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International Journal of Nursing and Health Science is an international peer-reviewed journal. The journal aims providing academic platform for scholars, graduate students, academics and health care professionals to publish their intellectual contributions in area of nursing and health sciences. The journal publishes review articles, original research articles, and other related health professional articles bi-annually.

Objectives

1. To publish knowledge, concepts, theories, innovations, guidelines and new technologies in nursing and health science
2. To be a supportive resource for academics, students, and instructors in health institutions and organizations in Thailand and overseas
3. To promote research and development of knowledge in nursing and health science
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We would like to invite you to submit papers for consideration of publication in the international journal of nursing and health science and/or subscribe the IJNHS.

Yours sincerely,

Assistant Professor Dr. Janjira Wongkhomthong
President and editor-in-chief
International Journal of Nursing and Health Science (IJNHS),
Christian University of Thailand

Content

Factors Influencing Family Participation in Caring for Traumatic Brain Injury Patients

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Abstract

The purpose of this descriptive study was to examine factors influencing family participation in caring for traumatic brain injury patients. Samples consisted of 200 family members of the patients with mild to moderate traumatic brain injury admitted in a traumatic unit of tertiary level hospital in Pathumthani Province. Data was collected using the Demographic Data Record Form and the Family Members Stress questionnaire, The attachment between family member and patients questionnaire, The social support questionnaire, The family participation questionnaire. The reliability test was conducted by using Cronbach's alpha coefficient analysis which were .86, .80, .82, and .89 respectively. Descriptive statistics and stepwise-simple regression were used to analyze the data.

The results showed that family participation in caring for traumatic brain injury patients were at moderate level (82.50%). 2) Stress of family members were at moderate level (85%). 3) The attachment between family members and patient were at good level (100%). 4) The social support were good level (55%). 5) The factors to Stress of family member, Attachment between family member and patient, and the social support were significant predictors with family participationin caring accounted for 59.80% ($F = 19.023$, $p < .01$)

Keywords : Family members of traumatic brain injury patients / Stress of family members / Attachment between patients and family members / social support / family participation in caring for brain injury patient.

Introduction

Background and significance of the problem

According to the reports of the Accident Information Center, the injury caused by accidents have significantly increased over the years. In the year 2013, it was found that the number of accident-related injuries were 578,490 and 6,834 dead. For Pathumthani province, were found that 3,329 people injury from accident 365 dead. Most patients were injury (70.50%) by car accident. After recovering most patients were suffered with physical, emotional, and behavior changes (Intira Taaue, Katsinee Autiyaprasit, Prangtip Chayput and Bunpot Sitinamsuwan, 2011) such as loss of self-worthiness, hopelessness, fear, anxiety, sadness, and feeling of loss of power. According to this report, the patients need comprehensive care to crew holistic needs including emotional and physical impairment of the patients (Sunida Autnuchit, Vipa Chachae, and Phaneat Songsawat, 2011). The severity of the injuries reduced quality of life as a whole, especially the function of the organwere lossed (Leanne, Jane, Luke, Tamzyn, Cheryl, Nicholas, 2007; Peter, George, Simon, David, Mohamad, 2009).This holistic approach is to improve the quality of life of the patients (Yaovaluck Chaichana, 2010) and the family members had to cope with shock and fear of losing their loved ones. Regret and anxiety about the patients (Fortinash Holoday-Worret, 2008) made it deep serious for their family members, and their stress level was increased specially when they had to take care the patients with self - care restriction.

The family participation in caring of the patients is a concept focusing on the role of family members as a center of care which brings about several good outcomes including making the patients relaxing, comforting, cooperating and warm. The family members seemed to who taking care of the patients significantly reduced stress and anxiety (McDougall, 2007; O'Neil Lapinsky, 2008). The problems faced by the family members occurring due to the incident result in the ability in adaptation to such situation. These adaptations can be evaluated by the changes of their acts. (McCubbin & McCubbin, 1996) The participation of the family member to the health care team by providing support and care to the patients help to maintain balance in their families (Jintana Watcharasin, 2007; McCubbin & McCubbin, 1996). From the study of Tussanee Tappho (2009), the study results showed that the needs for family participation in caring traumatic brain injury patient were at many level (99.20%). From the literatures review it was found that the stress of the family members was correlated family participation in caring ($r = .270$) (Walainaree Pommala, 2010). The attachment between patients and family member was correlated family participation

in caring (r = .240) (Walainaree Pommala, 2010), and social support it was found that social support can decrease family members stresses and they can take care of their loved ones (Dararat Pandee, 2549). This was supported by the authorities and others to persuade the family members to participate in patients' care (Pikul Jareonsuk, 2007). In addition, social support is a key factor which is needed to help the injured and their families with a better quality of life (Pitak Thongsuk, 2007).

So, these factors have become points of interest for researcher to study about the factors influencing or forecasting of the family participation in caring traumatic brain injury patients. These guidelines encourage the family members to truly care for their patients and effectively help them recover faster. The guidelines also help reducing the stress of the family members as well as preparing them to in change caring when the patients return to their home.

The Purpose of the research

1. To study family participation in caring for traumatic brain injury patients.
2. To study the factors influencing family participation in caring for traumatic brain injury patients.

Theoretical framework of the research

The Resiliency Model of Family Stress, Adjustment, and Adaptation by McCubbin & McCubbin, (1996). The Resiliency Model consists of two phases, namely Family Adjustment which is adjusting to the crisisand Family Adaptation which is adaptation after the crisis. This model consists of event (A) which causes the problem, and the event (AA) which includes the pile-up of problems: interaction with existing (B) and new resources (BB) which depends on the nature of the family (T) and results in family's perception (C, CC)to events and support (A, AA) leads to cope with crisis (PSC) and bring about the adaptation to crisis. The coping of family member to problem composes of 4 following ways :

1) Show up to solve of the family problem.

2) Deal with stress or coping with event that happened.

3) Seek other sources of help.

4) Change positive approach to accept the events that occurred.

For the adaptation of the family member to the crisis situation can be evaluated from:

1) Health condition the strength of physical and mental health.

2) The appropriate function an role of family members.

3) Maintaining good relationship in their the family and family bonding In this study, patient's head injury is considered to be a situation causing a problem or in other words, the head

injury is the stressor. Lack of existing resources of family members on how to deal with the stressor will affect their adjustment and adaptation to this stress or problem. This may, in turn, result in a situation whereby family members will stop caring (Pikul Jareonsuk, 2007) or in some cause, they many avoid to visit the patient because such as they way not cooperate the uncertainly of the patient′ s condition, lack of confident to car, which cause stress to care, which to family member (Dararat Pandee, 2549), and it may result in the family members′ behavior, in the medical treatment of the patients. In addition, the crisis also depends on the level of dependency and depth of relationship between the patients and their family members. A close intimate relationship with feelings of love, mutual concern, and a feeling of being a part of the family are some of the factors that may affect how family members and patients react to the present crisis. (McCubbin & McCubbin, 1996) The bad relationship between the family members and patients cause stress. In such situation, support from the staff and the adjustment affects of the family members′ role in dealing with the stress (Chureekorn Tathong, 2007). The role of the family members and other factors also affect the possibilities of them in the care of the patients with head injury. (Pikul Jareonsuk, 2006), and the social support also forces the administrator to specialize in the care of the patients. From literature review it is found that the nature of participation in the care of the patients consists of four areas. (Tussanee Tappho, 2009; Tutton & Ager, 2003)

1. The exchange of information between families and staff.

2. The planning and decision making in order to maintain the care that patients should recive.

3. Caring activities.

4. The assessment of activities to ensure the role of family members in caring for patients to achieve a balance in the family.

Method of research

Population and sample

The population used in this study is the family members, the traumatic brain injury patients was admitted surgical ward in the Pathumthani Hospital and Thammasat University Hospital.

The sample 200 of this study were family members of the traumatic brain injury patients. The sample were sufficient to make the outcome of this study reliable. (Power = .80, Effect Size = .20)

The characteristic

The characteristic of a sample consist of (a) characteristic of patients and (b) characteristic of family members

A. characteristic of patients

1. Patients must be both male and female who were above 20 years old.

2. The patients injury severe score (AIS) or no injury but They are in mild to moderate or not in a life threatening condition based on the system (AIS).
3. The rated consciousness level (GCS) of the patients in level 2 must be from mild (GCS 13- 15) to moderate (GCS 9-12).
4. Patients must be out of the critical condition and must have normal vital signs and must have received treatment in hospital for at least 3 days.

B. characteristic of family members

1. Family members must be both male and female of age 20 years.
2. They must be sensible with no hearing problem, and able to speak and understand Thai language for communication.
3. They must be able to care for themselves and for the patients.
4. There must be an intimate relationship between the family members and the patients. It can be close kin or someone who has given primary care to the patients for at least 2 days while they were hospitalized.

The Research Instruments:

1. The record of the traumatic brain injury patients' demographic data, evaluation of the nature and severity of the injury, and the treatment involved
2. The record of personal information of the family members of the traumatic brain injury patients
3. The family members stress questionnaire (Dararatpandee, 2006) holding the Alpha Cronbach's coefficient at .91
4. The attachment between family member and patients questionnaire (McCubbin & McCubbin, 1996) Walainaree Pommala (2010) translated by experts (Forward - Backward translation) and having the reliability of .89
5. The social support questionnaire (JureeSansuk, 2003) having the reliability of .82.
6. The family participation questionnaire (Tussanee Tappho, 2009) having the reliability of .89

Research results

The results showed that:

1.The (66%) traumatic brain injury patients were aged between 30-39 years (Mean = 36.10). The (76.60%) of patients were male, (64.60%) were married, (62.90%) worked as an employees, (62.30%) of patients were car accidents, (37.70%) had subdural hematoma, (47.40) were injury at frontal lope, (84%) received medical treatment, (62.30%) were no other organs injuries, (99.40%) were at mild traumatic brain injury (Mean = 14.81, S.D. = 0.51), and (98.30%) were severe injury score at mild level.

2. The family member were aged between 30-39 years and 40-49 years (Mean =39.13, S.D.=9.99), (88%) were female, (83.50%) were married, (52%) were relation of wife and husband, (39%) worked as an employees, (45%) had an average monthly family income from 11,018.86 Baht, (36.50%) graduated in the secondary level, (99%) the family members had no underlying, and (98.50%) no experienced in caring

3. The family members stress of traumatic brain injury patients were moderate levels of 85% (Mean = 45.08, S.D. =2.93) as show in the Table 1.

Table 1 – The table showing the frequency, percent, average, and standard deviation (n=200)

The stress level of family members	N	Percent	*Mean*	S.D.
Less	5	2.50	33.33	1.31
Moderate	170	85.00	43.44	1.19
Many	25	12.50	58.48	.71

4. The attachment between family members and patient were at good level (100%) (Mean = 35.49, S.D. = 1.98) as shown in the table 2.

Table 2 – The table showing the frequency, percent, average, and standard deviation (n=200)

The attachment between patients and family member	N	Percent	*Mean*	S.D.
Bad relationships	0	0	0	0
Good relationships	200	1.98	35.49	.98

5. The social support were moderate level. (55%) (Mean = 31.92, S.D. = 2.22) as shown in the table 3.

Table 3 – The table showing the frequency, percent, average, and standard deviation (n=200)

The social support	N	Percent	*Mean*	S.D.
Mild level	50	25.00	20.63	1.21
Moderate level	110	55.00	35.44	1.01
High level	40	20.00	39.68	1.25

6. The family members participation in caring of traumatic brain injury patients with many level (82.50%, Mean = 109.50, S.D. = 7.45) ware determined by the fact that included the care practice, the evaluation and the benefits expected to be obtained high level but the planning and decision making and the exchange of information of medium level as shown in Table 4 and 5.

Table 4 – The table showing level of participation in caring to frequency, percent, average, and standard deviation (n=200)

The level of participation in caring	N (200)	Percent
Many (107 - 145 Score)	165	82.50
Moderate (68 - 106 Score)	35	17.50
Less (29 - 67 Score)	0	0
(Mean =109.50, *S.D.* =7.45)		

Table 5 – The table showing the average, standard deviation and level of family participation in caring (n=200)

Participation in Caring	*Mean*	*S.D.*	Level
Participation in Caring (total)	116.50	8.86	Many
The care activity	50.39	4.50	Many
The expected benefits	8.71	0.90	Many
The condition evaluation	7.43	0.45	Many
The exchange of data and information	29.78	2.67	Moderate
The planning and decision making	15.07	1.81	Moderate

7. The analysis predicted factors of the family participation in caring of traumatic brain injury patients show that the family members stress of traumatic brain injury patients, the attachment between family member and patients, and the social support can the predict family participation in caring (59.80%, R = .598, p< .01) are as shown in table 6.

Table 6 – The table shows a analyze predicted the family participation in caring of traumatic brain injury patients by multiples regression statistics (n=200)

variable.	B	Beta	t	P-Value
The family members stress	.198	.314	4.739**	.000
The attachment between family member and patients	.132	.289	4.362**	.000
The Social support	.156	.301	4.761**	.000

B = 2.817, R =.598, R^2 = .348, R^2 adjust = .341, F =19.023, $^{**}p < .01$

Discussion

The study result showed that (82.50) family member of traumatic brain injury patients were Participation in caring the patients at many level. This could be explained that when a family member was injury cause stress to family members. They had to cope with situation in reduce to retain balance in the family. The social support could reduce stress among family member (55%), and the attachment between family member and patients put them to participation in caring (100%). When considering participation in caring composed of 5 following

1.The exchange of data and information

From the study result showed that family members were involved in the care of patients with head injury. The exchange of information was at moderate level which opposite to Walainaree Pommala (2010) since she found the family members of patients with small scale brain traumatic injury at many level (98.50%), cases making the patients feel good about their recovery. The exchange of information between the staff and family member were at moderate level because family members trothed the medical staff in caring the patients.

2. The planning and decision making

From the study result showed that the family members were involved in the planning and decision making process at moderate level. Since the educational learn of were at secondary level (36%), and they did not have experienced in caring the patients (98.50%), and in Thai society still believe that the health personals in clouding the doctors and the nurses are expertise and knowledge.

3. The caring activity

From the study result showed that the family members of the patients with head injury were involved in caring the patients in many levels of care because they are parts of the family which they

have to love, care, and commit to each other. In addition, the hospital's policy, encourage family members to involve in patients' care: which made patients become closer to their family members, and all the family members also feel good and willing to do all activities to take care of patients (Auma Sukdee, 2009).

4. The condition evaluation

From the study result showed that in the field of condition evaluation, the family participation of at many level also involved in activities for the patients. The family members assessed exactly as the officers did to care for the patients. As a result, the patients' symptoms whether better or worse under the administration of medical officer could be tracked by the participating family members as they understood the patients' symptom and the changes in their conditions when occured. This showed that the assessment will help the family members to be aware of the progress of the patients' symptoms. This is important to help the family members in reducing their anxiety about the patients' codition. (Pikul Jareonsuk, 2006) and also help family members to know the benefits of their participation in the care of their patients and to bring happiness and make balance in the family. (Jintana Watcharasin, 2006 ; Walainaree Pommala, 2010)

Factors prediction of the family participation in caring for traumatic brain injury patients.

1. the family members stress of traumatic brain injury patients able to predict from the family participation in caring for the traumatic brain injury patients (β = .314, P < .01), which means that the family member stress had a one standard unit to involve in the participation in caring for the patients at .314. This was consistent with the past studies in which even a family member or a care giver's stress occurs much despite their willingness to participate in caring of the patients because individuals who committed to love and care, and they need to be involved in the process of patients' care. (Walainaree Pommala, 2010 ; Pikul Jareonsuk, 2006; Auma Sukdee, 2009)

2. the attachment between family members and patients was able to predict the family participation in caring for the traumatic brain injury patients. (β = .289, P < .01) which means that the attachment between family member and patients had a one standard unit to involved in the participation in caring of the patients at .289. This study suggests that when someone in the family had an illness, they needs love and care for each others, the family members engage with the patients, and cope with the problems and adapptation. (McCubbin & McCubbin, 1996). This makes it possible for the family members to take care of each

other (Jintana Watcharasin, 2006 ; Ruja Phupaiboon, 1998) and this was consistent with the previous studies which revealed that the attachment between family members and patients correlated to participation in caring (Walainaree Pommala, 2010)

1. The social supports was able to predict in the family participation in caring for the traumatic brain injury patients. (β = .301, $P < .01$) which means unit to involve in the participation in caring for the patients at .404. This suggests that there will be more participation if the family member gets assistance and support from their entire family and the staff. This was consistent with the previous studies which revealed that the social supported was related to participation in caring and it is also important for families and patients to have better quality of life.

