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SHORT PAPER

A Comparison of the Factor Structure of the Self-Harm Antipathy Scale and related Demographic Characteristics between Korea and Japan

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ABSTRACT

The aim of the present study was to compare the factor structures of the Korean and Japanese version of the SHAS and analyze the commonalities and differences of the related social, cultural and education in two countries. Both scales were found to have the same four-factor structure, but the included items differed. The correlation coefficient between suicide and unemployment rates in Korea was 0.83, except for during 1998 to 2001, when both rates suddenly increased. Regarding religion in Korea, about 50% of suicide attempters were nonbelievers, about 30% were Christian, and about 20% were Buddhists. The correlation coefficient between the suicide and unemployment rates in Japan, where about 50% of suicide attempters were Shintoists and about 50% were Buddhists, was 0.89. The commonalities observed in the suicidal social and personal backgrounds may be associated with other commonalities between the Self-Harm Antipathy Scale version of Korea and Japan. The differences observed in religion may be associated with the other differences between the Self-Harm Antipathy Scale version of Korea and Japan.

< Key-words >

Japan, Korea, Self-Harm Antipathy Scale, self-injurious behavior, suicide

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I. Introduction

Nurses working in the emergency department are required to respond to patients with an empathetic attitude who have attempted suicide or self-injury (Japan Clinical Paramedic Society, 2009; WHO, 2000). However, currently, nurses often report finding it difficult to respond to and feel somewhat resistant toward such patients (Aoki & Katayama, 2017; Herron, Ticehurst, Appleby et al., 2001; Japan Clinical Paramedic Society, 2009; Mackay & Barrowclough, 2005).

The Self-Harm Antipathy Scale (SHAS) was developed to measure nurses' attitudes and antipathy toward self-injury patients and better grasp the current situation (Patterson, Wittington & Bogg, 2007).

The original SHAS, which was developed in the UK by Patterson, Wittington and Bogg (2007), evaluates the degree of antipathy felt by nurses toward self-injury patients on a 7-point Likert scale. Based on a factor analysis, the original SHAS is composed of 24 items out of a 30-item pool. In addition, a six-factor structure consisting of "Competence appraisal", "Care futility", "Client intent manipulation", "Acceptance and understanding", "Rights and responsibilities", and "Needs function" is used. Cronbach's α coefficient for each factor ranges from 0.52–0.81.

The Korean version of the SHAS (SHAS-K) was translated into Korean by Kwon and Lee (2017) and its reliability and validity have been confirmed. Based on a factor analysis, the SHAS-K is composed of four factors- "Competence Appraisal", "Acceptance and understanding", "Client intent manipulation", and "Care futility"- consisting of 14 items. Cronbach's α coefficient for each factor ranges from 0.54–0.88.

The Japanese version of the SHAS (SHAS-J) was translated into Japanese by Aoki and Katayama (2016), and its reliability and validity have been confirmed. Based on a factor analysis, the SHAS-J is composed of four factors- "Low empathic competence", "Care futility", "Lack of active understanding", and "Ignorance about rights and responsibilities"- consisting of 24 items. Cronbach's α coefficient for each factor ranges from 0.54-0.83.

Although the SHAS-K and SHAS-J have the same number of factors, either the factor names or the composition of the items included in the factors differ. Therefore, comparing the situations of the two countries, which have the highest international suicide rates, to find commonalities and differences could be important for suicide prevention.

The mental health nursing is necessary in the emergency department for patients who self-injury or suicide. Therefore, the aim of the present study was to compare the factor structures of the Korean and Japanese version of the SHAS and analyze the commonalities and differences of the related social, cultural and education in two countries. By these comparisons, the attitude of Korean and Japanese nurses to patients who have attempted suicide or self-injury can be much better understood.

II. Methods

This study compared the papers written by the authors. The second author obtained information about the present state of suicide in Korea, while the first and third authors obtained information about the present state of suicide in Japan. The collected data were adjusted by the first author, and these data were then compared and examined for commonalities and differences in terms of the factor structures of the SHAS-K and the SHAS-J. The social and personal backgrounds of suicide attempters, and the religious and education backgrounds of their nurses were compared between Korea and Japan.

III. Results

1. Factor structures of the SHAS-K and SHAS-J

“Acceptance and understanding” and “Competence appraisal”, which are factors of the SHAS-K, were in agreement with the items included in “Low empathic practice competence”, which is a factor of the SHAS-J. “Care futility” and “Client intent manipulation”, which are factors of the SHAS-K, were consistent with some of the items included in “Care futility”, which is a factor of the SHAS-J. The SHAS-K did not include “Ignorance about rights and responsibilities” and “Lack of active understanding”, which are factors of the SHAS-J (Table 1).

