Asian Journal of

HUMAN SERVICES

Printed 2018.0430 ISSN2188-059X
Published by Asian Society of Human Services

April 2018
VOL. 14

Asian Society of Human Services

The word ‘Human Services’ is used when someone faces social challenges for ‘help’ or ‘support’ people.

‘Human Services’ is expanding rapidly its area such as field of social welfare, medical, nursing, clinical psychology related mental care, health promotion for aging society, assist family for infant and child care, special supporting education corresponding to vocational education, education support sector corresponding to era of lifelong learning and fluidization of employment corresponding to the area of career development.

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ORIGINAL ARTICLES

Factors Affecting Discharge to Home of Geriatric Health Services Users: An Analysis of Physical Conditions and the Contents of Care Received P.1

Kazutoshi FURUKAWA, Megumi KODAIRA, Yuko FUJIO, Yoshimi SAKATA, Takahito TAKEUCHI

Survey to Assess Information-gathering During the Process of Designing Care Plans Regarding Nutrition Improvement P.11

Yuko FUJIO, Yoshiko ENOMOTO, Kazutoshi FURUKAWA, Megumi KODAIRA, Noriko OGAWA

Acute Hospital Nurses' Recognition of and Approaches to Functional Recovery/Independent Excretion Care for Elderly Patients with Pneumonia P.24

Yoshiko ENOMOTO, Yuko FUJIO, Megumi KODAIRA, Yoshiyuki INOUE, Yoshimi SAKATA

Constructing 'the Psychopath': A Discourse Analysis of Psychologists' Understandings of Psychopathy P.38

Kitty CLARK-MCGHEE, Maria CASTRO ROMERO

A Study on the Characteristics of Network Consumption Behaviors and Evidence-Based Analysis of Influencing Factors P.53

Fan FAN, Honggi KIM

Consideration of Constructs for the Social Skill Training Program Development for Children with ADHD Tendency: Focus on the Analysis of the Practical Report P.66

Aiko KOHARA, Haejin KWON, Yoshino KOMINE, Changwan HAN

Instructions for Authors P.84

Publication Manual P.85

Publication Ethics and Malpractice Statement P.87

Human Services

DOI: http://dx.doi.org/10.14391/ajhs.14.1
Asian Journal of Human Services, VOL.14 1-10

ORIGINAL ARTICLE

Factors Affecting Discharge to Home of Geriatric Health Services Users:
An Analysis of Physical Conditions and the Contents of Care Received

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ABSTRACT

Japan's long-term care insurance system, which was put in place in 2000, is roughly divided into at-home care services and facility services. Facility services comprise three types: special nursing homes, geriatric health service facilities, and medical care facilities. To obtain useful findings for the promotion of discharge to home, this study analyzed the discharge-related data of a geriatric health services facility promoting home care. On examining the 52-month data (from 2012) of 541 users discharged from the facility, the energy intake was shown to most markedly influence the feasibility of discharge to home, followed by the duration of the time spent out of bed and nocturnal incontinence rate. The importance of mealtime assistance and necessity of prolonging the duration of the time spent out of bed by supporting diurnal arousal and independent urination during the night-time were also suggested as effective approaches to promote discharge to home.

Received
November 7, 2017

Revised
December 8, 2017

Accepted
January 11, 2018

Published
April 30, 2018

＜Key-words＞
Japan, geriatric health services facility, discharge-related data analysis, discharge to home, discriminant analysis

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Asian J Human Services, 2018, 14:1-10.

DOI: http://dx.doi.org/10.14391/ajhs.14.1
Asian Journal of Human Services, VOL.14 1-10

I. Introduction

Japan's long-term care insurance system, which was put in place in 2000, is roughly divided into at-home care services and facility services. Facility services comprise three types: special nursing homes, geriatric health service facilities, and medical care facilities. Currently, there are 4,045 geriatric health services facilities located throughout Japan. These facilities are also called 'middle facilities', as they are in an intermediate position between hospitals and home care service providers or between medical and welfare services (Japan Association of Geriatric Health Services Facilities, 2016a). In 2012, the care fee calculation system for geriatric health services was revised, and the basic fees and additional fees applied to support discharge to home or home care facilities were newly defined. At that time, geriatric health care service facilities focusing on home discharge were classified into three main types: those promoting home care (type-1); those supporting home care with additional medical fees (type-2); and the conventional type (type-3) (Japan Association of Geriatric Health Services Facilities, 2015). The classification requirements for type-1 and -2 facilities include: rates of discharge to home of >50 and >30%, respectively, and bed turnover rates of 10% or higher and 5% or higher, respectively. Thus, those not meeting these requirements are classified as type-3 facilities. The rate of type-1 facilities, which was limited to 3.8% in April 2012, slowly increased to 9.4% in October 2013, 10.6% in October 2014, and 16.4% in October 2015. Similarly, the rate of type-2 facilities was 10.4% in April 2012 and slightly increased to 24.0, 24.4, and 29.6%, respectively. In contrast, type-3 facilities had accounted for as high as 85.8% until April 2013, but its rate decreased to 54.0% in October 2015 (Japan Association of Geriatric Health Services Facilities, 2016b). These changes in the rate of discharge may represent the gradual responses of these facilities to national measures to promote discharge to home and home care.

Since geriatric health services facilities were classified into 3 types in 2012, several studies have been conducted to examine discharge from the facility to home. For example, the Japan Association of Geriatric Health Services Facilities conducted a survey, and reported that "a limited number of users desiring to return to home in the facility" and "insufficient approaches" were negative factors for discharge to home (Japan Association of Geriatric Health Services Facilities, 2013). A questionnaire survey, involving care managers working in geriatric health services facilities, revealed that activities of daily living (ADL) support and information for family care-givers are provided more frequently in type-1 compared with other facilities (Nakamura, 2016). Furthermore, in an interview-based survey to examine nurses working in geriatric health services facilities, facility staff recognized "a high ADL level", "the absence of severe dementia", and "a shorter duration of facility use" as factors promoting discharge to home (Hatakeyama, Masumitsu, Osawa et al., 2016). The importance of leading users and their families to accurately recognize support for discharge to home in the early stages, establishing

DOI: http://dx.doi.org/10.14391/ajhs.14.1
Asian Journal of Human Services, VOL.14 1-10

systems to fulfill users' and facilities' needs, and providing support through multi-professional collaboration to promote discharge to home was also noted in another interview-based survey, involving multiple professionals, including nurses, working in geriatric health services facilities (Hayashi, 2015). However, as all of these previous studies targeted facility staff, factors influencing the feasibility of discharge from geriatric health services facilities to home remained unclear. Therefore, this study analyzed the discharge-related data of a type-1 facility to obtain useful findings for the promotion of discharge to home.

II. Definitions of terms

1. Functional recovery care

Functional recovery care is a theory of care established and defined by Takeuchi as 'supporting individuals to achieve and improve/maintain their physical, mental, and social independence through care' (Takeuchi, 2017).

2. Basic care approaches

Functional recovery care is provided through basic care approaches, covering 4 important areas of health: "fluid", "nutrition", "exercise", and "excretion". Takeuchi defines that "these areas should be commonly addressed in any type of older people care" (Takeuchi, 2017).

III. Methods

1. Subjects and data collection

A total of 541 users discharged from a facility meeting the requirements for type-1 geriatric health services facilities within the 52-month period between April 2012 and July 2016 were studied. With the agreement of the facility chief, anonymized discharge-related data, not containing information that might allow the identification of individuals, were collected from the facility.

2. Study items

The following items were analyzed:

1) Basic information

The sex, age, care level based on the Long-term Care Insurance System, place of residence before facility admission, duration of facility use, and discharge destination (home/ other facilities).

DOI: http://dx.doi.org/10.14391/ajhs.14.1
Asian Journal of Human Services, VOL.14 1-10

2) Physical condition

The BMI, serum albumin level, degree of mouth opening, degree of tongue protrusion, and consciousness/spontaneity level; the degree of mouth opening is the distance between the lower edge of the upper lip and the upper edge of the lower lip when opening the mouth at the maximum, while that of tongue protrusion is the distance between the tips of the lip and tongue when protruding the latter forward at the maximum. The consciousness/spontaneity level was measured using a 5-item test developed by the study facility, in which higher scores indicate higher consciousness/spontaneity levels. “Meals”, “conversations”, “friendly talks”, and “recreational activities” are rated on a 4-point scale from “spontaneous (4)”, “following others’ behavior (3)”, “requiring guidance on some occasions (2)”, and “requiring guidance at all times (1)”. Similarly, “dozing” is rated on a 4-point from “never (4)”, “occasionally (3)”, “once a day (2)”, and “several times a day (1)”. Thus, the total score ranges from 5 to 20.

3) Contents of care

The fluid intake (daily mean), energy intake (daily mean), total walking distance (daily mean), duration of the time spent out of bed (daily mean), frequency of going out (monthly mean), diurnal incontinence rate, frequency of lower garment contamination during the daytime (monthly mean), nocturnal incontinence rate, and frequency of lower garment contamination during the night-time (monthly mean).

3. Analysis

All subjects were classified based on their discharge destinations: home (home group) and other facilities (non-home group), to calculate their means (standard deviations) and medians (interquartile ranges), and compare them using the unpaired t-test and Mann-Whitney U-test. Furthermore, discriminant analysis was performed, with the home and non-home groups as objective variables and the contents of care (fluid intake, the energy intake, total walking distance, duration of the time spent out of bed, diurnal incontinence rate, and nocturnal incontinence rate) as explanatory variables. Statistical analysis was performed using SPSS Statistics 24 for Windows, with the significance level set at $p<0.05$.

4. Ethical considerations

Prior to the study, the chief and support consultant managing data of the study facility were provided with written and oral explanations to obtain their written consent. The data provided by them were anonymized, and they did not contain information that might allow the identification of individuals, such as names.

In addition, the study was previously approved by the ethics committee of Seirei Christopher University (approval number: 16011).

DOI: http://dx.doi.org/10.14391/ajhs.14.1
Asian Journal of Human Services, VOL.14 1-10

V. Results

1. Distribution of subjects' attributes

The subjects' mean age was 86.2±6.8 (range: 59 to 101). The numbers of home and non-home group members were 247 (45.7%; 56 males and 191 females; and mean age: 84.9±7.2) and 294 (54.3%; 88 and 206; and 87.2±6.3), respectively. Table 1 outlines the distribution of their attributes.

<Table 1>Distribution of Subjects' Attributes (n=541)

item	category	number (person)	rate (%)
Sex	Female	397	73.4
	Male	144	26.6
Age (years old)	<60	1	0.2
	60-64	4	0.8
	65-69	4	0.8
	70-74	21	3.9
	75-79	45	8.3
	80-84	141	26.1
	85-89	131	24.3
	90-94	153	28.3
	95-99	35	6.5
	>100	6	0.1
Care level based on the Long-term Care Insurance System	1	71	13.1
	2	140	25.9
	3	118	21.8
	4	114	21.1
	5	98	18.1
Place of residence before facility admission	Medical institutions	275	50.8
	Home	257	47.5
	Home (others)	7	1.3
	Care and welfare facilities	1	0.2
	Unknown	1	0.2
Duration of facility use (day)	<99	282	52.1
	100-199	105	19.4
	200-299	44	8.1
	300-399	23	4.3
	400-499	14	2.6
	>500	73	13.5
Discharge destination	Non-home group members	294	54.3
	Home group members	247	45.7

2. Basic information regarding the home and non-home groups

As shown in Table 2, the mean age and duration of facility use were significantly lower and shorter, respectively ($p<0.001$ in both cases), in the home compared with non-home group.

DOI: http://dx.doi.org/10.14391/ajhs.14.1
Asian Journal of Human Services, VOL.14 1-10

<Table 2> Basic Information Regarding the Home and Non-home Groups

item	Discharge destination	Frequency	Means	Standard deviations	Medians	Interquartile ranges	p value
Age (years old)[1)]	Non-home group	294	87.2	6.3	87.0	83.0-92.0	0.000 ***
	Home group	247	84.9	7.2	85.0	80.0-91.0	
Duration of facility use (day)[2)]	Non-home group	294	358.7	532.7	147.0	50.1-379.3	0.000 ***
	Home group	247	152.4	304.8	88.0	48.0-124.0	

1) Unpaired t-test
2) Mann-Whitney U-test
***p<0.001

3. Physical conditions of the home and non-home groups

As shown in Table 3, significant differences were observed in all physical health-related items. The BMI and serum albumin level were significantly higher in the home compared with non-home group (p<0.001 in both cases). The home group also showed significantly higher degrees of mouth opening and tongue protrusion and consciousness/spontaneity level (p<0.001).

<Table 3>Physical Conditions of the Home and Non-home Groups

item	Discharge destination	Frequency	Means	Standard deviations	Medians	Interquartile ranges	p value
BMI[1)]	Non-home group	291	21.17	3.54	21.40	18.8-23.3	0.000 ***
	Home group	246	22.29	3.28	22.30	20.2-24.6	
Serum albumin level (g/dL) [1)]	Non-home group	280	3.39	0.49	3.40	3.1-3.8	0.000 ***
	Home group	217	3.59	0.46	3.60	3.3-3.9	
Mouth opening (mm) [1)]	Non-home group	285	38.71	10.01	40.00	35.0-45.0	0.000 ***
	Home group	246	42.02	8.89	40.00	35.0-50.0	
Tongue protrusion (mm) [1)]	Non-home group	284	31.98	15.67	35.00	30.0-40.0	0.001 **
	Home group	246	37.09	12.39	40.00	32.8-45.0	
consciousness/spontaneity level (point) [1)]	Non-home group	292	12.7	5.0	13.5	8.0-17.0	0.000 ***
	Home group	247	16.8	3.2	18.0	15.0-19.0	

1) Unpaired t-test
**p<0.01, ***p<0.001

4. Contents of care for the home and non-home groups

As shown in Table 4, there were significant differences in all items, excluding the frequency of lower garment contamination during the night-time. Both the fluid and energy intakes were significantly higher in the home compared with non-home group (p<0.001 in both cases). The values representing the total walking distance, duration of the time spent out of bed, and frequency of going out were also significantly higher (p<0.001), with significantly lower diurnal incontinence and nocturnal incontinence rates in the home group (p<0.001). The frequency of lower garment contamination during the daytime was also significantly lower in the home group (p<0.05).

DOI: http://dx.doi.org/10.14391/ajhs.14.1
Asian Journal of Human Services, VOL.14 1-10

<Table 4>Contents of Care for the Home and Non-home Groups

item	Discharge destination	Frequency	Means	Standard deviations	Medians	Interquartile ranges	p value
Fluid intake (mL/day) 1)	Non-home group	294	1458.4	429.2	1500.0	1177.3-1818.8	0.000 ***
	Home group	247	1673.3	316.5	1800.1	1500.0-1850.0	
Energy intake (kcal/day) 1)	Non-home group	294	1133.1	375.0	1200.0	941.5-1402.0	0.000 ***
	Home group	247	1397.8	197.7	1442.0	1221.0-1563.1	
Total walking distance (m/day) 2)	Non-home group	294	183.7	267.7	125.9	10.0-228.2	0.000 ***
	Home group	247	379.4	398.6	261.0	143.6-498.0	
Duration of the time spent out of bed (hour/day) 1)	Non-home group	293	11.2	4.7	13.0	10.0-14.0	0.000 ***
	Home group	246	13.9	1.3	14.0	14.0-14.0	
Frequency of going out (time/month) 1)	Non-home group	294	2.8	3.3	2.0	1.0-3.3	0.000 ***
	Home group	246	7.6	5.3	7.0	4.0-11.0	
Diurnal incontinence rate (%) 2)	Non-home group	293	51.9	34.6	53.8	18.1-85.2	0.000 ***
	Home group	247	31.2	31.8	17.9	1.3-56.5	
Lower garment contamination during the daytime (time) 2)	Non-home group	294	2.7	4.5	1.0	0.0-4.0	0.033 *
	Home group	247	2.0	2.9	1.0	0.0-3.0	
Nocturnal incontinence rate (%) 2)	Non-home group	293	77.6	35.4	100.0	60.5-100.0	0.000 ***
	Home group	247	52.7	44.1	56.3	4.5-100.0	
Lower garment contamination during the nighttime (time) 2)	Non-home group	294	2.5	4.2	1.0	0.0-3.0	0.156
	Home group	246	1.9	3.0	1.0	0.0-3.0	

1) Unpaired t-test
2) Mann-Whitney U-test
*:p<0.05, ***p<0.001

5. Discriminant analysis

The obtained eigenvalues and the results of a test to confirm the significance of discriminant functions are shown in Tables 5 and 6, respectively. The canonical correlation of 0.475 achieved in the former and the sufficient significance confirmed in the latter indicate sufficient discriminant functions ($p<0.001$). Among the standardized discriminant coefficients shown in Table 7, explanatory variables showing higher absolute values were the energy intake (0.48), duration of the time spent out of bed (0.38), and nocturnal incontinence rate (-0.38).

<Table 5>Eigenvalues

Function	Eigenvalues	Cumulative contribution rate	Canonical correlation
1	0.291	100	0.475

<Table 6>Significance of Discriminant Functions

Function test	Wilks's λ	χ^2	Degree of freedom	p-value
1	0.775	136.093	6	0.000

DOI: http://dx.doi.org/10.14391/ajhs.14.1
Asian Journal of Human Services, VOL.14 1-10

<Table 7>Standardized Discriminant Coefficients

Contents of care	Function
	1
Fluid intake	0.09
Energy intake	0.48
Total walking distance	0.17
Duration of the time spent out of bed	0.38
Diurnal incontinence rate	0.02
Nocturnal incontinence rate	-0.38

VI. Discussion

On analyzing the 541 users discharged from the study facility to home or other destinations within the 52-month period (4 years and 4 month) to clarify factors related to each type of discharge, significant differences were observed, as the home group showed more favorable scores for all items, excluding the frequency of lower garment contamination during the night-time. Among these scores, those related to nutrition particularly varied between the home and non-home groups. The home group's mean energy intake was 1,397.8 kcal/day, while the non-home group's value was limited to 1,133.1 kcal/day. Similarly, the serum albumin level as a nutritional index was 3.59 g/dL in the home group and 3.39 g/dL in the non-home group. In both cases, the values were higher in the home group. Furthermore, multivariate analysis to compare the contents of care for each group revealed that the energy intake was shown to most markedly influence the feasibility of discharge to home. In a previous study comparing the nutritional status and mental/physical conditions of the care-dependent older people living at home and facility users, their mean energy intakes were 1,389.06±317.32 and 1,327.27±244.44 kcal, respectively. Similarly, their mean serum albumin levels were 3.82±0.46 and 3.62±0.42 g/dL, respectively. In both cases, the values were higher among the care-dependent older people living at home (Fujio, Ogawa, Kodaira et al., 2016). A similar tendency was observed in comparison of the types of food consumed, as the rates of consuming regular types of food were 76.9 and 51.8%, respectively (Fujio, Ogawa, Kodaira et al., 2016). Another study analyzing the serum albumin levels and mental/physical conditions of care-dependent older people also highlighted the importance of improving their nutritional conditions to promote the recovery of their mental/physical functions (Fujio, Shimada,Sugiyama et al., 2017). As these data indicate that the nutritional conditions of care-dependent older people living at home is more favorable than those of facility users, and the results of the present study also support

DOI: http://dx.doi.org/10.14391/ajhs.14.1
Asian Journal of Human Services, VOL.14 1-10

this, the nutritional status may be a useful index of discharge to home.