Therefore, health professionals should give priority to such factors, and promote participation in caring for traumatic brain injury so that they can recover soon.

Theoretical and Prectical Implications

For Nursing Practice

The nurse should promote family member in caring as following

1. The nurse should evaluate the relationship to the patients and families who take care of the patients should have closed relationship.

2. The nurse should find method to decrease stress and anxiety for family members before preparation them for caring the patients. as follows :

2.1 The administrator should develop system and policy about family- member participation in caring.

2.2 The nurse educator should develop teaching and learning for nursing student about the family participation in caring.

Suggestion for further study

The program to reduce stress and anxiety of family member and should be developed to promote the family participation in caring.

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The Emergent Changes on the Gender Roles of Isinai Father and Sons in the Light of Socio-Economic and Political Changes in the Society

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Abstract

This study determined the emergent changes on the roles of Isinai fathers and sons in the light of socio-economic and political changes in the society. It also determined the perceptions on sexuality of Isinai fathers and sons in Dupaxdel Sur, Nueva Vizcaya. This study used empirical phenomenological approach in determining the emergent changes on the gender roles of Isinai fathers and sons in Dupax Del Sur, Nueva Vizcaya. Utilizing the semi-structured interview method with the use of researcher-made questionnaire, respondents' lived experiences about their household roles and gender relations with their wives and children were determined. The Social Cognitive Theory was used to explicate such lived experiences. The respondents were purposively chosen. The study showed (1) differences in the perceptions of the two generations of fathers about masculinity and femininity across ages; (2) educational attainment did not affect man to see man and woman as the same or different; (3) whether the work was white collar or blue collar, there were still perceived differences more importantly among son respondents in white collar job who saw some differences between a man and a woman; (4) more son respondents than father respondents believed that both husband and wife should attend to different household chores including paid work; and (5) husband-wife relationships for both generations were not affected because both believe in shared responsibilities.

The study concludes that roles between husband and wife in an Isinai family is becoming more egalitarian though the husband remains as the head of the family. Furthermore, fathers belonging to older generations does not mean they hold on to conservative ideas about masculinity; and fathers belonging to younger generation does not mean that they are more tolerant to changes on masculinity. This study recommends that inclusion of women's view on the changes taking place in men's role in the family as well as the coping mechanisms of men regarding gender role changes in the family.

Keywords : Gender Roles, Household Roles, Gender Relations

INTRODUCTION

History stands witness to the changing views about gender in the Philippines. Pre-Hispanic Philippines marked a period in time when men did hunting and women did most of the gathering; a kind of division of labor which manifested the dichotomy of men and women. Such differences were also manifested on specializing and positioning wherein women functioned domestically, thus stayed at home; and men were seen taking on more dominant roles and functions. Society assigns to women their responsibility of caring for their children as they are seen as physically equipped to bear and nourish them. On the other hand, men was tasked to provide income for their families, occupying "the world of production" (Nedeau, 2012). But with social dynamism and cultural adaptability, the Philippines stands out as one of the countries where women are given recognition to take on roles which are once being carried out by men only.

As a matter of fact, the Philippines ranked 12th out of the 86 countries in terms of gender equality in 2012 according to the Social Institutions and Gender Index; the same index however reported the Philippines as the 7th out of the 102 countries in the same area in 2011. Add to this the report by the 2011 Global Gender Gap rankings by the Geneva-based World Economic Forum which ranked the Philippines 8th among 135 countries.

According to World Bank's 2012 report, the Philippines was doing relatively well in terms of a number of indicators

on gender equality compared with other countries in the East Asia and the Pacific. Also in the said report, Southeast Asian women in general and Filipino women in particular seemed to be empowered within the home and in the society as well.

Still noteworthy however was the fact that gender equality in the Philippines was so sharp that even though gender stratification or the demarcation line separating women from men becomed thinner and slimmer, many women suffer from violence which includes trafficking, prostitution and even domestic violence. It is so sharp that in general "society still places many gender problems as trivial and marginal" (Partnership for Development Assistance in the Philippines, Inc., 2012).

According to one of the authors of the World Bank Report, as cited by Jimenez (2012), 'despite improvements in gender relations, domestic violence was still "unacceptably" high as up to 5.6 million Filipino women have been abused by their partners'. Furthermore, 'two-thirds of adult women in the Pacific region have experienced violence in the hands of a partner. In the Philippines, around 18-19 percent of women reported domestic violence'.

In spite of the fact that women gain recognition, reassuring the existence of gender equality, though a sharp moved toward it, there are women who were still victims of domestic violence. These were women who experience violence from their husbands who might not accept the fact that their wives were already the ones working for them, which was a deviation from the accustomed cultural tradition. In the observation/ analysis of Kamarovsky (1973), while most men supported the idea of women entering into the labor force, they resist modifying their own behavior in support of their partners. It was in this light that this research paper was anchored. Hence, this research was conducted to determine the emergent changes on the gender roles attached to being masculine in the light of socio-economic and political changes in the society.

Gender norms expressed within the household were reinforced and reflected in larger institutions of society. "Gender relations are not confined to the domestic arena - although households constitute an important institutional site on which gender relations were played out - but were made, remade and contested in a range of institutional arenas" (Kabeer, 1997).

According to Silberschmidt (1999), socio-economic changes had left men with a patriarchal ideology bereft of its legitimizing activities. He further stated that unemployment or low incomes prevent men from fulfilling their male roles as heads of households and breadwinners. The fact that woman's roles and responsibilities have increased,

it has affected men's social value, identity and self-esteem, and hence such socio-economic changes had affected traditional gender role and male sexual behavior.

Majority of men were caught in a paradoxical and frustrating situation where their male roles were being undermined. The lack of employment or low and insufficient income had prevented them from fulfilling their expected roles as men, husbands as well as providers of the needs of their wives, children and other dependents. Contrary to this, women have become contributors to the needs of the household. With these socio-economic changes, male roles were becoming peripheral; they were not being able to live up to their prescribed and expected roles, thus having serious consequences on the male gender identity, social value and self-esteem (Silberschmidt, 1999).

Economic changes and the changes they effect on gender roles could produce significant household stress, humiliation, and conflict in both men and women. Unable to contribute adequately to the family, men might feel powerless, redundant, burdensome, and might react violently. Women, on the other hand, continue to care for their families and sometimes walk out of abusive relations. Women may gain confidence as they start earning and retaining cash incomes, yet due to their tenuous connections to employment they may also remain vulnerable. The Georgia PPA reports that in many men were unable to keep up with the socially mandated role of breadwinner, "their sense of emasculation and failure often leads to a host of physical ailments and sharply increasing mortality, alcoholism, physical abuse of wives and children, divorce and abandonment of families" (Georgia PPA, 1997). Thus, familial relationships are affected.

Though men and women enter into marriage, Sociologist Jessie Bernard (1982) stated that there were actually two different marriages, that of a woman's marriage and of a man's marriage. The latter having a dominant husband was an evidence of a patriarchal set up in the household. Bernard (1982) concluded that 'there was no better guarantor of long life, health, and happiness for a man than a woman well socialized to devote her life taking care of him (her husband) and providing the regularity and security of a well-ordered home'. She came up with this conclusion when she explained that 'married women had poorer mental health and more passive attitudes than single women, and report less personal happiness' contrary to married men who lived longer than single men, mentally better off, and report being happier'. Hence, it could be noted that there exists power relations between men and women that was 'husbands dominating their wives and leaving them to perform virtually all the housework' (Macionis, 1994).

Also within the household were changes on how one member of a family relates with another. How one related with another member of the family is bound and influenced by one's gender. In fact, gender was at work even before the birth of a child (Lengermann and Wallace, 1985). Parents deal correspondingly with the gender of their children. Bernard (1981) stated that soon after birth, parents introduce their daughter to the "pink world" and their son to the "blue world". Witkin-Lanoil (1984), as cited by Macionis (1994), stated that 'both fathers and mothers encourage sons to be strong and aggressive while raising daughter to be weaker and less assertive'. Thus, fathers and mothers related with the members of their family depending on the gender of the person involved.

This research study then considered how socio-economic and political changes have affected traditional gender roles. In this study, it determined the emergent changes on the roles of Isinai fathers and sons in the light of socio-economic and political changes in the society. It determined the perceptions on sexuality of Isinai fathers and sons in Dupaxdel Sur, Nueva Vizcaya.In particular, this study aimed to: (1) explain the perception of Isinai fathers and sons on sexuality in terms of (a) masculinity and (b) femininity; (2) describe the changes in the household roles of men in their immediate family; (3) describe the changes on how men relate with wives; and (4) explain the emergent changes on the gender roles of the respondents using the Social Cognitive Theory.

LITERATURE REVIEW

Family Development and Changes

The family was a haven where there is unity of interacting persons (Burgess, and Locke, 1953) whose central purpose was to create and maintain a common culture that promotes the development in terms of the physical, mental, emotional and social aspects of each family members (Duvall, 1967). According to Bales (1950) and Homans (1950), family interaction was the process by which a family relates to life outside itself, and through which a member's action is stimulated by the behavior of other members within the family. To simply put it, Duvall (1967) stated that family interaction is the sum total of all the family roles being played within the family.

These roles were defined by norms. As such, the family and the larger society expect a person to do such roles given his position. The family then was composed of a number of positions. These positions were related to each other in dyads, that was, the position of the father to his son and the concurrent role of that position to his son; the position of the husband to his wife and the concurrent role of that position

to his wife; and that one family member can had two or more positions: both husband and father, as well as son, brother, etc. (Ibid). Thus, whatever position a person has comes expected roles. For instance, the father plays the role of a breadwinner, teacher, disciplinarian and so forth.

Furthermore, a woman had to be a good cook; and a man had to be a good steady provider before it was possible for his wife to get a job to supplement his earnings. Both men and women had learned their roles in their own respective homes before they entered into marriage. These children also had learned their place, and those that are expected of them. All of these were influences, in one way or another, by the society. It was the society which assigns to men what man's work was and what woman's work is, and those that were expected of the children. As Duvall (1967) clearly puts it, the family lived according to relatively rigid rules traditionally established and maintained by social and moral pressures of the entire society.

It is reinforced and reflected in larger institutions those gender norms that were expressed within the household. As cited, "gender relationswere not confined to the domestic arena-although households constitute an important institutional site on which gender relations are played out - but are made, remade and contested in a range of institutional arenas" (Kabeer, 1997). To simply put it, gender relations were not defined in the household, but these gender relations as well as gender identities were shaped by larger institutions, and family members also had roles in creating new gender norms (retrieved from the internet, August 28, 2012).

As a person develops, he might take on new roles and abandon old ones. Thus, according to Duvall (1967), the roles expected from a person's positions may change over time. She further stated that "if the individual was to be an acceptable member of the family, he must play those roles expected of him by virtue of his position in the group. If he does not, or was incapable of doing so for one reason or another, his adjustment will suffer, as does the adjustment of the family group." Furthermore, men in many parts of the world had lost their traditional occupations and jobs under increasing economic pressure, were that women have taken on additional income earning tasks while they were continuing their domestic tasks. These changes that were taking place within households had touched core values about gender identity, gender power, and gender relations (retrieved from the internet, August 28, 2012).

It was also stated that:

"anxiety about what is a "good woman" or a "good man" seems pervasive. Values and relations are being broken, tested, contested, and renegotiated in silence, pain, and violence. What is striking is that despite widespread changes in gender roles, traditional gender norms have shown remarkable tenacity, leaving families struggling to meet the often contradictory demands (Ibid)."

Moreover, the entrenched nature of men's identities as 'breadwinners and decision-makers' were undermined and eroded by changing social and economic environments. These socially defined roles of men and women were not only unattainable; they sometimes stand in stark contradiction with reality (retrieved from the internet, August 28, 2012).

With the roles becoming more complex and flexible today, both men and women expect a wide variety of roles from each other. These expectations differ from couple to couple and from family to family. In one home, a woman was expected to work outside (Duvall, 1967) and enter the labor force in order to boost family income (Macionis, 1994) while in another home a woman was seen to be in the home (Duvall, 1967). In one family, a man was expected to be a companion to his wife and children and that the traditional view that earning an income was a man's role no longer holds to be true (Macionis, 1994) while in another home the role of a man is traditionally defined (Duvall, 1967).

Masculinity and Femininity

Kaufman (1987), as cited by Silberschmidt (2001) stated that while masculinity connotes power, it was also terrifyingly fragile because it existsed as an ideology; it existsed as scripted behavior; it existed within gendered relationships. The essence of manhood or male gender was constructed around at least two conflicting characterizations. The first was that being a man was natural, healthy and innate; but the second, a man must stay masculine. He should never let his masculinity falter. Masculinity is so valued, so valorized, so prized, and its loss was such a terrible thing that one must always guard against losing it (Cornell, 1995). As a consequence, men should always be on guard and defend and demonstrate their masculinity. Moreover, in the point of view of men there is a strong correspondence between masculinity and sexual activity which is the inverse for the female system. However, male honor is dependent on women's appropriate behavior. For this reason, femininity and female sexuality represent an active and threatening power to male identity and masculinity (Silberschmidt, 2001).

Social constructs of the social functions of men and women comed hand in hand with the adoption of a socially defined vision of the sexual division of labor (Cornell, 1995; Bourdieu, 1998). These constructs were not static and a-historical but historically and socially constructed. Even so, these constructs still seem to have some universal overtones since men benefit from inherited definitions of masculinity and femininity. While, on the one hand, masculinity almost world-wide has increasingly becomed constructed from men's wage-earning powers. This means that for men there is a strong correspondence between masculinity, sexual activity and status that was the inverse for the female system (Silberschmidt, 2001).

In the study conducted by Hasyim (retrieved from the internet, August 28, 2012) entitled Man Can be Allies: Men's Involvement in Ending Domestic Violence in Mumbai, "for the respondents, being a man means having more freedom than a woman because men had wider space to move (inside or outside house). As men, they are free to go anywhere and at any time they want. As men they could make any decision at any time for themselves and others but at the same time men have to shoulder most of the responsibility in the family."

Changing Household Roles

In a survey research of 3500 Americans that was conducted in 2008 by the Families and Work Institute and released in March 2009, gender roles were changing both at home and work; both young men and women alike were challenging traditional gender roles and expecting to share in paid work as well as tending the household and children.

In that survey, roughly the same percentage of men and women believed in traditional gender roles. About 42 percent of men and 39 percent of women agreed with the statement that it' was better for everyone "if the man earns the money and the woman takes care of the home and children." Compared to the research done in 1977 where 74 percent of men and 52 percent of women supported traditional gender roles.

It was also noticeable that more men than women have shifted their views on gender roles between 1977 and 2008. Men in dual-earning households changed their attitudes the most, with only 37 percent holding traditional views in 2008 versus 70 percent in 1977 (Families and Work Institute, 2009).

Older generations historically hold more traditional views on gender than young people. But the report found members of older generations being more open to non-traditional gender roles than in the past.

The report showed that 56 percent of men said that they did at least half the cooking, up from 34 percent in 1992. Wives see it slightly differently, with only 25 percent saying men did at least half, up from 15 percent in 1992.

There's an even greater difference of perception about who did the work with regards to house cleaning. Fifty three percent of men said that they did at least half, up from 40 percent in 1992. But only 20 percent of women said their spouse did at least half, up from 18 percent in 1992. The report then showed that there was not a statistically significant difference.

Further, the report had said that "it has clearly become more socially acceptable for men. They were involved in child care, cooking and cleaning over the past three decades than it was in the past."

It was also revealed in the study of Hasyim (retrieved from the internet, August 28, 2012) that "there is a consensus among the discussants that the role of men is to earn money. Men will only handle household tasks which need physical strength such as moving heavy objects while women will be responsible for most of the household tasks such as looking after the children, cleaning the house and preparing the food."

