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Attitude to Health in Healthy and Chronically Ill Adolescents Attending Urban Schools

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Abstract: Among public health indicators are now man's relation to health is considered as an important social and psychological characteristics. To determine the attitude to health in healthy and chronically ill adolescents in urban schools in southern Russia. Questionnaire related to the health of R.A. Berezovskaya, MHLC, self-reported health. attitude to health among the chronically ill and healthy adolescents has more similarities than differences. In general, teenagers demonstrate socially desirable patterns of responses: value, responsible attitude to health, the importance of a healthy lifestyle. Chronically ill adolescents Brings in answers and your life experience. They are less sure of the functional value of health have more doubts about the importance of proper nutrition, etc. In addition, they feel a certain ought to actively engage in their own health and are more interested in learning about health. They are characterized by lower but much more realistic self-assessment of health. Adolescents of both groups evince a certain mistrust of the health care system. Those and others observed a significant correlation between the value-motivational and cognitive components as well as between the emotional and behavioral components of attitudes towards health. Estimates on the emotional and behavioral components, focused on the life experience of adolescents are significantly lower and approximately the same in both groups. The findings may help improve the effectiveness of health education which should be built taking into account the life experiences of students with the active involvement of the affective sphere, promoting the internalization of the value of health.

Key words: Health, students, chronically ill teens, nutrition, Russia

INTRODUCTION

Health of the younger generation is an asset for any social system because It reflects the potential prosperity of the nation and the state in the future. For modern Russia, this issue is of particular relevance, since in recent years in all regions of the country marked deterioration in the health of adolescents, increasing the share of chronic diseases Baranov *et al.* (2014). A similar trend was also observed in the United States Halfon and Newacheck (2010). These facts determine the significant public attention not only to the problems of pediatrics but also to health education issues. As the Russian sociologist I.V. Zhuravlev, modern social in the field of health policy in Russia includes not only a passive state is concerned about the health of children and adolescents but also the formation of their active and responsible attitude to their own health and the health of others for further inclusion in the social policies as equal partners of the state Zhuravlev (2012). In this regard, the number of health indicators alongside traditional demographic, medical conditions and began to include such socio-psychological characteristics such as quality of life, health-related, self-preservation behavior, attitude to health and others Medic and Osipov (2008). Categorized "attitude" has a long history of development in the Russian science. Originally it was developed VN Myasishchev within psychology and meant the inner side of human relationships with reality. In the 1980s, the DN Loranskaya introduced in the scientific literature the term "health-related", most often defined as a system of individual, electoral identity ties with the various phenomena of reality, contributing to or, conversely, threaten human health and self-esteem of their individual physical and mental states Berezovskaya (2011). Currently, Russia is a concept widely used in psychological, sociological, socio-medical and educational research Zhuravleva (2012b, 2002). R.A. Berezovskaya has proposed a four-model relation to health, including the value-motivational, cognitive, emotional and behavioral components. Value-motivational component is seen as a link between the cognitive and

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behavioral components of attitudes towards health. The trend of positive development related to health implies a gradual shift from neutral to external emotional and internal relations, when not so much a growing awareness in the field of health, how much is transformed personal sense of health and need to be updated in its preservation and maintenance Berezovskaya (2011). Attitude to health is a dynamic entity. In children and adolescents it is formed in the course of directed socialization of children, ie while in the field of health education and spontaneously, under the influence of environmental micro and macro environment, personal characteristics and human health. In turn, how it is formed attitude to health, it depends on the orientation of health-related behavior (Menshe, 2010).

Thus, the study of the relationship to health is an urgent problem which is currently far from complete. In this context, the purpose of our empirical research was to investigate the characteristics of the relationship to health in healthy and chronically ill adolescents in urban schools in southern Russia.

MATERIALS AND METHODS

Participants: The study involved 60 teenagers, students in urban schools of the Rostov region (Russia) aged 14-15 years (23 boys and 37 girls). The survey was conducted with the consent of the teenagers and their parents. The first group included 30 adolescents with a chronic physical illness (11 boys and 19 girls) (HIA). The disease in all cases recorded by health professionals for >2 years. All adolescents were observed in specialized professionals. 17 teenagers suffer from diseases of the gastrointestinal tract, 13 - asthma. The second group consisted of 30 healthy children (12 boys and 18 girls) (HA). Their lack of chronic diseases is confirmed by data from the medical records.

