〔原　著〕

A Japan-U.S. Comparison of Family Functions from the Perspective of Mothers Utilizing "Family Houses" —Cross-Cultural Research Using the Feetham Family Functioning Survey—

Naohiro Hohashi[1)]　Chikako Koyama[2)]

Abstract

Family functions in Japan and the U.S. were compared by means of Japanese and English versions of the FFFS (Feetham Family Functioning Survey), whose subjects were Japanese and American mothers using "family houses." Japan showed significantly lower sufficiency of family functioning in two of the 25 survey items : "Time with health professionals" and "Time you are ill." Thus it is necessary to improve the protective and rest functions within Japanese families.

Likewise, when the survey results for Japan and the U.S. were compared in three areas of family function, Japan tended to show a lower sufficiency of family functioning in "Relationship between family and subsystem." This can be attributed to the characteristic of the Japanese family to draw a clear boundary between family members and others. It is necessary to adjust the relationship between the family and the subsystem (acquaintances, relatives and people such as neighbors with whom the family has strong interrelationships) in the context of cultural background.

The family function scores and importance scores disclosed that the family functions that required family nursing intervention in Japan were "Problems with children" and "Satisfaction with marriage" and in the U.S., "Problems with children." In other words, in both Japan and the U.S. intervention is necessary to relieve worries over children in the hospital and children left at home. Also, with respect to "Satisfaction with marriage" in Japan, assistance in supporting sexual-love functions between husbands and wives can be considered. It is necessary to re-confirm improvements in the health care environment with emphasis not only on sick children but also on family life.

As described above, it was possible for the medical staff members to reach a deeper understanding of the Japanese family against the background of culture, and to receive suggestions for considering family nursing intervention through cross-cultural research.

Key words : Family House, Family Functioning, FFFS, Japan-U.S. Comparison

[1)]Child and Family Health Nursing, Faculty of Health Sciences, Kobe University School of Medicine
[2)]Ward No. 2, Kobe University Hospital

I. Introduction

In both Japan and the U.S. children with chronic illness are often brought to hospitals in urban centers for state-of-the-art health care. But admission to or regular outpatient treatment at such a hospital places a heavy financial, mental, and physical burden on the family who live far from an urban center.[1)2)] However, the New System Regarding Allocation of Nurses (Ministry of Health, Labor and Welfare) in principle prohibits the family from accompanying the patient on a round-the-clock basis and, therefore, presently there is barely any space or facilities for families in the wards.[3)]

In recent years, in order to ease the burden on families, "family houses" have been extensively constructed.[1)] A "family house," located near a hospital, provides sick children and their families inexpensive accommodations where they can find repose. Momentum for the "family house" came from the Ronald McDonald House (hereafter RMH), which was established in the U.S. in 1974. Other RMHs followed in succession. Their operation depends upon assistance from an organization of unpaid volunteers.[4)5)] Meanwhile, in Japan, the first "family house," Esaka House, was established by volunteers in 1988. Japan's first RMH was finally established in 2001. The comparatively high construction costs in Japan and the fact that volunteer activities have not taken root in Japanese society[6)] have delayed the establishment of "family houses." But the 1998 supplementary budget of the former Ministry of Health and Welfare provided for the development of 32 accommodation facilities for families of children with chronic diseases.[1)]

A "family house" is expected to supply, in particular, residence, economic, protective, and rest functions to the family. However, the functions of families using "family houses" have never been the subject of research. There are several scales for evaluating family functions. One is the FFFS (Feetham Family Functioning Survey), developed by Feetham and others in the U.S. It was developed by nurses, which is its salient feature, and is frequently used in family nursing research.[7)] Moreover, a Japanese version, FFFS Japanese Language Version I, has been developed, providing a basis for comparison of family functioning in Japan and in the U.S.[8)] Japan's "family house," introduced on the model of RMH, must satisfy needs particular to the Japanese people, such as the need for mental health care.[1)] In this way cultural background must also be taken into consideration when dealing with the issue of family nursing.

Thus this study compares Japanese and U.S. family functions from the perspective of Japanese and American mothers who have used "family houses" and RMHs. The purposes are to analyze the imperfections and insufficiencies of functions of the Japanese family and to identify areas where family health nursing is necessary.