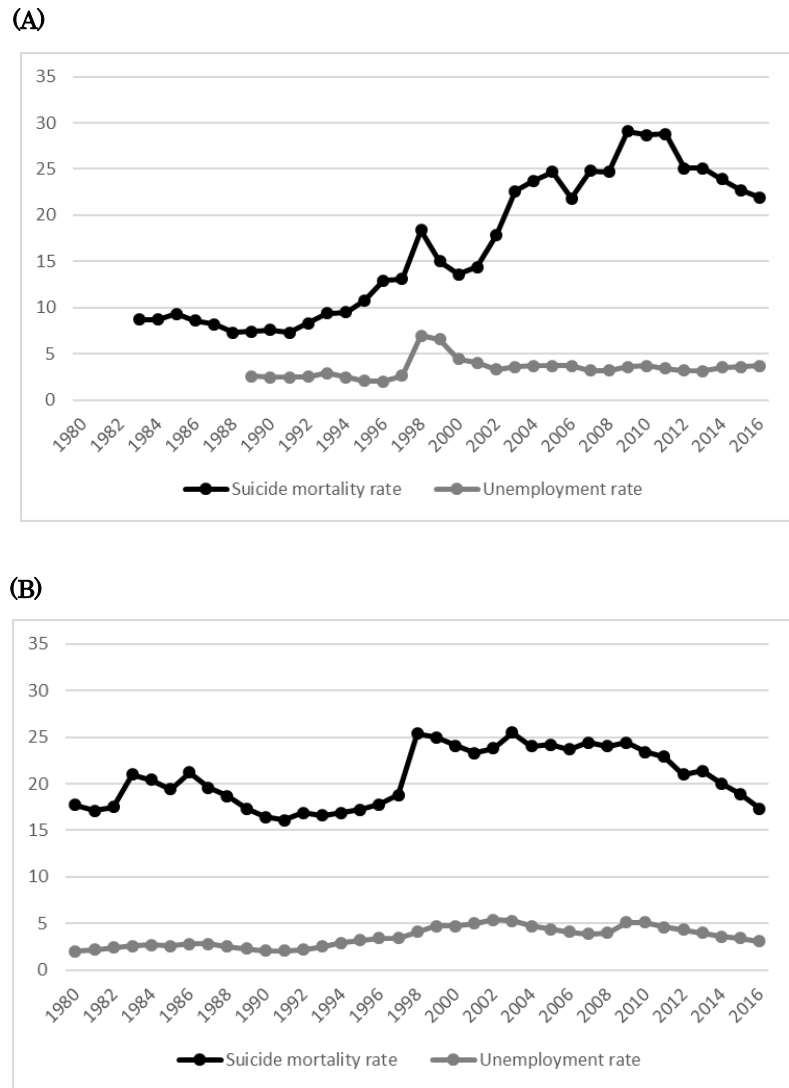
2. Suicide and unemployment rates

The correlation coefficient between the suicide and unemployment rates in Korea from 1989 to 2016 was 0.28. However, except for the 4 years between 1998 and 2001, when the suicide and unemployment rates suddenly increased, the correlation coefficient was 0.83 (Figure 1-A). The correlation coefficient between the suicide and unemployment rates in Japan from 1980 to 2016 was 0.89 (Figure 1-B).

<Table 1> The Difference in factor structures of the original SHAS, SHAS-K and SHAS-J

ITEM	Factor		
	Original SHAS	SHAS-K	SHAS-J
27 <i>r</i> I find it rewarding to care for self-harming clients	Competence appraisal	Acceptance and understanding	Low empathic practice competence
26 <i>r</i> I acknowledge self-harming clients' qualities			
28 <i>r</i> I can really help self-harming clients		Competence appraisal	
21 <i>r</i> I feel concern for the self-harming client			
23 <i>r</i> I demonstrate warmth and understanding to self-harming clients in my care			
24 <i>r</i> I help self-harming clients feel positive about themselves			
30 <i>r</i> I am highly supportive to clients who self-harm			
20 <i>r</i> I listen fully to self-harming clients' problems and experiences			
19 <i>r</i> A self-harming client deserves the highest standards of care on every occasion			
4 Self-harming clients do not respond to care	Care futility	Care futility	Care futility Care futility
10 There is no way of reducing self-harm behaviours	Care futility	Care futility	
5 When individuals self-harm, it is often to manipulate carers	Client intent manipulation	Client intent manipulation	
6 People who self-harm are typically trying to get even with someone			
15 A self-harming client is a person who is only trying to get attention	Care futility		
1 People who self-harm are usually trying to get sympathy from others			
7 A self-harming client is a complete waste of time	Acceptance and understanding		
16 Self-harming clients have only themselves to blame for their situation			
11 People who self-harm lack solid religious convictions			
22 I feel critical towards self-harming clients			
29 I would feel ashamed if a member of my family engaged in self-harm			
2 <i>r</i> People should be allowed to self-harm in a safe environment	Rights and responsibilities		Ignorance about rights and responsibilities
8 <i>r</i> An individual has the right to self-harm	Care futility		
9 Self-harm is a serious moral wrongdoing			
12 <i>r</i> Self-harm may be a form of reassurance for the individual that they are really alive and human	Needs function		Lack of active understanding
14 <i>r</i> Acts of self-harm are a form of communication to their situation			
17 <i>r</i> For some individuals self-harm can be a way of relieving tension	Acceptance and understanding		
18 <i>r</i> Self-harming clients have a great need for acceptance and understanding			
3 <i>r</i> A rational person can self-harm			
13 <i>r</i> Self-harming individuals can learn new ways of coping			
25 I feel to blame when my clients self-harm			