In addition to this, "another responsibility of men as fathers is to teach their sons social values such as how to respect others and how to be a great man. Men will take over the women's responsibility to look after the children only when she can no longer control them" (Ibid).

In the same study, it was shown that "there are different opinions among discussants regarding working women. Some discussants thought that the main role or duty of women is to work within the household. If the wife works outside the house to earn money, she could not fulfill her household duties100 percent".

But in the research conducted by Silberschmidt (2001) it was revealed that even if men was benefiting from patriarchal structures, a majority was caught in a paradoxical and frustrating situation where their male roles were being seriously undermined. On the one hand, men were the acknowledged heads of households, and they have the formal authority. On the other, lack of employment or low/insufficient income prevents men from fulfilling their expected roles as men, husbands, and in particular as providers of the needs of wife, children and other dependents.

In the relationship survey conducted by Crompton and Lyonette (2008) with regards to household chores/ housework, 81% of British people in 1994 asked had said that it was always or usually the woman who did the laundry but in 2006 the figure stood at 77%. Both in

1994 and in 2006, 42% of men and women in relationships felt that it was usually or always the woman who did the grocery shopping. In 1989, 32% of men and 26% of women thought that it was "a man's job to earn money; a woman's job is to look after the home and family". But in 2006, 17% of men and 15% of women agreed with the statement.

With regards to the length/ duration of doing the housework, the UK National Statistics (2000) reported that on average, women spend over 2 hours and 30 minutes a day doing housework: cooking, washing up, cleaning and ironing; 1 hour and 30 minutes more than men. Both sexes spend similar lengths of time gardening or looking after pets. Do-It-Your own (DIY) and car maintenance are the only household chores that men, in general, spend more time on than women.

In the article of McVeigh (2012) entitled Forty Years of Feminism - but women still do most of the housework, he stated that married women do more housework than their husbands. He stated such based on the analysis by the Institute for Public Policy Research thinktank where eight out of 10 married women do more household chores, while just one in 10 married men does an equal amount of cleaning and washing as his wife. Just over one in 10 women - 13% - say their husbands do more housework than they do, while only 3% of married women do fewer than three hours a week, with almost half doing 13 hours or more. In addition to these, patterns of housework have changed only slightly. More than eight out of 10 women born in 1958 said they do more laundry and ironing than their partner, while seven out of 10 women born in 1970 agreed.

Changing Gender Relations in the Family

In the research of Silberschmidt (1992a; 1992b) conducted in rural Kenya, particularly in the Kisii District, it was revealed that already in mid-1980's, because of fundamental socio-economic change in the 20 century, conventional and stereotyped assumptions about men and women, their roles and relations are needed to be reconsidered and re-conceptualized. Collapsing traditional structures, the emergence of new unstable situations, new social roles, norms and values had affected male and female gender identity and the relations between sexes. The socio-economic change has affected men more deeply than women and that men's roles and identities have been challenged and undermined, whereas those of women have, in some ways, been strengthened (Silberschmidt, 1999).

When Silberschmidt (1999) used the findings from Kisii as a stepping stone to investigate the impact of socio-economic change on the lives of men and women in an urban context in

Tanzania (Dar es Salaam), it was revealed that the research findings from Dar es Salaam supported the Kisii findings. In the study there was a strong need to rethink stereotyped assumptions about men and women. It underpinned in particular an urgent need to explore the interaction between men's changing roles, their gender identity and their sexual and reproductive behavior.

In the South African study of Viljoen and Steyn (1996), it was evident that there is a movement away from the male-dominant authority pattern to a state of affairs where the husband is still seen as head of the household, but with his wife as junior in some cases equal partner in the decision-making process. Thus, Viljoen and Steyn (1996) suggested that although the husband may still hold the dominant power position in many families, there is evidence of a movement towards a more egalitarian pattern - marital relationship characterized by companionship.

Lloyd (1965), as cited by Singh (2012), observed that a good number of Yoruba women traders share economic responsibilities of their households with their husbands, and have much economic power, yet they practice obedience when approaching their husbands. They would kneel to serve their sitting husbands food and drink. Thus, although a woman may be dominant in other spheres she must be publicly seen as submissive to her husband. Even men who try to tolerate dominant wives do so only so long as such wives defer to them in public.

Caldwell and Caldwell (1987) observes that the patriarchal system in most of West Africa leaves the role of reproductive decision-making within the household to men while the wives are left to bear the economic burden arising there from. Furthermore, Adams and Castle (1994) examined reproductive decision-making within and beyond the households in rural West Africa and identified the complexity of gender power relations which determines women's control over resources as one of the factors that influence women's reproductive options and behavior.

Lamphere (1974), who conducted an empirical study in New Mexico and Arizona, theorized that a direct relationship exists between the power structure of the family unit and the relationship between women within the relevant domestic group. That is to say that where power and authority are shared between men and women in the family, women are usually able to co-operate and form close ties with one another. However, where men alone monopolize power and authority, individual women work secretly to influence the men.

In his study, Conklin (1973) stated that couples are acquiring new roles and developing new relations and those changes are closely related to education,

urbanization, and the possibility of acquiring non-farming jobs.

According to Smit (2006), the role of the man in the family had not only undergone changes with regards to the husband-wife relationship, there had also been a shift in the level of the man's involvement in rearing and care-taking of his child/ren.

According to Lewis and O'Brien (1987), the new father refers to the man who was highly nurturant towards his children and was also becoming increasingly involved in the daily care-taking of the children. Active nurturant fatherhood, to use the concept coined by Ritner (1992), can be summarized as "the development of new roles for fathers that better reflect the needs of children in this modern era of changed roles for mothers. It means restoring fathers to the lives of many children who live without them" (Garbarino, 1993).

According to the research conducted in 2008 by the Families and Work Institute and released in March 2009, 73 percent of employees said working mothers can have as good a relationship with their children as stay-at-home mothers contrary to 58 percent in 1977.

Sixty seven percent among men in 2008 and 49 percent in 1977 believed that working father can have good relationship with their children while for women, 80 percent in 2008 believed working mothers can have equally good child relationships contrary to 71 percent in 1977 (Family and Work Institute, 2009).

Working fathers were spending one hour more on an average work day with their children under 13 years of age, compared with 1977. Moms spended about the same time compared with three decades ago. In terms of average work spent with children under 13 years of age, fathers younger than 29 spend an average of 4.3 hours with their children on a work day, almost two hours more than the 1977 average of 2.4 hours. Young mothers spend 5 hours with kids per work day, compared with 4.5 hours in 1977. Fathers aged 29 to 42 spend 3.1 hours with their children on an average work day, up from 1.9 hours in 1977 (Ibid).

It is also stated in the survey that men were also taking more responsibility for their children's care, which included managing child care arrangements. In 2008, 49 percent of men said they taked most or an equal share of child care responsibilities, up from 41 percent in 1992. Women agreed that fathers were stepping up, with 30 percent saying their spouse takes or shares the responsibility, up from 21 percent in 1992.

In the relationship survey conducted by Crompton and Lyonette (2008), it was revealed that, overall men have an extra half hour of free time each day than women. Women spend more time caring for their children than men, and this is true even for full-time

workers. Women living in a couple and working full-time spend on average nearly four and a half hours on childcare and other activities with their children on a weekday. For men in the same circumstances the comparable figure is just over three and a half hours.

Still on the same report, both men and women working full-time spend just over six and a half hours a day with their children at the weekend. Nevertheless, the time with their children is spent in different ways. Women spend around two hours on housework while with their children, compared with 1 hour and 20 minutes spent by men. In contrast, men spend around 1 hour and 20 minutes watching TV in the company of their children, compared with around 50 minutes by women.

Synthesis

In light of these literature reviews, the researchers find them with utmost importance into the further understanding and also the realization of the study. Since most of the related literature and studies reviewed were western-based, they therefore serve as viable groundwork for an in-depth analysis, especially setting of comparisons and contrasts to that of the Filipinos - the Isinai fathers and sons, specifically.

METHODOLOGY

This research utilized the methods of empirical phenomenological research, and the descriptive and qualitative method. It determined the respondents' perception on masculinity and femininity. Further, it described the household experiences of the respondents as well as gender relations in their immediate family. Furthermore, it described the emergent changes on the household roles of fathers and sons attached/expected in their sexuality in the context of their immediate family, as well as the emergent changes on how men relate with their wives and to the members of their family. The qualitative method was used in describing the aforementioned emergent changes on the gender roles of fathers and sons.

This research collected and presented information about the fathers' and sons' perception on the emergent changes on their gender roles from which conclusions were drawn. Hence, case study method was utilized. Data and information obtained from the fathers through the semi-structured interview was analyzed side by side with the data and information gathered from the sons. After the fathers were interviewed separately from the sons, a focused group discussion was supposed to be conducted; but due to the conflicts in the schedule of the respondents, the

focused group discussion was cancelled. The researchers have attempted to schedule the focused group discussion for three times, but a quorum has never been met.

Research Environment

The locale of the research was at Dupaxdel Sur, Nueva Vizcaya. Dupaxdel Sur is a third class municipality in Nueva Vizcaya. The town's name was derived from the Isinai word "dopaj" which means to lie down in complete relaxation. Dupaxdel Sur was originally a part of the original town of Dupax. The Congress in 1971 passed into law Republic Act 6372 which is known as "An Act Creating the Municipality of Dupax del Sur from the Municipality of Dupax in the province of Nueva Vizcaya". Former President Ferdinand Marcos amended some sections and signed it into law with the promulgation of Presidential Decree 586 on November 26, 1974 which paved the way for the division of Dupax into two municipalities: Dupax Del Norte and Dupax del Sur. Dupax del Sur is the home of many Isinais in Nueva Vizcaya. Specifically, the respondents were from Barangay Dopaj, Domang, Mangayang, Balsain and Bagumbayan.

Subjects of the Study

The respondents were composed of two male groups. The first group was composed of Isinai fathers and the second group was composed of Isinai sons. Isinai fathers were the respondents of the research study since the emergent changes on the relationship with their wives and to the other members of their family, and the emergent changes on their household roles in their immediate family were examined. To further determine or draw out the changes on the gender roles of males, another group of males from another generation was included. Hence, fathers' sons were included. The 20 pairs of fathers and sons were purposively identified as respondents of the study.

Since the respondents were purposively identified, the fathers to be included are those fathers who are living with their wives and have son/s and/or daughter/s. The fathers' sons must also have their own established family.

Research Instruments

This research study utilized the interview method, particularly semi-structured interview with the use of a questionnaire. The first part of the interview included the profile of the respondents i.e., age, educational attainment, and work status. The second part included questions about the views of the respondents about masculinity and femininity, and their society's construction of roles related to gender. The third part included

questions about the household roles of the respondents. The fourth part was about gender relations in the family, which included questions about the relationship of the respondent to his wife, and to the members of their family. The ideas of the respondents about the emergent changes which were acceptable and unacceptable to them and those roles that need to be maintained and changed and their suggestions toward a better understanding on the value and importance of understanding the changing roles attached/expected on their masculinity was supposed to be obtained through the focused group discussion.

Data Gathering Procedure

The necessary information needed for the research study were obtained through the following steps:

1. Identification of Respondents. The 20 pairs of fathers and sons were purposively identified as respondents of the study. Codes were assigned to each respondent to ensure confidentiality and anonymity.
2. Interview. The identified respondents were interviewed separately.
3. First Data Transcription. After the interview, the data obtained were transcribed. Transcribed data was the basis for analysis.
4. Focused Group Discussion. After a case to case transcription, the respondents were supposed to be gathered and interviewed as a group. However, this part of the data gathering procedure was not done due to the fact that the respondents have different schedules resulting to the inability of the researchers to arrive at a quorum. The second alternative the researchers have tried was to gather the fathers first, and then the sons but the same problem hindered the researchers for a focused group discussion. The third attempt was when the researchers sought the help of an Isinai elderly; but still, he failed to gather the respondents.
5. Second Data Transcription. The data that were supposed to be obtained from the focused group discussion were to be transcribed. But since the focused group discussion was cancelled, this part of the data gathering procedure did not push through.
6. Data Analysis. The researchers qualitatively analyzed after all the necessary data have been transcribed. The analysis was on a case to case basis. The data obtained from the fathers were analyzed separately from the data obtained from the sons. After which, the data obtained from the fathers and sons were compared.

Data Analysis

This research study was descriptive. It made use of the qualitative method to analyze gathered/obtained data. The qualitative analysis of the data was on a case to case basis.

The researchers went through the following stages to qualitatively describe on a case to case basis the data obtained from the respondents.

1. The perception of the Isinai fathers and sons on sexuality in terms of masculinity and femininity was discussed. The age, educational attainment and work status of the respondents was considered in the discussion of the respondents' perception about masculinity and femininity.

2. The social constructions of the Isinais related to gender roles that were obtained based on the experiences/ observation of the respondents were analyzed.

3. The experiences of the respondents in terms of their household roles and their relationship with their wife and children were analyzed. The data obtained from the fathers were analyzed separately from the data obtained from the son. The age, educational attainment and work status were considered.

4. The experiences of the respondents were then analyzed using the Social Cognitive Theory.

5. Through a comparison of the experiences of the fathers and sons has been made, the emergent changes on the household roles and their relationship with their wife and children were analyzed.

6. After socio-economic and socio-political changes on the gender roles of the respondents have been determined, the Social Cognitive Theory was then reexamined.

FINDINGS

The following are the findings of the study.

1. Profile of the Respondents and their Perception of Masculinity and Femininity.

The study showed that (a) there were differences in the perceptions about masculinity and femininity across ages, and generations: that was, fathers and sons have different perceptions about masculinity and femininity. Among the father respondents, there were differences in perceptions, as well as among the son respondents: (b) comparing the results obtained from the son respondents and the father respondents, educational attainment did not affect man to see man and woman as the same or different: and, (c) the findings reveal that fathers who are in a white collar job and sons in the white collar job as well have differences in the way they perceive masculinity and femininity. Fathers tend to see no differences, while sons see differences.

2. Emergent Changes on Household Roles

Findings revealed that more sons share household responsibilities with their wives than fathers. This meant that more sons believed both husband and wife attend to different household chores: also, with paid work.

3. Emergent Changes on Gender Relations

This study showed that for both generations, there are problems concerning gender relations; that was, husband-wife relationship is affected because the wife economically provides as well for the family. However, it also revealed in the study that for both generations, there were husband-wife relationships between fathers and sons that were not affected because they believe that both men and women share the same responsibilities but the father remains the head of the family.

4. Emergent Changes on the Gender Roles of Men and the Social Cognitive Theory

There were three structural concepts of Social Cognitive Theory-expectancies-beliefs, competencies-skills and goals. Goals were related to the ability of individuals to anticipate the future and be motivated and directed towards it; expectancies refer to the beliefs of individuals concerning their own abilities in handling tasks and challenges presented by particular kinds of situations; and competencies refers to the ability of the person to solve problems and cope with the problems of life (Pervin and Oliver, 2001).

A. Goals

Findings revealed that father and son respondents saw themselves as the head of the family. Apparently, being the breadwinner, they find ways to support, and to serve and meet their family's needs. They do their best to find and earn for a living and so, as head of the family, they must put their family first in their priorities.

B. Expectancies

It is evident in this study that there were respondents who adjust from situations to situations. Their society saw them as men, and they saw themselves as heads of the family. However, findings reveal that respondents allow their wives for paid work depending on situations like when the husband was jobless and/or helpless, or when their wives have earned college degrees.

C. Competencies

Findings revealed that respondents were flexible and made necessary adjustments, even though these adjustments are divergent to what they saw and perceive about their masculinity; that was they did household chores and allow their wives to financially provide for the family even they saw themselves as breadwinners and heads of the family.

5. Dysfunctional Expectancies and the Emergent Gender Role Changes

As what was revealed in this study, there were respondents who experience conflict between what the societies

expects of them, and the gender role changes that were taking place. These respondents' perception of masculinity runs contrary to what they did at home and, and to what their wives did for the family. That was, they view themselves as heads and breadwinners of the family but they could not cope with the situation that their wives were working also for the family.

CONCLUSION

In the light of the above findings, the following conclusions are drawn:

1. Perceptions about masculinity and femininity might be altered depending on situations. While men saw themselves as men taking on masculine roles, they might put themselves taking on roles depending on the situation.