Instruments: The study used three methods. The questionnaire "Attitudes to Health" (HAQ) developed by Russian scientists, R.A. Bereza based on the four-model attitude to health Berezovskaya (2011). It consists of nine questions, each of which is available from 4 to 10 answer choices. The subjects were asked to evaluate each answer on a 7-point Likert scale. Questions are grouped into scale, reflecting, respectively, the value-motivational, cognitive, emotional and behavioral components related to health. The author recommends that analysis of both the components and the responses to individual questions. Questionnaire "health locus of control" (MHLC) developed K.A. Wallston used a modification Greenberg. Questionnaire to determine the general perception of a person the degree of control over their health and includes three scales: the first scale defines an internal locus of control and the second and third scales assess external locus of control: control by the "powerful others" such as doctors and oversight side of the case, good luck. Performance is measured based on a 5-point Likert scale. There are low, medium and high levels of expression for each scale control. Higher on one of the scales indicate the dominance of a particular health locus of control.

Self-assessment of health was carried out using the technique T. Dembo, S. Ya. Rubinstein in the modification AM Parishioners (SRH). Teenagers form issued with the image of a line of 100 mm in height, in which the upper and lower points marked notable features and scale of the middle a barely perceptible point (tripolar scale). Subjects were asked to rate their state of health, given that the lowest point corresponds to the worst health status and the top very good. Statistical analysis was performed using the statistics (data analysis software system), version 10.0 for Windows, StatSoft, Inc. Differences in the level of expression of a characteristic determined by U-Mann-Whitney test. Correlations were determined using Spearman's rank correlation coefficient. Differences were considered statistically significant at $p<0.05$.

RESULTS AND DISCUSSION

Value-motivational component of attitude to health: The results of evaluation of value-motivational component relation to health are presented in Table 1. The medians and quartiles of the component as a whole are, respectively MdHIA = 127 (113.8-137), MdHA = 121 (110.8-133.3) ($p>0.05$). Notes: hereinafter in Table 2-5 Significant differences are marked with "*" ($p<0.05$) 1.1-1.7: happy family life; financial well-being; the existence of true friends; health; an interesting study; recognition and respect of others; independence (freedom). 2.1-2.7: a good education; financial security; capacity; luck; health; perseverance and hard work; support, the help of friends and acquaintances. 8.1-8.9: this is not necessary as I'm healthy; I do not have enough willpower; no time; no company (one boring); I do not want myself in anything limit; I do not know that for this to be done; no conditions; requires large financial costs; there are more important things to do. Teens in both groups assessed health as one of the most important terminal values along with a happy life in the family. Among the functional (instrumental) life values of the two groups isolated in the first place a good education and hard work. Adolescent

Table 1: Descriptive statistics on the results of the procedure HAQ (value-motivational component) in adolescents withchronic physical illness (HIA) and in healthy adolescents (HA) (points) (Question 1. People have different opinions different spheres of life. Assess how much given values are important to you at this moment)

Variables	1.1	1.2	1.3	1.4	1.5	1.6	1.7
HIA							
Md	7	6	6.5	7	6	6	6
Q_1-Q_3	6-7	5-6	6-7	6-7	4-7	5-6	4-7
HA							
Md	7	6	7	7	6	6	6
Q_1-Q_3	6-7	5.8-6	6-7	6-7	5.8-7	5-6.3	5-7

Table 2: Question 2. Do you think that you need to succeed in life?

Variables	2.1	2.2	2.3	2.4	2.5	2.6	2.7
HIA							
Md	6	6	5.5	5.5	5.5*	7	5
Q_1-Q_3	6-7	4-6	4.8-7	4-6	3.8-7	5.5-7	5-5.3
HA							
Md	7	6	7	6	7*	7	5
Q_1-Q_3	6-7	5-6.3	5.8-7	5-6	5-7	6-7	5-6

Table 3: Question 8. If you take care of your health is not enough, why not?

