practiced by men if possible; *socio-economic arrangements* – particularly patrilocal residence patterns in which elderly couples live together with their son, and the ensuing inheritance patterns in which sons inherit the largest share of parents' assets; and powerful *normative pressures* which push people to strive for sons in order to gain acceptance and recognition in families and communities. In short, when sons are preferred to daughters in contemporary Viet Nam, these wishes and dispositions are anchored in age-old kinship structures that valorize males at the expense of females. This research suggests that male-oriented kinship patterns are stronger and more rigid in the North than in the South, a finding that resonates with the results of the 2009 Census which showed that sex ratios at birth are considerably higher in the Red River Delta than in other parts of the country (UNFPA, 2010). Notably, however, this qualitative research found that people in all research sites expressed profound appreciation of daughters too. Daughters were held to be more reliable and hard-working than sons, and many people said that daughters too can care well for their parents in old age and worship the ancestors.

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Comparative Foundations of Informed Consent in the United States and Japan

Laura Specker Sullivan

Introduction

The problem of informed consent in Japan is not a new one. Indeed, as stated in one Japanese article from 2001, "informed consent in medicine has been bathed in the limelight for a long time" (Moji 1). To be sure, informed consent has remained a major topic in American bioethics as well, but as I will argue, it would be a mistake to think that the discussion about the practice in both countries, and even the practice itself, are the same. While for patients in both the United States and Japan the experience of giving informed consent may seem to be similar - acknowledging comprehension of the medical care suggested and consenting to receive such care - the theoretical and historical underpinnings of the practice in each country have important implications for how the practice is understood and undertaken.

Thus, while many Japanese and English articles rely on a general history of informed consent, referring to such globally recognized historical markers as the Hippocratic Oath, the Nuremberg Code and the Declaration of Helsinki, there are distinctive historical moments in the United States and Japan that have influenced not only the discussion on informed consent but the practices themselves. Furthermore, the distinctiveness of these historical moments has contributed significantly to the misunderstanding between the U.S. and Japan on the topic of informed consent. While superficially the practice and discussion surrounding informed consent may seem similar, these underlying factors have not only affected how each country sees their practice of informed consent as fitting into a broader world history, but have also ensured that the two countries do not quite see eye to eye on the theory behind and the goals of informed consent. Therefore, I believe that revealing these heretofore under-recognized historical moments will contribute to both countries' understanding of their own bioethical practices, not only enabling them to create more effective practices, but also allowing them to have a more fruitful discussion about the ethical goals of medical practice itself.

The Common History of Informed Consent

In general, it is thought that the modern practice of informed consent[1] can be traced to two significant international moments: the Nuremberg Code and the Declaration of Helsinki. While some studies restrict the significance of these two moments to the development of human protections in *research* ethics,[2] they have bearing on informed consent generally in that they created awareness of the need for protection of individuals from unwanted medical intervention. The Nuremberg Code was enacted in 1948 in the wake of World War II as a result of recognition of the so-called biomedical experiments undertaken by Nazi medical specialists on prisoners and those held in concentration camps. During the trial at the Nuremberg Military Tribunals of the twenty doctors and three administrators who participated in such experiments, the defendants were convicted of crimes against humanity, and the judges at the trial took it upon themselves to craft a code that would protect research subjects against future abuses (Faden and Beauchamp, hereafter F&B, 155). The first principle of the Code emphasizes the importance of voluntary consent in the context of human subject research, where voluntary consent entails

> …free power of choice, without the intervention of any element of force…constraint or coercion; and should have sufficient knowledge and comprehension of the elements of the subject matter involved as to enable him/her to make an understanding and enlightened decision.[3]

While the Nuremberg code was never explicitly incorporated into American law, it was a watershed moment in research ethics, the first time that a clear distinction between legal and illegal research on human subjects had been made (USHMM). The code itself influenced governmental and professional codes in the U.S. in the 1950's and 1960's, and significantly shaped the modern idea of informed

[1] Setting aside the Hippocratic Oath and 17th and 18th century reflections on the relationship between physician and patient, I concentrate here on the modern notion of informed consent.

[2] Faden and Beauchamp separate their historical consideration of clinical and research ethics in their influential book, A History and Theory of Informed Consent, although they do admit that the two ideas have relevance for each other.

[3] http://www.ushmm.org/information/exhibitions/online-features/special-focus/doctors-trial/nuremberg-code, hereafter USHMM

consent, as will be seen below. However, many saw it as imprecise, and "pressure to develop less general guidelines for specific fields began to mount" (F&B 156).

As traced by Faden and Beauchamp, this led the World Medical Association (hereafter WMA, itself founded in 1947 as a result of the Nuremberg Trials) to begin constructing its own set of guidelines for responsible medical research. According to the WMA, the resulting set of guidelines, known as the Declaration of Helsinki, is the "WMA's best known policy statement."[4] It was first adopted in 1964 and has been revised nine times since, with the most recent revision made in October 2013 at the 64th General Assembly of the WMA. In the 1964 version, the Declaration states in its 9th principle that potential subjects of research

> …must be adequately informed of the aims, methods, anticipated benefits and potential hazards of the study and the discomfort it may entail…The physician should then obtain the subject's freely given informed consent.[5]

Subsequent principles outline the need for caution in cases where the patient is in a dependent relationship upon the physician conducting the research, is incompetent to provide consent, or is a minor. Thus, the Declaration of Helsinki seeks to give a more detailed account of what informed consent entails. As with the Nuremberg Code, however, the Declaration of Helsinki has served less as a binding legal code and more as a guideline that has informed the creation of other more localized codes. As Faden and Beauchamp point out, the Nuremberg Code was the first code created by a court system for the medical profession, while the Declaration of Helsinki was the first code to be created by the medical profession itself.

In addition, as stated above, contemporary informed consent theorists often refer to these codes as the beginning of the recognition of the need for individual consent within medicine more generally. According to Faden and Beauchamp "there was no broad interest in consent to research prior to the Second World War" (F&B 152). Thus, the attempt to deal with the medical atrocities committed during World War II serves as an important international marker in the development of the individual's right not only to self-determination but to freedom from pressure or coercion in the

[4] http://www.wma.net/en/20activities/10ethics/10helsinki/, WMA

[5] http://irb.wayne.edu/policies/2-3_declaration_of_helsinki.pdf

context of medical practice and research, and the particular embodiment of this right in the practice of informed consent.

American Historical Moments

While the history of informed consent in the United States certainly relates to the global events described above, the practice and the discussion surrounding it are given a certain flavor by the court cases and medical cases which have brought it into relief. As Faden and Beauchamp write, "Informed consent is a creature originally of law and later snatched from the courts by interdisciplinary interests and spearheaded by an ethics driven more philosophically than theologically" (F&B 92). As such, it is absolutely necessary to recognize the rich sociological and legal history that underlies the contemporary practice.[6]

Furthermore, as stated previously, many Japanese researchers writing on informed consent refer to the particular American history of the practice, especially the background of American case law, in their analyses and so it will be helpful to outline some of these historical moments here. I will not outline all of the cases that have contributed to the American legal doctrine of informed consent, but rather will concentrate primarily on the cases that have been most significant in the bioethical literature and in the discussion of informed consent in Japan.