Another important finding from multivariate analysis was that the duration of the time spent out of bed and nocturnal incontinence rate markedly influenced the feasibility of discharge to home, following the energy intake. This may be explained by the burden of family care-givers, which can be reduced by prolonging the times patients spend out of bed and preventing nocturnal incontinence among them. In this respect, these 2 approaches may promote discharge to home. In addition, support approaches that promote fluid and energy intakes may also be needed, as it is necessary to increase the diurnal arousal level, in order to prolong the duration of the time spent out of bed.

As a study limitation, the analytical data used in this study were obtained from a single type-1 facility. Furthermore, other factors possibly influencing the feasibility of discharge to home, such as family conditions promoting home care and the influence of post-discharge home care services, were not systematically examined. To address these challenges, it may be necessary to continue to examine the study items using data from other facilities. Moreover, based on data obtained by continuing the study, there is a need for widely disseminating support methods that increase the discharge to home rate.

VII. Conclusion

This study examined factors influencing the feasibility of discharge to home by analyzing 541 users discharged from a geriatric health services facility promoting home care within a 52-month period. Among the study items, the energy intake most markedly influenced such feasibility, followed by the duration of the time spent out of bed and nocturnal incontinence rate. The results suggest the importance of mealtime assistance, as well as the necessity of prolonging the duration of the time spent out of bed by supporting diurnal arousal and independent urination during the night-time as effective approaches to promote discharge to home.

Acknowledgment

The authors would like to express their gratitude to those of the study facility who cooperated with the study.

This work was supported by JSPS KAKENHI Grant Number JP16K04210.

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Human Services

DOI:http://dx.doi.org/10.14391/ajhs.14.11
Asian Journal of Human Services, VOL.14 11-23

ORIGINAL ARTICLE

Survey to Assess Information-gathering During the Process of Designing Care Plans Regarding Nutrition Improvement

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ABSTRACT

The present study aimed to clarify information-gathering during the process of designing care plans regarding nutrition improvement in nursing care insurance services. A total of 2,000 nursing care insurance service providers were randomly selected from the nursing care insurance service networks throughout Japan, and an anonymous self-completed questionnaire survey was conducted care managers. This study identified a low rate of including nutrition indices as information-gathering items during the process of designing care plans regarding nutrition improvement. This was suggested to be attributable to the type of service, fundamental qualifications, and education. To design care plans aimed at nutrition improvement for older people requiring care, it is necessary to provide care managers with standardized education on nutrition indices and older people's independence. In addition, the need for education in basic professional education courses was suggested.

Received
December 1, 2017

Revised
January 5, 2018

Accepted
January 25, 2018

Published
April 30, 2018

＜Key-words＞
nutrition improvement, care plans, information-gathering, education

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Asian J Human Services, 2018, 14 11-23.

DOI: http://dx.doi.org/10.14391/ajhs.14.11
Asian Journal of Human Services, VOL.14 11-23

I. Introduction

Malnutrition is the factor for older people to require care. The revision of the Long-Term Care Insurance Act in 2006 included care prevention and preventing the level of care need from becoming higher, and nutrition management was introduced as the mainstay of the revision. However, according to the "Research on Comprehensive Evaluation and Analysis regarding the Effects of Care Prevention Programs" in 2008, among particular older people or those requiring support who may continue requiring care after the initiation of care prevention programs, individuals requiring nutrition improvement account for approximately 30% of the older people. (Tsuji, Ueda, Okubo, et al., 2009) In addition, according to the "Survey Report about Understanding the Eating Condition and Nutritional Status of Patients Receiving Home-Based Care" in 2012, approximately 30% of the older people receiving home-based care suffer malnutrition based on the MNA-SF (Mini Nutritional Assessment-Short Form) and BMI (Body Mass Index) [National Center for Geriatrics and Gerontology, 2012]. Thus, as issues regarding: 1) older people starting to require care and 2) the level of care need becoming higher, malnutrition has yet to be resolved.

This may be attributable to the absence of systems whereby identifying the risk of malnutrition among older people (analysis) leads to care approaches that facilitate nutrition improvement (problem-solving). Regarding the identification of such a risk, in 2014, researchers conducted an awareness survey concerning the nutritional status of older people requiring care involving nursing care insurance service workers, and revealed that both home-based and facility workers were hardly aware of the BMI and Alb levels, which are indices of nutritional status. (Fujio & Kodaira, 2014) These results suggested that information-gathering and -sharing for identifying the risk of malnutrition were not standardized. In 2015, a survey was conducted to assess the nutritional status and mental/physical function of facility users and at-home older people requiring care who utilized nursing care insurance services. As a result, correlations were noted between Alb levels and the following 4 factors: the BMI, dietary habits, dietary intake, and locomotion ability. This indicated that these 4 factors may be predictors of Alb levels. (Fujio, Ogawa, Inoue, et al., 2016) In 2016, a survey was conducted to assess the nutritional status and mental/physical function of older housing facility users, which were not covered by nursing care insurance. This identified correlations between malnutrition and the locomotion ability/cognitive dysfunction. (Fujio, Shimada, Sugiyama, et al., 2017) These results suggested that older people with malnutrition start requiring care or require more care.

Against this background, the present study investigated information-gathering during the process of designing care plans regarding nutrition improvement in nursing care insurance services. Care plans are designed through a procedure from information-gathering, to analyses, and then to planning (care plan designing process).

DOI:http://dx.doi.org/10.14391/ajhs.14.11
Asian Journal of Human Services, VOL.14 11-23

The present study aimed to clarify whether or not information was gathered in order to determine the risk of malnutrition among older people.

II. Subjects and Methods

1. Study and Procedures

1) Study Design

A quantitative, descriptive study (anonymous self-completed questionnaire survey)

2) Study Period

Between November 2016 and December 2016 (2 months)

3) Subjects

Care managers providing nursing-care insurance services

4) Study Items

Basic attributes: age, sex, type of service, type of profession (medical profession or welfare profession), years of experience, number of charges. Information-gathering items: body weight, BMI (Body Mass Index), the serum albumin (Alb) level, food style, dietary intake, fluid intake, appetite, eating assistance, susceptibility to choking, eating posture, dental condition, ability to walk, consciousness level, taking medicine, life will, economic condition. Reasons for not including nutrition indices as information-gathering items. Education on nutrition indices.

5) Ethical Considerations

This study was conducted with the approval of the Ethics Committee of the Faculty of Health Science and Nursing, Juntendo University (approval number: 28-06). The following were explained to the subjects: Participation in the questionnaire survey must be based on their own free will. As the survey was anonymous, individuals could not be identified. Obtained data would be coded, analyzed, and used only for the present study. Only people who had consented to the study participated in it, and the completion of the questionnaire form was regarded as the consent.

2. Date Collection

Concerning data collection, 2,000 facilities were randomly extracted from the Welfare and Medical Service Network System (WAM NET) of all 47 prefectures in Japan.

3. Statistics Analysis

Using SPSS Statistics Ver. 22.0, analyses were performed to clarify whether or not correlations existed between the presence/absence of nutrition indices as information-

DOI: http://dx.doi.org/10.14391/ajhs.14.11
Asian Journal of Human Services, VOL.14 11-23

gathering items and basic attributes/education on nutrition indices. The age of the subjects, years of experience, and the number of people of whom they were in charge were analyzed using the unpaired t-test. The type of service and type of profession were analyzed using cross-tabulation, followed by chi-square tests. The level of significance was set at 0.05. In addition, the subjects were asked to freely describe the reasons for not including nutrition indices as information-gathering items, as well as opportunities for education on nutrition indices, and their descriptions were analyzed.

III. Results

A total number of 780 (response rate: 38.0%) completed questionnaires were collected, and 714 (effective response rate: 35.7%) subjects provided effective answers.

1. Basic Attributes (Table.1)

The mean of age 47.33±9.68 (Min: 23, Max: 76). Male 172 (24.1%), female 542 (75.9%). Regarding the type of service, 263 (36.8%) of facility and 451 (63.2%) at-home care managers, respectively. The most common fundamental qualification was certified care worker (n=478 [66.9%]), followed by nurse (n=78 [10.9%]). Concerning the type of profession, 526 (73.6%), 144 (20.2%), and 44 (6.2%) subjects were welfare professionals, medical professionals, and others, respectively. The average duration of experience was 7.35±4.68 (Min: 0.2, Max: 21.0) years, and the average number of people of whom each subject was in charge was 38.13±23.40 (Min:1, Max: 150).

2. Information-gathering Items (Table.2)

The investigation items for information-gathering comprised those that were suggested to be related to the nutrition status of older people requiring care based on previous studies of malnutrition risk-related factors (Takahashi, 2006), malnutrition indices (Fujio, Ogawa, Inoue, et al., 2016), oral function training, and assessment items for dietary support (Kikutani, Yoneyama, Teshima, et al., 2005). As shown in Table 2, the factor least commonly included as an information-gathering item was Alb levels (23.9%), followed by the BMI (52.1%). These factors are indices of nutrition status.

3. Presence or Absence of Education on Nutrition Indices

The numbers of subjects receiving and not receiving education on nutrition indices were 177 (24.8%) and 537 (75.2%), respectively.

DOI:http://dx.doi.org/10.14391/ajhs.14.11
Asian Journal of Human Services, VOL.14 11-23

<Table.1> Basic attributes (%) n=714

Age		47.33±9.68
Sex		
	Male	172(24.1)
	Female	542(75.9)
Type of service		
	Facility	263(36.8)
	At-home	451(63.2)
Basic license		
	Doctor	0(0.0)
	Nurse	78(10.9)
	Physical therapist	1(0.1)
	Occupational therapist	3(0.4)
	Nutritionist	52(7.3)
	Dental hygienist	10(1.4)
	Care worker	478(66.9)
	Social worker	48(6.7)
	Other	44(6.2)
Type of profession		
	Medical profession	144(20.2)
	Welfare profession	526(73.6)
	Other	44(6.2)
Years of experience		7.35±4.68
Number of charges		38.13±23.40

DOI: http://dx.doi.org/10.14391/ajhs.14.11
Asian Journal of Human Services, VOL.14 11-23

<Table.2> Information-gathering items (%)n=714

Information-gathering items	No	Yes
Body weight	109(15.3)	605(84.7)
BMI (Body Mass Index)	342(47.9)	372(52.1)
Alb (serum albumin) level	543(76.1)	171(23.9)
Food style	34(4.8)	680(95.2)
Dietary intake	299(41.9)	415(58.1)
Fluid intake	341(47.8)	373(52.2)
Appetite	200(28.0)	514(72.0)
Eating assistance	13(1.8)	701(98.2)
Susceptibility to choking	47(6.6)	667(93.4)
Eating posture	334(46.3)	380(53.2)
Dental condition	73(10.2)	641(89.8)
Ability to walk	37(5.2)	677(94.8)
Consciousness level	228(31.9)	486(68.1)
Taking medicine	30(4.2)	684(95.8)
Life will	85(11.9)	629(88.1)
Economic condition	187(26.2)	527(73.8)

4. Relationships between the Presence/Absence of Nutrition Indices and Basic Attributes/ Education on Nutrition Indices (Table.3) (Table.4)

The BMI was included for a significantly higher percentage of subjects in charge of care plans than those with the average number of assigned care plans, Alb levels were significantly higher for subjects younger than the mean age, and these levels were significantly higher for subjects in charge of a higher number of care plans (p<0.05). No correlations were noted between years of experience and the BMI/Alb levels. The BMI and Alb levels were higher for facilities than at-home care managers (p<0.05). The BMI and Alb levels were higher for medical than welfare professionals (p<0.05). The BMI and Alb levels were higher for subjects receiving education on nutrition indices than those not receiving it (p<0.05).

DOI:http://dx.doi.org/10.14391/ajhs.14.11
Asian Journal of Human Services, VOL.14 11-23

<Table.3> Correlations between the BMI and basic attributes/education on nutrition indices (%) n=714

		BMI				*P*
		No (%)		Yes (%)		
		Mean ± SD		Mean ± SD		
Age [1]		337		366		0.112
		47.94 ± 9.50		46.78 ± 9.82		
Years of experience [1]		337		368		0.112
		7.19 ± 4.52		7.50 ± 4.84		
Number of charges [1]		327		362		0.000***
		32.69 ± 18.81		43.06 ± 25.94		
Type of service [2]						
	Facility	70	(26.6)	199	(72.4)	0.000***
	At-home	272	(60.3)	179	(39.7)	
Type of profession [2]						
	Medical profession	52	(36.1)	92	(63.9)	0.000***
	Welfare profession	270	(51.3)	256	(48.7)	
Education of nutrition [2]						
	No	283	(52.7)	254	(47.3)	0.000***
	Yes	59	(33.3)	118	(66.7)	

[1] Unpaired t-test [2] χ^2 test *** $p<0.001$

DOI: http://dx.doi.org/10.14391/ajhs.14.11
Asian Journal of Human Services, VOL.14 11-23

<Table.4> Correlations between Alb levels and basic attributes/education on nutrition indices (%) n=714

		Alb level				*P*
		No		Yes		
		Mean ± SD		Mean ± SD		
Age		536		167		0.005**
		47.93 ± 9.43		45.43 ± 10.26		
Years of experience		537		168		0.466
		7.28 ± 4.65		7.59 ± 4.81		
Number of charges		524		165		0.000***
		34.20 ± 18.89		50.66 ± 30.83		
Type of service						
	Facility	120	(45.6)	143	(54.4)	0.000***
	At-home	423	(93.8)	28	(6.2)	
Type of profession						
	Medical profession	91	(63.2)	53	(36.8)	0.000***
	Welfare profession	419	(79.7)	107	(20.3)	
Education of nutrition						
	No	432	(80.4)	105	(19.6)	0.000***
	Yes	111	(62.7)	66	(37.3)	

1) Unpaired t-test 2) χ^2 test ** p<0.005 *** p<0.001

5. Reasons for Nutrition Indices Not Being Included (Table.5)

A total of 99 (91 [91.9%] welfare and 8 [8.1%] medical professionals) free descriptions were provided concerning the reasons for nutrition indices not being included as information-gathering items. The rates of including nutrition indices as information-gathering items significantly differed between medical and welfare professionals and, therefore, we categorized the 91 free descriptions provided by welfare professionals for whom the rates of including the BMI and Alb levels were low. As a result, the most common category was the [difficulty of information-gathering] (n=41), which was divided into the following 6 subcategories: the <<difficulty of keeping track of Alb levels (14)>>, <<nutrition indices not regarded as information items (11)>>, <<lack of information sources concerning nutrition (9)>>, a <<shortage of measuring equipment (5)>>, <<refusal by users (1)>>, and <<being busy (1)>>. The category of a [lack of knowledge and low-level awareness regarding nutritional status] (n=37) was divided into the following 6 subcategories: <<not feeling the need (19)>>, a <<lack of knowledge on nutrition (7)>>, <<issues that need to be resolved other than those related to nutrition (5)>>, <<leaving nutrition-related issues up to other professionals and/or families (4)>>, <<not receiving

DOI:http://dx.doi.org/10.14391/ajhs.14.11
Asian Journal of Human Services, VOL.14 11-23

inquiries from services (1)>>, and <<paying attention to the way to eat only (1)>>. In addition, the category of [feeling the need for information on nutrition indices] (n=13) was divided into <<gathering information only when necessary (10)>> and <<information gathering by registered dietitians (3)>>.

<Table.5> Reasons for nutrition indices not being included
(Responses made by welfare professionals alone) n=91

Category	Subcategory	Number
Difficulty of information-gathering	Difficulty of keeping track of Alb levels	14
	Nutrition indices not regarded as information items	11
	Lack of information sources concerning nutrition	9
	Shortage of measuring equipment	5
	Refusal by users	1
	Being busy	1
Lack of knowledge and low-level awareness regarding nutritional status	Not feeling the need	19
	Lack of knowledge on nutrition	7
	Issues that need to be resolved other than those related to nutrition	5
	Leaving nutrition-related issues up to other professionals and/or families	4
	Not receiving inquiries from services	1
	Paying attention to the way to eat only	1
Feeling the need for information on nutrition indices	Gathering information only when necessary	10
	Information gathering by registered dietitians	3

6. Opportunities for Education on Nutrition Indices (Table.6)

A total of 145 free descriptions were provided regarding opportunities for education on nutrition indices, and were categorized. Of these, 127 (87.6%) and 18 (12.4%) were about [practical training] and [professional education courses], respectively. Among the subcategories of [practical training], <<training provided by dietetic associations (36)>> was the most common, followed by <<training for care managers (26 [17.8%])>>, <training provided by organizations to which each subject belonged (25)>>, <<training provided by medical centers (21)>>, <<training provided by administrative bodies (9)>>, <<training provided by companies (4)>>, <<training provided by community-based comprehensive support centers (4)>>, <<training provided by academic societies to which each subject belonged (1)>>, and <<training provided by certified care worker associations (1)>>. The

DOI: http://dx.doi.org/10.14391/ajhs.14.11
Asian Journal of Human Services, VOL.14 11-23

category of [professional education courses] comprised <<nursing education courses (9)>> and <<other education courses (9)>>.

<Table.6> Opportunities for education on nutrition indices (n=145)

Education	Detailed educational opportunities	Number
Practical training	Training provided by dietetic associations	36
	Training for care managers	26
	Training provided by organizations to which each subject belonged	25
	Training provided by medical centers	21
	Training provided by administrative bodies	9
	Training provided by companies	4
	Training provided by community-based comprehensive support centers	4
	Training provided by academic societies to which each subject belonged	1
	Training provided by certified care worker associations	1
Professional education courses	Nursing education courses	9
	Other education courses	9

IV. Discussion

Focusing on information-gathering during the process of designing care plans regarding nutrition improvement, we conducted a survey for care managers throughout Japan. Concerning the basic attributes of the respondents, the most common fundamental qualification was certified care worker (60%), followed by nurse (10%). This finding is similar to a report made by the "Survey Report on the Quality of Long-Term Home Care Support Service Providers and Care Managers' Work (Mitsubishi Res. Inst., Inc; 2014)" that the most common qualification of care mangers was certified care worker (63.4%), followed by nurse (11.5%). Thus, the results of our study may reflect Japan's entire trend.