2. That even though the father respondents belong to older generation, it does not mean that they hold on to conservative ideas about masculinity; and it also did not mean that even the son respondents belong to younger generation, they were more tolerant to changes on masculinity.

3. That the economic changes taking place in the society, men and women took on shared roles whether it be a man's or a woman's role.

4. That there were men who viewed men and women as the same in terms of work find trouble in coping to the changes in the economic roles.

5. Isinai family was embracing modern values, in terms of gender roles, inasmuch as the work between a man and a woman was becoming more egalitarian. Even both the husband and the wife financially work for the family, the husband remains as the head of the family and that the wife still considers the husband as the head of the family.

6. That the Social Cognitive Theory could be used as an approach to better understand the emergent gender role changes of family men.

Recommendations

Based on the limitations and findings of this research study, the following are recommended:

1. A focused group discussion must be employed to collect and gather suggestions from the respondents themselves to better understand the value and importance of understanding the changing roles attached/expected on the respondent's masculinity.

2. Intervening variables can be included to further explicate the changes on the views/perceptions of the respondents about masculinity and femininity.

3. A research be conducted about how changing economic conditions are affecting the Isinai family structure.

4. A study be conducted that would include not only men but also their wives as to how women view the changes

that are taking place in the role of men in the family.

5. A study be conducted to identify how men cope with the changes in their gender roles in the family.

6. A quantitative study could be conducted regarding the changes in the gender roles specifically the household roles and gender relations between fathers and sons to further support the findings of the study and of previous studies but within the context of the Isinai household.

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The Relationship between Knowledge, Attitude and Practice of the Global Warming of Chonburi Church

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Abstract

Global warming, one of the recent concerns about global climate change, has been cited as an issue that the Christians should be the initiative leaders. This study aimed to examine the level of knowledge, attitudes, and practice o the global warming reduction. It also attempts to examine various kinds of relationship between knowledge, attitudes and practice of the global warming of Chonburi Church under the 7th District of the Church of Christ in Thailand, which is located in the area of urban and industrial estates. The population was 300 members, and the sample will be 172 members. The research tool started by reviewing literature, then by creating items based on concepts and theories and related research studies to cover the research objectives. The questionnaire consisted of six parts, including closed-ended responses and an open-ended question. The research revealed that most of the participants need the church to provide more of Christian knowledge and more activities to stimulate more actions toward global warming reduction.

Keywords : Global Warming Reduction, Christian, Church

The Significance of the Research Problem

Our world needs greenhouse gases as in the atmosphere that absorb and emit radiation within the thermal infrared range, and the global warming is when the amount of greenhouse gases is above the standard level. According to a research in 2006 the amount of gases was about 400 parts per million (ppm), which has never happened before. Also the level of gases tends to increase to 500 ppm in 2050, which causes the highest temperature in the last 20 years since 1980 (The Translation Team of The Joint Graduate School of Energy and Environment,2006:10)

In May 2014,the Environment Protection Agency (USA) expressed that all human activities causes greenhouse gases about 460,000 million tons. Carbon dioxide increased 35 percent in 1990. It was the result of deforestation. Between years 1990 and 2010, the amount of carbon dioxide increased 42 percent. Nitrous oxide increased 9 percent while methane gas increases 15 percent. Fluorinated gases increased more than 2 times in 2014 (Environment Protection, 2014)

Global warming is a serious issue that all countries must take actions and well cooperated in order to solve the problem. In 1990, Intergovernmental Panel on Climate Change (IPCC) reported about the unusual melting of glacier, the increase level of ocean water, and the increasingly intense natural disasters.

Since Thailand's economy is based on natural resources and many Thai people are farmers, Thai people are likely to be affected by the global warming. For that reason, in August 28, 2002, Thailand decided to volunteer to participate in greenhouse effect reduction to Kyoto Protocol, even though, Thailand is not requested to reduce greenhouse gases because it is a developing country.

Nowadays, people are concerned about sustaining the environment because of natural disasters that has happened more often. For Christians, they should be the first group of people to step out and practice on the global warming reduction. They need to gain knowledge of global warming reduction, in order to change their attitudes, in order to bring into practice. This is because Christians believe that God is the Creator of the world (Genesis 1:1) and God appoint them to be good steward of the world (DeWitt, 1998: 86-93). Thus, Christians in Thailand should also gain their knowledge, so that they can be the leaders in the global warming reduction. Furthermore, many people will believe that God is really the Creator of the world. If Christians do not take responsibility in taking care of the world, it means that they do not obey God. God created the perfect world, but human destroys it.

The population of this research was the Chonburi Church, which is in

Chonburi province, the eastern part of Thailand. This province is rapidly growing in terms of population, industries, and tourism (Regional Environmental Office 13, 2012). Therefore, the members of the Chonburi Church under the 7th District of the Church of Christ in Thailand, located in the center of Chonburi, area proper population to study about the global warming reduction. Chonburi Church has the total of 535 members with 460 full members and 75 non-baptized members. (The 7th District Church of Christ in Thailand, 2014) Thus, this is an opportunity to urge and create value among Christians in Chonburi Church, so that they can make an impact to the community, in the province and throughout the country.

Research Objectives

This study was designed to

1) Analyze the level of knowledge of global warming reduction of the Chonburi Church under the 7th District of the Church of Christ in Thailand.

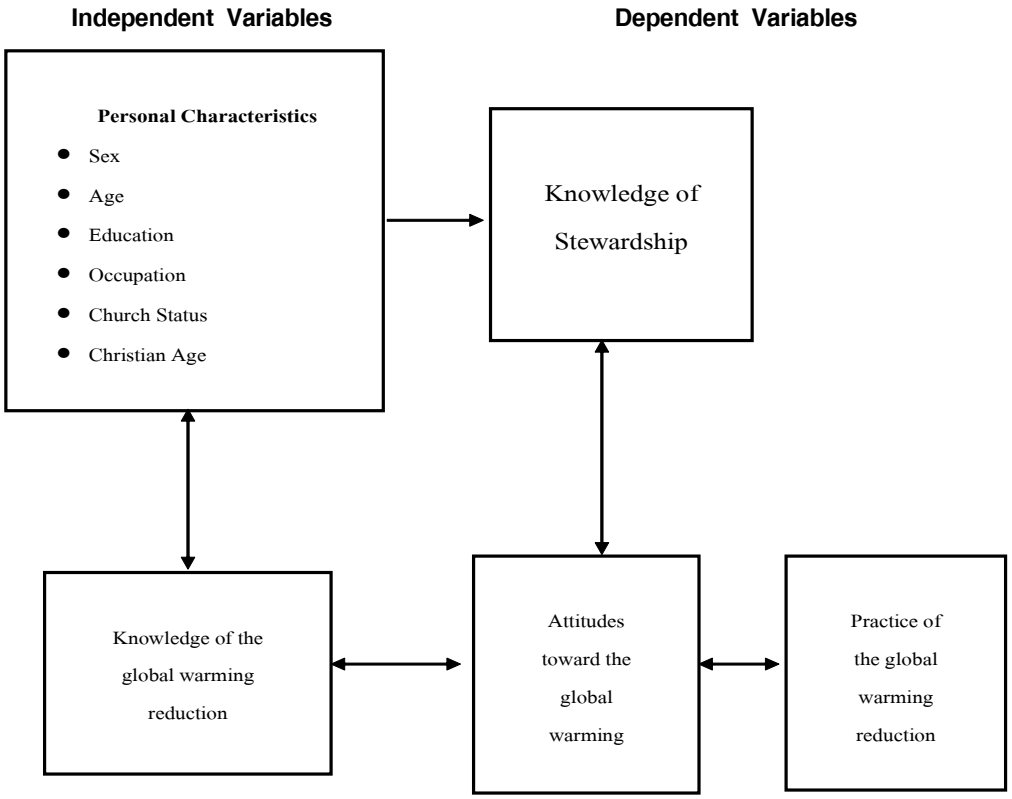
2) Analyze the level of knowledge of stewardship of Chonburi Church under the 7th District of the Church of Christ in Thailand.

3) Analyze the relationship the level of knowledge and attitudes of global warming reduction of Chonburi Church under the 7th District of the Church of Christ in Thailand.

4) Analyze the level of practice of global warming reduction of the Chonburi Church under the 7th District of the Church of Christ in Thailand.

5) Analyze the relationship between the attitudes and the practice of global warming reduction of Chonburi Church under the 7th District of the Church of Christ in Thailand.

Conceptual Framework



Research Methods

This study took place in the Chonburi Church under the 7th District of the Church of Christ in Thailand. The population was 300 members who attended the church service on Sunday and the sample will be 172 members, according to Taro Yamane's formula with 95% reliability.

The instrument of the study were questionnaires about the relationship among knowledge, attitudes, and practice of the global warming reduction of the Chonburi Church under 7th District of the Church of Christ in Thailand. The participants included pastors, leaders, and members of Chonburi Church.

Research Instrument

The research instrument in this study was developed by the researcher starting by reviewing literature, then by creating items based on concepts and theories and related research studies to cover the research objectives. The questionnaire consisted of six parts ; seven questions eliciting demographic information, eight closed-ended responses about the

knowledge of the global warming reduction, eight close-ended responses about the knowledge of being a steward, eight five-point scale responses about the attitude of the global warming reduction, eight five-point scale responses about the practice of the global warming reduction, and an open-ended question about suggestion and recommendation. The researcher submitted the revised research instrument to three specialists to evaluate its content validity and construct validity. The evaluation was collected from the thirty members of the Chonburi Church. The collected data was analyzed for the internal consistency of the instrument via the Cronbach's alpha coefficient analyzed. The reliability test should yield the result of 0.70-1.00 for the items to be applicable. The result of the Cronbach's alpha coefficient test for this instrument was 0.9, affirming its reliability and practicability.

Data Collection

The researcher issued a letter, signed by the Dean of the Bangkok Institute of Theology, to the President of Chonburi Church to ask for permission to collect data. The researcher contributed 200 copies of questionnaires to the members of Chonburi Church who attended the church service on February 22nd, 2015. The researcher distributed 200 copies of questionnaires to the targets using the convenient sampling technique, and then collected the data 178 copies (89.00%).

Data Analysis

The collected data of the research was analyzed by using descriptive statistics: frequency, percentage, and mean, to address the level of knowledge of the global warming reduction and the level of the knowledge of stewardship. The data was further analyzed by using the inferential statistics: Independent sample t-test for analyzing population mean, F-test for finding out whether there is any variance within the samples, and Pearson's correlation coefficient used for measuring of the linear correlation between two variables.

Research Findings

The research findings showed the majority (63.37%) of respondents were female, the main age group (23.26%) was between 41-50 years old, most had an education level lower than bachelor's degree (61.63%), most samples had freelance jobs, most of church status of the samples was full member of the church (57.56%), and length of being Christian was more than 10 years (58.14%).

Table 1. Levels of knowledge of the global warming reduction and stewardship

Factors	n	S.D.	Level
Knowledge of the global warming reduction	154	89.47	High
Knowledge of stewardship	116	67.42	High

Table 1 shows that the overall levels knowledge of the global warming reduction and stewardship were high. However, the knowledge of the global warming reduction is slightly higher than knowledge of stewardship.

Table 2. Levels of attitudes and practice of the global warming reduction

Factors	$\overline{X}$	S.D.	Level
Attitudes of the global warming reduction	4.07	0.900	High
Practice of the global warming reduction	3.90	1.025	High

Table 2 showsed that the overall levels of attitudes and practice of the global warming reduction were high. However, the mean level of attitudes of the global warming reduction was higher than the level of practice of the global warming reduction.

Hypothesis testing reveals that the difference in the education levels leads to the difference in their knowledge levels. Moreover, the relationship between the level of knowledge of stewardship and the level of attitude of the global warming reduction had positive correlation ($r=0.44$, $p=.05$), which had a low level of relationship. The relationship between the knowledge of the global warming and the attitude of the global warming also had positive correlation ($r=0.39$, $p=.05$), which also has a low level of relationship. Finally, the relationship between the attitude of the global warming and the practice of the global warming has a medium level of positive correlation ($r=0.53$, $p=.05$).

Research Conclusion and Discussion

1. The research findings revealed that overall of the respondents' factors of personal characteristics and knowledge of stewardship. The majority of the respondents were middle-aged women and students respectively. It was possible since Chonburi Church has been established for more than 90 years and the respondents inherited their faith from their ancestors. And they did not have high education because people who were not in the capital city are likely to work to gain their livings rather than going for education. According to the research analysis, Chonburi Chuch had the knowledge of stewardship in a high level and it was significantly different depending on their education levels. This result was correlated with the professional paper of Sappawut Pipatpun (1995), knowledge that was from the level of education could provide reasonable thinking (Sappawut Pipatpan, 1995: 13). Also, it correlated with Bloom's research, which expressed that knowledge can be developed from a simple level. With higher education, human can have higher information to recognize and develop from that knowledge (Bloom, 1965) Therefore, the difference in the level of education can affect the understanding of stewardship. Chonburi Church should facilitate members to have more understanding about stewardship because Thailand is a Buddhist country and the knowledge in the Bible mostly cannot be learned from other places except from the church.

2. The result shows overall of the respondents' factors of personal characteristics and knowledge of the global warming reduction. This kind of knowledge also in a high level because members can learn from the mass media, school, and other campaigns. However, the level of education also affects the knowledge of global warming reduction. The result of this research is correlated with Kamontip Puangpia's research, which revealed that the difference in education of high schoolers in Bangkok had an effect on knowledge attitudes and practice of the global warming reduction (Kamoltip Puangpia, 2010). Moreover, the church can create activities to stimulate values and learning among the church members.

3. The result on the knowledge of the global warming reduction of Chonburi Church is also in a high level with positive relationship with attitudes of the global warming reduction in a low level. This result supports the hypothesis that knowledge and attitude should have positive relationship. However, the relationship between the two factors should be correlated in a high level, referring to Zimbardo and Ebbesen, who reveals that if one has high level of knowledge, he or she should have high level of attitude as well (Zimbardo and

Ebbesen, 1969: 7-8). Also, Surapong Sotanasatien said that attitudes are related to believes, feeling or knowledge (Surapong Sotanasatien, 1990: 122). Nevertheless, according to Anchalee Pongkaset's research found that faculties and staff of Sirindhorn College of Public Health Yala has a medium level of knowledge in global warming reduction, but they have high level of attitudes. This can happen if one is lack of compliance, identification or internalization (Anchalee Pongkaset 2010: 469). In Chonburi Church's case, the church may not be able to convince or to create the values in order to change their attitudes. Michele T. Poff (2010) found that Christian values is diluted because of the impact of media and the values in the society. For that reason, the church can develop bible study classes and church activities to promote global warming reduction among church members as model to reach out to the surrounding communities.

4. The result on the practice of the global warming reduction is in a high level as well. The relationship between attitude toward the global warming and the practice was at the medium level. This result did not support the hypothesis, which is possible because of the social pressure or timely inconsistencies of a particular person (Zimbardo and Leippe, 1991). According to Kanjana Sookbua's research about knowledge and practice of the global warming reduction of students in Chaiyaphum Rajabhat University, the knowledge and practice of the global warming reduction are not related. The students had high level of knowledge but low level of practice (Kanjana Sookbua, 2008). Moreover, Laura M. Hartman suggested that Christian's voluntary attitudes and relationship among themselves and their neighbors can help change their behavior or practice of the global warming reduction (Hartman, 2008).

Implications from this research study

The recommendations were: 1) the Chonburi Church should increasingly realize and encourage the global warming reduction; 2) the church should integrate the knowledge of the global warming reduction with the knowledge of stewardship in all levels of the bible classes to increase the members' knowledge to change their behaviors in this regard; and 3) the church should design creative activities toward global warming reduction in the church and community. By so doing, the church can put knowledge into practice and then bear good witness of God, who created man and assigned him to take good care of all things as a faithful steward of God.

For further research, a qualitative research in the similar topic should be conducted. Other factors that affect the practice of the global warming reduction

should be conducted. Finally, this same topic of research should be conducted in a larger scale, namely the 7th District under Church of Christ in Thailand, Church of Christ in Thailand, and Thailand Protestant Churches Coordinating Committee.