II. Samples and Methods

1. Samples and methods of survey

In Japan, an explanation of the survey was mailed to the heads of the 32 accommodation facilities for families of children with chronic diseases in September 2002. The 12 facilities agreeing to participate became the subjects of the study. In October 2002, a questionnaire

and related materials written in Japanese were mailed to 75 mothers (limited to those with hospitalized children 18 years of age or younger) at the 12 facilities.

In October 2002, an explanation of the survey was mailed to the heads of 32 RMHs selected at random from 145 facilities in the U.S. that have been in operation as of August, 2002. The four facilities agreeing to participate became the subjects of the study. In November 2002, a questionnaire and related materials written in English were mailed to 84 mothers (limited to those with hospitalized children 18 years of age or younger) at the four facilities.

The package sent to the mothers contained a letter of request, a covering letter, the FFFS sheet, a self administered questionnaire concerning family attributes, a small token of gratitude, and a return envelope for the questionnaire. In the questionnaire concerning family attributes, items pertaining to sick children and their families and to the "family house" were created on the basis of previous research.[1)2)] The operational definition of a family was a group of two or more people sharing bonds and mutually recognizing one another as family. Also, the term husband included a partner performing the role of husband, irrespective of actual marital status. The covering letter to the mothers explained the purpose and methods of the study, that participation was by their own volition, and that their confidentiality would be protected. It asked them to respond only if they consented to these issues.

2. Structure of FFFS and Evaluation Method of Family Functions

The FFFS is a self-administered 27-item questionnaire that objectively evaluates the sufficiency of family functioning.[7)8)] Twenty-five items consist of multiple-choice questions. There are seven possible responses, from 1 (little) to 7 (much) on the Likert scale. From these responses the d score [the family functioning score (a high score indicates the insufficiency of family functions)] and the c score [the importance score (a high score means the item is believed important)] are calculated. Accordingly, an item with both high d scores and high c scores indicates nursing intervention was necessary[7)8)]. Furthermore, family functions can be classified broadly into three areas : "Relationship between family and the individual" (10 items) ; "Relationship between family and the subsystem" (8 items) ; and "Relationship between family and society" (6 items). These three areas account for 24 items altogether. (One of the 25 items was independent of the areas.) The total of the d scores of items in an area was the area's d score.[8)]

Also, two of the items were open-ended questions : "What is most difficult for you now?" and "What is most helpful for you now?"

3. Data tabulation and method of analysis

SPSS 11.0 for Windows was used for statistical analysis. When unanswered items were discovered in the questionnaire, only these were excluded from analysis.

III. Results

1. Response to the questionnaires

In Japan 35 mothers (46.7% response) returned the questionnaires by November 15, 2002. In the U.S. 39 mothers (46.4% response) returned the questionnaires by December 20, 2002.

Table 1. Attributes of Families Utilizing "Family Houses"

		Japan (n = 35)		U.S. (n = 39)	
Item		%	Average ± SD (range)	%	Average ± SD (range)
Parent age	Mother *		34.2 ± 5.4 yrs (25 ~ 49 yrs)		30.3 ± 7.2 yrs (18 ~ 44 yrs)
	Father *		36.5 ± 6.7 yrs (25 ~ 51 yrs)		31.8 ± 7.6 yrs (17 ~ 47 yrs)
Number of household members			4.3 ± 1.3 persons (2 ~ 7 persons)		4.2 ± 1.2 persons (3 ~ 7 persons)
Presence of family members	Father	96.7		94.7	
	Sibling(s)	73.3		71.1	
	Grandparents **	23.3		0	
	Relatives	6.7		2.6	
Mother employed/at home *	Employed	32.3		63.2	
	At home	67.7		36.8	
Age of sick child			5.3 ± 4.3 yrs (0 ~ 17 yrs)		3.6 ± 5.4 yrs (0 ~ 17 yrs)
Gender of sick child	Male	50.0		62.9	
	Female	50.0		37.1	
Time from home to hospital ***			225.5 ± 174.1 min (60 ~ 840 min)		110.2 ± 74.0 min (45 ~ 480 min)
Time from "family house" to hospital **			16.0 ± 22.6 min (1 ~ 90 min)		3.4 ± 1.7 min (1 ~ 7.5 min)
Duration of child hospitalization this time *			78.6 ± 95.1 days (1 ~ 360 days)		29.9 ± 43.6 days (0 ~ 150 days)
Length of stay in "family house" this time **			60.6 ± 77.1 days (1 ~ 240 days)		20.1 ± 31.9 days (1 ~ 150 days)

*: $p < 0.05$, **: $p < 0.01$, ***: $p < 0.001$ (comparison between Japan and U.S.)