The first such case is *Schloendorff v. Society of New York Hospitals* (1914), in which a patient consented to an abdominal examination under anesthesia but not to a full operation, and sued the hospital when it turned out that tumor found during the examination was removed, and thus that an operation was performed. Justice Benjamin Cardozo's decision that "Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault, for which he is liable in damages"[7] has become one of the most frequently referenced quote in the informed consent literature (F&B 123, Mariner 391).

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[6] Wendy Mariner has argued that the real import of the physician-patient relationship is extra-legal, and that informed consent as a legal standard can only go so far in regulating this relationship. However, given that informed consent as it is understood today is primarily grounded in case law, significant court cases will be the focus of this analysis.

[7] 211 N.Y 125, 105 N.E. 92 (1914)

Salgo v. Leland Stanford Jr. University Board of Trustees was decided considerably later, in 1957. This case was the first to use the term "informed consent" (further supporting the idea that informed consent is a creature of the courts), deciding in favor of the defendant, Martin Salgo (who had suffered paralysis as a result of a medical operation for which he had not been warned of the risk of paralysis), that

> A physician violates his duty to his patient and subjects himself to liability if he withholds any facts which are necessary to form the basis of an intelligent consent by the patient to the proposed treatment. Likewise the physician may not minimize the known dangers of a procedure or operation in order to induce his patient's consent.[8]

As Faden and Beauchamp indicate, this was one of the first times that the distinction was made that consent had to be sufficiently *informed* (F&B 126), and that conducting a medical procedure without informing the patient of the risks involved amounted to battery.

A third case, *Natanson v. Kline* (1960), grounded physician liability for informed consent in negligence rather than battery (F&B 129), finding that failing to inform the patient of the nature of the disease, the proposed treatment, the probability of success and failure and available alternatives, and the risks associated with treatment, *in plain language*, was negligence on the part of the physician. This made physicians vulnerable to allegations of malpractice even in cases where they had performed an operation successfully; if they had failed to inform the patient of all of the details of the operation, they were open to a malpractice suit (F&B 131).

Both *Salgo* and *Natanson* served as foundations for further cases in which informed consent was disputed along lines of either battery or negligence. Importantly, Faden and Beauchamp point out that in all cases, the primary issue was self-determination (F&B 132). In other words, in the battery cases the question was whether the medical treatment was conducted without sufficient informed consent, and thus impinged on the individual's right to determine for him or herself what will happen to his or her body. In the negligence cases, on the other hand, the question was one of risk: if the physician had failed to warn the patient of a risk associated with the medical procedure to be done, and as a result the patient was injured, then failure to disclose the risk could be seen as a source of the

[8] Salgo v. Leland Stanford Jr. University Board of Trustees, 317 P.2d 170, 181 (1957)

injury. However, if it was likely that the patient would have consented to the medical procedure even had the risk been disclosed, then the physician could not be said to be negligent (F&B 132). Thus while in the battery cases informed consent *in general* was required for patient self-determination, in negligence cases informed consent was required only to the extent that that which was disclosed would be relevant for the patient's decision-making process.

Finally, the case of *Canterbury v. Spence*, decided in 1972, was one of the first to combine elements of both battery and negligence. A patient fell from his bed and was paralyzed after a medical procedure, and in his lawsuit alleged that he had not been notified of the risk of paralysis. The court found that not only do physicians have a duty to disclose all the information needed for the patient to make an informed decision, but that the justification for this duty was based not on the physician's professional judgment of what was needed to make a decision, but on the patient's right to make the decision for him or herself. As Faden and Beauchamp note, this incorporated elements of both battery and negligence (F&B 136). They write,

> Canterbury therefore succeeded in reaffirming that self-determination is the sole justification and goal of informed consent, and that the patient's needs for information rather than the physician's practices must form the basis of any adequate standard of disclosure. On the other hand, it rejected an individual, subjective interpretation of these needs and turned instead to the reasonable person, that 'tired and weary old creature of tort law,' to place a limit upon patients' informational claims (F&B 137).

Accordingly, this means that only the general, reasonable person had their rights legally protected under this standard.

The cases considered above show that the development of informed consent in American case law has been marked by an increasing emphasis on self-determination (which relied on patient autonomy) as a primary justification of the right to either consent to or reject medical care (F&B 141). As Faden and Beauchamp argue, this shift from the prior focus of the medical community on beneficence towards the patient was primarily due to the grafting of the legal framework onto medical practice (F&B 143). In other words, medical practice on its own has historically been focused on patients' best interests, and the impact of U.S. case law was to move this focus towards self-determination in the name of protecting individuals from unwanted medical interventions or forseeable

medical mishaps.

Allen Buchanan's influential 1978 article, *Medical Paternalism*, is a good example of how this shift from beneficial or paternalistic medical care to care centered on patient self-determination manifested in the medical ethical context. Relying heavily on a 1967 by Donald Oken that found that 90 percent of American physicians did not inform patients of a cancer diagnosis, Buchanan argues that, while physicians' justification of this practice runs along three main lines: 1) disclosing such a diagnosis would harm the patient, 2) the decision of whether or not to inform lies within the physician's expertise, and 3) in the case of a serious illness or exceptional circumstances the patient is not capable of understanding the import of the diagnosis, none of these arguments is sufficient to justify withholding information in the medical context. Buchanan then makes the general point that in all three of these justifications *the legal duty to seek informed consent* is not overwhelmed by the physician's sense that the information provided would harm the patient, be outside the patient's purview of decision-making, or would not be comprehensible to the patient. Rather, it is up to the *patient*, as a rational individual, to decide whether the provided information is significant in their decision-making process. It is important to note here that Buchanan concentrates on informed consent as a legal duty owed to the patient by the physician, and furthermore, that the patient is owed this duty because they have the right to self-determination as a rational individual capable of making their own decisions.

Buchanan's argument is a striking example of the shift in understanding of the medical profession that came about in the United States in the 1970's and supports Faden and Beauchamp's claim that American informed consent and the subsequent emphasis on individual decision-making is a product of "grafting" the legal framework onto medical practice. In addition, Buchanan's insistence on the legal duty of informed consent as a knock down argument against physician's inclinations to shield their patients from cancer diagnoses makes clear the subsequent influence of case law on medical ethical arguments.

Thus, these moments in American case law are absolutely necessary to understanding the American practice of, and theory behind, informed consent. While it is true that the courts' decisions themselves were influenced by international events such as the Nuremberg Code and the Declaration of Helsinki, they are also particular products of American society and the American legal system during this period. We may perhaps think of the American development of informed consent as one particular way in which the general goal of the Nuremberg Code and Declaration of Helsinki, to ensure

the individual's right not only to self-determination but to freedom from pressure or coercion in the context of medical practice and research, was thought to be secured.