r: Reversal item



<Figure 1> Suicide mortality and unemployment rates in Korea and Japan.

(A) The suicide rate (%) is per 100,000 population and the unemployment rate is per population (%) in Korea.

(B) The suicide rate (%) is per 100,000 population and the unemployment rate is per population (%) in and Japan.

Source of number of suicides and unemployment rate in Korea: Statistics Korea (2017)

Source of number of suicides in Japan: National Police Agency (2017). Ministry of Internal Affairs and Communications Statistics Bureau (2017).

3. Age, gender, and reason for suicide

As of 2016, the highest percentage of individuals attempting suicide in Korea was those aged 50-59 years (20.4%), followed by 40-49 years (19.7%), 30-39 years (14.2%), 60-69 years (13.6%), and 70-79 years (13.1%). As of 2016 in Japan, the highest percentage

of individuals attempting suicide was those aged 40–49 years (17.1%) followed by 50-59 years (16.6%), 60-69 years (16.6%), 70-79 years (13.6%), and 30-39 years (12.9%). The proportion of elderly people (over the age of 60 years) attempting suicide was higher in Japan than in Korea.

Regarding sex, in 2016, 70.6% and 69.4% of those attempting suicide in Korea and Japan, respectively, were men.

In Korea, 61.0% of all suicide attempts were carried out because of psychiatric symptoms according to a survey by the Ministry of Health and Welfare of suicide attempters who visited an emergency room in 2013. In Japan, 49.9% of all suicide attempts were carried out because of health problems according to data from the Suicide Countermeasure Promotion Office of the Ministry of Health, Labour and Welfare in 2016.

4. Religion in Korea and Japan

In terms of religion, in Korea, about 50% of the suicide attempters were nonbelievers, followed by Baptists and Catholics at about 30%. In Japan, about 50% of the suicide attempters were Shintoists and about 50% were Buddhists (Table 2).

<Table.2> Religion distribution of Korean and Japan in 2015

Kinds of Religion	Number
Korea	
Buddhism	7,619,332
Baptist	9,675,761
Catholic	3,890,311
Won Buddhism	84,141
Confucianism	75,703
Chondogy	65,964
Dae Soon Buddhism	41,716
Daejonggyo	3,101
Others	98,135
Non-believer	27,498,715
Japan	
Shinto	89,526,176
Buddhism	88,719,287
Christianity	1,928,079
Various teachings	8,718,964

Source: Statistics Korea (2017). Agency for Cultural Affairs, Government of Japan (2017).

5. Education of nurses on suicide attempts and self-harm behavior

In Korea, only about 11.6% of nurses have participated in an education program for caring for patients who attempt self-harm (Kwon & Lee, 2017). In Japan, only about 31.5% of nurses have participated in training for caring for suicidal patients (Aoki & Katayama, 2017).

IV. Discussion

1. Factor structure of the SHAS-K and SHAS-J

SHAS-K and SHAS-J both have the same number of four factor structures, but a little different the factor structures. Unlike SHAS-K, SHAS-J has factor s of rights and responsibilities of suicide attempter. Also, client intent manipulation factor of SHAS-K is included in a factor of care futility in SHAS-J. That means that the Japanese nurses recognize that self-injury patients be blamed because they are trying to get attention or sympathy from others. These differences of a factor structure of SHAS-K and SHAS-J could be related the differences in social structure, culture and education between the two countries. The following discussion mentions these three differences. Social and personal backgrounds of suicide are reflecting social structure between the two countries. And religion is related to the culture of the country. Therefore, we will consider the social and personal backgrounds of suicide, the religion and the education below between Korea and Japan.