2. Attributes associated with families

Attributes associated with families were shown in Table 1. In the Japanese-American comparison, significant differences were observed in age of mother, age of father, presence or absence of grandparents in the household, percentage of mothers with jobs, time required from home to hospital, time required from "family house" to hospital, number of days of child's hospitalization, and number of days families use "family house" (one-way ANOVA or chi-squared test).

The children's diseases (classified according to the 10th Revision of the International Classification of Diseases) were in Japan neoplasms (9 children, 30.0%), congenital anomalies (8, 26.7%), genitourinary system diseases (4, 13.3%), diseases of eye and adnexa (3, 10.0%) and other diseases (6, 20.0%). The number of valid responses was 30. In the U.S., on the other hand, the diseases were circulatory system diseases (8 children, 21.1%), certain conditions originating in the perinatal period (8, 21.1%), neoplasms (7, 18.4%), respiratory diseases (5, 13.2%), endocrine, nutritional and metabolic diseases (3, 7.9%) and other diseases (11, 29.0%). Eleven other children had different diseases. There were 38 valid responses, and multiple responses.

3. d scores and c scores in the FFFS

Table 2 shows d scores and c scores by item. In the Japan-American comparison d scores for 2 of the 25 items show significant differences. Japan had significantly higher scores in "Time with health professionals" and "Time you are ill" (Mann-Whitney U test). As well, there were significant differences between Japan and the U.S. in c scores for 15 of the 25 items ; in all 15 items the American scores were significantly higher (Mann-Whitney U test). Table 3 ranks the top five items in terms of d and c scores, respectively.

When Japanese and American d scores for the three areas are compared (Table 4), Japan tends to have higher scores in "Relationship between family and subsystem" (Mann-Whitney U test).