Information-gathering, which was the focus of our study, is the beginning of a process in which care managers design care plans, and is also a beginning of care management required of these managers under the nursing care insurance system of Japan. Care management is implemented through a series of procedures from understanding facts accurately, to clarifying the issues by analyzing facts by means of certain approaches, to design plans to resolve these issues, and then to executing the plans. (Shirasawa, Hashimoto & Takeuchi, 2006) Information-gathering corresponds to the above-mentioned understanding. Against this background, in the present study, we investigate whether or

DOI:http://dx.doi.org/10.14391/ajhs.14.11
Asian Journal of Human Services, VOL.14 11-23

not nutrition-related items were included in information-gathering aimed in order to discuss nutritional status. As a result, the factor least commonly included as an information-gathering item was Alb levels (approximately 20%), followed by the BMI (approximately 50%), despite the fact that these items are indices of nutritional status. In previous studies, Alb levels and the mental/physical function of elderly people requiring care were suggested to be related to their locomotion ability and cognitive function. (Fujio, Shimada, Sugiyama, et al., 2017) Also, in dementia care, study meetings were held for families that aimed at improving body water, nutrition, activities, and bowel movements as fundamental care, which resulted in an increase in the rate of alleviating cognitive symptoms. (Kodaira & Takeuchi, 2015) On the basis of these previous studies, the finding that nutrition indices were not sufficiently investigated in our study needs to be recognized as an issue regarding older people requiring more care.

Analyses revealed that both the BMI and Alb levels showed correlations with the number of people of whom each subject was in charge, type of service, type of profession according to fundamental qualifications, and presence/absence of education on nutrition indices. These indices were included as information-gathering items for care managers who were in charge of many people. This result is consistent with a high rate of including nutrition indices as information-gathering items care managers of facilities. We suggest because the number of people of whom each staff member is in charge is higher in facilities than at-home, and various professionals, including medical professionals, are responsible for nutritional management in the facilities. This was also suggested in relation to the type of fundamental qualification, and the rate of including nutrition indices as information-gathering items was higher for medical than welfare professionals. These results indicate that nutrition indices are less likely to be included as information-gathering items for care manager at-home and those with welfare qualifications. This may be attributable to a report that approximately 30% of the older people receiving home-based care suffer malnutrition (National Center for Geriatrics and Gerontology, 2012). In addition, welfare professionals, who account for 70% of care managers, most commonly report the [difficulty of information-gathering] as the reason for not including nutrition indices as information-gathering items, which suggest the need to do so as a common practice during a care-plan designing process regardless of the type of service/professional.

The rate of including nutrition indices as information-gathering items was higher for care managers receiving education on both the BMI and Alb levels. Another reason for nutrition indices being not included as information-gathering items was because of a [lack of knowledge and low-level awareness regarding nutritional status], which indicated the importance of education on nutrition indices. In addition, among the descriptions concerning the detailed educational opportunities of care managers receiving education, 80% was about [practical education], 17.8% (n=26) was about compulsory <<care manager training>>, and other educational opportunities were voluntary. There is a need to provide care managers with standardized practical education on nutrition indices and older

DOI: http://dx.doi.org/10.14391/ajhs.14.11
Asian Journal of Human Services, VOL.14 11-23

people's independence. Concerning the necessity of practical training, in order to develop the quality care managers and promote care management, it is necessary to advance their expertise by improving training for current managers. (Shirasawa, Hashimoto & Takeuchi, 2006) In addition, the category of [professional education courses] was only reported by 20% of the subjects, and various fundamental qualifications are required of care manager, which suggests the need for education on nutrition indices.

The present study identified a low rate of including nutrition indices as information-gathering items during the process of designing care plans regarding nutrition improvement. This was suggested to be attributable to the type of service, fundamental qualifications, and education. To design care plans aimed at nutrition improvement for older people requiring care, it is necessary to provide care managers with standardized education on nutrition indices and older people's independence. In addition, the need for education in basic professional education courses was suggested.

IV. Acknowledgment

The authors wish to thank for care managers of the nursing care insurance service networks throughout Japan. This work was supported by JSPS KAKENHI Grant No. 16K12218. (Interprofessional Cooperation ICT Program Development aimed at "Nutrition Improvement")

DOI:http://dx.doi.org/10.14391/ajhs.14.11
Asian Journal of Human Services, VOL.14 11-23

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Human Services

DOI: http://dx.doi.org/10.14391/ajhs.14.24
Asian Journal of Human Services, VOL.14 24-37

ORIGINAL ARTICLE

Acute Hospital Nurses' Recognition of and Approaches to Functional Recovery/ Independent Excretion Care for Elderly Patients with Pneumonia

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ABSTRACT

The purpose of this study was to clarify the implementation contents of independent excretion care of elderly pneumonia patients, including nurses' thoughts, by acute care hospital nurses. Semi-structured interviews were conducted with 17 nurses working on a respiratory ward, and the obtained data were qualitatively and inductively analyzed.

The acute hospital nurses approached to independent excretion care included: performing such care through multi-professional liaison and learning from senior nurses. On the other hand, they faced dilemmas when performing excretion care that did not meet patients' requirements due to insufficient manpower and the prioritization of treatment in the clinical setting.

To perform independent excretion care for elderly patients with pneumonia, the following nursing support approaches may be necessary: continuously providing education focusing on excretion care, and tool development for independent excretion care.

Received
January 16, 2018

Revised
February 27, 2018

Accepted
March 6, 2018

Published
April 30, 2018

＜Key-words＞
acute care hospital, independent excretion care, elderly patient with pneumonia, functional recovery care

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Asian J Human Services, 2018, 14:24-37.

DOI: http://dx.doi.org/10.14391/ajhs.14.24
Asian Journal of Human Services, VOL.14 24-37

I. Introduction

As of October 1, 2015, the number of elderly persons aged 65 or over was 33.92 million, accounting for 26.7% (aging rate) of the total population in Japan（Cabinet Office, 2016）. It is likely that their number will further increase in the future. As aging-related issues, there are concerns over increases in the number of patients with dementia and social security benefits. Medical cost reduction is an important challenge for Japan. Therefore, care is being shifted from facilities to homes by the government. The aim of establishing the Integrated Care System to help citizens fulfill their lives in their communities even in the presence of diseases. However, there are problems to achieve. The problem in the acute care hospital is in the early return home. As one of the factors associated with this, importance is placed on disease/risk management, and ADL-focused care is less prioritized in acute care hospitals. Elderly patients are particularly vulnerable to disuse syndrome due to their inactive daily life during hospitalization and prolonged rest for treatment. The rate of being bedridden is the highest in acute care hospitals, as patients are forced to perform the majority of their ADL in bed（Ishikawa, 2002）. In Europe and the US, it has been reported that the walking ability of elderly patients hospitalized due to acute diseases is reduced by nearly 50%（Jane, Mark & Muhammad, 1998）. Hospitalization-related declines in ADL prolong elderly patients' stays in acute care hospitals, increase their transfer to care facilities, and lead to difficulty in discharging them to home.

Another negative factor for their discharge to home is the aging of their caregivers. There are a large number of the elderly caring for elderly patients. The numbers of spouses and daughters caring for such patients are time-dependently decreasing, while that of sons caring for them is increasing（Kawasaki city, 2017）. For aged male caregivers, the necessity of providing physical care increases their caregiving burden, making it difficult for them to continue to provide home care. Among physical care procedures, 'mealtime assistance' and 'excretion care' (62.6%) are the most burdensome for caregiving families（Cabinet Office, 2017）, indicating that these care procedures influence caregivers' decision-making for elderly patients to resume their home lives. In addition, excretion independence is essential for the elderly to maintain their dignity and QOL. Thus, 'excretion' is an important ADL for both the elderly and caregivers.

Based on these findings, excretion independence may be key to early discharge from a hospital to home and the continuation of community life. In this respect, it is necessary to simultaneously achieve 2 goals: initiating care for patients to achieve excretion independence ('independent excretion care') in the early stage of the acute period; and discharging them, with their diseases cured and excretion independence achieved.

In order to provide ADL-focused care as part of nursing during the acute period when treatment is prioritized, it may be important to clarify acute hospital nurses' recognition of and approaches to functional recovery/independent excretion care for elderly patients,

DOI: http://dx.doi.org/10.14391/ajhs.14.24
Asian Journal of Human Services, VOL.14 24-37

and develop future perspectives on nursing support.

Therefore, the purpose of this study was to clarify the implementation contents of independent excretion care of elderly pneumonia patients, including nurses' thoughts, by acute care hospital nurses.

II. Definition of term

The operational definition of terms used in this study is as follows.

Functional recovery care:

In this paper, the term 'independence' does not refer to all of the 3 components: 'physical independence', 'mental independence', and 'social independence'. Among these, it only refers to 'physical independence' as 'the care-dependent elderly's acquisition of the ability to perform activities (ADL) and instrumental activities (IADL) of daily living independently' (Fujio, 2011). Accordingly, 'functional recovery care' is defined as 'support for such patients to achieve physical independence'.

Independent excretion care:

Similarly, 'independent excretion care' is defined as part of functional recovery care and 'supporting excretion using general or portable toilets, rather than defecating/urinating using diapers', based on the terminology used for caregiver workshops held by the Japanese Council of Senior Citizens Welfare Service. These workshops aim to help caregivers learn functional recovery care skills. Since 2003, when the first workshop was held, 100 to 150 special nursing homes for the elderly have participated each year. As an index to conveniently measure outcomes, the council recommends the diaper use rate.

Acute care hospital:

In this study, we will make medical wards for patients in acute phase except high acute stage wards such as high-care units.

III. Methods

1. Study Design

Qualitative inductive research

2. Study subject

Three wards were selected from two centers belonging to the DPC Hospital "Function Evaluation Factor II" announced by the Ministry of Health, Labor and Welfare in March 2015. 17 nurses who worked in the respiratory department ward concurred with this study as a target.

DOI: http://dx.doi.org/10.14391/ajhs.14.24
Asian Journal of Human Services, VOL.14 24-37

3. Methods of data collection and study items

We conducted a semi-structured interview individually based on the interview guide. The interview time was less than 50 minutes, and the number of interviews was set to 1 person. I got permission and recorded it to an IC recorder.

Study items

Attribute: age, sex, educational background, position, years of experience in the current ward, years of nursing experience.

Main interview contents: The acute care hospital nurses' recognition of and approaches to functional recovery/independent excretion care.

In preparing an interview guide, we pretested two acute care ward nurses. The investigation period was from the end of March to May in 2017.

4. Data analysis

I wrote all the contents of the interview of 17 people obtained in this research into a serial talk. Narrative records were created and carefully and repeatedly read to extract information on the acute care hospital nurses' recognition of and approaches to functional recovery/independent excretion care, in addition to related emotions, while considering the overall contexts of their statements.

We summarized and encoded it to the extent that the meaning of context does not change. Next, we categorized it by comparing the similarity and dissimilarity of the code, and raised the abstraction level of the concept by attaching a suitable name as a unified code to the collection of a plurality of codes, and sub categories and categories were generated.

In order to improve the reliability and validity of data analysis, this research shared the analysis process among three researchers, and repeatedly confirmed and examined it. In addition, we supervised and interpreted supervisions by medical and medical welfare leaders throughout the process of analysis.

The results of analysis are shown in 3 different parentheses: [ ] (categories), < > (sub-categories), and ( ) (the number of codes).

5. Ethical considerations

This research was conducted with approval of the ethics committee of International University of Health and Welfare Graduate School (Approval No. 16-Ig1-143).

For the facility manager and nursing manager, the research representative spoke orally to explain the purpose, method, and ethical consideration of the survey using explanatory documents and gained understanding and understanding. For research collaborators, we explain verbally using the explanatory document about the purpose and the ethical consideration of the survey. Research collaborators can choose whether or not to cooperate with the survey, which will not cause any disadvantage. In addition, even

DOI: http://dx.doi.org/10.14391/ajhs.14.24
Asian Journal of Human Services, VOL.14 24-37

after accepting the cooperation of the survey once again, cooperation can be withdrawn until the end of the analysis, ensuring that no disadvantage will occur.

Ⅳ. Results

1. Subject Characteristics

The number of research subject was 17. The breakdown by nursing experience years was 3 persons of fresh nurse (less than 1 to 3 years), nine mid-care nurses (3 to 6 years), veteran nursing There were five masters (over 6 years). The age of research collaborators ranged from the 20s to the 50s, and the sexes were all female (Table1).

<Table1> Subject Characteristics

ID	Age	Sex	Years of nurising experience	Years of experience in the current wards	Educational background	Position
A	The 50s	女	33	1	Graduate school	The principal
B	The 20s	女	2	2	Vocational school	Staff nurse
C	The 30s	女	16	7	Vocational school	Team leader
D	The 20s	女	2	2	University	Staff nurse
E	The 20s	女	3	3	University	Staff nurse
F	The 20s	女	3	3	University	Team leader
G	The 20s	女	3	3	University	Team leader
H	The 20s	女	8	1	Vocational school	Staff nurse
I	The 20s	女	4	4	University	Team leader
J	The 20s	女	3	3	University	Staff nurse
K	The 20s	女	4	4	University	Team leader
L	The 30s	女	11	2	Vocational school	Team leader
M	The 20s	女	2	2	Vocational school	Staff nurse
N	The 40s	女	17	9	Vocational school	Team leader
O	The 20s	女	5	5	Vocational school	Team leader
P	The 20s	女	3	3	Vocational school	Staff nurse
Q	The 20s	女	3	3	Vocational school	Staff nurse

2. Result of analysis

1) Nurses' recognition of functional recovery care for elderly patients

There were 43 codes recounting the acute hospital nurses' recognition of functional recovery care for elderly patients, which were classified into 15 sub-categories and 9 categories (Table2).

DOI: http://dx.doi.org/10.14391/ajhs.14.24
Asian Journal of Human Services, VOL.14 24-37

Table2 Nurses' recognition of functional recovery care for elderly patients

[Categories]	<Sub-categories >	(Codes number)
[Supporting physical independence]	<Assist in returning to ADL before	2
	<Support to prevent ADL fall>	5
	<Support to expand the scope>	9
	<Support to encourge leaving bed>	3
	<Physical support>	1
[Supporting mental independence]	<Helping patients be able to do what they want>	3
	<Mental support>	1
[Supporting social independence]	<Supporting social independence>	1
[Care with respect for patients]	<Care with respect for patients>	2
[Teamwork facilitates functional recovery care]	<Teamwork facilitates functional recovery care>	3
[Functional recovery care is feasible when focusing on independence]	<I am practicing Functional recovery care>	1
	<It becomes possible by conscious of Functional recovery care>	2
[Functional recovery care is difficult due to the prioritization of routine work]	<Functional recovery care is difficult due to the prioritization of routine work>	5
[Functional recovery care is difficult due to the prioritization of symptom management]	<Functional recovery care is difficult due to the prioritization of symptom management>	3
[Functional recovery care is difficult in the case of the elderly]	<Functional recovery care is difficult in the case of the elderly>	2

We will explain representative category.

[Supporting physical independence (20)]

That means that ADL becomes unnecessary for intervention by others.

Examples of given comments:

"Assist in the situation before hospitalization as closely as possible."

"*As the symptoms improve, I urge you to return to the original ADL little by little.*"

[Functional recovery care is difficult due to the prioritization of routine work (5)]

That means that it is difficult to implement functional recovery care because the work is busy.

Examples of given comments:

"*It is rather difficult to make time for patients in a busy condition.*"

"*I am being chased by the response of a nurse call …*"

2) Nurses' recognition of independent excretion care for elderly patients

There were 40 codes representing the nurses' recognition of independent excretion care for elderly patients, which were classified into 18 sub-categories and 10 categories (Table3).

DOI: http://dx.doi.org/10.14391/ajhs.14.24
Asian Journal of Human Services, VOL.14 24-37

Table3 Nurses' recognition of independent excretion care for elderly patients

[Categories]	<Sub-categories >	(Codes number)
[Supporting natural excretion]	<Support to bring it closer to excretion status before hospitalization>	4
	<Aim for excretion in the toilet>	6
	<Withdrawal from a diaper>	2
	<Excretion away from bed>	1
	<Elderly patients themselves can take excretion brhavior>	4
	<Grasp the patient's current ADL and support it>	2
[The content of support varies depending on the presence/absence of micturition]	<The content of support varies depending on the presence/absence of micturition>	3
[Providing support, according to symptoms]	<Providing support, according to symptoms>	2
[Developing toileting habits]	<Developing toileting habits>	3
[Care with respect for patients]	<Relations that valued patient motivarion>	1
	<Care with respect for patients>	3
[Reducing the caregiving burden]	<Reducing the caregiving burden>	2
	<Independent excretion care affects outcome>	2
	<Independent excretion care reduces work burden>	1
[The necessity of collaborative systems for care]	<The necessity of collaborative systems for care>	1
[Toileting guidance enhances awareness]	<Toileting guidance enhances awareness>	1
[Independent excretion care is difficult in the case of the elderly]	<Independent excretion care is difficult in the case of the elderly>	1
[Independent excretion care is difficult in the case of the elderly]	<Independent excretion care is difficult in the case of the elderly>	1

We will explain representative category.

[Supporting natural excretion (19)]

That means that elderly patient can excrete yourself without using a diaper.

Examples of given comments:

"*The first is to go to the toilet and excrete without using a diaper.*"

"*Being able to go to the toilet and excrete it when you want to go.*"

[Care with respect for patients (4)]

That means that Excretory care is related to dignity, care that is done while respecting the intention of the individual.

Examples of given comments:

"*Independence of excretion is the most important thing for that person.*"

"*Caring while considering shame.*"

3) Nurses' approaches to independent excretion care for elderly patient and emotions

Similarly, there were 266 codes regarding the nurses' approaches to independent excretion care for elderly patients with pneumonia and emotions when performing them, which were classified into 43 sub-categories and 15 categories (Table4).