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The Development of Head Nurses' Competencies Scale for the Private Hospitals in Bangkok Metropolitan in the ASEAN Economic Community

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Abstract

This research aimed to develop a head nurses' competencies scale at private hospitals in Bangkok Metropolitan in the ASEAN Economic Community (AEC) and to test its quality. It was divided into two phases. The first involved the development of an assessment form, which was further divided into three steps: (1) the synthesis of components and competencies of head nurses at private hospitals in Bangkok Metropolitan in the ASEAN Economic Community by literature review and expert group discussion; (2) developing the measurement of head nurses' competencies and testing the content validity of the measurement by five experts; and (3) collecting data by the structural precision test done in samples consisting of 350 individuals from the group of 86 head nurses and 40 nurse inspectors who had been in their positions for at least one year, as well as from 224 experienced nurses who had worked for at least five years. The second phase involved a quality test for assessment scale, which was randomly selected from 64 head nurses and 30 nurse inspectors who had been in their position for at least one year as well as from 206 experienced nurses who had worked for at least five years. Then the collected data were statistically analyzed for the mean, standard deviation, and the consistency between the assessment scales evaluated by the individuals, their supervisors and their sub-ordinates by using intra-class correlation coefficient.

The research findings were that the head nurses' competencies scale at the private hospitals in Bangkok Metropolitan in the AEC consisted of the following six components and fifty items with the sum of variance 70.74%: 1) leadership and management (12 items); 2) the decision to solve problems (10 items); 3) communication skills and the use of information technology (9 items); 4) business management skills (8 items); 5) professional skill (7 items); and 6) management in the AEC (5 items).

The content validity index = .86, coefficient of reliability = .96, mean = 3.78, standard deviation (S.D.) = .58. The results also showed that the performance of head nurses as evaluated by the head nurses' themselves, by their supervisors, and by their sub-ordinates were all consistent (r = .92). This study suggested that the development of the head nurses competencies scaled is an important tool for nurse administrators in private hospitals that can provide the direction in the development of head nurses in their practice and administrative works, the improvement of offering nursing care, and the increase of nursing organization efficiency in the AEC.

Keywords: Competency, Head Nurses, Private Hospitals

Statement of the Research Problem

Thailand has entered to the ASEAN Economic Community (AEC) since 2015. The social, political, economic and technological contexts have been changed all the time which has produced great impact on nursing organization at the present and in the future which need a leader or nursing administrators with high performance and a professional management, because the social contexts has dynamically change. The reformation of the healthcare system to keep pace with the ongoing social context, in accordance with the Eleventh National Economic and Social Development Plan (2012-2016) has been crucial to the development of human resources particularly the development of public health personnel to suit both the production and distribution personnel (The Eleventh National Health Commission Office Plan, 2012) because human resource is valuable as the main engine to move the organization forward, as well as the foundation of innovation and intellectual property of organizations.

Nursing Organization is a main personnel group of the hospital that is a major driving force in the development of quality services.Nursing organization is an important organization that develops hospitals to fulfill the mission, vision, and strategic objectives identified. Nurse Executives at all levels are very important for the administration because the goal of nursing management arethe nursing service which high quality and efficiency, the customers are satisfied and the demand of the society and citizens are met. The head nurses are especially the most important person to bring the policies into qualify and successful operationbecause their duties associate directly to the patientsand directly responsible for nursing product. Head nurses therefore must have knowledge, skills and management competency. Moreover, they have to develop themselves continuously in order to

improve their competencies in providing effective health care service, and supervise health service management to be consistent with the goals and the changes that occur.

The administration is important to the organizations, particularly in the current situation, where the health services have high competition in both public or private organizations and in the midst of nurse staff shortages. Nurse executives at all levels need to develop competencies that will help the organization to survive and develop continuously. The existing competency were not appropriate with the change of competencies that requires in the current situation and in the future.

Competency assessment is a measure that practitioners have the knowledge, skills, experience, and expertise suitable in their task. (Thamrongsak Khongkhasawat, 2006) The standard of assessment must cover the vision, mission and goals of the organization.The definition of the assessment criteria must be clear, modern and in accordance with recipients in specific positions and define behaviors clearly. (Alongkorn Meesuttha, 2005)

Private hospitals are the health service business on which the clients have an expectation forhigh quality of nursing services.Thus, nurse administrators are the persons responsible for the operation and ward management. In the age in whichprivate hospital business is rapidly expanding and highly competitive.From literature review and preliminary studies by interviewing nursing administrators of private hospitals in Bangkok, found out that there was a highly selective process for recruiting and selecting experienced nurses to take position as a head nurse. However there was not the head nurse's competencies scale that was complete and cover all aspects has never been used so far. Furthermore, nursing administrators also needed competencies assessment scale of head nurses. There for the quest for this scale is still waiting for answer.

Thus, researcherswere motivated to develop a practically head nurses' competencies assessment scale at private hospitals in Bangkok in the AEC that can cover and can be categorized head nurse's competencies. This competency assessment scale can be practically used effectively as it has validity and reliability (Chuchai Samithikrai, 2007). In order for the head nurses'competencies assessment scale at private's hospital in Bangkok during the AEC has quality and actual implementation and nursing administrators can use this assessment as a guidelinefor assessing and planning the development of professional nurses into the head nurse.

Objectives of the research

1.To develop the head nurses' competencies assessment scale at private hospitals in Bangkok Metropolitan during

ASEAN Economic Community (AEC)

2. To examine the quality of head nurses'competencies assessment scale at private hospitals in Bangkok Metropolitan in ASEAN Economic Community (AEC)

Research methodology

This research was descriptive research and divided into 2 phrases as follow:

Phrase 1 The development of the head nurses'competencies assessment scale at private hospitals in Bangkok Metropolitan duringthe AEC consisted of 7 stages as follow:

1. Review the concept of head nurses'competencies at private hospitals in Bangkok Metropolitan during the AEC from literature, research papers related to the head nurses 'competency at private hospitals in Bangkok Metropolitan in the ACE. Then take the list of competencies to collect and summarize competency under the framework of the head nurses'competencies at private hospitals in Bangkok in the AEC and nursing administrators of American Organization of Nursing Executive. After that, get the head nurses'competencies at private hospitals in Bangkok Metropolitan in the AEC eight areas as follow: 1) Management: 2) Leadership: 3) Decision to solve problems and risks: 4) Communication and relationships building: 5) Professional skills: 6) Business and marketing skills: 7) Management in the AEC: and 8) Information technology. The eight areas consisted of 70 sub-competencies items.

2. Sent the competency assessment to specialists who were nursing administrators, hospital directors, hospital quality management specialist and research professionals at private hospitals in Bangkok to elevate the scale of head nurses 'competencies whether covers the vision and mission of nursing organizations and hospitalsas defined. The competencies of head nurses at a private hospital in Bangkok had seven areas as follow: 1) Leadership and management: 2) Decision to solve problems and risks: 3) Communication and relationships building: 4) Professional skills: 5) Business and marketing skills: 6) Management during the AEC: and 7) Information technology. The seven areas consisted of sub-competencies 66 items.

3. Analyzed the contents from reviewing literature and focus groups by classifying competency list of head nurses at private hospitals in Bangkok Metropolitan during the AEC. Then checked the accuracy of the content, language and seven competencies were chosen which consisted of 63 sub-competencies items: 1) Leadership and management: 2) Decision to solve problems and risk: 3) Communication and relationships building: 4) Professional skills: 5) Business and marketing skills: 6) Management in the AEC: and 7) Information technology.

4. Developed assessment form and developed research instrument to

assess head nurses' competencies at private hospitals in Bangkok Metropolitan during the AEC.A behavioral measure of competency assessment set by a rating scale of 5 levels and the rating showed the desired behavior assessment.

5. The assessment form were sent to 5 experts and to check the content validity (CVI). The content validity index = 0.86. Remaining 7 competencies that consisted of sub- competencies list 60 items. Took the assessment form to trial with a sample of thirty people. Then, calculate the reliability of data by a computer program.The reliability of the assessment form was .96

6.Factor analysis was conducted, the sample group were 86 head nurses and 40 nurse inspectors who have been in their position for at least one year, and 224 experienced nurses who have worked at least five years. The total samples were 350 people. Then data were analyzed using principle component factor analysis, orthogonal varimax and analysis resulted were 6 head nurses' competencies and 50 sub-competencies items. The factor loading was between .491-.843 as follows: 1) Leadership and management 2) Decision to solve problems 3) Communication and Information technology 4) Business management 5) Professional skills 6) Management during the AEC respectively.

7.Taking the result from step 6 to make the head nurses' competencies assessment at private hospital in Bangkok in the AEC for three set with the same content in order to give assessor 3 groups as follow: group 1 was the head nurses' competencies assessment that evaluate by supervisors, group 2 was the head nurses' competencies assessment that evaluate by head nurses, and group 3 was the head nurses' competencies assessment that evaluate by subordinates.

Phase 2 Test the quality of the head nurses'competencies assessment at private hospitals in Bangkok during the AEC by 300 samples consisting of 64 head nurses and 30 nurse inspectors who had been in their position for at least one year as well as 206 experienced nurses who have been working at least five years at private hospital in Bangkok.

Population and samples

The simples were selected by random sampling method, there were 300 samples, consisted of 4 groups as follow:

Group 1 : Five nurse executives

Group 2 : Fifteen middle level nurse managers

Group 3 : Seventy-fivefirst level nurse managers

Group 4 : All professional nurses with 205 working experiences over five years.

Ethical considerations

The questionnaire and the research proposal reviewed by the Human Research Ethics Board of Christian University

of Thailand and Human Research Ethics Board of private hospitals in Bangkok. In collecting data, the samples were informed about the purposes, research methods, data collection methods, and asked for participate in the research study. They were inform of their right to end their participations. The sample responses were collected by using only data code in this research. Presenting the findings will be presented as a whole and the fact that it had only been verified.

Data analysis

Phase 1 the development of the head nurses 'competencies assessment scale at private hospitals in Bangkok Metropolitan during the AEC

1) The sample personal data analyzed by using the frequency and percentage.

2) The opinion related to the head nurses' competencies assessment scale at private hospitals in Bangkok Metropolitan during the AEC analyzed by using the frequency mean and standard deviation

3) Calculate the correlation of each variable by using Pearson's correlation coefficient.Test the significance of the correlation matrix by using the results of correlation test of Barlet (Barlet's Test of sphericity). Factor analysis with principle component factor analysis and orthogonal varimax

Phase 2 Test the quality of the head nurses'competencies assessments scale at private hospitals in Bangkok duringthe AEC

1) Test the validity of assessments scale by using internal consistency with Cronbach's alpha coefficient.

2) Find the concordance between assessors by using intra-class correlation coefficient. The results showed that the assessments scalewas consistent and in the same way.

The Research results

1) The study of development the head nurses' competencies assessment scale at Private hospitals in Bangkok Metropolitan during the AEC by using factor analysis. Considering the index Kaiser-Meyer-Olkin (KMO) measure of sampling adequacy was .96, which was over than .5 and closer to 1 indicated that the variable was appropriate for analyzing factor analysis and Bartlett's test of sphericity had the significant = .00, which was less than .05, the eigenvalues having cut-off point >1 or not .That meant the variables were related and suitable to analyzeby factor analysis. Then the variables were analyzed by principle component factor analysis and orthogonal varimax which had a total of six factors consisted of 50 variables. The variance was 70.74 percent.

Factor 1 Competency Assessment of leadership and management. The weight for factor loading were between .82 to .52

as follows: 1) Be flexible. Accepting and adapting to change in circumstances;2) Emotional Maturity. Emotional expression isappropriate to the situation;3) Good personality that can be trust and faith; 4) Able to promote and maintain the atmosphere in the ward; 5) Acceptable behavior; 6) Fair and reasonable; 7) Stick to the principles of ethics, mercy is the basis for the administration; 8) Analysis of the organization in order to define target and strategic plan (SWOT analysis); 9) Able to plan and definethe rate of nursing staff that are in accordance with the policies of the nursing department and the hospital; 10) Focus on improving and developing planning up to date, suitable and consistent with the situation; 11) Be the leadership who take the change to nursing care to bemodern and quality. Moreover, they can persuade subordinates to accept the change;and 12) Supporting to create the innovation and applying their knowledge in working effectively.

Factor 2 Competency Assessment of the decision to solve problems. The weight for factor loading were between .81 to .48 as follows: 1) Identify problems and solve immediate problem as well; 2) Able to make the decision that is appropriate to fix the problem; 3) Be clever and courageous in decisions to achieve operational efficiency; 4) Able to review the guidelines for risk that might be a problem; 5) Able to analyze system and predict problems that may occur; 6) Be bold to think and do what is right and face the problems with confidence; 7) Able to analyze and assess problems or risks that may occur in the ward and define guidelines to prevent proactive problems; 8) Able to manage the risks in nursing care and apply theories to use in situations appropriately; 9) Report and record the incidents that occurred clearly and correctly; and 10) Able to manage conflict effectively.

Factor 3 Competency Assessment of communications and information technology. The weight forfactor loadingwere between .79 to.54 as follows: 1)Able to clearly, appropriately communicate which is precious to the receiver and facilitates understanding; 2) Able to coordinate and negotiate to the other personnel for assistance; 3) Use the communication skills with patients, personnel at every level and interdisciplinary team efficiently; 4) Able to adjust the pattern and method of communication to be appropriate to the audiences to convince them to consider objective; 5) Able to use computer information technology for management; 6) Able to use information technology to search information for supporting nursing and management; 7) Able to adapt new technology to enhance work's efficiency and able to manage information technology; 8) Development of personnel about using information technology and communication in the operation;and 9) Provide the appropriate suggestions according to

academic principle to subordinates or the personnel in healthcare's team related to special instrument or new medical technology in ward.

Factor 4 Competency Assessment of business management. The weight for factor loading were between .83 to .65 as follows:1) Have the knowledge and understanding about the value of the cost of health care systems; 2) Able to analyze the marketing opportunityof health services to use information for nursing service management responding to service users' need; 3) Able to manage and improve service system to enhance efficiency and effectiveness of ward by using participatory management; 4) Able to adjust nursing care plan appropriately to the patients' need and care plan; 5) Analyze cost to use as a guideline to control expense efficiently; 6) Able to improve plan to be updated and consistent with the situation;7) Able to manage human resources and instrument usage worthily; and 8) Regulate the office supplies usage to save and appropriate to the type of use.

Factor 5. Competency Assessment of professional. The weight for factor loading were between .78 to .50 as follows: 1) Adhere and behave to professional ethics; 2) Be the leader of learning and self-improvement related to professional consistently; 3) Have an updated knowledge in the professional field and related field; 4) Able to use empirical knowledge and research to apply to nursing; 5) Disseminate academic knowledge in the meeting and journal's publication to present in the country and aboard; 6)Encourage the subordinates to be a member of professional organization and build a nursing network services both inside and outside the ward; and 7) The ability to build partnership inside and outside the profession.

Factor 6 Competency Assessment of the management in the AEC. The weight for factor loading were between .79 to .51 as follows: 1) Have knowledge and understanding about ASEAN Economic Community and the participation in the ASEAN Economic Community; 2) Develop themselves in using English language or other languages in the ASEAN; 3) Develop subordinates in using English language or other languages in the ASEAN; 4) Able to build a network with nurses in ASEAN;and 5) Develop personnel and the participation about the ASEAN Economic Community.

Table 1 The Eigen value, the percentage of variance, the cumulative of variance and the competency list of head nurse at private hospital in Bangkok in the AEC.

Factor	Eigen Value	Percentage of Variance	Cumulative of Variance	Amount of Unit of Competency	Core Competency
1	19.751	27.651	27.651	12	Leadership and Management
2	10.021	12.022	39.673	10	Decision to solve problems
3	7.480	9.036	48.709	9	Communications and Information Technology
4	6.412	8.107	56.816	8	Business Management
5	5.016	7.909	64.725	7	Professional
6	3.432	6.012	70.737	5	Management in the AEC

2. The results of the test quality of head nurses'competencies scale at private hospital in Bangkok in the AEC

Quality assessment testing, researchers evaluated average ofthe head nurses' competencies scale which got the average at a high level ($\overline{X}$ = 3.78) evaluated by head nurses'self-assessment, got the average at a medium level ($\overline{X}$ = 3.48) evaluated by supervisors, got the average at a high level ($\overline{X}$ = 3.71) evaluated by subordinates

Reliability of assessment scale by using Cronbach's alpha coefficient which evaluated by head nurses'self-assessment, supervisors and subordinates. The reliability were .91, .92, and .93 respectively and the reliability of the whole of assessment scale was 0.96. Moreover, the reliability which evaluated by head nurses' self-assessment, supervisors and subordinates by using Intra-class correlation coefficient (ICC) was .96 at the .05 level of statistical significance. It showed that the difference of evaluators' work position which evaluated of head nurses'competency in private hospital in Bangkok during the AEC was not significantly different at 0.5.