4. Responses to the open-ended questions in

Table 2. Average Scores on FFFS Items

	Contens of Likert-scale questions	d score Average ± SD	c score Average ± SD
1.	Discuss concerns or problems with friends (Ⅱ)	0.8 ± 0.9	4.6 ± 1.9]**
		0.8 ± 1.2	5.8 ± 1.5]
2.	Discuss concerns or problems with relatives (Ⅱ)	0.7 ± 1.1	5.6 ± 1.4]*
		0.6 ± 1.0	6.4 ± 1.1]
3.	Time spent with spouse (Ⅰ)	2.4 ± 2.2	5.7 ± 1.6]**
		1.6 ± 1.6	6.6 ± 1.1]
4.	Discuss concerns or problems with spouse (Ⅰ)	0.8 ± 1.0	6.0 ± 1.5
		0.9 ± 1.4	6.5 ± 1.3
5.	Time spent with neighbors	1.2 ± 1.3	3.6 ± 1.4
		0.9 ± 1.2	3.2 ± 2.1
6.	Time for leisure or recreation (Ⅰ)	1.6 ± 1.5	4.8 ± 1.5
		1.7 ± 1.3	4.7 ± 1.7
7.	Help from spouse (Ⅰ)	1.2 ± 1.4	5.6 ± 1.3]**
		1.2 ± 1.5	6.4 ± 0.9]
8.	Help from relatives (Ⅱ)	0.9 ± 1.4	5.6 ± 1.2
		0.9 ± 1.5	5.2 ± 2.1
9.	Time with health professionals (Ⅱ)	1.6 ± 1.9]*	5.4 ± 1.6]*
		0.7 ± 1.4]	6.3 ± 1.2]
10.	Help from friends (Ⅱ)	1.1 ± 1.3	3.2 ± 1.7]△
		0.8 ± 1.3	4.1 ± 2.2]
11.	Problems with children (Ⅱ)	2.7 ± 2.1	6.5 ± 1.0
		2.0 ± 2.0	6.6 ± 0.8
12.	Time with children (Ⅰ)	1.5 ± 1.7	6.5 ± 0.9]*
		1.0 ± 1.4	6.8 ± 0.5]
13.	Time children miss school (Ⅲ)	1.7 ± 1.9	5.5 ± 2.0
		2.0 ± 2.3	6.1 ± 1.6
14.	Disagreements with spouse (Ⅰ)	1.5 ± 1.5	5.4 ± 1.9]*
		1.7 ± 1.8	6.3 ± 1.5]
15.	Time you are ill (Ⅲ)	1.4 ± 1.6]*	5.1 ± 2.1
		0.8 ± 1.4]	5.5 ± 2.3
16.	Time spent on housework (Ⅰ)	1.6 ± 1.5	5.0 ± 1.6]**
		1.3 ± 1.4	6.0 ± 1.4]
17.	Time you miss work (including housework) (Ⅲ)	1.8 ± 1.8	5.2 ± 1.7
		2.2 ± 2.2	5.7 ± 1.8
18.	Time spouse misses work (including housework) (Ⅲ)	1.5 ± 1.7	4.9 ± 1.8
		1.7 ± 2.3	5.3 ± 2.3
19.	Emotional support from friends (Ⅱ)	1.0 ± 1.3	4.8 ± 1.6]***
		0.8 ± 1.5	6.2 ± 1.6]
20.	Emotional support from relatives (Ⅱ)	0.8 ± 1.5	5.7 ± 1.4]*
		0.8 ± 1.3	6.3 ± 1.3]
21.	Emotional support from spouse (Ⅰ)	1.5 ± 1.9]△	6.3 ± 1.1]**
		0.8 ± 1.3]	6.9 ± 0.3]
22.	Time work routine is disrupted (Ⅲ)	1.5 ± 1.9]△	3.8 ± 1.7]**
		2.5 ± 2.2]	5.3 ± 2.1]
23.	Time spouse's work routine is disrupted (Ⅲ)	1.1 ± 1.4	3.8 ± 1.8]**
		1.4 ± 2.1	5.3 ± 2.0]
24.	Satisfaction with marriage (Ⅰ)	1.7 ± 2.0	6.0 ± 1.3]**
		1.4 ± 1.9	6.9 ± 0.3]
25.	Satisfaction with sexual relations (Ⅰ)	1.3 ± 1.7	3.8 ± 1.9]***
		1.3 ± 1.9	5.8 ± 1.9]

Upper figures : Japanese mothers (35), Lower figures : American mothers (39)

Ⅰ : Relationship between family and individual (10 items), Ⅱ : Relationship between family and subsystem (8 items), Ⅲ : Relationship between family and society (6 items)

△ : $p < 0.1$, * : $p < 0.05$, ** : $p < 0.01$, *** : $p < 0.001$

the FFFS (Table 5).

Responses to open-ended questions were classified by context and the top five were listed

Table 3. Top 5 Scores of FFFS Items

Item (Japanese mothers)	Average ± SD	Item (American mothers)	Average ± SD
d score (family function score)			
Problems with children	2.7 ± 2.1	Time work routine is disrupted	2.5 ± 2.2
Time spent with spouse	2.4 ± 2.2	Time you miss work (including housework)	2.2 ± 2.2
Time you miss work (including housework)	1.8 ± 1.8	Problems with children	2.0 ± 2.0
Satisfaction with marriage	1.7 ± 2.0	Time children miss school	2.0 ± 2.3
Time children miss school	1.7 ± 1.9	Time spouse misses work (including housework)	1.7 ± 2.3
c score (importance score)			
Time with children	6.5 ± 0.9	Satisfaction with marriage	6.9 ± 0.3
Problems with children	6.5 ± 1.0	Emotional support from spouse	6.9 ± 0.3
Emotional support from spouse	6.3 ± 1.1	Time with children	6.8 ± 0.5
Discuss concerns or problems with spouse	6.0 ± 1.5	Time spent with spouse	6.6 ± 1.1
Satisfaction with marriage	6.0 ± 1.3	Problems with children	6.6 ± 0.8

Japanese mothers (35), American mothers (39)

Table 4. Comparison of Japan-U.S. Family Functions Based on Three Areas of the FFFS