With this brief overview of the American history of informed consent in mind, in the following section I will turn to the moments in Japanese history that I believe are similarly significant for the Japanese understanding and practice of informed consent.

Japanese Historical Moments

It is admittedly difficult to find sources that give the history of informed consent in Japan in particular. Of the Japanese articles surveyed for this study, almost all primarily rely on international events such as the Nuremberg code or the Declaration of Helsinki, as well as influential American court cases, to make an argument for how informed consent ought to be understood or practiced in Japan. In addition, of the handful of articles published in English that address Japanese informed consent (written by both Americans and Japanese), only two refer back to original Japanese sources (Higuchi and Leflar) and all others rely on the analysis of a single case by a single author, Norio Higuchi, to make their comparison. Luckily, however, a few Japanese sources (and the English sources mentioned above) do look into the distinctive Japanese history of informed consent.[9]

First, it is important to note the particular history of medicine in Japan. For much of Japanese history medical practice was rooted in Chinese medicine,[10] and it was only with increasing interaction with the Dutch in the Edo period (1605-1868) that Japan began to practice what may be called Western medicine. As Ellen Gardner Nakamura has argued, the gradual adoption of Western medicine in the form of Dutch learning was largely on practical, social terms – to the extent that Dutch medical practices were applicable or useful to society, they were taken up and used. This is not to say that Dutch medicine was adopted wholesale; rather, Western medicine itself was adapted to local contexts in Japan according to the needs and social systems of its inhabitants; it was a "creative and adaptive exercise with a practical end" (Nakamura 173).

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[9] One particularly interesting article by KANITA Kentoshi proposes that informed consent may have been present in Japan as early as the 17th-18th century, when Japanese surgeon Hanaoka Seishu allegedly had patients sign a "letter of consent" indicating that they were asking the physician for a certain type of treatment and that they would not have any objections after the treatment (申分御座無く候) (Kanita 91).

[10] And also perhaps Arabic medicine. See Andrew Goble, Confluences of Medicine in Medieval Japan: Buddhist Healing, Chinese Knowledge, Islamic Formulas, and Wounds of War (2011).

In addition, from ancient times until the modern period, medical ethical standards were primarily based in Buddhist texts, which specified the ethical roles of the physician, nurse, and sick person – in short, all those involved in the medical setting. The thinking of this period was markedly participatory (resembling contemporary bioethics), and the most important factor in medical practice was having a 'heart of compassion/benevolence' (*jihi no kokoro,* 慈悲の心) (Japanese Bioethics Series, I, 75-76). Thus, from a very early period Japanese medical ethics was also beneficence-based.

As Japanese physicians became increasingly aware of Western medical practices, they continued to emphasize traditional Buddhist ethical systems, repeating the mantra of "Eastern morality, Western techniques/arts." While following the Meiji restoration in 1868 Japanese physicians intentionally patterned their practices after Western ones, especially Dutch, German, English, and America practices (Japanese Bioethics Series, I, 89), numerous physicians also published works on medical ethics, continuing to draw on sources in Japanese tradition. Hashida Kunihiko/Kuniyoshi (橋田邦彦), who write in the Taisho period (1912-1926), applied his study of Zen master Dōgen to the context of medical ethics in order to make the point that benevolent acts (*jinjutsu,* 仁術) are the first principle of medicine (Japanese Bioethics Series, I, 91). However, in the wake of World War II Japanese medical ethicists began to take the U.S. (and other countries) more expressly as a model, as I will discuss below.

The changing nature of the Japanese legal system proceeds along similar lines as that of the medical system. Much of early Japanese law is modeled on that of China, with significant Western influences after the Meiji restoration in 1868, and American influence following World War II and including the drafting of the post-war Japanese constitution. The post-war legal system is, according to John Owen Haley, almost a complete break with earlier legal standards in Japan (Haley 9). Contemporary Japanese law is based in a civil code, although it is also structured by case law. Haley further writes that the history of legal reform in Japan since World War II is one of "mutual adaptation of new rules, processes, and institutions to their social environment," and that what is unique about this history in Japan is that foreign models have been almost entirely self-selected (Haley 10).

This legal history is not unlike the current state of medical ethics in Japan. While Japan does have a native history of medical ethics as noted above, contemporary work on the subject is predominantly grounded in foreign models that have been, to a certain extent, 'self-selected.' In the following section I will trace what this means for informed consent.

As an admittedly foreign model, informed consent in Japan is regularly traced back to two sources: the support for individual self-determination in Article 13 of the Japanese constitution, which states that all citizens are to be respected as individuals, and have the right to life, liberty, and the pursuit of happiness, to the extent that it does not interfere with the public good,[11] and the introduction of the term "informed consent" into the Japanese language.

As discussed in Japanese bioethical literature, informed consent first came to be known in Japan in the 1970's when it was translated as *setsumei to dōi* (説明と同意), although at this time *infōmudo konsento* was also used (Matsui 70). According to Bai Kōichi, however, prior to the introduction of the American term the German word for duty to explain, *Aufklarungspflicht* was used, translated as *aufukurērungusu pufurihito* (Matsui 70), although perhaps more commonly translated as *setsumei gimu* (説明義務). Nevertheless, the main term used in the bioethical literature is still *infomūdo konsento*, and this serves as a potential tension in the Japanese context – while *infomūdo konsento* and the American history surrounding this term appears to be most significant in the Japanese bioethical literature, *setsumei gimu* appears to be more relevant to Japanese case law and specific governmental policies. Again, I suggest that the significance of this tension will become clear through my consideration of the cases presented below.

One of the most significant cases in Japanese history is that of Japan's first heart transplant, undertaken by Dr. Juro Wada in 1968 at Sapporo University Hospital. Dr. Juro Wada declared an unconscious boy, Yamaguchi, who had been brought to the hospital to be dead, made the decision to transplant his heart into another eighteen-year old boy, Miyazaki, who had chronic heart disease, and performed the subsequent operation. Questions quickly arose about the conditions under which the transplantation was performed. It was said that Dr. Wada had made the donor a candidate for organ transplantation prematurely, and that the condition of the recipient's heart did not require an immediate transplant. Based on these considerations, it seemed as if Dr. Wada had rushed the operation in order to perform one of the world's first heart transplants.

Four months after the transplantation occurred, a group of practitioners of Chinese medicine accused Dr. Wada of murder (the recipient of the transplant died three months after the operation).