Table 2 Reliability of head nurses' competency assessment at private hospital in Bangkok in the AEC

Head nurses' competencies at private hospital in Bangkok in the AEC	Validityof Head nurses'competencies scale		
	Self-assessment	Assessment by supervisors	Assessment by subordinates
1. Leadership and Management	.89	.90	.91
2. Decision to solve problems	.94	.94	.93
3. Communications and Information Technology	.90	.91	.90
4. Business Management	.94	.95	.95
5. Profession	.90	.91	.92
6. Management in the AEC	.94	.96	.97
Total	**.91**	**.92**	**.93**

Intraclass Correlation Coefficient

	Intraclass Correlation[a]	95% Confidence Interval		F Test with True Value 0			
		Lower Bound	Upper bound	value	df1	df2	Sig
Singer Measures	.521[b]	.474	.586	47.514	248	9622	.000
Average Measures	.976	.963	.891	47.514	248	9622	.000

Table 3 Comparison of average, standard deviation and head nurses' competencies scale at private hospital in Bangkok in the AEC

Competency list for assessment	**Self** (N= 64)			**Supervisors** (N=30)			**Subordinates** (N=206)		
	$\bar{X}$	SD	level	$\bar{X}$	SD	level	$\bar{X}$	SD	level
1. Leadership and Management	3.77	.59	High	3.46	.58	Medium	3.73	.72	High
2. Decision to solve problems	3.88	.61	High	3.44	.54	Medium	3.75	.65	High
3. Communications and Information Technology	4.28	.58	High	3.83	.48	High	3.98	.78	High
4. Business Management	4.08	.54	High	3.98	.62	High	3.87	.59	High
5. Profession	3.94	.80	High	3.88	.78	High	3.78	.78	High
6. Management in the AEC	3.46	.60	Medium	3.38	.72	Medium	3.51	.91	High
Total	**3.91**	**.63**	**High**	**3.66**	**.68**	High	**3.77**	**.71**	High

Discussion

The research showed that the development of the head nurses'competencies scale for the private hospital in Bangkok Metropolitan during the ASEAN Economic Community the head nurses'competencies assessment was consistent with the head nurses'competencies assessment that was consistent with mission and vision of nursing organization. The content validity of assessment was .86 and the reliability of assessment was .96 which consisted of 6 competencies as follows: 1) Leadership and Management composed of 12 items 2) Decision to solve problems composed of 10 items 3) Communications and Information Technology composed of 9 items 4) Business Management composed of 8 items 5) Profession composed of 7 items and 6) Management in the AEC composed of5 items. The descending order of the sum of the variance was 70.74. In a similar study conducted by Kanjana Arechep (2006), it was found out that these competencies were important competencies which head nurses had to develop themselves with knowledge and skills to provide nursing services to meet the needs of the clients and achieve the goals of organizations effectively. Furthermore, this study was consistent with the research conducted by Suphara Apinyanon (2006), Suphaluk Ratnasara (2008), Benjawun Buddiangkul (2014) and Frameworks of nurse leaders competencies of AONE (2005).

The quality of the competency assessment revealed that the total validity of competency assessment was .97. The validity assessed by supervisors, self-assessment and subordinates were .91,.92 and .93 respectively which was consistent with Lui M, Et al (2007) who studied about nurses'competencies assessment in China. The study found that the reliability of competency assessment was .89 and could use this assessment assessed nurses'competency in China. Moreover, the research was conducted by Andrew S,et al (2008) who studied about the attribute of competency assessment of nursing professional who just graduated in Australia showed that the competency assessment was suitable to use as a tool to assess nurses' competency who just graduated. The reliability of this assessment was .93 and the results of comparing head nurses' competencies scale among different work position by using correlation within the group and between groups revealed that the assessment results were consistent and in the same direction which implied that the difference of work position of the assessors yielded no significant difference in assessment result.

Practical Implications

1. The head nurses' competencies scale at private hospital in Bangkok during the AEC should be developed as a guideline for evaluating head nurses' competencies and should take the results

of assessment to improve the head nurses' competencies at private hospital in Bangkok during the AEC.

2. Nursing administrators can usedthis scale as a tool for the appointment head nurses and as a guideline for head nurses' training in private hospitals in Bangkok during the AEC.

Recommendation for further study

1. Further research should be done to develop the head nurses' competencies scale at private hospitals of other provinces such as Nakhon Pathom, Ratchaburi, Petchaburi, etc.

2. Further research can be done on other paramedical personnel at private hospital in Bangkok Metropolitan such as physical therapist, laboratory technician, etc. to develop a scale measuring their competencies in their contexts.

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Leader and Development of the Self

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Introduction

No one is born a leader; the focus is on self-development and continued growth in some areas of leadership.

This article focuses on how nurses develop themselves personally and professionally as leaders. The areas of development to be examined include characteristics of the leader; successful leadership behaviors; and additional factors that influence and facilitate leadership, such as attitude, motivation, failures, intentions, individual self-reflection, and emotional intelligence. To become an effective leader requires examinations of strengths and weaknesses. Also self-reflection are importance, which begins from fundamental thinking skills. The areas are identified within which most administrators are working, as they pursue more effective leadership methods. Bennis and Nanus (1985), divided leadership into two major aspects: characteristics and behaviors.

1. Characteristics

The characteristics of leaders focus on "beingness" and how these leaders are presented with other human beings. Five of these attributes comprise of the character of the leader; the **commitment,** these attributes leaders have to commit for themselves and their followers; the **connectedness,** they must maintain connected with their staffs and other stakeholders; **the caring and compassion,** they exhibit care and compassion for their followers, patients, and families; and the **confidence,** they must have confident in themselves and their followers.

Character signifies who a person is, when no one is around, when no one will discover what a person actually thinks, or more importantly, what he or she does. Guinness (1999) said, "Character is the inner form that makes anyone or anything what it is. The most likely would include moral accountability, forgiveness reliability and cultivating humility. Character is developed from the cradle; therefore, character development is a continuously evolving process. Building on the foundation which began during a person's youth, character is created

daily trustworthiness and a sense of responsibility... Character is based on the standards or values learned from family, faith, and a person's environment. Human beings assess their own actions and behaviors based on these standards and values. In addition, leaders must open their minds to changing thoughts, ideas, opinions, and behaviors when being presented with new evidences or circumstances.

Developing the strong character is a process. The key is to raise self-awareness and work proactively to increase strengths of the character leaders must be impeccable with their words. As a leader, words are the power. Your word is so powerful that it can change other's life; thus, take nothing personally, and always do your best. Keeping in mind that one's best changes from moment to moment, depending on one's emotion and mood. For example, when you are tired and stressed, 'the best' you can do at such a moment is different from 'the best' you can do when you awake freshly and ready for a new day.

Moral accountability is essential in building the strong character. Human beings are created to learn from mistakes, to experience how to correct such mistakes, and to be accountable for such correction. A major part of this accountability is the recognition when people have acted in violation to their own standard and acknowledgment of the wrong to the individual involved. For example, a failure to keep a promise must be followed by one's acknowledgment and apology for breaking the promise.

Forgiveness is essential to the strong character. Forgiving those who do wrong is paramount in cultivating the character. And at the same time, asking for forgiveness after being wrong to someone is equally important. If ones respond with resentment and desire for the revenge in the first instance, or smugness and glee in the second instance, the result is a lessening or weakening of the character. For this, ones seem less human than they could be.

Cultivating humility is the final key in building the character. Leaders with the strong character do not need public recognition. They do not need reassurances of being a great boss, or how much staff members appreciate everything the leaders do. Rather, leaders know they are the most effective one when the followers say, "We did it ourselves."

Besides, another part of the strong character is the ability to make and keep ***commitments***. In order to succeed in something, leaders find it necessary to understand the concept of commitment: this includes when to make commitments, and when or how to break them (Sull, 2003). In addition, the ***connectedness*** is as important as the

commitment, because the commitment contributes nothing without connectedness to people. Leaders make efforts to connect with other people. These people may be staff members, colleagues, or members of a network. In many respects, being connected is about being in a relationship with other human beings: it happens on the level of an individual rather than a group. Leaders develop creditability with people when they connect with them and show that they genuinely want to help. Understanding how people feel and think helps create a relationship, for examples, remembering everyone's name, listening to them, and being friends with them instead of being just a boss. Unquestionably, this group of employees will feel more connected to their leader: they know what their leader did for them, and how the leader related with them.

Relationship Building, some of these relationships are deeply personal and last many years. One person might admire the other's sense of humor and the ability to reduce tension while restoring calm and purpose, whereas the second person might admire the first person's integrity, hard work, and creativity.

Communication, a critical role in establishing relationships is the manner in which the leader communicates with peers, co-workers, and followers. Two aspects of communication are important: tools and attitude. Most people would agree that words are the least important aspect of communication, whereas tonality and body language are the critical aspects that convey a true attitude.

Compassion and Caring, commitment and connectedness are important, and they are interwoven with compassion and caring. Dutton et al. (2002) identified the critical nature of compassion in the face of tragedy that can be demonstrated by organizational leadership. The leader's ability to demonstrate a compassionate response in times of disaster or trauma that affects employees elicits humanity in members of the organization. As Porter-O'Grady and Malloch (2002) said, "Without feelings of deep sympathy and sorrow for others struck by misfortune and a genuine desire to alleviate suffering on the part of caregivers, patient care service would be no more than a robotic endeavor". Nursing leaders demonstrate this caring through knowing people and committing to help them grow personally and professionally. Kouzes and Posner (2002) believed that leadership is about people, and leaders must care about people. They found that expressing affection is pivotal to success and that human beings have a strong need for affection.

To have the first four characteristics, leaders must also have the confidence. Confidence, a belief in a person's own abilities and trust in oneself, creates a

boldness or self-assurance that enables the leader to grow personally and professionally (Crane, 2002).

This ongoing process of growth and expanding confidence helps the leader develop an effective vision of the future for the department or organization.. On the other hand, low self-confidence leads to reward-based, autocratic, and coercive styles of management/leadership and a downward in character development. One way in which leaders strives to grow and increase their self-confidence is to practice facing fear. Some may be afraid to write, thus they might take a writing course or force themselves to sit down at a desk and write. Some leaders fear confrontation with difficult people. To face such a fear requires sitting down with the person and talking to him or her, listening carefully, speaking from a caring and responsible position, and sharing what is true for the leader from a personal perspective.

2. Behavior

In addition to characteristics, leaders demonstrate specific behaviors that enable them to marshal the forces of their staffs and accomplish amazing goals in support of a motivational mission, some common behaviors: among these are visioning, building trust, empowering, coaching, getting results, and acknowledging.

Creating a Vision

Effective leaders, regardless of their style or their strengths and weakness, have a guiding purpose an overarching vision. The first task of the leader is to define the vision and mission with a focus on its uniqueness and ability to make a difference. A vision works only when people are willing to follow the leader. To achieve this, staff members must be inspired by a "brightness of the future." and staff members needed to stay focused on the goal.

Building Trust

Nothing happens without trust. Just as trust between the nurse and the patient has been documented to be the basis of keeping the chronically ill out of the hospital, trust has been demonstrated to be the key factor in holding the organization together. It is the lubricant that makes the organization run smoothly. To create trust, leaders make themselves known and understood by the staff. They make their positions clear. Trust is a very fragile commodity. Five ways in which trust is developed and maintained are as follows:

Empowering People

When leader empowers their followers, they bring out the best in them. They encourage and promote a positive mindset. They also support the staff with the belief that the staff can do what is required.

Coaching

Leaders establish a formal coaching process with people who report directly to them. The goal of this coaching is to support the personal and professional growth process. They share new learning and support the learning of the person they are coaching. Coaching is such an important aspect for leaders that some experts believe that leaders need to devote nearly 40 per cent of their time coaching their people.

Getting Results

Leaders are focused on results. They want to know and be responsible for the outcomes of decisions they make, as well as the plans and policies they put in place. Measures are put in place to evaluate results. This includes measures of outcomes such as number of patient falls, medication errors, pain management, staff satisfaction, patient satisfaction, and financial measures or hours of agency nurses. Leaders are focused on qualitative and quantitative measures. They want to use benchmarks to compare themselves and their facilities with other comparable institutions. Leaders see these results as a measure of their personal effectiveness and the effectiveness of all the programs they have instituted. At the same time, they would not sacrifice their staffs for "results".

Acknowledging

One of the most powerful tools a leader possesses is to acknowledge followers. Everyone wants to be acknowledged for what they do and who they are as a contributing member of the team or the organization. It seems as though people frequently say, "Thank you.", yet most people do not feel being acknowledged. This is because the word "thank you" often comes in a hurried and nonspecific manner.

Other influencing factors in self development

In addition to characteristics and behaviors, additional factors are involved in self-development. Focusing on improving skills in emotional intelligence, attitude, fear of failure and humor are valuable:

Emotional Intelligence

In the mid 1990s, Daniel Goleman (1995) presented the concept of emotional intelligence, which revolutionized the manner in which leadership is assessed. The five pivotal aspects of this framework include self-knowledge/self-awareness, self-mastery/self regulation, self-motivation, empathy/insight, and social arts/skills.

Self-knowledge/Self-awareness is the fundamental of emotional intelligence, and no doubt a cornerstone of leadership. The leaders must be able to recognize and categorize their own emotions, moods, and the drivers that create their behaviors and the responses. At the same

time, the leaders must recognize the effect of these emotions on the people around them (Johns, 2004).

Self-mastery/self-regulation refines the image and control of the leader's behavior. Reflection and self-awareness identify behaviors or attitude the leader finds less than useful. The next step is being able to control and shift these undesirable or ineffective behaviors and strategies. The outcome of self-mastery is to display the appropriate emotional response in a given situation. For example, when upset or reaction occurs, effective leaders have strategies by which they are able to soothe themselves, and this is also assumed the emotional response. Such strategies could include reading a novel, hiking, painting, playing a musical instrument, or going dancing.

Self-motivation is a passion for the leader's work, for the nursing profession, for quality patient care, and for the growth of staff. The focus is on the pursuit of goals related to these professional issues..

Attitude

Attitude is an inward feeling expressed by behavior. It can be seen with or without a word, because verbal and behavioral expressions are interrelated in which they reflect inward feelings. These expressions become the "window of the soul". Attitude is the primary source that determines whether people succeed or fail. Attitude determines a person's approach to life. One way for a person to assess attitude is to answer the question, "Do you feel the world is treating you well?" And if a person's attitude toward the world is positive, the world will, for the most part, treat that person well. On the other hand, when people feel badly about the world, they perceive themselves to have bad experiences or primarily negative feedback. It is easy to see how this person would have a negative attitude. Leader must be careful which way it hardens. They also must be aware of their primary attitude and approach to life in general, and to make choices about what approach they will take every day. The attitude and ability to be optimistic, based on reality, are critical to the approach toward mistakes and failures.

Fear of Failure .

Many healthcare professionals believe that they cannot tolerate mistakes. Failure in healthcare can be so catastrophic that it provokes considerable fear: fear of killing a patient, fear of losing one's job, fear of how the nurse will be perceived by others in the face of a significant failure. Thus fear can produce paralysis, the inability to move forward. Paralysis leads to giving up. In addition, fear can lead to procrastination, which delays decisions

that could jeopardize the leader's status and effectiveness. According to Maxwell (2000), procrastination could steal time, productivity, and potential. Fear of failure also leads to the lack of real purpose. To avoid the pain of failing, some people just put in their time, follow the rules, and do only what they are told to do. This purposelessness leads to self-pity, victim behavior, and blaming others for poor outcomes or lack of results. Such a scattered approach to work reinforces a lack of focus, decreases results, and creates hopelessness or an inability to see the brightness of the future.