Areas of relationships	d score Average ± SD	
Relationship between family and individual	15.3 ± 8.6	
	13.2 ± 9.6	
Relationship between family and subsystem	9.6 ± 6.0	△
	7.3 ± 6.8	△
Relationship between family and society	9.4 ± 6.0	
	9.9 ± 8.8	

Upper figures : Japanese mothers (35), Lower figures : American mothers (39)
△ : $p < 0.1$

IV. Discussions

1. A comparison of Japanese and American families using "family houses"

When the rate of three-generation families is considered, the family composition significantly differs between Japan and the U.S., with 23.3% of Japanese households including a grandparent, as opposed to 0% in the U.S. (Table 1). Also, the figure for working mothers was significantly higher in the U.S., at 63.2%, as opposed to 32.3% in Japan. In this way the differences in attributes of Japanese and American families became clear, and it is thought that a deeper understanding of the Japanese family derived from the assessment of cultural features will lead to suggestions for family nursing intervention for the Japanese family.

When the number of days of the child's hospitalization and the number of days the family uses the "family house" are considered (Table 1), it is seen that both figures are significantly higher for Japan, and it can be said that the existence of the "family house" is closely related to residence function of the family. As for the children's diseases, neoplasms were top in Japan (30.0%), but ranked third in the U.S. (16.7%). For example, in the U.S. hospitalization during the incipient stage of leukemia is 7 to 10 days, far shorter than in Japan. Because subsequent treatment takes place at home in the U.S.,[9] mothers may be likely to use a "family house" for a smaller number of days.

Among the top five responses, "What is most difficult for you now?" (Table 5), financial burden was cited the most in Japan (8 out of 26). Staying at an inexpensive "family house," and thereby saving on accommodations and transportation, reduces the financial burden. However, even if the lodging expense is low, extended hospitalization of a child is thought to be a great burden.[1] Moreover, because many of the users of "family houses" are young parents (Table 1) without a solid livelihood, the finan-

Table 5. Top 5 Responses to FFFS Open-ended Questions

Japanese mothers		American mothers	
What is most difficult for you now? (Japanese mothers [26], American mothers [39])			
Financial burden	8 (30.8)	Child's illness	11 (28.2)
Uncertainty of future	6 (23.1)	Separation from family	8 (20.5)
No time to spend with other children	5 (19.2)	Own health problems	6 (15.4)
Family and own health problems	5 (19.2)	No time to spend with other children	6 (15.4)
Anxieties and worries over child's illness/treatment	4 (15.4)	Workload (including home chores)	5 (12.8)
Other (9 items)	15 (57.7)	Other (12 items)	20 (51.3)
What is most helpful for you now? (Japanese mothers [26], American mothers [39])			
Presence and support by family, relatives and acquaintances	18 (69.2)	Availability of family house	19 (54.3)
Assistance with housework and child raising	6 (23.1)	Presence and support by family, relatives and acquaintances	14 (40.0)
Exchanges with other "family house" users	5 (19.2)	Support by medical staff	8 (22.9)
Children's happiness and growth	4 (15.4)	Exchanges with other "family house" users	5 (14.3)
Financial assistance	4 (15.4)	Being together with the sick child	3 (8.6)
Other (9 items)	15 (57.7)	Other (12 items)	20 (57.1)

No. persons (%), multiple responses given

cial burden may impact upon their living conditions.[1] Currently the average length of stay at a hospital in Japan is 4.2 times longer than in the U.S.[10] Because reform of the Japanese medical system is leading to shorter hospital stays, the burden on the family arising from its living away from home is expected to grow lighter.

In Japan a trip from home to the hospital takes 225.5 minutes (110.2 minutes in the U.S.), but use of a "family house" reduces the time to 16.0 minutes (3.4 minutes in the U.S.) (Table 1). It is thought that use of the "family house" is a great relief for families because it allows them to secure time with children and provides a place from which they can quickly reach the hospital in case of an emergency. The top five responses to the item "What is most helpful for you now?" (Table 5) included "Exchanges with other 'family house' users" in both Japan and the U.S. (3rd place in Japan, 4th place in the U.S.). The "family house" can be expected to constitute a place of peer support where families in similar circumstances exchange information and provide mutual assistance.[1]

However, it takes a significantly longer time from a "family house" to a hospital in Japan than it does in the U.S. In Japan the longest time was 90 minutes. Because a "family house" cannot carry out its function unless it is close to a hospital,[4][11] it will be necessary to reexamine the locations of Japan's "family houses."