[11]http://www.kantei.go.jp/foreign/constitution_and_government_of_japan/constitution_e.html

However, based on lack of evidence and other reasons,[12] the case against Dr. Wada was dropped (Feldman 134-136). However this wasn't the end of the case's significance. The lack of consensus within the medical community about the case led to public distrust of the medical profession's ability to decide such important matters. Indeed, this case has been called the 'loss of innocence' of the medical profession in Japan (Leflar (1996) 68). As Rihito Kimura notes, "The Japanese were simply afraid of an unwarranted and premature diagnosis of death by physicians acting on brain criteria, and that the desire for donor organs would cut short their medical care" (Kimura (1998) 55). Thereafter, patients no longer trusted doctors to act in their best interest. This was at first taken as simply a case of an overambitious physician, but numerous subsequent cases have proceeded along similar lines (Shimizu 26-36).

The fact that the term "informed consent" was not adopted in Japan until the after the Wada case in the 1970's is not insignificant. Prior to this case Japanese patients probably had little reason to think that their physicians would act in anything other than their best interest, or would propose courses of treatment that were not the best at the time. As one author notes, it was not until the discussions on brain death and organ transplantation that (American-style) bioethics really landed in Japan (Japanese Bioethics Series, I, 175). In this context of growing uncertainty in the relationship between physician and patient, it can be said that Japanese scholars intentionally took the American standard of informed consent as a model; thus the overwhelming reliance in scholarship on informed consent on American case law. However, following the adoption of informed consent as a model, Japan began to develop its own case law.

In what is said to be the forerunner of cases dealing with informed consent in Japan, in 1971 a physician discovered cancer in the left breast of a woman who was undergoing a mastectomy of her right breast, and decided to perform a double mastectomy. The woman sued the hospital for damages on the grounds that the mastectomy of her right breast was unnecessary, and the Tokyo District Court decided that generally a physician must obtain the consent of the patient before performing a large

[12] One of the reasons why the case was so difficult to prove may have been Japan's lack of clarity on what constitutes medical malpractice. According to Robert Leflar, even in 2009 Japan had not yet resolved what defines an "unnatural death." This, combined with Japan's 'more publicly rigorous stance towards medical error' may have contributed to the confusions surrounding the Wada case (Leflar (2009) 446). The lack of guidelines or procedures on determination of brain death, informed consent, and organ transplantation made the Wada transplant case even more complex.

operation, and that since the diagnosis of breast cancer was not urgent, the defendant was culpable (Japanese Bioethics Series, I, 189). Here, the case proceeded along similar lines to early American cases, focusing on the need for a physician to obtain consent from a patient before performing an operation.

Subsequently, in 1981 the Japanese High Court passed judgment on the physician's duty to explain. The parents of a young boy who died during an operation sued the physician, alleging that the risks of the operation had not been sufficiently explained. The court ruled that while on the one hand physicians have a clear duty to explain (*setsumei gimu*, 説明義務), in an emergency situation this explanation can be simplified (Japanese Bioethics Series, I, 189). Following these decisions, in 1990 the Japanese Medical Association presented a report on *setsumei gimu*, and the Monbukagakusho[13] followed in 1995 with a report on informed consent. In the former, the need to build a trusting relationship between physician and patient, based on the particularly Japanese physician-patient relationship, was emphasized, while the latter report focused on dispute avoidance through the physician ably presenting their specialized understanding to the patient (Japanese Bioethics Series, I, 189).

While it can certainly be said that in Japan there was a loss of trust in the beneficence of the physician due to occurrences like the Wada case, it is not necessarily the case that there was a concomitant increase in the desire for patient self-determination. Uchiyama Yuuichi writes that the particular shape of informed consent in Japan is one in which the principle of informed consent is acknowledged in the form of the duty to explain, and that particular court decisions have tended to give priority to the physician's discretionary power (Uchiyama 57).

Thus, it can be argued that the emphasis in Japanese law is much less on the importance of consent, as it has come to be in the American system, and more on the physician's duty to explain according to their *sairyouken* (裁量権), or discretionary power. Indeed, an article from 2011 in the Nikkei Medical Online states that while most lawsuits in Japan used to be attributable to error in medical operations or treatment, in the past ten years the number of lawsuits involving violation of a physician's duty to explain has been increasing, with most of the cases involving no actual medical

[13] Japanese Ministry of Education, Culture, Sports, Science, and Technology.

error, but rather allegations that explanations of similar treatment options or the merits and demerits of different treatment options were insufficient (Mizusawa).[14]

Consideration of subsequent cases further highlights the extent to which physicians' discretionary power is emphasized in Japanese case law. Uchiyama refers to a case decided by the Tokyo High Court in 1985 that provided a certain amount of relief in a physician's duty to explain all aspects of treatment, finding that in situations where the physician deems it would cause useless anxiety to the patient or the family, certain details may be exempted, and in some cases, the patient need not be told the details of the diagnosis at all (Uchiyama 57). This is the oft-cited situation in which cancer diagnoses need not necessary be told to the patient, and may be revealed to the family of the patient alone. This standard is itself based on the 1989 case of Makino v. Red Cross Hospital, frequently referred to in the English-language literature on informed consent in Japan.[15] In this case, translated and analyzed by Norio Higuchi in an article published in 1992, a patient died after not being told her cancer diagnosis, and her family subsequently sued. The decision, a landmark one in Japan, was that the physician has a general duty to inform the patient or family of the details of the condition, but that the physician maintains "the discretion as to whom, when, and in how much detail he should inform" (Higuchi 460).

Japanese law has continued to support this discretionary power of the physician, as a set of guidelines published by the Japanese Medical Association in 2008 outlines the physicians' duty to explain, but exempts exceptional cases in which the physician believes that informing the patient would cause excessive psychological shock and would affect proper treatment. In such cases, the physician must consult with another physician and should make their judgment cautiously or prudently, and importantly must inform the appropriate family members of the patient's condition.[16] No such stipulation is present in American law or medical guidelines.

The cases above show a tendency on the part of the Japanese court system and Japanese medical community to consider informed consent to be primarily an issue of the physician's duty to

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[14]The number of cases involving medical error climbed steadily from 1996, when 575 lawsuits were made, to 2005, when 999 were made (Iida 21). Since 2005, however, the number of lawsuits relating to medicine have been (on average) declining, reaching 793 new cases in 2012 (The reason for this recent decline is as of yet unclear). http://www.courts.go.jp/saikosai/vcms_lf/201305izitoukei1.pdf

[15] See Kroft, Lambris, Leflar, Annas and Miller.

[16] http://dl.med.or.jp/dl-med/teireikaiken/20080910_1.pdf (p.3)

explain, rather than one of the patient's self determination. Rather than stipulating who, when, and how the physician must inform, the Japanese courts leave this up to the physician to determine. In other words, whereas American case law has sought to fulfill the goals of the Nuremberg Code and Declaration of Helsinki through support of an individual's right to self-determination, Japan has pursued similar aims through restructuring the physician's duty to explain and their discretionary power. In Japan, the 'reasonable person' standard is imposed not on the level of the patient, but on that of the physician.