Humor

The use of humor by the leader helps to solidify the group or team. The strongest leaders love to laugh, and most often they laugh at themselves (Lyons, 2002). Laughing together helps establish a bond and support within the group or team. Humor can improve productivity and supports tasks that require intense concentration Humor is a powerful and persuasive form of communication, enrolling, and holding the staff member's attention.

Tools for self-development

1. Personality or Work Style Profiles

These tools can assist in assessment of co-workers or staffs. help everyone learn how to work together more effectively and understand each other.

Another type of tool, referred to as a 360 degree assessment (Swain et al., 2004), includes assessments of performance and feedback from subordinates, peers, and supervisors. Therefore, the 360 degree assessment feedbacks from each group works for the leader benefits, in seeing how relationships change or remain the same with these different groups. It can pinpoint areas in which the leader could benefit from coaching to improve the working relationship.

2. Learn and Role Model Balance in Life

Healthcare professionals are notorious in working long hours and not taking care of themselves. Such work patterns lead to exhaustion and burnout. It is critical for nursing leaders to take care of themselves and then to model self-care to other staff members rather than modeling 60-to 80-hour work weeks. The following four areas in which imbalance frequently occur are as follows: physical, intellectual, emotional, and spiritual.

Physical

Caretaking of the physical aspects of the self is important. Excessive fatigue from long hours from too many shifts and inadequate sleep leads to unclear thinking and reasoning. Other important physical aspects include a healthy diet, adequate The body needs

exercise, which encourages endorphin release and a sense of well-being. The important concept is taking care of oneself physically, and occasionally, also focusing on a special physical treat.

Intellectual

From an intellectual perspective, it is critical to maintain a sense of humor. A leader might want to review past events and look for the number of times situations evolved in which everyone had a "big belly laugh." Without laughter, physical and mental problems ensue.

Emotional

Attention to the emotional aspects of the self includes such activities as meditation and thinking about personal growth. A book on self-forgiveness may be helpful, because most human beings find it difficult to forgive their own mistakes. Journaling and actively pursuing self-reflection may be helpful.. After completing the weekly assignments, friends could have dinner together and discuss what they had learned. The objective is to free up the mind and emotions from the workplace and to focus on something totally different.

Spiritual

Attending to the spiritual aspects of life can mean pursuing a religious belief system, including an active spiritual life. It might be focusing on improving unconditional acceptance of oneself and others. It should be something that replenishes the spirit; thisdoes not necessarily mean religion. Enjoying nature or the outdoors, or perhaps entertaining family or friends may enhance a person's spirit so that a level of peacefulness is attained.

3. *Ongoing Learning*

Reading, journal club, courses, national meetings, networking, and coaching are ways to stimulate learning and growing. Nurse leaders should ask themselves following questions : How many journals/magazines do I read per month? Do I have a structured way to discuss what I am reading/learning with a peer? Do I take any courses just for the joy of learning something new?

Conclusion

Although the characteristics, behaviors, and the additional tools provided in this article do not constitute a thorough list, they are examples of self-discovery and self-development. Cultivating these various aspects and elements benefit the effectiveness of leading. Characteristic, behavior, and tool are distinct in its own right, yet they are interrelated and reinforced each other. Investment in developing the self, thus, benefits the organization as a whole.

Key points to consider as a leader

Analyze characteristics and behaviors of yourself as a leader and develop a plan for how you will continue to expand in your areas of strengths and what you would like to do with your weak areas.

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Behavioral and Emotional Competence as Resilience Factors for Later Substance Use Disorders Among School-Aged Children

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Abstract

Substance use-related disorders have long been a serious global concern. It is not only prevalent among adults but also recently, among young children. This paper presents school-aged children's vulnerability to later substance use-disorders considering their developmental milestones and psychological needs. In order to reduce risk, there is a need to prevent them from the early use of illicit substances, and increase their resilience against adversity. Resilience as a trait can be improved by looking into its indicators. In relation to substance-use disorders, the main resilience indicator is behavioral and emotional competence. Thus, a child's behavior in the early years could lead to future psychological and social problems such as substance abuse. The individual, family, and community factors influencing behavior and emotional competence in children are also presented in this paper.

Keywords: Child Behavior Problems, Resilience, Indicators of Resilience, Substance Abuse, Addiction

Introduction

The World Health Organization (WHO/UNDCP, 2003) predicts that from 11% total disease burden in the year 1990, substance abuse alongside other mental disorders will surpass all physical illnesses such as ischemic heart disease and diabetes as a major cause of disability by 2020. In the year 2000, tobacco, alcohol and illicit drugs contributed to about 12.4% of all deaths worldwide (UNODC, 2013). Among children and adolescents, substance abuse is increasing worldwide. As reflected in the 2011 survey released by the National Survey on Drug Use and Health (NSDUH) involving the age group of 12 to 17 years and older, around 22.5 million Americans were considered as current drug users while a drastic increase of 1.2% or 3.6 million users was observed between the years 2007 to 2011. Initiation of drug use on an average day as reported in 2010 and 2011 brings about 7,639 alcohol drinkers, 4,594 new illicit drug

users and 400 new marijuana new users. Approximately, this brings to 8,400 new users per day and the number continues to increase.

In certain countries, substance abuse is becoming a serious concern even among young children. The United Nations International Children's Fund (UNICEF) reports suggest that substance abuse is a rising phenomenon against the children of Iraq (IRIN news, 2007) with a 30% increase since 2005 and a nearly 10% increase in 2012 (Global research, 2013). In the 2007 news report from Baghdad, preliminary survey showed high cases of addiction among street children and the middle class.

In the South-East Asian region, a joint project by the World Health Organization and United Nations International Drug Control Programme (WHO/UNDCP) involving three rapidly changing countries-Thailand, Philippines and Vietnam, revealed that the young people as early as 10 or below are vulnerable to substance use. Statistics showed that first use of either cigarette, beer, wine and cannabis are first started by the age group of <10-12 years old. Among these counties, the Philippines has the greatest number of young people initiating illicit substances at an earlier age and engage in a wider variety of substances compared to Thailand and Vietnam accounting to around 2.3% to 7 % in the use of cannabis, heroin, cocaine, ecstasy and injections (WHO/UNDCP, 2003). Furthermore, in a research study conducted by the Dangerous Drugs Board of the Philippines, the age group of 10-19 with 469,749 users in 2008 is considered as most vulnerable to drug abuse. Initiation of drug use as early as 8 to 9 years old is recorded highest in the Regions X, VII and National Capital Region (Balmes,2008).

Consequences of Substance Abuse

Substance abuse consequences include developing serious mental and physical illnesses such as respiratory complications, depression and HIV/AIDS; involvement in illegal activities such as driving under the influence of alcohol, selling illicit drugs, crimes; broken families and social relationships and even loss of career (WHO, 2013). Psychotic symptoms also emerge especially with the use of Cannabis (Chen & Lin, 2009) while memory and cognitive problems occur in people using methylenedioxymethamphetamine (MDMA). In the 2008 Report from UNODC/UNAIDS, it is estimated that out of 11-21.2 million people injecting drugs, approximately 4 million may be living with HIV/AIDS.

Among the illicit drug users, only very few are reported and very few received the treatments. Globally, only around 12% to 30% received treatment in 2008 which is translated that between 11 and 33.5 million problem drug users did not receive their needed treatment.

There is an increasing number of individuals needing treatment for illicit drug use regardless whether a need for one is perceived or not. In the 2011 report by NSDUH, 19.3 million persons aging 12 years and older needed treatment but did not receive any. For multiple drug users, very few received treatment for both drugs and alcohol use and almost half of this group reported that they have used their own resources to receive the recent specialty treatments. In the Philippines, there is no officially identified national epidemiological data collection system for alcohol and drugs (WHO, 2010). However, it is estimated that 62.5% of all cases received treatment from the public sector with out-of-pocket payment as the most significant financing method.

This creates a big concern and question especially to the marginalized members of society-the poor, the jobless, the less educated and the unreported cases. Considering the challenges of treating substance use disorders-high relapse rates, lack of treatment resources, and social stigma: there is a need to halt the growth of substance abuse through promotive and preventive efforts especially among children and adolescents.

The previous paragraphs present a number of significant information that substance abuse is 1) a serious global concern and burden: 2) bringing detrimental consequences to different sectors of society-the individual, family and community: 3) prevalent across age groups ; 4) increasing in rate even among young children: and 5) facing great challenges in treatment and rehabilitation. Unless something is done to halt the increasing rate of substance abuse, society will continue to face its consequences at a greater gravity and because treatment and rehabilitation are difficult, promotive and preventive efforts are crucial. In the previous sections, initiation of illicit drugs mostly begins at the adolescent stage, that is between 10 and 19 years old (WHO, 2013). Hence, preventive and promotive efforts can be best targeted to younger school-aged children.

The School-Aged Children

The primary goal of illness prevention and health promotion is to change behavior-broadly defined as action, emotion and cognition. An interesting age group that is very amenable to the change in behavior is middle childhood or the school-aged children (Lester et al., 2006). Famous theorists, Freud and Piaget consider this stage as the plateau in development, or the time when children consolidate the gains they had during the rapid growth of the preschool and when preparing for adolescence (Eccles, 1999). The middle childhood stage is characterized by the following 1) the ability to identify and articulate ones emotions

and of others 2) acquisition of self-competence 3) the ability to reason and make sense of the world and 4) intense interest in moral issues (Charlesworthet al., 2007).

A child's ability to express emotions and be sensitive to others is collectively termed as 'emotional intelligence'. It is the ability to motivate oneself and persist in the face of frustrations, to control impulse and delay gratification, to regulate one's moods and keep distress from swamping the ability to think, to empathize and, to hope (Goleman, 2006). An interesting activity for children called the marshmallow test can be viewed in you tube (https://www.youtube.com/watch?v=QX_oy9614HQ). This is where several kids wrestle waiting to eat a marshmallow for another one, a simple test on self-control and delaying of gratification.

The acquisition of self-competence is a recognized developmental task in this stage. This is referred to by Erik Erikson (1963) as the stage of Industry vs Inferiority where a child seeks for opportunities to exhibit individual skills, abilities, talents and achievements. A middle child's experiences at this stage may delay a child's attempts to attain self-mastery. The family, the school and the community play a major role in helping children attain a growing sense of self-competence by providing opportunities to both fail and succeed along with sincere feedback and support. Acquiring this serves as a protective factor during adolescents and early adulthood.

During this period, children develop thinking and conceptual skills and advances in learning and understanding. Awareness skills also dramatically develop in middle childhood. As the child is exposed to the school and community, one gains an awareness of culture, gain more information in problem solving, and takes the perspectives of others. Through understanding others and learning from the environment, children build their capacity to reason.

Another very important milestone in the middle childhood stage is moral development enhanced by direct teaching and inclusion of moral values such as kindness, respect, honesty. In elementary school setting, children are at higher risk of bullying than that in high school or college (Astor et al. & Meyer, 2004). In moral development, the family, school, peers and the greater community play a major role in shaping a child's unique values and goals.

Children from 6 to 11 years begin to experience dramatic changes in social participation beyond their own families. The family, peers, social and educational environment help shape a child's moral, cognitive, and emotional developments. Being able to achieve a sense of competence, to define and

articulate ones emotions, to provide sound reasoning in the common sense of the word, and to assimilate expected community values are essential elements to successfully overcome adversities and maintain positive mental and social health outcomes.

However, the current society bombards the child with challenges that are threatening to one's psychological well-being. Growing in poverty, experiencing abuse and neglect, exposure to substance abuse and parental psychopathology (Lester et al., 2006) all put a child to a greater risk of long-term psychological dysfunctions. Though many children in these circumstances end up with long-term problems as adults, many are still able to overcome adversities and grow into well-functioning adults. This has been an intriguing phenomenon to researchers-a question on why is it that some children growing up in adverse circumstances still attain positive psychological outcomes? To answer this question, researchers had been exploring since 1970 the individual and contextual influences that protect the child at risk from later negative outcomes, a term they refer to as 'resilience'.

In the recent years, there has been a shift of research and practice from a deficit-based approach related to maladaptive functioning and psychopathology to the approach that highlights strengths and resources to improve adaptive functioning so as to attain positive outcomes. This strength-based approach has led to the exploration of the concept 'resilience'.

Resilience

The World Health Organization has referred to 'resilience' as one of the aspects that can promote positive mental health and prevent substance abuse (WHO, 2004). Evidences from research have shown that this is a major protective factor significantly related to later substance abuse (Meschke & Patterson, 2003). In a study conducted among 173 adolescents, 11 to 18 years of age in a foster care in Lithuania, it was found out that a stronger general resilience is negatively correlated ($r=-.191$, $p < .05$) with a lower frequency of tobacco, alcohol and drug use (Isganaityte & Cepukiene, 2012). In another research study supported by the National Institute on Alcohol Abuse and Alcoholism, Tanja, Alim and colleagues also referred to resilience as crucial to the prevention of substance abuse (Alimet al., 2012). In their study, the development of addiction and its chronic, relapsing nature is due to acute and chronic stress-related mechanisms and can be managed through enhancing individual resilience and coping responses.

The term 'resilience' had its origins from early literature in psychiatry to examine children who appeared to be "invulnerable" to difficult life situations. Over

time, the word invulnerable has been replaced by the word 'resilience' and a new field of research was born (Ramirez, 2007). The origin of research on resilience is deeply rooted in the history of medicine, education and psychology. It was in the year 1970 when resilience research emerged under the context of developmental psychology or the study of behavior and adaptation using a developmental perspective (Lester, et al., 2006). To date, various definitions and research perspectives on resilience have emerged ranging from biological or neurological explanations to behavioral and psychosocial viewpoints.

The concept of resilience has received numerous definitions from scientists and other disciplines. It is understood as positive adaptation or the ability to maintain or regain mental health, despite adversity (Hermann et al., 2011). Cicchetti (2010) has expanded the definition covering 'protective and vulnerability' forces at multiple levels of influence-culture, family and the individual. Another definition is by Brooks (2006), that is, being able to lead a more successful life than expected despite being at a greater risk than the average for serious problems.

Aside from various definitions, there is also confusion about the conceptualization of resilience as a trait vs. a dynamic process (Luharet al., 2000). Rooting from the literatures of Block and Block (1980), the term ego-resiliency came out. This refers to a group of traits that show general sturdiness and resourcefulness of character. Thus, the terms "ego-resiliency" and "resilience" differ for two reasons. First, ego-resiliency is a trait while resilience is a dynamic process; and second, ego-resiliency does not imply exposure to adversity while resilience does.

Behavior problems as a resilience factor for later substance-use disorders

In a research review conducted by Walsh and colleagues (2010), it was presented that indicators of resilience in childhood functioning fall around three main categories behavioral and emotional competence, social competence, and academic achievement. Among these, behavior and emotional competence is mostly associated with the development of later substance abuse. In several research studies, resilience in children had been assessed through the extent of behavior problems (Herrmanet al., 2011). In rural Australia, the resilience of a Mcommunity of children and adolescents (5-16 years old) was assessed using the Strengths and Difficulties Questionnaire (SDQ), a screening tool composed of five scales: emotional symptoms, conduct problems, hyperactivity/inattention, peer relationship problems and prosocial behavior which are designed to detect emotional and behavioral problems as

well as social functioning as rated by their parents and teachers (Dunstan & Todd, 2012). In another study by Bell and colleagues, behavioral resilience was assessed among 531 5-9 year olds living in the out-of-home care in Canada using the same questionnaire, the SDQ to assess conduct and emotional problems and prosocial behavior.

Resilience was also assessed in a study aiming to explore factors that differentiate children with poor adjustment from those with resilience. Resilience among 219 children in families exposed to intimate partner violence were assessed by measuring the child's emotional and behavioral problems within two broad categories, internalizing and externalizing behaviors, using the Child Behavior Checklist (CBCL) (Achenback & Edlebrock, 1993). The same measurement was used for resilience in a longitudinal study by Criss and colleagues (2002) involving 585 families with 5-year-old children followed up until grade 2. Their internalizing and externalizing behaviors were assessed by their teachers at 2nd grade using CBCL. Given these studies, behavior problem as a correlate of resilience among school-aged children will be the focus of this paper and will be explored further.