2. Social and personal backgrounds of suicide

Korea's suicide and unemployment rates both increased after the 1998 Asian currency crisis, the 2008 Korean currency crisis, and the Lehman shock. Since 2012, the Korean government has enacted laws against suicide, and as a result, the current suicide rate in Korea has shown a downward trend. On the other hand, the suicide and unemployment rates in Japan have remained high since 1998 when the bubble burst. However, since the Japanese government enacted basic suicide measures in 2008, the current suicide rate in Japan has also shown a downward trend. In addition, the suicide and unemployment rates in both countries have shown a high correlation, except for the 4 years in which the unemployment rate in Korea suddenly increased. From the above, Korea and Japan both appear to be influenced by their own respective economic situations, suggesting that social backgrounds should be taken into account to strengthen measures for suicide prevention. Most of the suicide attempters in Korean are men of working age (40–60 years), and most of the suicide attempters in Japan are men of a similar age (40–70 years). In addition, the reasons given most frequently for suicide attempts in Korea and Japan were psychiatric symptoms and health problems, respectively. From the above, the personal backgrounds of suicidal people in Korea and Japan were the same: men of working age with mental and physical problems. Generally, the retirement age in Korea

is 60 years, while that in Japan is 65 years. In many cases, those with health problems cannot work, which increases the possibility of unemployment. Therefore, as a measure to prevent suicide in both Korea and Japan, the introduction of a counseling program regarding work for male patients of working age who have health problems is considered necessary.

3. Religion

In Christianity, suicide is an unacceptable offense against life, society, and God (Liegeois & Schrijver, 2017). On the other hand, in Buddhism, suicide can represent the purification of one's life up to the present and restore innocence; it does not prevent the person from going to heaven (Picken, 1979). In Shintoism, death and God are natural nearby feelings, and life and death are regarded as continuous (Hiroi, 2003).

Korea is a country with many Christians compared with other Asian countries. In addition, many nonreligious Korean people are enthusiastic about ancestor worship and legal affairs. By comparison, Japanese people often believe without perceiving their own religion, and often do not recognize the religion they believe. In addition, many Japanese people believe in both Shintoism and Buddhism.

Therefore, in both Korea and Japan, religion is different, as are attitudes toward patients who attempt suicide or self-harm. In Korea, many Christians are against suicide, but many Buddhists hold views that may strengthen suicide orientation; in addition, Korea has a larger percentage of nonbelievers. By contrast, in Japan, there are many Shintoists who do not share the same hatred of death as Buddhists. Therefore, the fact that the SHAS-K did not include "Ignorance about rights and responsibilities" and "Lack of active understanding", which are factors of the SHAS-J, was considered to be associated with religious differences between Korea and Japan.

4. Education

In a previous study, attitudes and education geared toward patients who attempt self-harm interact, and thus training, supervision, and support for nurses caring for such patients is needed (Conlon & O'Tuathail, 2012). In both Korea and Japan, many of nurses have not participated in practical educational programs for patients who attempt self-harm or suicide. In a previous study, many nurses in Japan reported finding it difficult to understand how to assist suicide attempters or provide proper care (Aoki & Katayama, 2017). In addition, a survey of nursing students in Korea conducted using the Q-strategy showed that educational programs based on the subjectivity of attitudes toward patients who attempt suicide was needed (Cho, Lee, & Park, 2017).

Therefore, training nurses for caring of patients who attempt self-harm or suicide is needed in both Korea and Japan. An educational program for promoting care therefore needs to be developed in consideration of diverse factors such as experience, culture, and religion and the subjectivity of nurses.

5. Limitation

This study is a study based on limited the tool and the environment, and there are limits to using the results. The nurse's attitude toward self - injured patients has a large personal factor so the results of this study may not be relevant.

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CONTENTS

ORIGINAL ARTICLES

Using Videos to Analyze the Effectiveness of START Education for Japanese Nursing Students

Kazuyuki AKINAGA et al., 1

Effects of the OSCE to Motivate Students to Learn Before Clinical Practice

Yuko FUJIO et al., 13

The Current Status and Its Implications of Public-Private Partnerships for Official Development Assistance in Korea: Focusing on Disability-Inclusive Development Cooperation

Juhee HWANG et al., 25

Effects of a Structured 8-week Nordic Walking Exercise Program on Physical Fitness in the Japanese Elderly

Kimiko YAMAMOTO et al., 38

Study of "Individuality" on Nursing Care Job

Kimiko YAMAMOTO et al., 52

SHORT PAPERS

A Comparison of the Factor Structure of the Self-Harm Antipathy Scale and related Demographic Characteristics between Korea and Japan

Yoshimi AOKI et al., 66

Issues of Specific Educational Curriculum Development for Resource Rooms and Special Needs Classes in Japanese High Schools

Mitsuyo SHIMOJO et al., 76

REVIEW ARTICLES

Importance of Physical Activity and $\dot{V}O_{2max}$: Five Major Determinants of $\dot{V}O_{2max}$

Masahiro KOHZUKI et al., 85

Importance of Physical Exercise in Oldest-old Adults: A Literature Review Study

Chaeyoon CHO et al., 93