I believe this shows that the difference in informed consent practices in the U.S. and Japan is not necessarily one of essential cultural differences or divergent philosophical systems. Rather, the reason for differences in informed consent between the U.S. and Japan is more concrete – both countries have had different experiences, both legally and socially, with informed consent as a concept and a practice. However, what may have made the conversation about informed consent between the U.S. and Japan so difficult is that the American standard of informed consent was self-consciously adopted as a model in Japan, and so the Japanese practical divergence from this standard seems to threaten it. Furthermore, in their adoption of the American standard Japanese scholars seem to have forgotten their own history of the practice, with confusing consequences. However, I hope to have shown that Japanese medical ethical thought has a different history than that of the U.S., and given this it is unsurprising that the two practices of informed consent differ.

Current Issues

Irrespective of the historical moments outlined in this paper, a recurring issue in international and cross-cultural bioethics has been whether the persistent divergence of the Japanese practice of informed consent from the American norm poses a threat to ethical universalism. The general lines of the argument are as follows. Medical ethics relies on the use of certain principles (often taken to be those outlined by Beauchamp and Childress in their 1979 book *Principles of Biomedical Ethics*) to deduce the best approach to particular cases. These principles serve as guidelines for reasonable people conducting a rational analysis of a given situation. In order for a decision regarding a situation to be acceptable to the medical ethical community, one must be able to justify one's reasoning using said principles. The Japanese practice of informed consent has been particularly sticky because, in general,

the justification for physician's decisions about how they practice informed consent has *not* been traceable back to these principles, although some have tried (Fujita, Akabayashi and Slingsby). Thus, a seemingly endless tug of war has continued between American and Japanese bioethicists, with American bioethicists either denouncing Japanese practice as unethical or trying to figure out just why the Japanese practice is so different from the American one,[17] and Japanese bioethicists either providing justification based on a set of distinctively *Japanese* medical ethical principles (Akabayashi and Slingsby), or trying to find ways to reform Japanese informed consent so that it more readily fits the American model (Moji.)

However, given the foregoing discussion, what is remarkable is that very few contemporary bioethicists have looked into the grounds of the Japanese practice. Instead, many assume that the divergence of Japanese informed consent from the American standard is in itself a problem by posing as a threat to ethical universalism or serving as evidence of Japan's lack of ethical sophistication. However, what I hope to have shown in the foregoing analysis is that ethical practices and ethical discussions are necessarily historically embedded. Indeed, as Ruth Faden and Tom Beauchamp point out,

> 'Informed consent' is a creature of a broad range of social practices and institutions in the twentieth century. To remove the notion from contemporary cultural and historical contexts in which it was nourished in order to test retrospectively for its presence in other cultures is a dangerous undertaking requiring special precautions (F&B 55-56).

Taking this statement even further, I suggest that it is also a dangerous undertaking to "remove the notion from contemporary cultural and historical contexts in which it was nourished" and apply it without special precautions to different cultures and contexts.

This is not to say that ethical standards are completely culturally relative; rather, it is to assert that what makes a practice ethical is the form of reasoning that went into deciding whether and how a practice should be undertaken, and in an international discussion the form of reasoning that should be the topic of the discussion, not the particular localized outcomes of the reasoning process. In conclusion, I will now present a possible direction for reasoning in the Japanese context.

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[17] For reference, see the 2006 issue of the American Journal of Bioethics.

Future Discussion

Rather than trying to mimic the American practice of informed consent and its concomitant justification, Japan should proceed exactly how it has in its interactions with foreign ideas and practices in the past – by creatively incorporating the goals and techniques of the practice into its existing social structure. Indeed, numerous articles have argued that the import of informed consent in Japan is utilitarian, in that the goal is to increase the quality of medical care available and to support patients during medical treatment (Uchiyama 58, Okamoto 87). While the conversation about informed consent in Japan has been focused more on physicians' professional responsibilities than on individual self-determination, this need not exclude creative thinking about how to ensure that physician and patient are meeting each other on morally equal ground. This reflects the values of Japanese medical practice as focused on meeting societal and individual needs in a participatory context, and links back to early emphases on benevolence in medical practice. The goal of policies like informed consent is to follow in the footsteps of the Nuremberg Code and Declaration of Helsinki, ensuring the protection of the individual patient within the group, family, and medical contexts, but the means to bring this about need not be the same.

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Living In Two Homes: Shared Physical Custody After Parental Union Disruption and the Psychological Well-Being of Children

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Abstract

This paper studies shared physical custody in Sweden. We ask whether children in shared physical custody settings differ in psychological well-being compared to children living most of the time with a single parent or with a parent and a stepparent. The analysis uses OLS regression and is based on the Swedish Surveys of Living Conditions (ULF), nationally representative rich datasets with information from both parents and children. The results indicate that children living in a 50/50 shared physical custody setting with alternating residence between the households of the mother and the father have a somewhat higher level of psychological well-being than children who live full time or most of the time in one parental household.

1. Introduction

The emergent complexity of family forms in the past decades has got a lot of attention within the social sciences and while the evidence for a negative association of divorce and other family structure transitions is considerable the literature on shared physical custody of children is much more limited, especially based on randomly selected nationally representative samples. The reason is likely the fact that it still is relatively rare in most countries. This paper studies children in Sweden, a country that is often considered a fore-runner in development of new family life patterns that are soon followed by other industrialized countries. Shared residence for children is still a relatively new phenomenon in Sweden, but has quickly become increasingly common. The phenomenon has however not yet been widely analyzed.

One should not confuse shared *physical* custody and shared residence with shared *legal* custody. Whereas shared legal custody only gives both parents the legal right to decisions about the child's upbringing, school choices, religion etc. 50/50 shared residence means that the child actually *lives* equal, or near equal, time with both parents, alternating between separate households. This makes it possible for both parents to engage in active parenting and gives children the possibility to have

ongoing contact with both parents after separation. But living in two different households and alternating not just between two geographical locations but also potentially between two different "parental regimes" with different rules and customs may create instability and increase children's ill-being.

In this paper I ask whether children in shared physical custody settings report lower levels of psychological well-being compared to children living in a more traditional post-separation residential setting.

1-2. Shared Physical Custody and Child Well-Being

The negative association between family structure changes or living in post-divorce family settings and a wide variety of child outcomes is a well established finding in the family studies literature (among many see for example Amato, 2001; McLanahan & Sandefur, 1994; Thomson et al., 1994). Shared physical custody as a more recent phenomenon is far less studied and the findings has not yet been as widely theorized as in case of child outcomes of divorce, single parent- or stepfamily life.

Shared physical custody and shared residence can however theoretically predict both positive as well as negative associations with child well-being. One way in which it can ameliorate harmful effects of family dissolution is by limiting loss of parental resources, both social and financial, something that has been shown to mediate some of the adverse outcomes (see for example McLanahan, 1999; Thomson et al. 1994; Sweeney, 2007). By sharing custody and care of the child it can benefit from a steady contact with both parents. A steady everyday-like contact can also strengthen the parent-child bond and facilitate the kind of authoritative parenting style that Amato and Gilbreth (1999), in a meta-analysis of nonresident fathers' role in children's well-being, found to be positive for child development (Gilmore, 2006). Shared residence can also reduce the work load for a single parent, increase the parent's cooperation and reduce conflicts and potential custody disputes (see Emery, 1999). Having continuous contact with both parents may decrease children's psychological ill-being created by worrying for the absent parent or feeling responsibility to take care of a parent (see Nielsen, 2002).