2. A Japanese-American comparison of family functioning by 25 items and 3 areas

An examination of the d scores by individual items (Table 2) shows that Japan has significantly lower sufficiency of family functioning in "Time with health professionals" and "Time you are ill." It is necessary to suffice the protective and rest functions within the Japanese family. In the U.S., patient advocacy has become prevalent, and hospital patients can always avail themselves of counseling. In Japan, however, the physician and patient have traditionally had a vertical relationship. It is thought one reason for such a relationship is the absence of the family doctor system.[12] Moreover, at American RMHs, the hospital staffers also serve in the role of advisers[13] and there is a well-developed system of consultation with healthcare workers.[11][14] In contrast, only 10.3% of Japanese "family houses" have established counseling rooms, and professional assistance from

nurses, healthcare workers and others capable of providing counsel[1)15)] should be offered.

In only two of the 25 items significant differences were observed in d scores between Japan and the U.S., but c scores for 15 of the 25 items differed significantly. There was a wider disparity between Japan and the U.S. in items evaluated as important, which establishes the fact that Japanese and American families maintain different values. Table 3, which lists the top five items in d scores and c scores, shows that "Time with children" ranked among the top five in c scores (1st in Japan, 3rd in the U.S.), disclosing that both Japanese and American mothers value time spent with their children. On the other hand, this item was not included among the top five d scores for either Japanese or American mothers. This can be thought to reflect the fact that family function was sufficient in that mothers could spend time with children in hospitals near the "family houses" they were using. However, "Problems with children" was ranked among the top five items in d scores (1st in Japan, 3rd in the U.S.), which indicates that worries over children persisted. In response to the question "What is most difficult for you now?" the lack of time with children other than the sick child was among the top five responses in both Japan and the U.S. (3rd in Japan, 4th in the U.S.) (Table 5). Thus intervention to relieve anxiety with respect to children in the hospital and children left at home is necessary.[16)]

Items that ranked among the top five in both d scores and c scores (Table 3) were "Problems with children" and "Satisfaction with marriage" in Japan and "Problems with children" in the U.S. Those items with both high d scores and high c scores suggest nursing intervention is necessary. As for intervention in the Japanese family with respect to "Problems with children," consideration of mothers' difficulties calls for relieving anxieties and worries over the sick child and assuring time with other children (Table 5). It is necessary to pay personal attention that satisfies each family's needs by, for example, creating an environment in which the mother can with peace of mind return home to spend even a short time with the rest of her family.[17)] It is conceivable that in addition to the enhanced support from medical social workers and other specialists,[1)] as mentioned earlier, nurses could assist mothers from distance to prevent them from feeling isolated and establish with them trusting relationships in which they could freely consult about their children's condition or prognosis.[18)] As well, nurses are expected to demonstrate a sympathetic attitude toward mothers,[19)] to provide them with accurate information at appropriate times and to give satisfactory explanations.[18)] Also, it is thought "Satisfaction with marriage" ranked among the top five in both scores because leading two lives meant less time with one's spouse, causing a decline in the sexual-love functions. Because it has been shown that having a child with a chronic disease can lead to family problems and divorce,[20)21)] it is desirable that the health care environment be improved not only for the sick child but also with an emphasis on family life. A big function of the RMHs in the U.S. is to provide a place resembling the home where the sick child and family can gather.[22)] It is thought that spending time together and sharing various problems among family members is an effective method of support for families. For example, it is conceivable that nurses could give

considerations to enabling mothers to be in close touch with their distant husbands, encourage paternal visits to promote time when parents can talk and arrange sleepovers at a "family house" when convenient for fathers.[18]