DOI: http://dx.doi.org/10.14391/ajhs.14.24
Asian Journal of Human Services, VOL.14 24-37

Table4 Nurses' approaches to independent excretion care for elderly patient and emotions

	[Categories]	<Sub-categories >	(Codes number)
Approaches to independent excretion care	[Performing care through multi-professional liaison]	<performing care through multi-professional liaison>	24
		<Work on the whole hospital>	2
		<Perfoming care exchange infoemation among nurses>	20
	[Performing care aiming at physical independence]	<Understand patient's ADL>	7
		<Perfoeming care to prevent lower ADL>	5
		<Grasup excretion behavior>	2
		<Understand excretion pattern>	3
		<Make urination induction>	1
		<Care aimed at excretion of the toilet>	1
		<Assess the necessity of balloon catheter>	2
	[Performing care from the viewpoint of treatment as a priority]	<Performing care from the viewpoint of	5
		<Performing care from the viewpoint of disease>	2
		<Performing care from the viewpoint of doctor's instructions>	1
		<Performing care from the viewpoint of symptom and treatment>	1
		<Performing care from the viewpoint of safety>	11
	[Performing care while considering the content of treatment and current condition]	<Performing care while considering the content of treatment and current condition>	4
		<Performing care while considering the content of symptom>	12
		<Understand symptoms>	2
	[Performing patient-centered care with respect]	<Relationship to improve motivation of patients>	4
		<Implement patient-aware care>	14
	[Performing nurse-led care]	<Change contents of care according tu whether excretory appeals or not>	10
		<Determination of excretory care for the convenience of the nurxing side>	6
		<Nurses cayyr out excretory care>	1
	[Performing care as part of routine work]	<Performing care as part of routine work>	12
	[Performing care in consideration of treatment outcomes]	<Performing care in consideration of treatment outcomes>	5
	[Performing care with cooperation from other family members]	<Performing care with cooperation from other family members>	5
	[Learning from senior nurses]	<Learning from senior nurses>	5
Emotions	[The necessity of resolving problems in the current hospital system]	<Difficult due to lack of collaboration	5
		<Ifficult cooperation independent excretion care difficult>	1
		<Difficulty in workload>	19
		<We can not proactively implement it>	4
		<Securing manpower of nurses>	11
		<Difficult to implement at the limit of the ward structure>	3
	[Necessity of considering appropriate nursing systems to provide unified care]	<Low recognition of nursing independent excretion care>	6
		<Devices that allow anyone to do a unified assessment are necessary>	4
		<Missing education on independent excretion care>	3
		<Excretion care content varies depending on experience>	18
	[Independent excretion care is difficult due to patients' own problems]	<Difficult due to patients' own problems>	16
		<Difficult due to patients' desease>	1
	[Dilemmas when performing excretion care that does not meet patients' requirements]	<Dilemmas when performing excretion care that does not meet patients' requirements>	7
	[Independent excretion care is feasible]	<Independent excretion care is feasible>	1

DOI: http://dx.doi.org/10.14391/ajhs.14.24
Asian Journal of Human Services, VOL.14 24-37

We will explain representative categories.

[performing care through multi-professional liaison (46)]

Sharing information with multi-professional liaison, meaning to perform independent excretion care.

Examples of given comments:

"*Information sharing with rehabilitation person and conference.*"

"*Caregiver cooperation also leads to independent excretion care.*"

[the necessity of resolving problems in the current hospital system (43)]

In order to carry out independent excretion care, it means that it is necessary to solve the problem of the hospital system.

Examples of given comments:

"*It is difficult carry out independent excretion care as it is clattering.*"

"*We have not been able to independent excretion care due to lack of personnel.*"

4) Relationship among these categories

On analyzing the relationships among these categories, performing such care were explained as the following process.

The acute hospital nurses [performed care, aiming at physical independence]. This is based on their recognition of the goal of functional recovery/independent excretion care as the achievement of such independence. They [performed care through multi-professional liaison], while considering collaborative systems as necessary. In the case of novice nurses, they performed independent excretion care, while [learning from senior nurses]. Furthermore, the recognition that independent excretion care should be performed in consideration of symptoms while considering [the content of treatment and current condition]. For example, when patients' breathing conditions stabilized, they changed the contents of independent excretion care.

On the other hand, they were importance is placed on risk management such as disease and safety control, it is necessary to [perform care from the viewpoint of treatment as a priority]. And insufficient manpower forced the nurses to [perform care as part of routine work] and [nurse-led care]. Therefore, as represented by the category: [dilemmas when performing excretion care that does not meet patients' requirements], they faced dilemmas when they had to perform nurse-led excretion care, while aiming to provide [patient-centered care with respect]. At the same time, some of them regarded functional recovery/independent excretion care as difficult in elderly patients.

They also realized [the necessity of resolving problems in the current hospital system], such as insufficient manpower, to appropriately perform independent excretion care in acute hospitals. As well as that of [considering appropriate nursing systems to provide unified care], as the content of practice varies between novice and senior nurses.

DOI: http://dx.doi.org/10.14391/ajhs.14.24
Asian Journal of Human Services, VOL.14 24-37

V. Discussion and Conclusions

Analysis clarified the acute care hospital nurses' recognition of functional recovery/independent excretion care for elderly patients with pneumonia, with the details of their approaches to such care and related emotions. Based on the results, appropriate nursing support to provide independent excretion care for elderly patients with pneumonia in acute care hospitals is discussed as follows:

1. Nursing support for the provision of unified independent excretion care

1) Necessity of continuous education in the clinical setting, disease management, and the development of tools for care

The acute care hospital nurses recognized independent excretion care as <the content of excretion care varies depending on experience>. Among them, novices were particularly fully occupied by disease management as a nursing duty, preventing them from sufficiently performing independent excretion care. Novice nurses have been reported to face challenges related to nursing practice, including difficulties in making temporal arrangements and accurately recognizing the situation, a lack of skills for ADL support, and insufficient learning（Nagata, Oyama & Miki et al., 2005）. When performing excretion care as part of ADL support, they tend to realize their insufficient skills, as it is difficult for them to smoothly provide patients with assistance for excretion（Fukui, 2009）. However, in a previous study examining the status of group education for novice nurses in acute care hospitals, such education mainly focused on assistance with medical care. The mean length of group education to teach excretion support skills was limited to 20 minutes, which was the second shortest among 15 education items（Ministry of Health, Labor and Welfare, 2007）. In the present study, one of the acute hospital nurses stated: "*I have the impression that our education is pointless, as it does not specifically focus on excretion or other important ADL*", revealing insufficient continuous education for ADL support in the clinical setting. In fact, compared with other nursing skills specified by the Ministry of Health, Labour, and Welfare in the 'Basic Nursing Education Goals to Be Achieved by Students Before Graduation'（Takemura, 2015）, the skill to support excretion is one of those that is more difficult to acquire through clinical training（Nakajima, Kameyama & Ota, 2007）. This also highlights the necessity of providing continuous education in the clinical setting.

Furthermore, other nurses stated: "As the majority of nursing staff are young in our department, tools (such as assessment scores) may be useful to nurture their autonomy" and "Such assessment and measures to support patients' independence on a step-by-step basis remain insufficient", indicating the necessity of devising methods to resolve differences in the quality of care between experienced and inexperienced nurses. Therefore, in addition to continuously providing education, it may also be necessary to develop tools for independent excretion care while performing risk management.

DOI: http://dx.doi.org/10.14391/ajhs.14.24
Asian Journal of Human Services, VOL.14 24-37

2) Promoting liaison among nurses

When performing independent excretion care, the acute care hospital nurses aimed to provide [patient-centered care with respect]. On the other hand, they faced [dilemmas when performing excretion care that does not meet patients' requirements], as they were forced to perform care [from the viewpoint of treatment as a priority], rather than the perspective of ADL.

Some previous studies examined nurses providing excretion support, and reported that they faced dilemmas when it was difficulty for them to provide ideal excretion support due to various causes, including operational difficulties, difficulty in establishing optimal support methods for individual patients, and differences in recognition between patients and staff（Hashimoto, 2012）. The results of the present study support this finding.

In other previous studies, the importance of classifying problematic situations and addressing them as challenges for all staff members, rather than individual nurses, to avoid/reduce dilemmas faced by them（Yokota, Kamimura & Oda, 2011）. And the effectiveness of creating opportunities to exchange opinions regarding clinical ethical issues in medical environments（Iitsuka, Kamota, Watanabe et al., 2011） were suggested. However, as one nurse stated: "*Staff members need unified approaches to care for individual patients based on their own intentions, including reporting to the care leader. We do not have enough time to discuss appropriate management in each case*", the acute care hospital nurses realized that information-sharing among nurses was insufficient, and multi-professional liaison systems for independent excretion care had yet to be established. Based on these findings, in order to enable acute care hospital nurses to perform excretion care without facing dilemmas, it may be necessary to establish liaison among nurses by creating sufficient opportunities for them to exchange information regarding independent excretion care as the first step.

3) Creation of environments to pass on and share 'clinical wisdom'

Regarding independent excretion care, one of the acute hospital nurses stated: "*I feel that my awareness of excretion independence has been enhanced since I became a leader*", representing their perception that <the content of excretion care varies depending on experience>. At the same time, as knowledge also varies among nurses, others felt that <the content of excretion care varies among individual nurses>. It is certain that nurses' knowledge varies depending on their experience. But Nakamura（Nakamura, 1992） noted the importance of 'clinical wisdom' in comparison with 'knowledge based on modern science'. In the setting of nursing care, nurses' insights based on their intuition, experience, and analogical reasoning may also be essential（Sato, 2013）. In fact, among the acute care hospital nurses, novices performed independent excretion care, [learning from senior nurses], as one of them stated: "Observing senior nurses encourage patients to excrete using toilets, I learned that this is the essence of functional recovery care". Thus, they learned about nursing practice by observing senior nurses' approaches and commitments.

DOI: http://dx.doi.org/10.14391/ajhs.14.24
Asian Journal of Human Services, VOL.14 24-37

Nurturing model nurses in order for novices to learn about independent excretion care through seniors' experiences and statements, and develop nursing autonomy may be another future challenge, as the importance of creating environments for novice nurses to share seniors' statements as a basis for the provision of unified independent excretion care was also suggested.

2. Performing independent excretion care through multi-professional liaison as a solution to insufficient manpower

Insufficient manpower and temporal restrictions made it difficult for the acute care hospital nurses to actively perform independent excretion care.

Japan is currently facing a serious deficiency of nurses. It is likely that nursing roles will become even more important in the future, with further decreases in the birth rate and the progression of aging（Kenporen, 2011）. Therefor nurses will have increasingly heavy workloads, making it more difficult for them to provide ADL-focused intervention. Based on such a situation, it may be necessary to consider measures to perform independent excretion care, even with limited nursing manpower. In the present study, the acute hospital nurses performed care [through multi-professional liaison]. Excretion care is a basic care procedure, but it requires multifaceted approaches and sufficient skills（Moriizumi & Oomi, 2009）. Therefore, multi-professional liaison is indispensable for it.

The nurses frequently mentioned liaison with physical therapists and care workers (assistants). For example, one of them stated: "*Care skills vary among individuals, but the presence of skillful care workers is greatly helpful for us*", while another stated: "*We are trying to establish a system for all staff members, including nurses and assistants, to similarly manage these affairs*". Based on this, care workers who support patients' ADL through collaboration with nurses may also play a key role in performing independent excretion care in acute care hospitals.

On the other hand, as educational and personal backgrounds markedly vary among care workers, it may be crucial to provide education specializing in functional recovery care for them to acquire skills needed for independent excretion care in acute hospitals. Yasuda et al. examined nursing/caregiving specialties and collaboration, and noted the importance of 'establishing trust-based relationships between care workers and nurses to discuss issues from the standpoint of patients, rather than either party' to promote collaboration/liaison between them（Yasuda, Yamamura, Kobayashi et al., 2004）. Based on this, it may also be necessary to establish liaison/collaborative systems for nurses and care workers to share information and goals, in order to provide ADL-focused patient support using the former's medical knowledge for appropriate judgment and the latter's insight into daily life.

For the elderly independent excretion care is the most dignity-related act among the ADL. In this study, it became clear that disease treatment is given priority in acute care hospital, it is difficult to carry out care with life perspective. In order to solve the problem,

DOI: http://dx.doi.org/10.14391/ajhs.14.24
Asian Journal of Human Services, VOL.14 24-37

it was suggested the necessity of education and tool development for independent excretion care.

Acknowledgment

I would like to express my gratitude to all the nurses in the acute hospitals that we cooperated in this research. This work was supported by The Yuumi Memorial Foundation for home Health Care in 2016.

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Human Services

DOI: http://dx.doi.org/10.14391/ajhs.14.38
Asian Journal of Human Services, VOL.14 38-52

ORIGINAL ARTICLE

Constructing 'the Psychopath':
A Discourse Analysis of Psychologists' Understandings of Psychopathy

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ABSTRACT

Background: Psychopathy is a controversial psychological construct used within forensic settings to understand the psychology of forensic service users. Contemporary research into psychopathy indicates ontological confusion, limitations with assessment practices and the presence of a negative bias towards individuals identified as psychopathic.

Aims: A moderate social constructionist epistemology underpins this study. Its purpose was to widen the clinical frame of psychopathy via sociological inquiry through an examination of how 'the psychopath' is constructed discursively by a particular group of specialists working directly with individuals with a psychopathy label.

Methods: Subjects were eight clinical psychologists currently working throughout the UK in forensic mental health settings (low, medium and high-secure hospitals). Semi-structured interviews were conducted and the data were analysed qualitatively, using Discourse Analysis methods.

Findings: Analysis demonstrated that persons with psychopathy are constructed as problematised individuals, located within four overarching, recurrent discursive sites: dangerous, challenging, manipulative, and psychologically deficient. Participants utilised 'at risk' and 'trauma' discourses to explain the aetiology of psychopathy and 'intuition' talk was employed as a marker of the presence of psychopathy. The findings of the study and their clinical implications are discussed.

Received
March 18, 2018

Revised
April 8, 2018

Accepted
April 11, 2018

Published
April 30, 2018

<Key-words>
psychopathy, clinical psychology, discourse analysis, forensic mental health

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Asian J Human Services, 2018, 14:38-52.

DOI: http://dx.doi.org/10.14391/ajhs.14.38
Asian Journal of Human Services, VOL.14 38-52

I. Introduction

The Ministry of Justice (2011, p. 4) defines psychopathy as a "particularly severe form of antisocial personality disorder" and states that it is an important personality disorder-type within offender services due to its relationship with high levels of re-offending, violence and failure to comply with treatment. Correspondingly, a long-standing endeavour to identify the presence of psychopathy across prison and forensic populations persists (Jeandarme, Edens, Habets et al., 2017). Despite this imperative, there remains an absence of clarity with regards to the conceptualisation of psychopathy (Kirkman, 2008; Lilienfeld & Arkowitz, 2007). Multiple definitions of the construct are used which are, at times, contradictory and only partially overlapping (Skeem, Poythress, Edens et al., 2003). Nonetheless, most mainstream literature into psychopathy has particular descriptive qualities in common. These are a lack of empathy, and a 'cold', callous personality, as well as behavioural features of impulsivity, antisociality, criminality and a failure to act 'morally' (e.g. Berg, Hecht, Latzman et al., 2015; Farrington, Ullrich & Salekin, 2010; Schaich Borg, Kahn, Sinnott-Armstrong et al., 2013).

In the UK, psychopathy has historically been a legal rather than a clinical category. Several psychometric measures are used in prison and forensic settings to establish the presence of psychopathy, most notably the Psychopathy Checklist Revised (PCL-R Hare, 2003). However, recent research points to limitations of a range of psychopathy assessment tools (Singh, Grann & Fazel, 2011). The implications of this raise serious ethical concerns when one considers that those assessed for, and classified with, psychopathy are subject to harsher criminal sentencing in Europe (Pham & Saloppé, 2013) and more likely to be sentenced to the death penalty in the USA (Blais & Forth, 2014; Edens, Davis, Fernandez et al., 2012). A high PCL-R score has also been found to be the strongest predictor of whether an individual is recommended for release from high security settings (Manguno-Mire, Thompson, Bertman-Pate et al., 2007).

To date, the social component of psychopathy has been poorly investigated, perhaps pointing to the pervasiveness of the belief that some people are pathologically 'bad'. A very small number of studies have investigated how psychopathy is constructed discursively and how this contributes to the way individuals with the label are understood. Recent studies demonstrate a blurriness of fact and fantasy in scientific discourse when delineating psychopathy and positioning the psychopath (Federman, Holmes & Jacob, 2009; Hamilton, 2008). Likewise, studies have demonstrated the complexity of experts' talk and its powerful, constitutive effects, such as the construction of personality disorder treatment (whether preventative or curative) as both a therapeutic necessity and a professional ethical duty (Pickersgill, 2009; Richman, Mercer & Mason, 1999). Along these lines, this article examines both the dominant discourses drawn upon by clinical psychologists when constructing psychopathy and psychopaths,

DOI: http://dx.doi.org/10.14391/ajhs.14.38
Asian Journal of Human Services, VOL.14 38-52

and the co-occurring subjectivities and implications for action that are made possible for clinical psychologists through these various discursive constructions.

II. Subjects and Methods

1. Participants and Data Collection

A purposeful sampling method was utilised for recruitment to the study. Eight participants were interviewed in total, in line with recommendations for in-depth analysis and to achieve theoretical saturation (Georgaca & Avdi, 2012). Three participants were male, five were female. All participants were between the ages of 30 and 50 and identified as White British. Participants were working in low, medium and high secure NHS forensic services across the UK.

Individual interviews were conducted with each participant using a semi-structured interview guide, developed in reference to the literature, to ensure a degree of uniformity in the topics covered during each interview. Broadly speaking, the interviewees were asked to talk about how they understood the concept of psychopathy, their experiences of working with this identified group, their thoughts on the impact of the label and related assessment processes on themselves, the individuals assigned the label, and the systems in which they practice.

Interviews were digitally recorded and transcribed verbatim by the lead author using a Jefferson-lite approach (Banister, Bunn, Burman et al., 2011). A total of 435.7 minutes of data were produced (mean = 54.46; range = 48.18–65.86).

2. Epistemology

This study draws on a moderate social constructionist framework. Research in this tradition assumes that the types of reality available are co-constructed socially and through language, whilst also being shaped by underlying material structures and mechanisms. Central to the moderate social constructionist argument is the presence of an interacting and interactive process between individual and society, which shapes available ways of being in the world, as well as what can be claimed as valid knowledge (Elder-Vass, 2012).

3. Methodology

Data were analysed qualitatively, using a Discourse Analysis method (Willig, 2008) which outlines a six-stage non-linear process of analysis via identification and investigation of: 1) discursive constructions; 2) discourses; 3) action orientation; 4) subject positions; 5) practice; 6) subjectivity. According to this methodological approach, 'discourses' are recurrent systems of statements used to talk about objects and events in the world. As such, a Discourse Analysis enables exploration of the distinctive ways that a phenomenon can be talked about, points to operations of power and ways in which

DOI: http://dx.doi.org/10.14391/ajhs.14.38
Asian Journal of Human Services, VOL.14 38-52

individuals are 'subjectified'; that is, the particular kinds of self that are made possible (Foucault, 1982).

III. Results

1. Discursive Constructions of Psychopathy

Four overarching discursive constructions of psychopathy were identified; dangerous, challenging, manipulative, psychologically deficient. This article focuses on one example from each discursive site to evidence the analytical point.