On the other hand joint physical custody can also be argued to decrease children's emotional well-being. Children may become stressed from a lack of stability due to constant changes of households (see Bauserman, 2002). Besides changing physical location a child may also need to

constantly adapt to changes in parenting regimes creating emotional instability. Opponents of shared physical custody have also warned for stress created by children getting caught up in high conflict parental relationships (see Bauserman, 2002).

Any association between shared physical custody and child well-being could also be spuriously produced by selection of parents with certain pre-existing characteristics that are associated with well-being of the child. The shared physical custody families could for example have higher socioeconomic status and more resources as it has been shown that these socioeconomic groups are more likely to be early adaptors of new family behaviors (see for example Blossfeld et al., 1995; Härkönen & Dronkers, 2006: Lesthaeghe, 2010). They can also have lower inter-parental conflict levels and be more child-oriented in general.

2. Previous Research

The scholarly literature on shared physical custody is still rather limited. Many studies rely on small non-random samples that are not nationally representative and a considerable share of the child outcome studies are based on children of high conflict parents and court cases. The relativelt large number of research reviews on shared physical custody and children's well-being (Bauserman, 2002; Buchanan & Jahromi, 2008; Fehlberg et al., 2011; Gilmore, 2006; Harris-Short, 2010; Nielsen, 2011; Smyth & Moloney, 2008; Smyth, 2009; Trinder, 2010) likely reflects a growing interest from academics, policy makers as well as social- and legal practitioners in custody legislation.

The previous research has in general presented positive associations between shared physical custody and emotional well-being but the literature varies greatly in quality and methodology. Some rely on clinical or court based non-random samples whereas others use nationally representative samples of parents or children. There are also differences in whose reports are used for measuring the well-being of the child with some using parent's reports and others information directly from the child. Another factor making comparisons between studies harder are different definitions of shared physical custody, with definitions like living at least 25 percent, 33 percent, 35 percent or 50 percent with each parent. However the literature do tend to point in the direction of the absolute amount of time with a parent being less important than the quality of the relationship (see for example Gilmore, 2006).

The findings pointing to mixed or adverse outcomes of shared physical custody tend to be from non-random samples (Neoh & Mellor, 2010; Smart et al. , 2001) and from studies of children from high conflict parents (McIntosh, Burns et al., 2010; McIntosh, Smyth et al. 2010). A recent

review of the research on shared physical custody in non-high conflict families presents a rather positive picture of the findings with the vast majority pointing to a positive association with different measures of child well-being (Nielsen, 2011). A widely cited meta-analysis by Bauserman (2002) showed that children in joint physical custody were better adjusted than those in sole custody settings, on all categories of adjustment except academic, and presented no difference in behavioral adjustment compared to children in original two-parent families. Advising against a legal presumption for shared physical custody Gilmore (2006) concludes in his review that although parental contact after divorce is beneficial for child development the benefits are rather small and it can in cases of high parental conflict have adverse effects.

Most of the research in the field has hitherto been conducted in the Anglophone countries. But in a large sample multilevel analysis of children's life satisfaction in 36 countries Bjarnason and colleagues (2010) showed that children in shared physical custody settings reported higher levels of life satisfaction than those in other non-intact families but that this was an effect of higher family affluence. They also showed that the relative difference between children of different family structures were similar in all countries, supporting previous comparative findings (Breivik & Olweus, 2006b), but that children in the Nordic countries had higher levels of well-being compared to children in the same family type in countries with a less generous welfare state model. In a similar multi-level analysis of school aged children in 36 countries Bjarnason and Arnarsson (2011) showed that children in shared physical custody had equal or better communication with their parents, which have been supported in a later study (Carlslund et al., 2012), and that even though the child spends less time in a certain household the quality as well as quantity of time together with parents is higher in shared physical custody.

Some studies comparing children of shared physical custody with those in original two-parent families, in the Nordic countries, have shown that these children are in most parts equally well off (Breivik & Olweus, 2006: Jablonska & Lindberg, 2007) whereas others find that children in post divorce family types are more at risk for negative outcomes but no difference between shared and sole physical custody (Carlslund et al., 2012). Other continental European studies have shown slightly positive effects of joint physical custody for children as well as parents, especially fathers (Spruijt & Duindam, 2010; Sodermans et al., 2013). Melli and Brown (2008) showed that children of divorce in Wisconsin had fewer stress related illnesses as well as less depression and other health problems in shared physical custody compared to sole mother custody. In a longitudinal study of post-divorce

custody arrangements children in shared physical custody were better off academically, emotionally and (Buchanan & Maccoby, 1996).

Most of the studies hitherto are cross-sectional and rarely have measures on pre-divorce characteristics so it is difficult to say whether there is a positive selection of parents with certain traits into shared custody arrangements. The cross-sectional evidence does however show somewhat higher education and income among those with shared custody (Juby et al., 2005; Kitteröd & Lyngstad, 2012; Melli & Brown, 2008) as well as lower levels of conflict and more inter-parental cooperation (Bauserman, 2002; Öberg & Öberg, 2004). Although presenting some differences in parental characteristics between the two types of custody arrangements both Nielsen (2011) and Melli and Brown (2008) conclude that the parents with shared physical custody of children do not differ greatly from those with sole custody. It is however important to control for both socioeconomic factors as well as parental cooperation and conflict when studying the well-being of children in different custody arrangements and to keep this in mind when reading studies based on child data without parental reports on these issues.

2-1. Shared Physical Custody in Sweden

This paper focuses on children in Sweden, a country that is often considered a forerunner in family demographic behaviors like cohabitation, divorce, childbearing across partnerships and family reconstitution (van de Kaa, 2001). Sweden is also the country with the highest share of children living in joint physical custody arrangements (Bjarnason & Arnarsson, 2011). The development has been quite rapid with about 1 % of children of divorce, separation or non-union birth sharing residence equally between two parental households in the mid 1980's to over one fourth twenty years later (Lundström, 2009). Studies based on Swedish administrative registers have shown that the average geographical distance between children and non-coresident parents has decreased during the past 20 years which has been interpreted as an effect of the increased commonality of shared physical custody (Raneke, 2011; Stjernström & Strömgren, 2012).

The Swedish child custody laws are a result of policy makers' ambition to make family life more gender equal and have developed in this direction since the 1970's along with other family policies like individual taxation of married couples or gender neutral parental leave for example (Schiratzki, 2008). The laws and policies have aimed at enforcing fathers' caring obligations both

within unions, regardless of marital status, as well as after a union dissolution (Bergman & Hobson, 2002).