When family functions are examined in each of the three areas (Table 4), it is seen that the sufficiency of family function of "Relationship between family and subsystem" tends to be lower in Japan. Also, a previous study[23] of Japanese mothers who have healthy children attending nursery school shows that the average d scores in the FFFS were 14.8±9.8 in "Relationship between family and individual," 8.4±5.3 in "Relationship between family and subsystem" and 8.9±6.0 in "Relationship between family and society." Although it is not an exact comparison, because of the different ranges in children's ages, if compared with the results of this study (Table 4), d scores show the greatest difference in "Relationship between family and subsystem" and reveal that the family functioning of this area in this study was lower than that in a previous study. The subsystem consists of people with whom the family has strong interrelationships, such as acquaintances, relatives and neighbors.[8][24] Japanese have a special concept called "uchi-soto" (inside vs. outside).[25] The family, which erects a solid boundary between itself and others, has weak relationships with the subsystem, and is hesitant to receive its support. It has been pointed out that in Japan an unfortunate feature of social support for mothers with babies is that neighbors provide the least help.[26] In consideration of this deeply rooted cultural background, it is necessary to try to improve the level of family functioning through adjustment of the family-subsystem relationship.

V. Conclusion

The functioning of Japanese and American families using "family houses" was compared. Amongst FFFS items, Japan had significantly lower sufficiency of family functions in "Time with health professionals" and "Time you are ill." When examined by area, Japan tended to have lower sufficiency of family function in "Relationship between family and subsystem." Furthermore, items for which nursing intervention is necessary included "Problems with children" and "Satisfaction with marriage" in Japan and "Problems with children" in the U.S. In this way, the features of the functions of Japanese and American families using "family houses" have been established, and because of the deeper understanding of the Japanese family from a cultural viewpoint, family nursing intervention for the Japanese family should be provided.

Acknowledgments

The exceptional support of Dr. Yasumi Uchida of the Japan Foundation of Cardiovascular Research during this study is hereby gratefully acknowledged. The study was founded in part by Grant-in-Aid for Scientific Research (B) (2), #15390670 (granted to Naohiro Hohashi), from Japan Society for Promotion of Science (JSPS).

〔受付 '03.12.11
採用 '04.4.23〕

References

1) Hohashi, N., Ishimi, S., Iwata, S., et al. : A survey on the actual conditions of "accommodation facili-