1) Dangerous

Individuals with psychopathy were constructed as dangerous in a variety of ways: to more vulnerable service users; to staff, both physically and psychologically; to society at large. The prevailing sense was that psychopaths are responsible for a disproportionate amount of distress and difficulty in forensic settings, despite their rarity; this discourse is in keeping with prevailing messages about psychopathy and aligns with wider extra-discursive practices, such as the Dangerous and Severe Personality Disorders governmental initiative (Duggan, 2011). In making sense of the psychopath as uniquely dangerous, this discursive construction is part of a framework which legitimises the need to incarcerate and contain. In the following extract, this sense of dangerousness is produced through multiple mechanisms: (1) emphasising that psychopathy is 'more than' Anti-social Personality Disorder (APD); (2) emphasising that a person with psychopathy 'feels' different to all others; (3) articulating a need for 'intuition', implying that psychopathy is difficult to predict and foresee:

Extract 1 I think we've got lots of antisocial people here but not many psychopaths, if you wanna call it that, but it's a subset I think of APD. Erm (.) so you know if you look at the PCL assessment, half of it is basically antisocial PD you know, have they done all these things in the past that tick the box, (.) erm but then you've got that sort of feeling, I mean it's kind of a- it's a bit of intuition and experience I suppose, and working out who you would score highly I think, but it's very much the sort of charismatic (.) you know lying, real sort of lack of empathy type of err type of people you know who are high PCL scorers, and antisocial (.) is maybe a bit more about erm I suppose both are to do with early circumstances but I think (.) you can put anyone into kind of really difficult situations and they might end up with antisocial PD, I think it takes (.) specific people to end up with sort of high PCL scores I think. (.) It's a small subset I'd say.

The participant draws on a number of discourses in this construction of psychopathy; he emphasises that APD and psychopathy are separate but related to one another, with

DOI: http://dx.doi.org/10.14391/ajhs.14.38
Asian Journal of Human Services, VOL.14 38-52

APD constructed as comparatively commonplace across forensic settings. He legitimises this knowledge by drawing on the PCL-R as an objective diagnostic practice and, doing so, privileges associated biomedical assumptions of individualism and internal pathology. Thus, psychopathy is constructed as something rare but clinically identifiable.

The participant draws on 'intuition' talk to exemplify psychopathy's distinctness. This was a common discursive mechanism across the dataset; its effect is to move possible constructions of the psychopath away from, or beyond, psychological assessment processes and nosological features, into a non-scientific space, whereby reliance on subjective 'feelings' are legitimate means for the identification of psychopathy. One consequence of this talk is that the participant positions themselves away from a status of scientist-practitioner, instead producing clinical experience and 'gut-feeling' as useful forms of knowledge. Likewise, instinct talk means that the construction of the psychopath as deceitfully charming -a 'classic' characterisation of the psychopath- does not require legitimation by objective means; as with all 'folk devils', the deviance of the psychopath is not necessarily located in the acts they commit, but in how they 'make' others feel (Cohen, 2002).

The construct of empathy is identified as a central lacking feature of psychopathy. Empathy is a concept within the purview of professional psychology and an example of a lay-term which has been co-opted by the psychology profession as technical language (e.g. its inclusion on the PCL-R). By subsuming lay descriptions into professional terminology, asymmetric power relations are maintained and individuals with psychopathy are reproduced as sites for psychological attention and state intervention.

The participant then emphasises different aspects of a biopsychosocial model to construct both APD and psychopathy as contrasting psychopathologies; while both are acknowledged as arising in part from "early circumstances", a bio*psychosocial* discourse constructs APD as a natural response by "anyone" in extreme circumstances, whereas a *bio*psychosocial discourse constructs individuals with psychopathy as having a predisposing vulnerability to developing the disorder. The practical implication of these constructions is that the behaviours of some individuals are difficult to comprehend without the use of the psychopathy label. Through such talk, the PCL-R and the psychopathy label are established as useful clinical tools for making sense of these behaviours, and for validating professionals' emotional responses.

2) Challenging

Participants constructed psychopathy as extremely challenging for staff teams to manage. Psychological language of 'splitting' and 'boundaries' was routinely called upon in this construction, suggesting that these terms have particular cultural valence within forensic contexts. Several participants expressed ambivalence about the psychopathy concept and the 'challenging' construction was utilised to manage this ambivalence; through it, the label is presented as necessary and helpful within forensic contexts. Thus,

DOI: http://dx.doi.org/10.14391/ajhs.14.38
Asian Journal of Human Services, VOL.14 38-52

participants adopted a theoretical critical position towards psychopathy but negated this within their practice by constructing psychopathy as a useful and meaningful concept for day-to-day working:

Extract 2 I think I quite enjoy working with people sometimes that are less (.) less psychotic in some ways and more (.) kind of (.) you know more of a personality presentation. I think you often have to think much more about the dynamics in the therapeutic relationship and as a psychologist you often feel like you have to- they're the people I use supervision more for, if that makes sense. Thinking about difficulties, you feel like boundaries are often pushed more erm (.) you know kind of often they're the people that (.) the team struggles more with like nursing staff and things, you might be thinking about how to work with them directly, and support (.) nursing staff from kind of barriers constantly being (.) pushed and maybe teams feel like they're being split and (.) you know people are told different things and you know er (.) lying or telling fibs is a quite predominant feature and can be quite hard to manage in a team erm when people are sort of told different things and played in different ways and I think psychology can have a real use in that kind of like (.) you know, as sort of overall consultation and and sort of leadership role.

The participant begins by framing the additional challenge posed by those with psychopathy as an exciting alternative to other work, recruiting clinical language and mental illness versus personality disorder distinctions into this construction. As in extract 1, psychopathy is constructed as a rare and unusual phenomenon, with the label used by staff as an explanation for an otherwise incomprehensible individual. Through this discursive construction, high levels of supervision are framed as necessary, further reinforcing the construction of psychopathy as professionally challenging.

The participant describes the nature of the challenge presented by individuals with psychopathy, utilising metaphors of boundaries and splitting; both are concepts within the particular purview of professional psychology, drawn from psychodynamic discourse. As in extract 1, the challenge posed by the psychopath is described using technical knowledge which constructs the observation of psychopathy as neutral and objective, whilst simultaneously enabling a role for psychology in its explication and governance.

The participant describes ways in which the team "struggles" in relation to individuals identified as psychopathic; most notably, dishonesty and misinformation are central to this struggle. Behaviours constituted as challenging (e.g. "telling fibs") are institutionally deviant and, therefore, they should be managed distally through extra-discursive structures (i.e. secure facilities), and proximally, through consultation and leadership from knowledgeable psychology professionals. Thus, the constitutive and reinforcing relationship between a body (the psychopath), a collective (psychology

DOI: http://dx.doi.org/10.14391/ajhs.14.38
Asian Journal of Human Services, VOL.14 38-52

professions) and institutions (medicine, government) is illustrated in the discursive construction of psychopathy as challenging (Lemke, 2013).

3) Manipulative

A recurring construction of psychopathy across participants' talk was an individual identifiable by their capacity to manipulate others. Related terms used were deceitful, dishonest, scheming, slippery, duplicitous and devious. This construction is in keeping with dominant depictions throughout the wider literature, which signify the psychopath as deviant or 'bad' (e.g. Berg, Hecht, Latzman et al., 2015; Borg, Kahn, Sinnot-armstrong et al., 2013). The concept 'manipulative' is another lay term which has been appropriated by psychology professionals and given a status of scientific, objective trait; its inclusion on the PCL-R is evidence of this process of language co-option:

Extract 3 I think er feeling as though you're being kind of manipulated, erm (.) sometimes (.) people can be quite skilled- but the thing about kind of manipulation (.) is err I think it's quite unsettling, because whereas people with other personality disorders you can feel as though you're being manipulated, (.) it- you- it's more kind of easily understandable, and it's almost- you put it in the frame of (.) the life that they've been through, so you can see the lens by which the person is in-interpreting you and trying to move in a in a certain kind of direction or- yeah. Whereas with kind of- with people with psychopathy, it's almost like you don't know the reason for which they're doing it in that way and sometimes it can just be in order to manipulate you, because that's one of their kind of their strengths (.) so you don't necessarily see the kind of the reason why somebody's pushing or pulling you in a certain direction. It's also I think gives you a <u>real</u> sense of feeling ill at ease erm and and unsafe, because you're not- it's almost like it's excavating the ground from beneath your feet, kind of thing. Erm with other people, you can more quickly get on to ground (.) where you're working on common goals together (.) er whereas the ground kind of <u>shifts</u> er with people with psychopathy […][1] If you're not clear about the concept, which lots of people aren't, then you find that you're either using the label in a very black and white way, which doesn't help you or you don't know that that much about it and you're slipping about all over the place, without having, you know, <u>anchor</u> points kind of for yourself (.) and you can't use the other person as an anchor

[1] Denotes text omitted for brevity

DOI: http://dx.doi.org/10.14391/ajhs.14.38
Asian Journal of Human Services, VOL.14 38-52

The participant draws on the language of the PCL-R (Hare, 2003) whilst simultaneously utilising intuition talk to describe "a feeling" of manipulation. As in extracts 1 and 2, the behaviours of, and emotional responses towards, individuals with psychopathy are constructed as incomprehensible. This is reinforced by a concurrent construction of other 'kinds' of service user, whose violence or damaging behaviours are comprehensible in the context of their diagnoses and histories. Hence, a unique form of manipulation is assigned to the psychopath, one that is especially inexplicable and alarming. A 'relational spectrum' of deviancy is constructed, whereby the extent of an individual's deviance is measurable according to the extent of professionals' discomfort (Foucault, 1991). Out of this construction, the label of psychopathy is positioned as a meaningful explanation for both an individual's behaviours and a professional's feelings. In so doing, a mutually reinforcing surveillance process is in action, requiring psychology professionals to engage in self-regulatory monitoring and formulation of their own internal emotional responses.

Throughout this extract, the participant employs an extended metaphor of being on unstable ground to describe the quality of his experience. Through this, the psychopath is constructed as disruptive and powerful with a corresponding subject position of vulnerability and professional instability. This construction necessitates introspection on the part of the clinical psychologist, thus, evaluation of one's internal states in-vivo becomes part of the sense-making process. The metaphor and comparative construction are simultaneously extended, serving to emphasise the unique challenge that individuals with psychopathy pose to the therapeutic endeavour, as compared to other service users. From this position, the participant establishes specialist knowledge about psychopathy as essential for preventing therapeutic uncertainty and misuse of the label through oversimplification. In this way, knowledge of psychopathy and self-knowledge are constructed as valuable safeguards, uniquely essential when working with psychopaths due to their manipulative nature.

4) Psychologically Damaged

Persons with psychopathy were constructed as vulnerable figures who are psychologically damaged, possibly not in control of, or responsible for, their actions. Various psychology theories were drawn on in this talk. A tension was present in the construction: participants drew on 'trauma' discourses (e.g. Dillon, Johnstone & Longden, 2012; Patel, 2011) to explain subsequent psychological deficiency and also 'genetic vulnerability/at risk' discourses (e.g. Laajasalo & Häkkänen, 2004) to evidence a predisposing deficiency; though both were present, the extent to which participants privileged one discourse over another varied:

Extract 4 […] psychopathy is a defence erm a defence against psychosis erm (.) and the fragmentation of the mind that that implies and <u>also</u> at the route of that is erm (.) just a a <u>terrible</u>, <u>terrible</u> attachment disorder, a

DOI: http://dx.doi.org/10.14391/ajhs.14.38
Asian Journal of Human Services, VOL.14 38-52

> deeply disorganised attachment in the sense that (.) the child really hasn't been able to (.) establish any any sort of stable internal object, so everything's terribly frightening and awful and I think the people we see, you can see that, it coexists doesn't it and people move in and out of that; it's often people have attracted- and he[2] talks about this, people have attracted several different diagnoses throughout their lives, most commonly personality disorder, some kind of PCL-R assessment that indicates psychopathic traits and erm just psychosis or psychotic disorder erm and that coupled with sort of depression, anxiety and other things, but yeah. So psychopathy is the sort of cold-front, if you like, of the the the sort of terrible sequela of disorganised attachment.

A system of profession-specific knowledge is established, through which the psychopath can be understood via complex psychodynamic formulations. An image of a psychologically deprived child is called upon to emphasise a sympathetic stance and also to legitimise a nuanced, non-reductive conceptualisation; co-occurring expert and subversive subjectivities are constructed. The construction of psychopathy as a sad consequence of an adverse early life and some form of predisposing characteristic localises explanations of psychopathy at the level of care-giving and nurture experiences and is articulated as ultimate evidence for the authenticity of object relations and attachment theories. Thus, psychopathy's status as archetypal personality disorder is reproduced. This construction also neutralises the need to investigate wider, societal-level factors by relocating the 'badness' of psychopathy, as per lay-understandings, from the individual to the parent-child constellation. Moreover, in locating a forensic-specific construction of the psychopath as damaged but comprehensible through particular psychology knowledges, and by drawing on an 'at risk' discourse, a legitimate claim can be made for state intervention in order to prevent future psychopathy; this claim is explicitly made elsewhere in the dataset.

IV. Discussion

Persons with psychopathy were constructed as problematised individuals in a variety of ways: dangerous, challenging, manipulative, psychologically damaged. Psychiatric and diagnostic discourses of classification and related traits were frequently drawn on to describe psychopathy, privileging associated biomedical assumptions of individualism and internal pathology. Reliance on psychology and psychiatry technologies (e.g. formulation and diagnostic labelling) in order to 'understand' and make sense of individuals was apparent and the scientific value of diagnostic systems (DSM

[2] The participant is referring to Rob Hale, a psychopathy theorist

DOI: http://dx.doi.org/10.14391/ajhs.14.38
Asian Journal of Human Services, VOL.14 38-52

and PCL-R) was emphasised for their ability to distinguish differing psychopathologies. Constructions of those with psychopathy as uniquely challenging align with wider mainstream constructions of psychopathy in forensic settings and legitimises priorities of management rather than therapy strategies (Bowen & Mason, 2012; Mason, Caulfield, Hall et al, 2010; Mason, Hall, Caulfied et al., 2010).

An 'at risk' discourse constructed individuals with psychopathy as having a pre-existing vulnerability to developing the disorder; this is resonant with findings from previous discursive literature (e.g. Pickersgill, 2009) suggesting the availability of this discourse for forensic practitioners, beyond the bounds of the present study. The 'at risk' discourse was also located alongside a 'trauma' discourse and rooted in a 'forensic specific' context, which constructed individuals with psychopathy in forensic mental health settings as victims of their early life experiences; this appears to relate to previous studies into the presence of a relational interaction as contributing to the manifestation of psychopathic traits (e.g. Brody & Rosenfeld, 2002; Giovagnoli, Ducro, Pham et al., 2013). Multiple psychological theories were utilised to legitimise this discourse.

'Intuition' talk occurred across participants' accounts. This straddled scientific (clinical judgement) and mythical (a "feeling" or "sense") discursive locations, further distinguishing individuals with psychopathy as both 'other' and otherworldly, as well as emphasising that the concept itself is elusive. Previous discursive research findings on the presence of an overlap between 'professional' and 'lay' understandings of psychopathy is resonant here (Federman, Holmes & Jacobs, 2009; Hamilton, 2008), as well as legitimising contemporary concerns regarding the use of expert opinion during court proceedings (Scott, 2014). Perhaps most significantly, this research finding serves to operationalise previous research into clinical limitations of the use of psychopathy as a psychological concept (McPhail, 2013).

In summary, participants' talk produced psychopathy and those so ascribed as simultaneously bad and mad, and located them in a unique moral and social space, implying a biopsychosocial understanding for psychopathy. These findings dovetail with the wider essentialist research agenda which prioritises investigation of a biological hypothesis for psychopathy and, increasingly, a neurobiological hypothesis (e.g. Baron-Cohen, 2011). Interest in psychosocial factors is positioned through this lens, with 'signs and symptoms' of psychopathy (i.e. behaviours and characteristics) understood as manifestations of some form of psychological damage. Processes of medicalising deviance and reifying psychopathy were, therefore, operant in participants' accounts, making a culture of social control a legitimate practice. This is concordant with concerns raised by critical researchers (e.g. Cohen, 2002).

1. Implications for Practice

The findings of this research point to important clinical and research implications in relation to psychopathy in forensic settings. Arising recommendations are aimed at

DOI: http://dx.doi.org/10.14391/ajhs.14.38
Asian Journal of Human Services, VOL.14 38-52

mental health professionals working with those identified as psychopathic, those involved in service and policy development, and researchers investigating the field.

1) Clinical Labelling and Diagnosis

Despite acknowledging the limitations of the psychopathy label, participants repeatedly articulated that it would not be possible to do away with it because it stands in for an experience that mental health professionals find difficult to understand, and that labelling is a part of contemporary human life. *If* labelling is an inevitable process, a potential solution might be to re-vision the label away from its controversial history. One possible alternative might be for clinicians to begin using the term 'high risk, high need' (McPhail, 2013), which more appropriately reflects that individuals with psychopathy in forensic settings often require high levels of therapeutic input and care and moves away from the moral overtones and elusiveness of the psychopathy label, shedding its historical baggage in the process. Research has indicated that this conceptualisation engenders more positive outcomes for individuals (Wilson, Cortoni & McWhinnie, 2009). Labelling theory is resonant here; it may be that the label psychopathy promotes deviant behaviour, while an alternative label makes different ways-of-being possible (Thoits, 2010).

2) Policy and Service Development

The findings of this research indicate the presence of a complex relationship between medical and legal domains; a biolegal space (Foucault, 1988). Clinical psychology has the capacity to apply its skills base to service and policy development agendas, therefore, it is important that this is taken as an opportunity to foster shifts in discourses at a systemic institutional level. One possibility in this regard is that policy developers, and healthcare professionals advising them, emphasise ontological uncertainties related to psychopathy within policy and guidance documents. Policy has a key role in governing clinical practice, thus, discussion of practice guidance and its clinical and social implications should occur concurrently; to separate them is unethical. In coproducing these issues, clinicians would be better placed to make fully-informed decisions about their practice. While this may produce a quandary for clinicians to actively navigate in daily practice, such awareness-raising is essential in providing ethical healthcare to service users (Horley, 2013).

Service practices should be evaluated in light of the absence of a clearly defined conceptual definition of psychopathy and questioning whether it is appropriate to measure something that is not clearly defined in the literature. This may relate to practices within forensic systems, which can act as boundaries to the production of alternative ways of understanding people with this label. For example, the absence of any strengths-based clinical tools may reinforce problematised constructions. It is possible that the development and introduction of an alternative, strengths-based

DOI: http://dx.doi.org/10.14391/ajhs.14.38
Asian Journal of Human Services, VOL.14 38-52

measure for psychopathy, may enable different understandings of the phenomenon, or enrich the presently underdeveloped alternative descriptions that are available to clinicians.

2. Critical Review

In interviewing clinical psychologists this research seeks to attend to the continuities and discontinuities in how psychopathy is talked about by an invested and dominant professional group, and to attend to the dynamic constitution and reconstitution of manifold and contradictory discourse practices (Davies & Harré, 1990). Additionally, psychologists in forensic settings are most likely to conduct psychopathy assessments (rather than psychiatrists or nurses), meaning that they hold an expert position in relation to the construct. Thus, they are the preferential research population for this study.