Variables	8.1	8.2	8.3	8.4	8.5	8.6	8.7	8.8	8.9
HIA									
Md	5	6	6*	5*	5*	5*	5	5*	4*
Q_1-Q_3	4-5	4-6	4.8-6	3-7	3-6	2.8-5	2-5	3-6	3-5.5
HA									
Md	4	4.5	5*	3.5*	4*	3*	3	3*	3*
Q_1-Q_3	2.8-5	3-6	4-6	2.3-5	2-5	1-5	2-5	2-5	2-5

Health in the number of such priorities include values and health. Among chronically ill teens functional (instrumental) estimated the value of health is significantly lower. Motivational component in HAQ questionnaire related to health is investigated for the reasons explained by insufficient or irregular actions of health maintenance. Such motives are more pronounced in chronically ill adolescents. The level of their assessments in six of nine cases is significantly higher. Ranking motives frequency consent to them, given the scores from 5 to 7 points ("rather agree"-"totally agree"), for the chronically ill adolescents is as follows: there is no time (76.7%), it is not necessary, do not know what do need financial costs (66.7%); I do not have enough willpower (60%); I do not want to limit yourself to no more than (56.7%); no company, no suitable conditions (53.3%); there are more important things to do (30%). In healthy adolescents ranking different motives: there is no time (66.7); I do not have enough willpower (50%); not necessary need financial costs (43.3%); no suitable conditions (40%); no company (36.7%); I do not want to limit yourself in anything, there are more important things to do (33.3%); I do not know what to do (26.7%) (Table 2 and 3).

The cognitive component of attitude to health: Cognitive component was assessed in all three methods used in the study. Table 4 shows the self-assessment of health outcomes and indicators on health locus of control. A high level of HLC for all three scales = 23-30 points; average HLC = 15-22 points; low level of HLC = 6-14 points. Chronically ill adolescents rate their health significantly higher compared with healthy peers. All of the surveyed teenagers internal locus of health control dominates the control by powerful others or the case will, although the overall figures for all three scales are within the boundaries of the middle level, ie reflect the "control from time to time." Table 4 shows the performance evaluation of the cognitive component of the HAQ procedure. The medians and quartiles cognitive component as a whole are, respectively MdHIA = 69.5 (62.8-77), MdHA = 67.5 (61-73) ($p>0.05$). Note: 3.1-3.7: quality of care; ecological situation; learning; feeding habits; bad habits; Lifestyle; lack of concern for their health. 4.1-4.5: television and radio; doctors; newspapers and magazines; friends and acquaintances; non-fiction books about health. As chronically ill teens and their healthy peers are mostly evaluated positively influence all proposed health factors. Preference is given to the two groups affected by lifestyle and lack of concern for their health. Healthy teens appreciated significantly higher impact on their health eating habits and bad habits. The relatively lower scores in both groups received such factors as learning and quality of care. Chronically ill teenagers appreciated significantly higher impact on their awareness of the health doctors, television, theme of popular science books, magazines and newspapers. No significant differences between the groups are not only seen on the influence of friends and acquaintances (Table 5 and 6).

The emotional component of attitudes towards health: Evaluation results HAQ emotional component shown in Table 4. The medians and quartiles emotional component as a whole are, respectively MdHIA = 61 (55-72.8), MdHA = 61.5 (51.5-75.3) ($p> 0.05$). Note: 5.1-5.10: calm;

Table 4: Descriptive statistics on Self-Rated Health (SRH) and Health Locus of Control (MHLC) in adolescents with Chronic Physical Illness (HIA) and in Healthy Adolescents (HA)

		Health Locus of Control (MHLC) (points) *		
Variables	SRH (%)	Internal LC	Control moguschest. other	Control the case will
HIA				
Md	66*	21	9	7.5
Q_1-Q_3	50-75	18.75-23	7-12.25	6-9
HA				
Md	77.5*	21.5	8	16
Q_1-Q_3	69.25-90	19-24	5-10.25	13.75-19.25

Table 5: Descriptive statistics for HAQ procedure results (cognitive component) in adolescents with chronic physical illness (HIA) and in healthy adolescents (the HA) (scores) Question 3. What do you think, which of the following factors have the most significant impact on your health?

Variables	3.1	3.2	3.3	3.4	3.5	3.6	3.7
HIA							
Md	5	6	5	6*	5.5*	6	6
Q_1-Q_3	4-6.3	5-6	3-6	5-6	4.5-6	5-7	5-7
HA							
Md	6	6	5	6*	6*	7	6
Q_1-Q_3	4.8-7	5.8-7	4-6	5.8-7	5.8-7	6-7	6-7

Table 6: Question 4. Evaluate the impact on your health in the field of awareness provides the information obtained from the following sources

Variables	4.1	4.2	4.3	4.4	4.5
HIA					
Md	6*	7*	5*	5	6*
Q_1-Q_3	5-7	5-7	4-6	5-5.3	4.8-6.3
HA					
Md	5*	5*	5*	5	5*
Q_1-Q_3	4-6	5-6.3	4-5	3.8-5	3-6

Table 7: Descriptive statistics on the results of the procedure HAQ (emotional component) in adolescents with chronic physical illness (HIA) and in healthy adolescents (the HA) (scores) (Question 5: How do you feel most when health is not all right?)