Behavior problems represent a key developmental outcome and serves as a strong predictor of future adjustment (Guttmannova, K., 2007). Majority of child researchers have classified behavior problems as either internalizing or externalizing manifestations of behavior. Internalizing behavior is characterized by an over control of emotions usually directed to self and includes social withdrawal, feelings of worthlessness or inferiority and dependency. Externalizing behavior, on the other hand, is characterized by an under control of emotions directed to others including difficulties in relating with others, rule breaking, irritability and belligerence (Achenbach & Edelbroc, 1978; Joshi & Sachdev, 2000).

Factors Influencing Behavior and emotional competence in Children

Research has consistently linked several factors to behavior and emotional problems in children and can be grouped into a) Individual b) Family and c) Community factors. Individual factors include age, gender, ethnicity or race, temperament, and academic performance or cognitive capacity. Family factors include prenatal exposure to alcohol and cocaine, marital conflict, ineffective parenting, maternal psychopathology and distress and experience of abuse, poor parent or mother-child interaction such as punitive or too caring rearing patterns, exposure to violence, history of familial neglect and institutional rearing, and the experience of abuse. Community factors

reflected in research studies include peers, child care quality outside the immediate family, and economic disadvantage.

Individual factors

Individual factors studied in relation to behavior problems in children include age, gender, race or ethnicity, temperament, and academic performance or cognitive capacity. In middle childhood, males have higher levels of behavior problems compared to females as seen in many researches (Bennett, D. et al., 2007; Dubois-Comtoiset al., 2013; Sod., B et al., 2001). In a longitudinal study involving 243 French-speaking mother-child dyads it was found out that male gender is a predictor of externalizing and internalizing behavior problems with a standard canonical discriminant function coefficient of .26, r=0.27, $p < 0.01$ for externalizing problems (Dubois-Comtoiset al., 2013). This is supported by another longitudinal study involving 517 kindergarten to grade 2 students who are part of 585 families being studied. Results showed that males are more prone to developing externalizing behavior problems though the relationship is weak (r= .19, $p < .001$). However, two studies reviewed did not show the same results. Separate studies by Spratt (2012) and McFarlane (2003) presented that children do not significantly differ in internalizing and externalizing behavior problems when classified according to gender. Spratt and colleagues studied 3 to 10-year-old children with and without a history of familial neglect and those who experienced institutional rearing. Results showed that their behaviors do not significantly differ according to gender. Similarly, McFarlane and colleagues involved the mothers in assessing their children's (18 months to 18 years) behaviors. Differences in the findings of these studies could be due to the type of research method, longitudinal studies tend to reveal significance in gender while cross-sectional researches showed otherwise.

Gender, however, is not a stand-alone factor in most studies. Male children exposed to prenatal alcohol and cocaine (Sod et al., 2001), those with abused mothers (McFarlane, et al., 2003), have experienced poor mother-child interaction and ambivalent attachment patterns (Dubois-Comtoiset al., 2013) are at highest risk of developing behavior problems. It appears also that males who receive quality child care are given more protection against the development of behavior problems than girls (Votruba-Drzalet al., 2010). Gender is also associated with other factors related to behavior problems such as peer acceptance, harsh discipline, and friend's aggression (Bell et al., 2013).

Race as a factor showed varied results. In two of the studies review race did not have any relationship with

behavior problems in children (McFarlane et al., 2003; Spratt et al., 2012). However, in a study involving 531 5-9 year olds from out-of-home care, ethnicity is correlated with externalizing behavior problems, although the relationship is weak (r=.19, p <.001) as well as with harsh discipline, ecological disadvantage and peer acceptance (Bell et al., 2013). Similarly, a high protection against the development of behavior problems can be observed in African American children than for Hispanic, White or other children (coefficient= 3.13, p <.05). On the other hand, children with difficult temperament (r=.10, p <.05) is correlated with the development of externalizing behavior (Crisset al., 2002; Martel et al., 2009). In another study by Martel and colleagues (2009), it was found out that poor reactive control or poor temperament leads to a disruptive behavior (r = -.43, p <.01) in children and eventually later substance abuse. A child's cognitive capacity as reflected in academic performance is negatively correlated with behavior problems in school aged children (Bell et al., 2013; Kim et al., 2013) with r= -13, p <.01 and r= -0.253, p <.05, respectively. The better a child performs in school, the lesser are the manifestations of behavior problems. It can be noted; however, that the statistical relationships found were weak.

Family Factors

A huge body of research studies had pointed to the significance of parenting and family relationships in the manifestation of behavior problems in children. Prenatal exposure to alcohol and cocaine, marital conflict, ineffective parenting, maternal psychopathology and distress and experience of abuse, exposure to violence, history of familial neglect and institutional rearing, and the experience of abuse in the family were among the factors identified.

Children who are exposed prenatally to alcohol regardless of quantity of intake have significantly higher odds by 3.2 of having delinquent behavior with a variance of 0.6%-1.7%. This is a study of 506 parent-child dyads involving women who reported alcohol consumption of at least 0.5 oz per day whose children were assessed at 6-7 years of age (Soodet al., 2001). Similar results were found among 10.5 year olds who were prenatally exposed to cocaine but this time there was an interaction between exposure and gender. Cocaine exposed males had higher behavior problems than females [F (1,142) = 4.05, p<.05)].

Many studies also showed the important role of maternal factors in the emergence of behavior problems in children. In a meta-analysis including 134 studies with children showed that mental health problems in mothers such as depression were significantly associated

with both externalizing and internalizing problems even psychopathology in children (Connell and Goodman, 2002). This is confirmed by a study conducted by Comtois and colleagues (2013) involving dyads of mother and child whereby results showed that maternal psychosocial distress such as depression actually predicted the presence of externalizing (discriminant function coefficient= 0.55, r = .58, p <0.01) and internalizing behavior problems (discriminant function coefficient = 0.65, r = .58, p <0.01) above clinical cut-off levels. In another study, maternal psychopathology also came out one as the most significant predictor of adverse behavior outcomes in children, accounting for 13.0% to 29.1% variance of the overall symptom scores (Sood, et al., 2001). Children whose mothers were victims of abuse, specifically, intimate partner violence also had a remarkably higher behavior problem than those whose mothers did not (McFarlane et al., 2003). This result is from a study conducted among 330 Black, White and Hispanic children who were exposed and not exposed to intimate partner violence.

Other than maternal factors, parent-child relationship as characterized by controlling attachment patterns either punitive or caregiving type can also predict membership in both child internalizing and externalizing clinical problem groups. Children who were controlled by punishment showed more aggressive and delinquent behaviors as well as symptoms of anxiety and depression while those who experienced control in a caregiving pattern showed greater symptoms of simple phobia and more thoughts of suicide that their secure peers. The quality of mother-child interactions was significant too (coeff =-.05, r =-.39, p <0.01). In this study, mothers with higher stress or depression levels showed a strained interaction and a lack of mutual pleasure. Given such an unsatisfactory parental behavior, the child learns that he cannot rely on the parent for help in regulating their internal emotional states and adapt to stressful situations leading to the development of internalizing and externalizing behavior problems (Dubois-Comtoiset al., 2013; Crisset al., 2002).

In relation to parenting is a similar issue on family neglect. Research supports that positive family atmosphere is related to low levels of behavior problems in children. Those who have experienced neglect-physical, medical, emotional neglect or abuse, have higher levels of behavior problems as well as symptoms of cognitive and language deficits. Neglect is a strong predictor of behavior problems, in a study involving 3 to 10 year olds, a high variance of 41% and 49% for internalizing and externalizing behavior problems, respectively can be accounted for from the experience of neglect in the family or a care-giving

relative (Graham-Bermannet al., 2009). This is supported by a retrospective study of inmates with substance abuse who had experienced neglect such as being left alone and psychological maltreatments during their childhood (Cuomo et al., 2008).

Community Factors

Peer acceptance which include companionship, and having a sense of connection to the bigger group is negatively correlated ($r = -.42$, $p < .001$) with behavior problems in children. A similar concept to peer acceptance is friendship consisting of intimacy, and trust and support which is also negatively correlated ($r = -.21$, $p < .001$) the development of behavior problems as well (Crisset al., 2002). As to the relationship between the quality of child care given outside their homes and behavior problems, a study was conducted on 2,400 low-income children from age 0 to 14, it was found out that good quality care was linked to significant reductions in externalizing behavior ($r = 2.16$, $p < .050$) among children (Votruba-Drzalet al., 2010). While economic status of the family of school-aged children with atopic dermatitis has a negative weak relationship to both internalizing and externalizing behavior problems with $r = -.391$, $p < 0.05$ and $r = -.253$, $p < 0.01$, respectively (Kim &J Jin Im, 2013; Crisset al., 2002).

Summary

The previous paragraphs showed the state of knowledge related to substance abuse which is especially affecting school-aged children, resilience and the individual, family, and community factors influencing resilience. It is recommended that research efforts be directed not only in the treatment of substance use disorders but also on the prevention of early initiation of illicit substances especially in children. This will reduce the cost of treatment and minimize the serious individual and social consequences of substance use.

Consistent with the WHO's recommendation, school-aged children who are vulnerable members of the population because of their age and developmental stage, can be protected from developing later substance use disorders through strengthening their' resilience' against adversity. Among the different indicators of resilience, it is behavioral and emotional competency that has the most significant influence in later substance use disorders. Thus, behavior problems exhibited early in childhood cannot be neglected. Early identification and awareness of factors that influence behavior problems and resilience in children may prevent the development of later substance use disorders. Among the factors that have shown significant influence to resilience and behavior problems in children include

gender, temperament, poverty, maternal psychopathology, and family relationships. Although these factors mostly showed weak relationships, these could provide insights in strengthening resilience among children. More research, preferably by local geographical region considering differences in culture and social context, is needed in order to strengthen evidence to support these findings which may be helpful in creating future programs to prevent early illicit substance use among children.

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Example of Research Article

Roles of Travel Incentives on Employee Motivation and Performance

Dr. Nucharee Supatn[1]

[1] Assistant Professor of Department of Management, Martin de Tours School of Management and Economics, Assumption University

Abstract

Travel incentive is a type of the organizational reward that includes individual business meeting, group travel to offsite business meetings, as well as the travel and tours to any places outside the office. The influences of three factors related to travel incentives i.e. destination image, need for travel, and self-congruity on employees' perceived value on the travel incentives, their work motivation, as well as their job performance were tested in this research. Questionnaire survey was conducted. The 418 sets of data were collected from the employees of the firms located in central business districts. The structural equation modeling was performed to determine the relationships among major constructs. The results indicated that destination image influenced perceived value and job performance. Need for travel influenced both work motivation and performance of the employees. Self-congruity influenced perceived value and work motivation. Perceived value could influence work motivation. Finally, work motivation was found to influence job performance of the employees.

Keywords : Perceived Value, Destination Image, Need for Travel, Work Motivation, Job Performance

Example of Academic Article

An Integrative Literature Review of Global Nursing Ethics

Yoshimi Suzuki[1], Rie Sayama[1]

[1]Faculty of Nursing, Toho University

Abstract

Objectives : The purpose of the integrative literature review is to investigate the literature concerning GNE from the viewpoint of the kind of literature, the countries where the primary authors live, and the major topics related to ethics. We then will generalize on the present condition of GNE. **Method :** Our review was based on the methodology of Cooper's integrative review. We searched the literature of the last ten years using the Pubmed database, CHINAL, and Japana Centra Revuo Medicina. 86 literatures that met our criteria were analyzed. **Findings :** (1) 53 out of the 86 literatures contained "Information". (2) Regarding where the primary authors live, 42 live in the United States, 11 in the United Kingdom, and seven in Canada. (3) The numbers of major topics reviewed were : 1) Nursing ethics between each country, (a) 21 ethical issues related to immigration of nurses, (b) ten related to global nursing cooperation, (c) seven regarding comparison of nursing ethics between countries; 2) nursing ethics on a global scale, (a) 12 related to interpretation and use of global code of ethics for nurses, (b) 11 related to ethical consideration in global nursing research. **Implication :** (1) This research indicates that the knowledge of GNE has been spreading. Although the importance of GNE has been recognized, future research may be required. (2) The top three authors are from English speaking countries indicating that geographical bias exists in the countries that deal with GNE. (3) GNE depends on the context, so, it is necessary to pay attention to where and how they are used.

Keywords : Global, International, Nursing, Ethics, Literature Review

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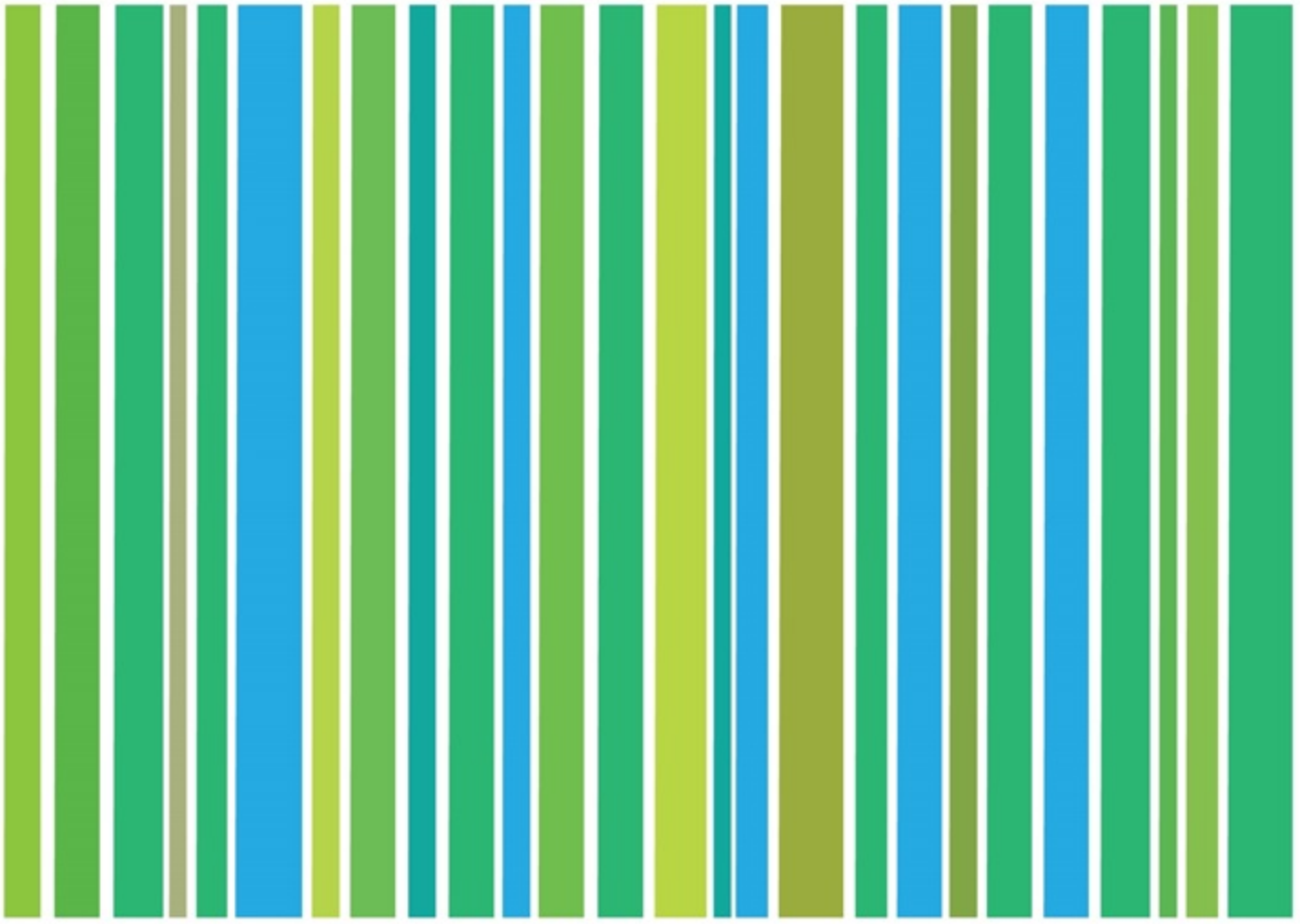

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