Given the extreme nature of prevailing discursive constructions of psychopathy, when clinical psychologists were asked to talk about their work it is unsurprising that a dis-ease with underlying assumptions was expressed and negotiated throughout their accounts. It is possible that asking professionals to describe how and why they work in particular ways implies that the legitimacy of their practices is being called into question. Indeed, scepticism as to the motives of the researcher, and what might be 'uncovered' about current practices, were concerns articulated by those who declined to participate in the study.

Acknowledgment

The author wishes to thank the clinical psychologists who participated in this study.

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Human Services

DOI: http://dx.doi.org/10.14391/ajhs.14.53
Asian Journal of Human Services, VOL.14 53-65

ORIGINAL ARTICLE

A Study on the Characteristics of Network Consumption Behaviors and Evidence-Based Analysis of Influencing Factors

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ABSTRACT

Due to the broad variety of network resources and the fast pace of day-to-day living, more and more consumers are switching to the network for shopping. In this context, characteristics of network consumption behaviors are studied in this paper. The Howard & Sheth pattern is modified based on the S-O-R model (stimulus-organism-response). Human behavior is usually following the S-O-R model, which was first set up by Reynolds in 1974. This paper adjusts the Howard and Sheth theory based on the S-O-R model and classifies the factors influencing online consumption behaviors into five categories: individual consumers, risk awareness, retailer characteristics, marketing, and consumption intentions. Hypotheses regarding the factors which influence network consumption behaviors are proposed. A questionnaire survey is then performed to collect sample data. The structural equation model is then adopted to test each of the hypotheses.

＜Key-words＞
curve model network consumption, consumption behavior, evidence-based analysis

Received
March 20, 2018

Revised
April 4, 2018

Accepted
April 9, 2018

Published
April 30, 2018

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Asian J Human Services, 2018, 14:53-65.

DOI: http://dx.doi.org/10.14391/ajhs.14.53
Asian Journal of Human Services, VOL.14 53-65

I. Introduction

The advent of network and the expansion of network coverage have exerted considerable impact on consumption to the point where a new group has emerged, i.e., online consumers. As more and more consumers are switching to the network for shopping, online shipping has emerged as a new fashion (Yan Xueyuan, 2014). Currently, the number of online shopping websites is increasing in China. By December 2015, China had 413 million online shoppers, increasing at 14.3% by 5.183 million compared to the previous year. The Internet shopping market of China is growing steadily. In particular, the size of mobile Internet shoppers has increased dramatically to 340 million at a rate of 43.9%. The proportion of mobile Internet consumption has risen from 42.4% to 54.8%. China's total retail sales was 3.88 trillion yuan for 2015, up 33.3% compared with the previous year. Retail sales of commodities transacted over the Internet was 3.24 trillion yuan, up 31.6% compared with the previous year. It increased faster than the growth rate of the total retail sales of consumer goods at 20.9%, accounting for 10.8% of the total retail sales of consumer goods (China Online Shopping Market Research Report, 2015).

Online consumption is characterized by transaction convenience, wide choices and environment privacy. Due to these reasons, many retailers keep increasing their market shares by switching to the Internet to sell their products. Despite this, some retailers failed during fierce competition. Therefore, in order to find the reason for these failures, both retailers and researchers divert their attention to the characteristics of online consumption behaviors and the influencing factors (Jiang Sufang, 2009).

II. Literature Review

Online consumption behavior is a behavioral process where the consumers meet their demands by finding, purchasing, using and evaluating products or services of their interest over the Internet. What is consumed over the Internet is available from the virtual network platform. Shopping of these products or services is a dynamic interaction between consumers and network resources, whose ultimate goal is to meet the unique demands of consumers (He Yu, 2018). For the research model, by the retailing research, the factor of individual consumers (GT) is highly possible influences the internet shopping. The features of consumers themselves, as well as the experience of internet shopping have huge impacts with clothing suppliers. Stephenson and Willett (1969) considered that customers can be divided into three types: entertainment type, convenient type, and price guide type. Risk awareness (FX) is the uncertainty of purchasing process by the consumers. Consumers also have this risk awareness with the result of purchasing online. And the specialty of online shopping makes customers feel more risks than the traditional shopping. By the support of technology, increasing the

DOI: http://dx.doi.org/10.14391/ajhs.14.53
Asian Journal of Human Services, VOL.14 53-65

risk awareness can help consumers improving the ability of forecasting (M Samadi, 2009). Retailers sell products at the end of the selling process. They give service to customers only, not wholesalers or producers. Retailers (LS) image is set up by external characteristic and operation power. In the traditional business, the popularity and credibility of a retailer are the most important company assets. It is same with the online business. Customers prefer good reputation online shop rather than the common ones(S Saleem, 2011). In the marketing (YX), 4Ps (Product, Price, Promotion, place) analysis helps companies making decisions to motivate customers go shopping (Mendelson and Bolls, 2002). About consumption intention (MY) extensive studies have been carried out to reveal relationship between consumption intention and consumption behavior. According to the Theory of Reasoned Action proposed by Fishbein & Ajzen in 1975, behavior arises from intention. Based on the technical acceptance model and the innovation diffusion theory, Cheng Hua (2003) constructed a model to describe the consumers' acceptance of online shopping. The influence of consumption intention on consumption behavior was clarified, and the external variable of consumption characteristics was introduced to the model. Consumption Behavior (Y) is people's buying attitudes and intentions. If a group of people is exposed to some form of advertising of a product or a service they will then response to the advertised message with certain definable behaviors (S Saleem, 2011).

1. Related work on characteristics of individual online consumers

The characteristics of individual online consumers refer to the age, gender, education and profession of individual consumers who do Internet shopping (Zhao Xueju, 2014). Views regarding online consumption vary among researchers. According to Li & Russell (1999), the 4% shopping deviation can be explained by consumer characteristics, and that the demographical features have certain influence on consumption behaviors. But Bhatnager et al. (2000) refuted this, saying that the demographical features do not have considerable influence on consumption behaviors. In its 2013 Report on Behaviors of the Chinese Internet Shoppers, iResearch stated that gender has little influence on online shopping behavior. The 25-30 age group accounts for the largest proportion of online consumers, followed sequentially by the 19-24 and 31-35 age groups. These three age groups occupy 77% of the total online consumers in China. Hence, the 19-30 age group is the backbone of the Chinese online consumers. Investigation about the profession of online consumers indicated that students and white-collar workers approximately account for 8% of the total online consumers in China. Professionals, technicians and teachers occupy about 8%. These demographical features demonstrate that certain demographical features do have influence on online consumption behaviors. According to Martin et al. (2011), the demographical features do not have considerable influence on online consumption behaviors because the online consumption market has no constraint on age group, income level and gender. In a Forsythe & Bo Shi survey (2003), 43% of all

DOI: http://dx.doi.org/10.14391/ajhs.14.53
Asian Journal of Human Services, VOL.14 53-65

existing netizens have an undergraduate degree, but for the new netizens, only 29% of them have completed undergraduate education. It also showed that the online consumers mainly consisted of middle-income groups. Zhong Xiaona (2005) reported that the fundamental demographical features do not have considerable influence on the consumers' cognition of shopping, and that only age and income have differential influence on the consumers' cognition and risk awareness.

2. Representation of characteristics of consumption behaviors

The environment of online consumption is different from that of real-world consumption. Online consumption happens under the Internet-enabled virtual environment or website for shopping online, where the consumers are anonymous and cannot communicate face-to-face with the retailers. Moreover, the consumers can browse around and purchase the products without any temporal or spatial constraints (Weng Shuzhen, 2014). Based on existing works and taking our own research into account, the characteristics of online consumption behaviors are as follows.

(1) A high proportion of impulsive shopping: This refers to the behavior of consumption where the products are purchased on impulse rather than being planned beforehand. As the number of netizens is increasing, more and more people endeavor to collect market information via the network. The broad variety of information about the products over the Internet inclines the consumers to purchase on impulse. Therefore, online consumption is very impulsive (Yu-Chi Sung, 2007).

(2) A high demand for convenience: When the rhythm of life accelerates, there is a greater demand for quality, price and convenience of daily necessities. The modern logistics and operational management technologies accelerates the circulation of products, enabling the consumers to be more informed about product quality and price via the Internet. In addition, the consumers are clearer about their needs under the Internet environment and choose the most convenient means to satisfy them(Chen Hai Quan, 2013).

(3) More discretion is left to consumers: With further division of labor, the wide choices of products heighten the consumers' awareness of risk. As a result, more and more consumers are risk-averse and no longer trust spoon-fed marketing. Prior to the purchase of daily necessities, especially durable goods (e.g., computer and washing machine), the consumers usually collect information in different ways for comparison and analysis. Even if the analysis might be incomplete or inaccurate, the consumers can find psychological balance (Jia Yuemei, 2001) and avoid regret which may occur after purchase, deriving psychological satisfaction from their trust in and pursuit of the products. When the uncertainty of modern society increases and the demand for psychological stability grows, consumers have more discretion over consumption.

(4) The pursuit of brand products: The brand effect is so influential that the pursuit of brand products has emerged as a fashion. In this context, the retailers are devoted to the

DOI: http://dx.doi.org/10.14391/ajhs.14.53
Asian Journal of Human Services, VOL.14 53-65

establishment of their brand over the Internet. Through the use of the network, the consumers can keep themselves informed of product information and make their decisions by comparing the prices and performance of various brand products(Chen Hai Quan, 2013).

(5) Dominance of online shopping: Due to progress in e-commerce, online shopping and retrieval of product information via the network are no longer merely a fashionable behavior. Rather, it has become an indispensable part of daily consumption for network users. By establishing online shopping platforms, the retailers make it easier for consumers to access the channels of product distribution, thereby arousing the consumers' enthusiasm for shopping over the Internet. Reforming the traditional means of marketing reshapes the behavior pattern of consumers in the era of network. (Wang xin long, 2015).

(6) Customization of consumption: The consumers begin to pursue customization rather than blindly follow fashion trends. The consumers can collect product information more quickly and comprehensively from the Internet. For some new and customized products, consumers can make their decisions based on the information collected. The retailers can also disseminate product features more widely using the network (Dong xiao mei, et al., 2010).

Ⅲ. Methodology

1. Hypotheses and Research Model

It has been reported in previous works that the factors which influence consumption behaviors can be classified into three types, i.e., consumers, environment and enterprise marketing. Because the quantification of these three factors is influenced by many tiny factors, it is hard to determine the way each factor influences consumption behavior. Taking the purchase process of consumers into account, the research on this issue will be variable and intractable. The amount of information involved in the research will also be very large and the conclusions will hardly explain the real-world consumption behavior (Shi Shuzheng, 2011). In order to simplify the research, this paper adjusts the Howard and Sheth theory based on the S-O-R model and classifies the factors influencing online consumption behaviors into five categories: individual consumers, risk awareness, retailer characteristics, marketing, and consumption intentions. The hypotheses are listed in Table 1.

DOI: http://dx.doi.org/10.14391/ajhs.14.53
Asian Journal of Human Services, VOL.14 53-65

<Table 1> Research hypotheses

Research hypotheses	Contents
H1	Factors of individual consumers are correlated with consumption intention
H2	Factors of individual consumers are correlated with consumption behavior
H3	Sensed risks are correlated with consumption intention
H4	Characteristics of retailers are correlated with consumption intention
H5	Marketing factors are correlated with consumption intention
H6	Marketing factors are correlated with consumption behavior
H7	Consumption intention is correlated with consumption behavior

The characteristics of consumers themselves have considerable influence on their consumption behaviors. In order to shop online, the consumers have to equip themselves with necessary network and computer usage skills as well as familiarize themselves with Internet shopping procedures. The accumulated experience about online shopping yields insights into the future behaviors of consumption, helping them evaluate product quality more accurately (Dong xiao mei, 2010).

Therefore, H1: the factor of individual consumers is correlated with consumption intention and hypothesis

H2: the factor of individual consumers is correlated with consumption behavior.

Risk awareness refers to the perception of uncertainty which arises during the shopping process. Internet shopping is virtual and the chance to check the products beforehand is lacking, resulting in uncertainty over payment and delivery. Furthermore, Internet shopping may cause leakage of personal and private information, thereby increasing the consumers' perception of risk (Wang Juan, 2015) and affecting their desire to purchase.

In this context, H3: risk awareness is correlated with consumption intention.

Retailers refer to the enterprises or individuals that provide products or services to consumers rather than wholesalers or manufacturers. Traditionally, the retailers tend to win recognition from the public and consumers by showcasing their external characteristics and internal strengths. Reputation is an important part of enterprise assets in the traditional marketing paradigm. Under the network environment, the retailers still have enormous influence on the consumers' purchasing intention. Usually, the consumers favor the brand products of traditional enterprises (Jiang Sufang, 2009) because these enterprises have good reputation. It has been extensively proven that the retailer's good image and quality of service make it easier for consumers to accept their products, stimulating their desire to purchase.

Therefore, H4: characteristics of retailers are correlated with consumption intention.

DOI: http://dx.doi.org/10.14391/ajhs.14.53
Asian Journal of Human Services, VOL.14 53-65

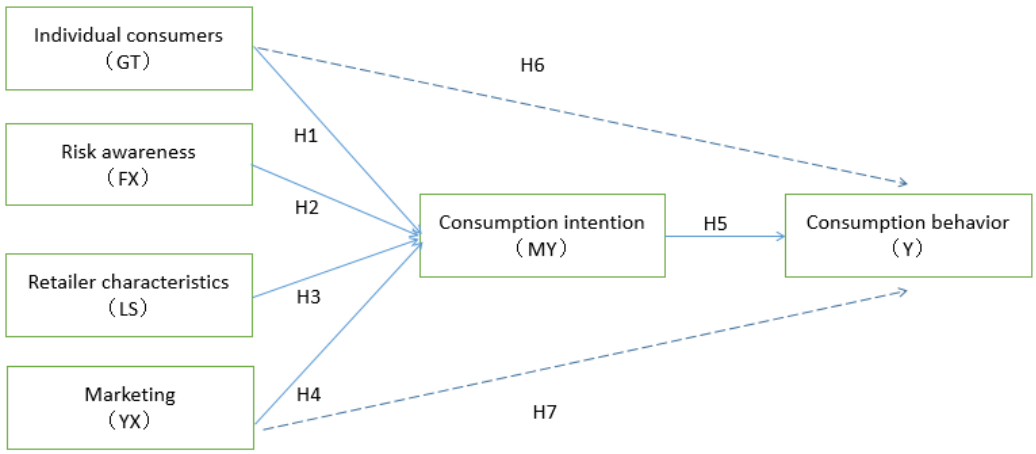
During online shopping, the consumers' perception of the brand, price and advertisement shapes their attitude and intention, exerting direct influence on their purchase behavior. Brand loyalty will cause repeat consumption and even recommendation to others. Appropriate pricing on the part of retailers promotes customer loyalty. Too much advertisement may affect the consumers' consumption psychology and behavior (Pei Haiseng, 2012).

In this context, H5: the marketing factors are correlated with consumption intention, and hypothesis H6: the marketing factors are correlated with consumption behavior.

It has been reported in some studies that there is a correlation between consumption intention and consumption behavior. Fishbein and Ajzen (1975) formulated the reasonable behavior theory, stating that intention causes behavior. Chen Hua (2003) established a model for online consumption behavior using the technology acceptance model and the innovation diffusion model. The external variable of consumer characteristics was introduced to demonstrate the influence of consumption intention on consumption behavior.

Therefore, this paper proposes hypothesis H7: there is a correlation between consumption intention and consumption behavior.

Based on the abovementioned hypotheses, a model of factors which influence online consumption behaviors is established, and the correlation between these factors is obtained, as shown in Fig. 1.



<Figure 1> Model and hypotheses

2. Research Implementation and Evidence-Based Test

1) Sample collection

A questionnaire survey was sent out and evidence-based analysis was carried out using the statistical theories. Scale was determined based on the hypotheses described above. Questions in the survey consisted of basic information on online consumption and questions about each variable. Questions concerning individual consumers, risk

DOI: http://dx.doi.org/10.14391/ajhs.14.53
Asian Journal of Human Services, VOL.14 53-65

awareness, retailer characteristics and network marketing were mainly obtained from existing literature. The respondents were asked to fill out the questionnaire and each variable was measured using a seven-point scale, where 1-7 represented completely disagree and completely agree, sequentially. A total of 512 questionnaires were distributed, and 87.3% of them (i.e., 447) were returned. The features of the data samples are presented in Table 2.

<Table 2> Descriptive statistics of samples

		Frequency	Percent
sex	man	114	25.5
	woman	333	74.5
age	18years	5	1.1
	18~25years	262	58.6
	26~30years	70	15.7
	31~40years	76	17.0
	41~50years	26	5.8
	51~60years	8	1.8
edu	<Bachelor	132	29.6
	Bachelor	217	48.5
	master	82	18.3
	doctor	16	3.6
cost	<1000yuan	107	23.9
	1000-3000yuan	148	33.1
	3000-5000yuan	64	14.3
	5000-8000yuan	77	17.2
	>8000yuan	51	11.4

2) Test and analysis

The scale's reliability and validity was tested by checking the questionnaire's internal consistency and structural validity. Each dimension of the scale was divided into 29 sub-items, Retailer characteristics reliability index is 0.927, Consumption intention reliability index is 0.947, Risk awareness reliability index is 0.892, Marketing reliability index is 0.917, Individual consumers reliability index is 0.869.

The scale's validity was tested using the Kaiser-Meyer-Olkin (KMO) test and Bartlett spheroidal test methods. Results indicate that it was suited for factor analysis, as the KMO value of the 29 items was 0.939, higher than 0.6. Also, the accumulated variance of all factors was 72.447% during factor analysis. Therefore, the scale has great explanatory ability when used to measure relevant concepts. Furthermore, factors extracted from factor analysis was approximately the same as the classification of the theoretical framework. These results prove the high level of scale validity. The results of validity analysis and reliability analysis are shown in the Table 3. The measured results are all good.