ties for families of children with chronic diseases" throughout Japan—Regarding the problems and topics to organize facilities that are easy for families to use—, Japanese Journal of Research in Family Nursing, 9 (1) : 44—49, 2003
2) Aitken, T.J. & Hathaway, G. : Long distance related stressors and coping behaviors in parents of children with cancer, Journal of Pediatric Oncology Nursing, 10 (1) : 3—12, 1993
3) Maeda, M., Hohashi, N. & Sugishita, C. : Survey of actual conditions regarding family members accompanying sick children at Tokyo metropolitan hospitals with beds of 100 or greater, Japanese Journal of Research in Family Nursing, 5 (2) : 94—100, 2000
4) Baum, E.S. : The house that love built : Ronald McDonald houses offer support for families, volunteer opportunities, Imprint, 29 (1) : 46—47, 66, 1982
5) Sanford, C.C. : Ronald McDonald House—The house that love built, Pediatric Nursing, 19 (3) : 260—262, 1993
6) Iwai, K. : A home away from home, Jiyukokuminsha, Tokyo, 2003
7) Roberts, C.S. & Feetham, S.L. : Assessing family functioning across three areas of relationships, Nursing Research, 31 (4) : 231—235, 1982
8) Hohashi, N., Maeda, M. & Sugishita, C. : Development of the Japanese-language Feetham Family Functioning Survey (FFFS) and evaluation of its effectiveness, Japanese Journal of Research in Family Nursing, 6 (1) : 2—10, 2000
9) Ishiguro, A. : Nursing care of children in the United States with emphasis on leukemia and asthma, The Journal of Child Health, 52 (5) : 495—499, 1993
10) Iwasaki, S. & Takeuchi, M. : Medical treatment provision system and number of days hospitalized, Hospitals, 58 (2) : 114—119, 1999
11) Nishimura, K. : The future of outpatient pediatrics, Pediatrics of Japan, 35 (7) : 619—623, 1994
12) Lee, K. : The light and darkness of American medical care, Igaku-Shoin, Tokyo, 2000
13) Matsutani, M. : The chronicle and matters related to the establishing of accommodations for patients' families Part 1, Hospitals, 59 (10) : 880—886, 2000
14) Iwai, K. : Ronald McDonald House and American pediatric hospitals Part 2—Networks to support children with intractable diseases and their families, Nursing Today, 12 (2) : 68—71, 1997
15) Ueda, Y. : Hospital Hospitality House in Japan, Journal of Japan Society of Nursing and Health Care, 5 (1) : 1—8, 2003
16) Uno, K., Abe, M., Ishiguro, A., et al. : A questionnaire on admission with parents in pediatric ward, The Journal of Child Health, 56 (6) : 790—793, 1997
17) Inoue, T., Atoda, H., Koumoto, C., et al. : The significance of the mother's attendance on an infant in the hospital and the nurse's role, The Collection of Papers 24th times The Japan Society of Nursing—Child Nursing—, 86—89, 1993
18) Eguchi, Y. : How a family house can help the family of a child with an unfavorable prognosis, The Japanese Journal of Child Nursing, Monthly, 26 (13) : 1782—1784, 2003
19) Ono, K., Fukazawa, I., Kamiyama, Y., et al. : A study of parents during visits with a hospitalized infant, The Collection of Papers 24th times The Japan Society of Nursing—Child Nursing—, 76—78, 1993
20) Shirasaki, K. & Akasaka, T. : Regarding events in the lives of children with bronchial asthma and their in-hospital treatment, Japanese Journal of Pediatrics, 55 (1) : 89—95, 2002
21) Binger, C.M., Ablin, A.R., Feuerstein, R.C., et al. : Childhood leukemia : Emotional impact on patient and family, The New England Journal of Medicine, 280 (8) : 414—418, 1969
22) Breu, J. : Ronald McDonald Houses becoming more than just a home away from home, American Medical News, 28 (7) : 17—18, 1985
23) Hohashi, N. : Family functioning in Japanese families with hospitalized children, The 5th International Family Nursing Conference ABSTRACT, 75, 2000
24) Bronfenbrenner, U. : The ecology of human development : Experiments by nature and design, Harvard University Press, Cambridge, Mass, 1979
25) Nakane, C. : Japanese society, Weidenfeld and Nicolson, London, 1970
26) Maru, M., Kanematsu, Y., Narama, M., et al. : Characteristics of social support to mothers of young children, The Journal of Child Health, 60 (6) : 787—794, 2001

ファミリーハウスを利用する母親からみた家族機能の日米比較
—Feetham家族機能調査を用いたクロスカルチャー研究—

法橋　尚宏[1)]，小山智佳子[2)]
[1)]神戸大学医学部保健学科小児・家族看護学
[2)]神戸大学医学部附属病院第二病棟

キーワード：ファミリーハウス，家族機能，FFFS，日米比較

ファミリーハウスを利用している日米の母親を対象として，FFFS (Feetham Family Functioning Survey) の日本語版と英語版を用いて家族機能を比較した．25項目別にみた家族機能得点の日米比較では，「医療機関にかかったり，健康相談を受けること」と「体調が悪いとき」の家族機能充足度が日本のほうが有意に低く，日本の家族に対しては保護機能と休息機能の充足が望まれる．

また，3分野別にみた家族機能得点の日米比較では，「家族とサブシステムとの関係」の家族機能充足度が日本のほうが低い傾向がみられた．これは，家族員とそれ以外の人々の間に明確な一線があるという日本の家族の特徴と関係していると考えられ，文化背景を考慮しながら家族とサブシステム(知人や身内，近所の人のように家族との相互関係が強い人々）との関係を調整していくことが必要であろう．

家族機能得点と重要度得点からの評価により，家族看護介入が必要である家族機能の項目は，日本では「子どもに関する心配事」と「結婚生活に対する満足感」，アメリカ合衆国では「子どもに関する心配事」であった．すなわち，日米ともに入院中の病児と自宅に残している子どもに対する心配を軽減する介入が必要である．また，日本の「結婚生活に対する満足感」については，夫婦間の性愛機能への支援が考えられ，病児のみならず家族の生活をも重視した医療環境の整備の再確認が必要である．

このように，文化背景から日本の家族をより深く理解することが可能であり，クロスカルチャー研究により家族看護介入を考えていく示唆を得ることができた．