In 1977 shared legal custody after union dissolution, for both previously cohabiting and married parents, could be granted by court if it was in the best interest of the child and both parents agreed on it. In 1982 shared legal custody could be agreed upon by the parents without court decision. In 1992 a legal presumption for shared legal custody was introduced making it the default option after a parental separation and in 1998 the courts could grant shared legal-, as well as physical, custody even in cases where one of the parents was against it. In 2006 this was modified somewhat, putting more emphasis on the parents' ability to co-operate as well as the child's own will before ruling for shared physical custody and shared residence for children. This year it also became possible for separated parents to divide the non-means tested monthly child allowance if the child shares residence roughly equally between both households (Schiratzki, 2008). The vast majority of Swedish post-separation custody arrangements are agreed upon by parents without any involvement of the courts. Of the parents who cannot agree on an arrangement most come to an agreement after lawyer- or court mediation and in less than 2 percent of the divorces or separations involving children the final custody arrangement is decided by the court (Schiratzki, 2008).

In a qualitative study of separated and divorced families in Sweden (Öberg & Öberg, 2004) most parents motivated the decision to have shared physical custody with it being the most natural, reasonable and equal alternative. These parents regarded each other as good parents an saw no reason to deprive one of them from everyday life with the children. They thought that parents need their children as well as children need both their parents and that none of the two parents is more important to the child than the other. Furthermore they thought that shared physical custody was a way for both parents to continue the parental ambitions they originally had when they had children.

3. Data, Modeling and Method

The data for this study is from the Surveys of Living Conditions (ULF) from 2001, 2002 and 2003 and the child supplements of these. The cross-sectional surveys consist of a nationally representative sample of the Swedish population aged 18. The total response rate was 75% (Statistics Sweden, 2005). The data collection was done through in-home interviews and carried out by trained interviewers from Statistics Sweden. For the child supplements children age 10-18 residing with the respondent were interviewed, providing unusually rich data from two different perspectives. In this

paper children's reports are used on issues that can be assumed are better known by children themselves than their parents, such as questions regarding their psychological well-being. Parents' reports are used for questions that children might not have accurate information about such as parents' conflict level. Information on the child's living arrangements is also from the parents' reports. Furthermore information from administrative registers were added and linked to the respondents. For this study information from registers are used for respondent's income.

The children were interviewed simultaneously with the parent's interview after informed consent had been obtained from both legal guardians. While the parent was interviewed the children completed a self administered questionnaire while listening to the interview questions on headphones. The questionnaire had only the response options but not the questions and the child was asked to put it in an envelope, seal it and hand it to the interviewer immediately after having finished it, thus providing confidentiality to the child. 82% of the children residing with the adult respondent agreed to participate in the interview with the response rate being somewhat higher among younger adolescents and among those whose parent was the respondent in the adult interview.

The original sample consisted of 4084 children of whom 73% lived with two biological, or adoptive, parents, 9% with a single mother, 4% with a single father, 10% with a mother and a stepparent and 3% with a father and a stepparent. Less than 1% lived in another type of family setting, like foster parents or with a sibling or grandparent. This study focuses on the subsample of children who lived with a single parent or in a stepfamily. After dropping all children in the other family types the sample consists of 1081 children. Further only those children whose both parents were alive were kept dropping another 29 cases. To be able to measure inter-parental conflict level based on a survey question on how well the two divorced or separated parents agree on matters regarding the child, respondents who are not the parent of the child, i.e. stepparents were dropped leaving us with 824 children. Finally 15 children are dropped due to lack of information on residential arrangements and 3 children are dropped because of missing data on the dependent variable leaving us with a final sample of 806 children. Of these 60% live full time with one parent, 11% live most of the time with one parent and 29% share residence equally between two parental households. Of the children with equally shared residence 74% commute weekly between two households, 13% commute fortnightly, 4% every other day, and the rest have some other arrangement.

The dependent measure is a scale constructed out of 7 items measuring different aspects of what could be described as psychological well-being following an initial exploratory factor analysis

showing that the responses loaded onto a common factor. These are survey questions asking the child how well he or she agrees with the statements “I am often tense and nervous”, “I am often sad”, “I am often grumpy and annoyed”, “I get angry easily”, “I have difficulties sitting still and concentrating”, “I am happy most of the time” and “I have energy to do a lot” (or alternatively translated “I manage to do a lot”). The response options are “Applies exactly”, “Applies quite well”, “Applies quite badly” and “Do not apply at all”. All items are coded so that the “worst” option, with the lowest level of well-being, is given the value one and the “best” option the value four. The scale has a Cronbach’s alpha of 0.70, a mean of 3.05, standard deviation of 0.47.

The independent measure is a dichotomous variable for residential setting with children who are reported (by the parent) to live equally in both parental households commuting between them coded as one and children living full time or most of the time with one parent coded zero.

The child’s socioeconomic background is controlled for by a variable for the parent’s income after taxes based on information linked to the surveys from administrative registers. This is a three-category variable with one category for those in the bottom quartile of the income distribution, one for the top quartile and one for the two middle quartiles for each survey year. The model also controls for the age and sex of the child and the parent, parents’ immigrant status, the number of children in the household, whether the child lives in a stepfamily setting and whether the child lives in the Stockholm metropolitan area, the other metropolitan areas in Sweden or outside of them. A dummy variable for parental conflict, based on a question on how well the parent’s agree or get along on matters regarding the focal child, is constructed with those who reported agreeing “badly” or “quite badly” coded as one. Similarly a measure for parent-child conflict was constructed with children reporting getting along “badly” or “very badly” with either their mother or their father coded as one.

I use ordinary least squares regression to estimate the correlation between psychological well-being and the children’s residential setting. Because the sampling for the surveys was done on parental level the probability to be in the sample for a child in a two-parent family is twice as high as for a child living with a single parent. Weights are therefore used to adjust for this. In order to control for clustering, i.e. more than one child from the same family in the sample, I have used robust standard errors by using Stata’s cluster-command.

4. Results

Table 1 shows the frequencies and percentages for the independent variable children's residential arrangement or physical custody. 29 percent of all children with divorced or separated parents have 50/50 shared physical custody living equal time in two parental households. The rest live full time or most of the time with one parent.

Table 1. Descriptive Statistics. Independent Variable.

Children's residential arrangements	**Frequency**	**Percentage**
Full time or mostly with one parent	572	71%
50/50 shared residence	234	29%
Total	806	100%

Data source: Child-ULF 2001, 2002 & 2003

Table 2 shows us the distribution of the responses to the survey items, which the dependent variable is constructed out of, by type of residential or custodial arrangement. We can see that the items in general are positively skewed. The cross-tabulation of the responses by type of physical custody shows that the option representing the lowest well-being is overrepresented among those living most of the time or full time with one parent, whereas the other response options have a similar distribution as the overall population when it comes to custodial arrangement.