DOI: http://dx.doi.org/10.14391/ajhs.14.53
Asian Journal of Human Services, VOL.14 53-65

<Table 3> Results of validity analysis and reliability analysis

	1	2	3	4	5
LS3	.807	.152	.085	.242	.056
LS2	.799	.196	.123	.235	.032
LS6	.786	.297	.133	.182	.073
LS1	.734	.101	.089	.311	.087
LS7	.717	.290	.083	.218	.095
LS5	.716	.237	.042	.250	.199
LS4	.714	.329	.105	.218	.047
MY2	.237	.845	.133	.221	-.017
MY3	.225	.835	.132	.244	.014
MY5	.199	.831	.141	.199	-.031
MY4	.274	.801	.098	.282	.061
MY1	.267	.766	.084	.378	.053
MY6	.300	.704	.098	.303	.052
FX3	.123	.018	.882	.097	.076
FX4	.061	-.007	.866	.129	.160
FX2	.215	.136	.759	-.007	.199
FX8	-.006	.102	.736	.100	.351
FX9	-.034	.249	.693	.117	.181
FX1	.182	.194	.641	.155	.142
YX3	.325	.245	.152	.763	.008
YX4	.378	.249	.060	.752	.132
YX2	.285	.379	.139	.691	-.013
YX1	.235	.349	.134	.674	.000
YX7	.380	.415	.094	.633	.078
YX6	.338	.243	.114	.621	.201
YX5	.207	.460	.217	.531	-.049
GT1	.154	.025	.289	.000	.851
GT2	.156	-.008	.344	.072	.794
GT3	.077	-.005	.397	.102	.763
Cronbach's Alpha	.927	.947	.892	.917	.869
Total	12.359	4.123	2.166	1.214	1.148
Initial Eigenvalues % of Variance	42.616	14.216	7.470	4.186	3.959
Initial Eigenvalues Cumulative %	72.447				
KMO	.939				

DOI: http://dx.doi.org/10.14391/ajhs.14.53
Asian Journal of Human Services, VOL.14 53-65

3) Hypothesis test

SPSS 16.0 was used for statistical analysis. Table 4 shows the results obtained by analyzing path coefficients of the model.

<Table 4> Analysis results of the path coefficients

Relationship path	Path coefficient	Hypothesis	Result
Individual consumers → Consumption intention	.120	H1	Support
Risk awareness → Consumption intention	.123	H2	Support
Retailer characteristics → Consumption intention	.184	H3	Support
Marketing → Consumption intention	.588	H4	Support
Individual consumers → Consumption behavior	.044	H5	Support
Consumption intention → Consumption behavior	.140	H6	Reject
Marketing → Consumption behavior	.120	H7	Reject

Results indicate that the load values of individual consumers, risk awareness, retailer characteristics and marketing with respect to consumption intentions were all significant at the level of 0.001, their path coefficients being Individual consumers 0.12, Risk awareness 0.123, Retailer characteristics 0.184 and Marketing 0.588, respectively. Also, the load values of individual consumers, the marketing and consumption intention of consumption behavior is not at the level of 0.001. their path coefficients being Individual consumers 0.044, Consumption intention 0.140, and Marketing 0.120, respectively. From these results, it can be learned that individual consumers, retailer characteristics, marketing factors and consumption intentions were positively and significantly correlated with consumption behaviors, while risk awareness was positively and significantly correlated with consumption behavior. When it comes to the degree of influence of these factors on consumption behavior, Marketing have the most influence, followed sequentially by Retailer characteristics, Risk awareness and Individual consumers. Hypotheses H1-H7 were thus verified.

IV. Conclusion

Empirical study was performed to construct a model of factors which have influence on consumer behaviors. The relationship of individual consumers, risk awareness, retailers, and marketing with consumer behaviors was validated. The influence of these factors on consumption amount, scale and frequency was investigated. Questionnaire survey was conducted on online shoppers. The results were statistically analyzed via SPSS16.0 to verify the model and hypotheses. It is revealed that the factors of individual consumer and retailer is strongly and positively correlated with the consumption intention; the risk awareness is also strongly and positively correlated with the

DOI: http://dx.doi.org/10.14391/ajhs.14.53
Asian Journal of Human Services, VOL.14 53-65

consumption intention. The factors of individual consumer, retailer and marketing are strongly and positively correlated with the consumption behavior.

It is learned from multivariate regression analysis that the consumption intention and behavior is most influenced by marketing, followed by the factors of retailer characteristics, risk awareness and individual consumers. Occupation, disposable income and the amount of time spent each day on the Internet have significantly distinct influence on consumption behavior. But gender, age and educational background do not have significantly distinct influence on consumption behavior.

It can be learned that the retailer is the most significant factor in influencing online consumption intention and behavior. In this study, the factor of retailer is very wide-ranging, including the ability to provide accurate information, reputation, price competitiveness, payment method allowed, security and reliability of logistic service, and the ability to protect customer privacy. These are also the chief concerns of consumers. Therefore, the retailer is the most significant factor in influencing online consumption intention and behavior. Risk awareness also has significant influence on online consumption intention. Some customers are aware of the possibility that online shopping incurs the waste of time on product search and selection, threatens privacy and even prompts them to choose the wrong product. These concerns heighten the consumers' awareness of risk and weakens consumption intention. On the contrary, reducing the risk can strengthen consumption intention. The factor of individual consumers has great influence on consumption intention, but its influence on consumption behavior is slight. Similarly, the factor of marketing has great influence on consumption intention, but its influence on consumption behavior is also slight.

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Human Services

DOI: http://dx.doi.org/10.14391/ajhs.14.66
Asian Journal of Human Services, VOL.14 66-83

ORIGINAL ARTICLE

Consideration of Constructs for the Social Skill Training Program Development for Children with ADHD Tendency:

Focus on the Analysis of the Practical Report

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ABSTRACT

The IN-Child means of "inclusive education needs child". There is In-Child who shows remarkable difficulty in a behavior face about 3.6% in Japan (Ministry of Education, Culture, Sports, Science and Technology, 2012). However, there are a few concrete teaching programs to improve social skills according to the characteristics of ADHD tendency, and the effectiveness of its teaching programs has not yet been verified. The purpose of this study is to decide on the social skill training program for the children with ADHD tendencies in regular classes. We searched the practical reports on children with ADHD tendencies in foreign countries by using the ERIC-Institute of Education Science thesis database. Among them, 23 papers were related to practical reports. Since there were practices listed in the review paper, a total of 12 cases were analyzed. There were many programs that used rewards, such as token economy, thereby indicating that a program promoting voluntary activities with a reward is believed to be effective for children with ADHD tendencies.

＜Key-words＞
social skill traning, Inclusive Needs Child (IN-Child), constructs, ADHD tendency

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Asian J Human Services, 2018, 14:66-83.

Received
March 30, 2018

Revised
April 11, 2018

Accepted
April 13, 2018

Published
April 30, 2018

DOI: http://dx.doi.org/10.14391/ajhs.14.66
Asian Journal of Human Services, VOL.14 66-83

I. Introduction

Inclusive Needs Child (IN-Child) refers to a child in need of an inclusive education by a team, which is also comprised of experts. The needs are not dependent on intellectual or developmental delays due to physical, mental, and home environment (Han, Ota & Kwon, 2016). IN-Child refers to all children who are in need of inclusive education regardless of diagnosis.

Around 3.6% of the children who are attending regular classes showed remarkable difficulty in behavioral aspects, such as ADHD tendency (Ministry of Education, Culture, Sports, Science and Technology, 2012). However, there are a few concrete teaching programs to improve social skills according to the characteristics of ADHD tendency, and the effectiveness of its teaching programs has not yet been verified.

Han, Ota & Kwon (2016) developed the "IN-Child Record" (hereinafter called "ICR") to grasp the actual state of IN-Child. The ICR domain is shown in Table 1.

<Table 1> Construction of the ICR

Domain		Item
Physical	Stages of the body	Q1-Q10
	Posture, movement, and motion	Q11-Q20
Mental	Inattention (attention deficit)	Q21-Q27
	Hyperactivity and impulsivity	Q28-Q33
	Adherence	Q34-Q39
	Self-esteem	Q40-Q44
Daily Living	Social functioning	Q45-Q49
	Communication	Q50-Q54
Learning	Listening	Q55-Q59
	Speaking	Q60-Q64
	Reading	Q65-Q69
	Writing	Q70-Q74
	Calculating	Q75-Q79
	Reasoning	Q80-Q82

In a previous study on ICR, children with ADHD tendency who showed remarkable behavioral difficulties had problems in their daily lives, such as communication (Han, Yano, Kohara et al., 2017). In Japan, however, many teachers in regular classes have little knowledge about the special needs education, and they do not have sufficient teaching experience. Therefore, most educators feel that it is difficult to teach an IN-Child. It is necessary to propose the social skill training program to such teachers and solve the teaching difficulty. In addition, teaching about daily living skills according to

DOI: http://dx.doi.org/10.14391/ajhs.14.66
Asian Journal of Human Services, VOL.14 66-83

the actual state of the child can lead to acquiring the necessary skills for the child to enter as a member of society in the future. For this reason, it is deemed necessary to develop teaching programs focused on social skills for children with ADHD tendency.

Currently, teaching social skills to children with ADHD tendency is being practiced a lot. However, despite many studies regarding the teaching methods for improving social skills, only a few teaching programs have been systematized and validated. Moreover, the teaching content is not a teaching method according to the child's characteristics of ADHD (Ota, Kwon & Kohara, 2017). The program for children with ADHD tendency that is necessary for the educational field is a systematized program according to the characteristics of the children, as they can acquire the necessary abilities within society.

The development process of the social skill teaching program is as follows: 1. Proposal of the draft of the program (determination of construct and determination of contents); 2. Verification of content validity and modification of the draft of the program; and 3. Effectiveness verification of the program. In order to prepare the drafts of the construct of the program, Kohara (2017) analyzed the previous studies and practical reports of the social skill programs for the children in Japan. In addition, the previous studies were compared to that of the characteristics of children with ADHD tendency, and constructed the draft domain of the instruction program that focused on the four capacity building (Table 2).

The purpose of this study is to decide of constructs on the social skill training program for the children with ADHD tendencies in regular classes.

<Table 2> Draft of the Domain of the Social Skill Training Program for the IN-Child (ADHD Tendency)

Domain of Training Programs for Social Skills	Sub-Domain	Evidence Material (Practical Report)	ICR Domain
Schedule management ability	Time management	Soyama & Katada (2012)	Inattention (attention deficit)
	Schedule management	Iwanaga, Watamaki & Sasayama (2012) Miyamoto (2014) Harayama (2015)	Social functioning
Listening ability	Keep to Listening	Tsuzuki, Hyodo, Ito et al. (2016)	Listening
Expression ability	Express feelings	Hirayama, Shouji (2016) Takano, Enta (2017)	Speaking
	Ask a question	Asai, Kodaira & Osawa (2013) Harayama (2015)	Communication Speaking
Information organization ability	Situation organization.	Harayama (2015)	Communication
	Straighten up personal belonging	Totsuki, Hyodo, Ito et al. (2016)	Social functioning
	Emotional management	Soyama & Katada(2012)	Communication

DOI: http://dx.doi.org/10.14391/ajhs.14.66
Asian Journal of Human Services, VOL.14 66-83

II. Methods

1. Data Extraction Method

1) Extraction Method

The ERIC-Institute of Education Science thesis database was used for this study. The data was extracted by using the search keyword “ADHD social skill” according to the following data selection criteria.

2) Data Selection Criteria

- It should not be a medication therapy that uses methylphenidate.
- It should contain the description of the educational practice for children with ADHD or ADHD tendencies.
- The full text of the papers should be available for public inquiry.

2. Analysis Method

This study examines the concept of social skill training program by dividing the subjects into four categories, namely, target audience, program duration and frequency, program evaluation method, and program contents and effect. Furthermore, the contents of the program and the effect map are each analyzed in connection with the area of the program (Kohara, 2017) and the area of the IN-Child record, respectively.

III. Results

1. Practical Report on Children with ADHD Tendencies

A total of 193 cases were found after a query with the search keyword “ADHD social skill”. Among them, 23 papers were related to practical reports, with 9 of them available for full text inquiry.

Among the 9 cases, 8 of them were original dissertations and 1 of them was a review. Since there were 4 education practices listed in the review paper, a total of 12 cases were analyzed. The analysis results were reclassified as the subjects (Table 3), the deadlines (Table 4), and the evaluation method (Table 5). In addition, the correspondence analysis results between the map area / the ICR and the program contents / effects were summarized as shown in Table 6.

DOI: http://dx.doi.org/10.14391/ajhs.14.66
Asian Journal of Human Services, VOL.14 66-83

<Table 3> Participants of the Social Skill Training Program

Reference	Diagnosis (n), Age
25)	ADHD (1), N/A ADHD and Autism Spectrum (1), N/A Autism Spectrum(4), N/A
24)	ADHD (20), primary class
14)	ADHD (31),3-11 years old
10)	ADHD (4), N/A
19)	ADHD (N/A),N/A
22)	ADHD Tendency (1), 6 years old
7)	ADHD (18), 6-10 years old Teachers (18), N/A
8)	ADHD (44), 5-10 years old
20)	ADHD (16), 8-11 years old
3)	ADHD Tendency (114), 6-13 years old
6)	ADHD (41),8-10 years old
18)	ADHD (56), 8-12years old

<Table 4> Period of the Social Skill Training Program

Reference	Period
25)	Twice a week for a total of 3 hours (1.5 hours per meeting)
24)	Once a week for a total of 90 minutes (1.5 hours)
14)	The normal 8 to 10 sessions have been reduced to 7 sessions.
10)	The entire program lasted for about 2 months.
19)	9 hours per day, 5 days per week for a total of 8 summer weeks (3 hours per day in art, which is a child-chosen academic subject, and computer)
22)	N/A
7)	N/A
8)	2 to 3 times per week The duration of each setting was limited to 30 to 60 minutes.
20)	A total of 10 weekly 1-hour sessions
3)	18 weeks
6)	2 sessions per week 10 afternoon sessions (2 hours each)×5 weeks
18)	5 months

DOI: http://dx.doi.org/10.14391/ajhs.14.66
Asian Journal of Human Services, VOL.14 66-83

<Table 5> Outcome Measure of the Social Skill Training Program

Reference	Outcome Measures
25)	1. Parents' answers on The Social Skills Rating Scale 2. Parental interviews, direct observation of participants interacting with peers within the group, and previous results
24)	1. Testing 2. Research on the pupils' attention and spatial thinking (original, i.e. prepared by the author of the article) 3. Written questionnaire survey 4. Assessment of the learning and social behaviors based on the opinion of the teachers 5. Oral questionnaire survey 6. Research on behavior and personality peculiarities based on the self-assessment of the pupil
14)	1. Child Behavior Checklist, Conners' Teacher Rating Scale, and School Situations Questionnaire
10)	1. The subjects' behaviors were compared with the matched peers who represented an average teacher-expected behavior by using direct observation for at least 3 days a week for 20 minutes at 15-second intervals. 2. Preschool and Kindergarten Behavior Scales (PKBS) 3. ADHD Rating Scale-IV (ADHD-IV)
19)	1. Parent satisfaction surveys
22)	1. Vineland Adaptive Behavior Scale 2. The number of incidences of aggression were counted at 5 minutes and at 30 minutes after completion of the art activity during indoor freeplay time.
7)	1. Classroom behavior - This includes direct observations of classroom behavior. - This is a modified version of the Behavioral Observations of Students in Schools (BOSS) - Each observation session lasted for 15 to 20 minutes during academic instruction and related activities (e.g., independent seatwork). 2. Academic performance - On a weekly basis throughout the study, the classroom teacher administered brief pretests and posttests of academic material that were covered during the week. - These tests contained 10 to 20 items and typically took 2 to 3 minutes to complete. - Math tests contained written numerical problems to demonstrate the competency in performing arithmetic operations (e.g., addition, subtraction, multiplication, or division) being taught in the classroom. - Spelling tests involved the teacher dictating that week's spelling words, with the students providing written answers. - Pretests were administered on Mondays prior to the instruction, whereas posttests (identical in content to the pretests) were given on Fridays after the day's lesson had occurred. 3. Social validation - Students: Consumer satisfaction ratings (3-point Likert-type scale) - Teachers: 11 items requesting their perceptions of the impact and practicality of CWPT (a 3-point Likert-type scale)
8)	1. Home Situations Questionnaire (HSQ)
20)	1. Conners' Parent and Teacher Rating Scales-Revised: Short form (CPRS-R:S=CTRS-R:S) 2. Kaufman Brief Intelligence Test (K-BIT) 3. Social Skills Rating System (SSRS) 4. Children's Communication Checklist (CCC) 5.Working Together: Building Children's Social Skills Through Folk Literature
3)	1. Normal-behavior scale (SWAN, Teacher version) 2. Strengths and Difficulties Questionnaire (SDQ) 3. Social Skills Rating System (SSRS) 4. Teacher questionnaire (available on request) Each of the intervention elements during that week (0 = not used or inadequate use; 1 = adequate use; and 2 = good use)
6)	<Behavioral measures> 1. ADHD rating scale – IV 2. Social Skills Rating System (SSRS) 3. Emotion Regulation Checklist (ERC) 4. Strengths and Difficulties Questionnaire (SDQ) <Neuropsychological measures> 5. Icelandic WISC-IV subtests <Lumosity assessment tests (https://www.lumosity.com/)> 6. The outcomes required participants to make a motor response, while the others required the participants to withhold a response. 7. Letter memory was used to assess the visual working memory.
18)	1. Conners Comprehensive Behavior Rating Scale (CBRS) 2. Conners 3

DOI: http://dx.doi.org/10.14391/ajhs.14.66
Asian Journal of Human Services, VOL.14 66-83

<Table 6-1> Result of the Correspondence Analysis between the Social Skill Training Program and ICR Domain

Reference	Implementation Format, Implementation Details	Domain of The Social Skill Teaching Program	ICR Domain
25)	**[Type of class]** - Teachers worked on skills in such domains as recreation skills, emotional skills, and conversational skills. - The skills presented in this study are conversational skills and were taught in a large-group instructional format, with the adolescents sitting in a semi-circle facing the lead teacher (first author). **[Contents]** - Step1; Maintain eye contact throughout interaction The participant's face and body are oriented towards the conversational partner. The participant's eyes are oriented towards the conversational partner for the majority of the interaction, and the participant's eyes never look away from the face of the partner for more than 10 continuous seconds at any time during the interaction - Step2; Maintain appropriate distance throughout interaction The participant maintains a distance of at least one arm's-length away from the partner and no more than two-arm's-lengths away from the conversational partner during the entire interaction - Step3; Maintain appropriate body posture throughout interaction The participant maintains an erect and relaxed posture during the entire interaction. The participant does not engage in any distracting behaviors such as rocking, tapping feet, repetitive hand flapping, excessive fidgeting, repetitive manipulation of objects (e.g. twisting or spinning a pencil or paper clip), etc. - Step4; Maintain appropriate voice tone and volume throughout interaction The participant maintains a positive voice tone during the entire interaction. The volume of the participant's voice is loud enough that the observer and peer can hear each word clearly, but which is not loud enough to cause a reaction from other peers and teachers in the classroom. **[Effectiveness]** - While no participants fully generalized all of the skills to a more naturalistic setting with a typical peer, the participants did show partial generalization. - The teaching interaction procedure was successful in teaching conversational skills in a group-based setting to five adolescents: four on the autism spectrum, and one sibling with ADHD.	Expression ability Express feelings	Physical Posture, movement and motion Mental Hyperactivity and Impulsivity Daily living Communication Learning Listening Speaking

DOI: http://dx.doi.org/10.14391/ajhs.14.66
Asian Journal of Human Services, VOL.14 66-83

<Table 6-2> Result of the Correspondence Analysis between the Social Skill Training Program and ICR Domain

Reference	Implementation Format, Implementation Details	Domain of The Social Skill Teaching Program	ICR Domain
24)	**[Type of class]** The participants were at random divided into 2 groups. **[Contents]** Cognitive behavior exercises and fairy-tale methods with primary class pupils suffering from AD/HD were chosen in the supplementary education school: the city of pyramids, as two different approaches helping to develop the cognitive, psycho-motoric sphere, social behavior and social adaptation. In order to strengthen educational influence, graphical-logical tasks and relay-races were chosen as supplementary education means in both experimental groups. 1. The Fairy-tale Methods on the Basis of Visual Stimulus 1) activate attention, as fairy-tales consist of subject lines that should be followed to meaningfully understand the essence of the fairy-tales; 2) develop memory, as fairy-tales stimulate memorization of prior events of the plot and associate them with the new ones; 3) develop thinking and decision making ability—with the help of language of symbols, fairy-tales manifest particular life problems. 4) fairy-tales creation helps to develop verbal abilities, e.g. language fluency, number of words and sentences, complexity; 5) help to develop communication abilities, as the situation provided in the fairy-tales makes not only to listen but also to empathize with the problems of fairy-tale heroes. Fairy-tales also help to disclose what values and moral norms help to expect the happy end; 6) help to disclose the consequences of spontaneous and even aggressive behavior —fairy-tales show that angry behavior, a wish to harm comes to the end, as the one who wanted to harm another will suffer or even disappear from the fairy-tales; only moral and kind heroes will remain; 2. Cognitive behavioral training Cognitive behavioral training or cognitive-behavioral techniques are socio-educational means applied both in the school environment and at home. This educational means is grounded by positive environment, maintenance, application of means and methods that help to concentrate attention, assess one's own behavior and to manage it. 3. Relay-races (games) in Educational Practice 4. Graphical—Logical Tasks in Educational Practice It is important that graphical-logical tasks applied during the educational experiment with the children suffering from AD/HD that are based on "drawing motives": drawing various lines, zigzags, ornaments, forms, coloring checks. During the educational experiment, graphical-logical tasks for children with AD/HD were applied not only individually, but in pairs and groups. **[Effectiveness]** - They allowed to achieve purposeful changes of cognitive and psycho-motoric spheres. - Children's fairy-tales became more fluent. - Children started using more complex sentences in their fairy-tales.	Expression ability Express feelings Information organization ability Emotional management	Mental Self-esteem Learning Writing Reasoning

DOI: http://dx.doi.org/10.14391/ajhs.14.66
Asian Journal of Human Services, VOL.14 66-83

<Table 6-3> Result of the Correspondence Analysis between the Social Skill Training Program and ICR Domain

Reference	Implementation Format, Implementation Details	Domain of The Social Skill Teaching Program	ICR Domain
14)	**[Contents]** **The Barkley's Parent Training Program for Defiant Children (1987)** Educating about ADHD, managing inappropriate public behavior, ignoring minor misbehavior, improving positive attending skills and using token economies at home. **[Effectiveness]** - It proved group training was as efficacious as individual family training and the program worked for noncompliant and hyperactive behaviors. - It also improved the behavior of children on medication. - The program did not have a significant effect on classroom behavior	Information organization ability Situation organization	Mental Inattention(Attention deficit) Hyperactivity and Impulsivity Daily living Social functioning Communication Learning Listening
10)	**[Contents]** - At the beginning of each day, teachers reviewed general classroom rules of behavior. - During positive reinforcement phases teachers rewarded students with small buttons, placed on a displayed chart, each time the child followed established classroom rules. - At the end of each activity, the students were eligible for a large button. If the children accumulated enough large buttons throughout the day, teachers offered inexpensive rewards (crayons, markers, stickers, etc.) before dismissal. - During response cost phases, the chart was full at the beginning of the day and children lost buttons due to misbehavior. - They still needed a specific number of large buttons at the end of the day to receive rewards. - Each time the teachers added or removed a button, they explained the exact reason for their action in the form of praises or reprimands. **[Effectiveness]** - Over time, the average frequency of negative social behaviors lessened, despite some daily spikes. - Although the two girls (one was more volatile) tended to have higher scores than the two boys, scores for both components reflected positive improvement, which stabilized toward the end of the experiment.	Information organization ability Situation organization	Mental Inattention(Attention deficit) Hyperactivity and Impulsivity Daily living Social functioning Communication Leaning Listening
19)	**[Contents]** - Instructors used daily report cards, positive verbal reinforcements, time-outs and token economies to manage behavior. - Parents attended group training sessions on behavior management throughout the year. **[Effectiveness]** - All who responded rated the program as beneficial with eighty percent declaring it very beneficial for their child.	Information organization ability Situation organization	Mental Inattention(Attention deficit) Hyperactivity and Impulsivity Learning Listening

DOI: http://dx.doi.org/10.14391/ajhs.14.66
Asian Journal of Human Services, VOL.14 66-83

<Table 6-4> Result of the Correspondence Analysis between the Social Skill Training Program and ICR Domain

Reference	Implementation Format, Implementation Details	Domain of The Social Skill Teaching Program	ICR Domain
22)	**[Contents]** **The art therapy technique of directed art activities** - Teacher prompts at the beginning and during the activity are essential to maintain the subject's focus on the feeling. - After all students have completed their art work, the teacher leads a class discussion by asking each child two questions: "(Child's name), tell us about your (picture)" and "How do you feel about your (picture)?" **[Effectiveness]** - Although they did not note if the decreased rates of aggression correlated with increased rates of positive peer-initiated or self-initiated interactions.	Expression ability Express feelings Ask a question	Mental Hyperactivity and Impulsivity Daily living Social functioning Communication
7)	**[Type of class]** Teachers determined the peer tutoring pairs for all of the students in their classrooms. Students assigned to tutor the children with ADHD were perceived by their teachers to display a high frequency of appropriate behavior in the classroom and to be on grade level in all academic subjects. **[Contents]** **The classwide peer tutoring (CWPT)** - Baseline 1 (typical classroom activities), CWPT 1 (implementation of CWPT in math or spelling), - Baseline 2 CWPT 2. Each experimental condition lasted from 1 to 2 weeks. **[Effectiveness]** - Similar changes in task-related behavior were obtained for most of the peer comparison students, indicating that it is not the disability that is critical, but how an educational environment is arranged. - It was demonstrated that changes in both classroom behavior and academic performance can be obtained with this intervention in general education settings. - Both teachers and students reported CWPT to be an acceptable and at least moderately effective strategy for improving both behavior and academic performance for students with ADHD.	Information organization ability Situation organization Emotional management	Mental Hyperactivity and Impulsivity Daily living Communication Leaning Listening Speaking Leading Writing
8)	**[Contents]** **ADHD parenting program** - The recommend a procedure in which a parent sets one or two clear and specific rules for the child, establishes a positive and negative consequences for following the rules, reminds the child right before entering the situation, and administers the appropriate positive or negative consequences afterwards. - The implementation of a behavioral contract at home and received one additional session in which they were instructed to implement the above-described procedure for managing the children's behavior in out-of-home settings. The settings were limited to a trip to the store (such as a supermarket or a department store), a restaurant (such as McDonald's orsimilar), religious services, or to visit a friend or a relative (or to have a friend or relative visit the subject's home). **[Effectiveness]** The treatment group evidenced significant reduction in severity of the children's behavioral problems in the target situations (as tested with the HSQ).	Information organization ability Situation organization Emotional management	Mental Inattention(Attention deficit) Hyperactivity and Impulsivity Daily living Social functioning Leaning Listening

DOI: http://dx.doi.org/10.14391/ajhs.14.66
Asian Journal of Human Services, VOL.14 66-83

<Table 6-5> Result of the Correspondence Analysis between the Social Skill Training Program and ICR Domain

Reference	Implementation Format, Implementation Details	Domain of The Social Skill Teaching Program	ICR Domain
20)	**[Contents]** **The Working Together Program** - For the current study, 10 specific social skills were chosen from this program based on the relevance of the skill in addressing typical problems in social skills and social communication of children with ADHD. The skills selected included: (a) making conversation, (b) introducing yourself, (c) making positive statements to others, (d) speaking assertively, (e) using courtesy words, (f) asking for help, (g) offering and giving help, (h) giving and accepting criticism, (i) joining a play activity, and (j) negotiating conflict. **A generalization component** - At the end of each session, parents and teachers were provided with skill information and "way to go" slips that were to be used in the following week to positively reinforce the children for performing the specific skill taught in the session. - The "way to go" slips were collected each week and were exchanged for a celebration party when the sessions were completed. **[Effectiveness]** The Working Together program is a promising social skill intervention for children with ADHD and social skill deficits that can be efficiently carried out in the child's own school with their own peers.	Expression ability Express feelings Information organization ability Situation organization Emotional management	Daily living Social functioning Communication Leaning Speaking Lestening
3)	**[Contents]** **The PR Program** A behavioral teacher program addressing ADHD symptoms in the classroom through a eacher manual not requiring additional expert training. - Administered a universal program encompassing elements such as physical adjustments within the classroom (e.g., table set-up, creating a time-out corner) - Positively formulated classroom rules - Effective teacher instructions - Teacher strategies to reinforce appropriate behavior (such as a universal reward system for the entire classroom). - The individual program involves a Daily Report Card (DRC) in which teacher and student with ADHD symptoms set and evaluate mutually agreed goals (e.g., "stay seated during individual work" or "raise your hand before asking questions") to alleviate student's classroom problems. - The individual program consists of three intensity levels, differing in the number of times per day goals are evaluate (once a day in Level 1 and 3 times a day in Levels 2 and 3), and rewards are provided (once a day in Levels 1 and 2, and 2 times in Level 3). **[Effectiveness]** - The teachers mainly notice improvements in ADHD symptoms after using the PR program, with some improvements in social functioning. - Common elements of those effective programs that were also part of the PR program include psycho-education, the use of classroom management strategies, and the use of a reward and time-out system. - Implementation fidelity and satisfaction among teachers was high - The most teachers (98%) reported that they intended to use the program in the future, indicating a high satisfaction rate and perceived effectiveness of the PR program among teachers.	Information organization ability Situation organization Emotional management	Mental Hyperactivity and Impulsivity Daily living Social functioning Leaning Listening

DOI: http://dx.doi.org/10.14391/ajhs.14.66
Asian Journal of Human Services, VOL.14 66-83

<Table 6-6> Result of the Correspondence Analysis between the Social Skill Training Program and ICR Domain

Reference	Implementation Format, Implementation Details	Domain of The Social Skill Teaching Program	ICR Domain
6)	**[Type of class]** - The group of trainers, 2-4 for each course - The group of 6 children (except for one group with 5 children) in each class. - Split into two 3-person groups at the beginning of each session **[Contents]** **The OutSMARTers program** <Sesstion1-5> - The Emotion Station (45 minutes) The children learned about correctly identifying facial expressions in others, the necessity of sometimes hiding feelings, relaxation and anger management techniques and how to interpret ambiguous situations in a neutral or positive way - The Friendship Station (45 minutes) This program consisted of discussing and practicing meeting new kids, reading non-verbal messages people send out, compromising, working on a group project, and other similar activities - The Brain Training Station (for 20 minutes) They practiced solving three executive function tasks on a computer (2 working memory tasks with pictures and letters and 1 Stroop inhibition task, which became increasingly more difficult as the program progressed) <Sssion6-9> - The Stopping Station (45 minutes) They participated in various fun games intended to help them think before speaking or acting - The Problem Solving station (45 minutes) The children learned a formula for solving everyday problems that they then use to solve various issues concerning school, friendship and family issues. - The Brain Training Station (20 minutes) At the end of each session the children could shop using their tokens at the OutSMARTers store, where they could buy trading cards, stickers, raffle tickets, and more. **[Effectiveness]** - The OutSMARTers program was effective for children with ADHD. - The children showed decreased ADHD symptoms, improved social skills and better emotion regulation at post-treatment. - The impact of the working memory training was however not as clear as had initially been expected 0 The OutSMARTers program effective in treating children with ADHD, resulting in less inattention and hyperactivity/impulsivity symptoms, less emotional symptoms and better social skills.	Expression ability Express feelings Information organization ability Situation organization Emotional management	Mental Hyperactivity and Impulsivity Adherence Daily living Social functioning Communication Leaning Speaking Listening

DOI: http://dx.doi.org/10.14391/ajhs.14.66
Asian Journal of Human Services, VOL.14 66-83

<Table 6-7> Result of the Correspondence Analysis between the Social Skill Training Program and ICR Domain

Reference	Implementation Format, Implementation Details	Domain of The Social Skill Teaching Program	ICR Domain
18)	[Contents] **The social skills training attachment (SOSTRA) trial** Opening round– what has happened since the last time? — revision of the previous session; homework from previous session; presentation/education; role play/creative activities; new homework; closing round. [Effectiveness] In the SOSTRA trial discovered a large effect over time for both the groups together, e.g., the children's social problems scores, aggressiveness, and hyperactivity scores showed highly significant changes towards fewer symptoms	Information organization ability Situation organization Emotional management	Mental Hyperactivity and Impulsivity Daily living Communication Leaning Speaking Listening Reasoning

2. Area Correspondence Analysis of the Map Program

Table 7 summarizes the analysis of the practical reports by using the areas of the map program (draft proposal).

The areas where the corresponding program was located were: "Express feelings" of "3. Expression ability"; and "Situation organization" and "Emotional management" of "4. Information organization ability". The areas having no corresponding area were: "Time management" and "Schedule management" of "1. Schedule management ability"; "Keep to Listening" of "2. Listening ability"; "Ask a question" of "3. Expression ability"; and "Straighten up personal belonging" of "4. Information organization ability".

DOI: http://dx.doi.org/10.14391/ajhs.14.66
Asian Journal of Human Services, VOL.14 66-83

<Table 7> Correspondence between the Training Program Areas and the Implemented Programs

Domain of the Training Programs of Social Skill		Program Contents	Reference
1. Schedule management ability	Time management	N/A	
	Schedule management	N/A	
2. Listening ability	Keep to Listening	N/A	
3. Expression ability	Express feelings	- Group teaching	25)
		- Fairy-tale methods on the basis of visual stimulus	24)
		- Art therapy technique of directed art activities	22)
		- Working Together Program - A generalization component	20)
		- OutSMARTers program	6)
	Ask a question	N/A	
4. Information organization ability	Situation organization.	- Barkley's Parent Training Program for Defiant Children (1987)	14)
		- Token economy	10)
		- Daily report cards - Positive verbal reinforcements - Time-outs - Token economies	19)
		- Classwide Peer Tutoring (CWPT)	7)
		- ADHD parenting program	8)
		- Working Together Program - Generalization component	20)
		- OutSMARTers program	6)
	Straighten up personal belonging	N/A	
	Emotional management	- Fairy tale methods on the basis of visual stimulus - Cognitive behavioral training - Relay races (games) in educational practice - Graphical-logical tasks in educational practice	24)
		- Token economy	10)
		- Classwide Peer Tutoring (CWPT)	7)
		- ADHD parenting program	8)
		- Working Together Program - Generalization component	20)
		- OutSMARTers program	6)
		- PR Program	3)
		- Social Skills Training Attachment (SOSTRA) trial	18)

DOI: http://dx.doi.org/10.14391/ajhs.14.66
Asian Journal of Human Services, VOL.14 66-83

IV. Discussion

We searched the practical reports on children with ADHD tendencies in foreign countries by using the ERIC-Institute of Education Science thesis database. In addition, 193 cases were searched by entering the search keyword “ADHD social skill”, but only 23 cases were on practical reports.

In regard to the frequency of practice, all practice programs were conducted at least once a week, thereby suggesting that it is necessary to execute the program at least once a week.

In regard to the format of practice, group or paired activities have also shown an improvement in social activity (Piscalkiene, 2009). Accordingly, it is believed to be necessary to perform as a group or a pair, and to conduct self-evaluation and reflection after each activity.

As for the performance of the guidance program, there were many ambiguous notations that were difficult to interpret, such as “Antisocial behavior has decreased”, and there were many articles that did not describe this explicitly, such as an increase or decrease in specific actions.

There were many programs that used rewards, such as token economy, thereby indicating that a program promoting voluntary activities with a reward is believed to be effective for children with ADHD tendencies. However, the most important in improving the sociality of the children with ADHD tendency was to understand the behavior of the children, and to recognize the coping methods, such as the problem and the solution of the behavior, thereby suggesting that it is important to use a reward as a means, and to encourage the children to voluntarily engage in activities rather than only looking forward to those rewards.

The results of the correspondence analysis with the area (draft proposal) of the Social Skill Training Program showed that the majority of the practical reports dealt with “Express feelings” of “3. Expression ability” and “Emotional management” of “4. Information organization ability”. However, no practical report dealt with “Time management" and “Schedule management” of “1. Schedule management ability”; “Ask a question” of “3. Expression ability”; or “Straighten up personal belongings” of “4. Information organization ability”. Meanwhile, some practical reports on fostering the “Time management” and the “Schedule management” were found in Japan's previous researches. Therefore, it is believed that future researches should be carried out to develop the Social Skill Training Program for an IN-Child with ADHD tendency with reference to the program that is being carried out in Japan.

DOI: http://dx.doi.org/10.14391/ajhs.14.66
Asian Journal of Human Services, VOL.14 66-83

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Asian Journal of HUMAN SERVICES

Asian Society of HUMAN SERVICES

Asian Journal of Human Services
VOL.14 April 2018

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Publisher Asian Society of Human Services
Faculty of Education, University of the Ryukyus, 1 Senbaru, Nishihara, Nakagami, Okinawa, Japan
FAX: +81-098-895-8420 E-mail: ashs201091@gmail.com

Production Asian Society of Human Services Press
Faculty of Education, University of the Ryukyus, 1 Senbaru, Nishihara, Nakagami, Okinawa, Japan
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Asian Journal of Human Services
VOL.14 April 2018

CONTENTS

ORIGINAL ARTICLES

Factors Affecting Discharge to Home of Geriatric Health Services Users:
An Analysis of Physical Conditions and the Contents of Care Received

Kazutoshi FURUKAWA et al., 1

Survey to Assess Information-gathering During the Process of Designing Care Plans Regarding Nutrition Improvement

Yuko FUJIO et al., 11

Acute Hospital Nurses' Recognition of and Approaches to Functional Recovery/Independent Excretion Care for Elderly Patients with Pneumonia

Yoshiko ENOMOTO et al., 24

Constructing 'the Psychopath':
A Discourse Analysis of Psychologists' Understandings of Psychopathy

Kitty CLARK-MCGHEE et al., 38

A Study on the Characteristics of Network Consumption Behaviors and Evidence-Based Analysis of Influencing Factors

Fan FAN et al., 53

Consideration of Constructs for the Social Skill Training Program Development for Children with ADHD Tendency:
Focus on the Analysis of the Practical Report

Aiko KOHARA et al., 66

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Asian Society of Human Services
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