Table 2. Descriptive Statistics. All Items in Dependent variable by Type Residential Setting.

Survey item	Full time/mostly with one parent		50/50 shared residence	
	Freq.	%	Freq.	%
I am often tense and nervous				
Applies exactly	22	88%	3	12%
Applies quite well	99	71%	40	29%
Applies quite badly	267	70%	113	30%
Does not apply at all	184	70%	78	30%
I am often sad				
Applies exactly	26	96%	1	4%
Applies quite well	75	71%	30	29%
Applies quite badly	254	71%	102	29%
Does not apply at all	217	68%	101	32%
I am often grumpy and annoyed				
Applies exactly	19	86%	3	14%
Applies quite well	80	70%	34	30%
Applies quite badly	268	70%	114	30%
Does not apply at all	205	71%	83	29%
I get angry easily				
Applies exactly	80	78%	22	22%
Applies quite well	158	73%	58	27%
Applies quite badly	224	68%	105	32%
Does not apply at all	110	69%	49	31%
I have difficulties sitting still and concentrating				
Applies exactly	61	83%	12	16%
Applies quite well	187	73%	70	27%
Applies quite badly	210	68%	101	32%
Does not apply at all	114	69%	51	31%
I am happy most of the time				
Applies exactly	196	70%	82	30%
Applies quite well	343	70%	148	30%
Applies quite badly	26	96%	4	4%
Does not apply at all	7	100%	0	0%
I have energy/manage to do a lot				
Applies exactly	207	66%	108	34%
Applies quite well	289	74%	102	26%
Applies quite badly	66	80%	17	20%
Does not apply at all	10	59%	7	41%

Data source: Child-ULF 2001, 2002 & 2003

Table 3 presents all independent variables by type of physical custody or residential arrangement. We can see that children to high income earners are disproportionally in the shared custody category. Among low and medium earners 50/50 shared physical custody is much more rare than living full time or most of the time with one parent. Table 2 also shows that more boys than girls have shared residence and that a vast majority of the children of female respondents do not share residence equally. The prevalence of shared physical custody decreases with age with less than one fifth of the adolescents aged 16-18 living equally in two households whereas 35 percent of those aged 10-12 do so. Disagreement on matters regarding the child is more common among those not sharing residence equally as is disagreement between parent and child suggesting that those who choose shared physical custody may be a select group of parents who have parted on more amicable terms. For this reason it is important to control for conflict levels when analyzing outcomes of shared physical custody.

Table 3. Descriptive Statistics. All Variables by Child's Residential Setting.

Variable	Full time/mostly with one parent		50/50 shared residence	
	Freq.	%	Freq.	%
Parent's income category				
Low earners	181	86%	29	14%
Medium earners	326	71%	135	29%
High earners	65	48%	70	52%
Age of child				
10-12	191	65%	104	35%
13-15	202	70%	88	30%
16-18	179	81%	42	19%
Age of parent				
≤35	94	81%	21	19%
36-40	140	68%	65	32%
41-45	174	64%	97	36%
≥46	164	76%	51	24%
Sex of child				
Boy	283	68%	130	32%
Girl	289	74%	104	26%
Sex of parent				
Man	97	44%	124	56%
Woman	475	81%	110	19%
Immigrant status				
At least one parent born in Sweden	512	70%	223	30%
Both parent born outside of Sweden	60	83%	12	17%
Number of children in household				
1	152	80%	38	20%
2	207	66%	108	34%
3	148	68%	71	32%
≥4	65	79%	17	21%
Place of residence				
Metropolitan Stockholm	73	58%	53	42%
Other Metropolitan areas	84	86%	14	14%
Rest of Sweden	415	71%	167	29%
Parental conflict				
No	442	68%	202	32%
Yes	130	80%	32	20%
Parent-child conflict				
No	520	58%	227	31%
Yes	52	88%	7	12%
Stepfamily				
No	346	68%	161	32%
Yes	226	75%	73	25%

Data source: Child-ULF 2001, 2002 & 2003

An initial bivariate analysis of psychological well-being and 50/50 shared physical custody (result not presented in table) shows a positive association with a coefficient of 0.11 ($p<0.01$) for those who live equally, or near equally, in two parental households. The positive correlation holds when adding the control variables to the model. The results of this multivariate OLS regression are presented in table 4. We can see a positive, albeit slightly weaker, correlation (coef. 0.08, $p<0.1$) for the children who live with 50/50 shared custody compared to their peers living full- or most of the time with one parent, usually the mother. We can thus conclude that children sharing residence after a parental union disruption do not have lower psychological well-being compared to those who live full time with one parent, usually the mother. In fact we see a small positive correlation, statistically significant on ten percent level. This is however less than one fifth of a standard deviation. Looking at the control variables we can see a statistically significant negative correlation between psychological well-being and whether the child has reported having a conflicted relationship with the parent. The inter-parental conflict does not show any significant association.

4-1. Concluding Remarks

Like some other recent studies of emotional outcomes of shared physical custody this study shows that sharing residence equally after a parental union disruption may not be harmful for children. On the contrary children in 50/50 shared residence have slightly higher psychological well-being, confirming previous positive findings on other aspects of emotional well-being. The results can be interpreted as support for a positive effect of continuing everyday-like parental relationships after a family dissolution and as support for the finding from Amato and Gilbreth´s (1999) meta-analysis that authoritative parenting benefits children's development. The correlation is however weak and only statistically significant on a 10% level.

Table 3. OLS Regression: Children's Psychological Well-Being

Variable	Coefficient		Robust S.E.
Residential setting			
50/50 shared physical custody	0.08	*	0.04
Other arrangement	ref.		
Parent's income category			
Low earners	- 0.01		0.05
Medium earners	ref.		
High earners	0.03		0.05
Age of child			
10-12	0.05		0.04
13-15	ref.		
16-18	0.07		0.05
Age of parent			
≤35	ref.		
36-40	0.00		0.07
41-45	0.01		0.07
≥46	-0.02		0.08
Sex of child			
Boy	ref.		
Girl	-0.06		0.04
Sex of parent			
Man	ref.		
Woman	-0.06		0.05
Immigrant status			
At least one parent born in Sweden	ref.		
Both parent born outside of Sweden	0.08		0.08
Number of children in household			
1	ref.		
2	0.01		0.05
3	0.01		0.06
≥4	-0.01		0.09
Place of residence			
Metropolitan Stockholm	ref.		
Other Metropolitan areas	0.01		0.08
Rest of Sweden	-0.04		0.05
Parental conflict			
No	ref.		
Yes	-0.01		0.05
Parent-child conflict			
No	ref.		
Yes	-0.15	**	0.07
Stepfamily			
No	ref.		
Yes	-0.02		0.04
Constant	3.09	***	0.10

*** $p \leq 0.01$ ** $p \leq 0.05$ * $p \leq 0.10$

Data source: Child-ULF 2001, 2002 & 2003

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