Variables	5.1	5.2	5.3	5.4	5.5	5.6	5.7	5.8	5.9	5.10
HIA										
Md	5	2	2	3	2	4	4	3	2.5	2
Q_1-Q_3	2.8-6.3	1-3.3	1-3	1-3	2-5	1-3.3	3-5	1-6	2-5.3	1-4
HA										
Md	4	2	1.5	2	3	2	4	3	3	2
Q_1-Q_3	2-5,3	1-3	1-3	1-3	1-4.3	1-3	2-5	1-5	1-4	1-3.3

Table 8: Question 6: How do you feel most often when you learn about the deterioration of his health?

Variables	6.1	6.2	6.3	6.4	6.5	6.6	6.7	6.8	6.9	6.10
HIA										
Md	3	4	5	4	5	3	3*	3	2*	1
Q_1-Q_3	1-4	4-5	4-5.3	1-5	5-6	2-4.3	2-4.3	2-4.3	1-4.3	1-2
HA										
Md	3	5	5	4	5	3	4.5*	4	3.5*	1.5
Q_1-Q_3	2-4.5	3-5	3-6	1.8-5.3	5-6	2-5.3	2-5	2-5	1-6	1-3.3

satisfied; happy; happily; no danger; indifferent; nothing particularly concerned; self-confidence; He feels free; He feels a sense of inner satisfaction. 6.1 - 6.10: calm; regrets; concerned; He feels a sense of guilt; disappointed; he was afraid; annoyed; depressed; disturbed and very nervous; shame. Emotional attitude towards their well-being is expressed in the two groups is insignificant and has no significant differences between groups. In 66.7% of healthy adolescents and 56.7% of chronically ill adolescents is dominated by the answers to questions ranging from 1 to 4 points ("do not know" "strongly disagree").

The dominant feature, with which a greater or lesser extent respondents agree both subgroups (5-7 points), the answer is "I am calm" (46.7% and 53.3% of healthy chronically ill adolescents). Emotional attitude to manifestations of ill health is expressed to a greater extent. A significant part of adolescents of both groups agreed that their malaise upsets (answers 5-7 points are characteristic for 83.3% of chronic patients and 80% of healthy adolescents). Similarly, 63.3% of chronic patients and 60 healthy adolescents (%) agree that they are concerned in these cases. No statistically significant differences between groups observed that chronically ill adolescents with more confidence deny that they have irritation, anxiety or feelings of nervousness about the ailment (Table 7 and 8).

The behavioral component of attitude to health: Results of evaluation of the behavioral component of attitudes

Table 9: Descriptive statistics for HAQ procedure results (behavioral component) in adolescents with chronic physical illness (HIA) and in healthy adolescents (the HA) (scores) (Question 7: Do you do anything to maintain their health?)

Variables	7.1	7.2	7.3	7.4	7.5	7.6	7.7	7.8.	7.9	7.10
HIA										
Md	5	4	3	3	3	5	3	6.5	6	3
Q_1-Q_3	3-6	3-5	2.8-5	1-3	1.8-6	3-6	1-6	4-7	3-6	1.8-4
HA										
Md	5	4	3	2.5	2.5	5	3	7	4	3
Q_1-Q_3	3-6	2.3-5	2-5	1.8-3	1-4	3-6	1-5	4.3-7	2-6	1-4

Table 10: Question 9. If you feel unwell, then

Variables	9.1	9.2	9.3	9.4
HIA				
Md	3	4	5	5.5
Q_1-Q_3	2-4.3	3-5	5-6	5-7
HA				
Md	3	3	5	5
Q_1-Q_3	1-4	2-5	5-6	5-6

towards health are presented in Table. 5. Median and quartiles of severity of the behavioral component in general are, respectively MdHIA = 65,5 (55-72.8), MdHA = 64 (51.5-75.3) ($p>0.05$). Note: 7.1-7.10: exercise; I eat a diet; I care about sleep and rest; Tempered; I visit a doctor for prophylactic purposes; I watch your weight; I go to the sauna; avoid bad habits; I attend sporting or recreational clubs; practice special wellness system (yoga, shiatsu, etc.). 9.1-9.4: see a doctor; I try not to pay attention; I am treated himself; I turn to relatives or friends. The behavioral component of attitude to health is expressed in both groups are statistically similar. Estimates of the respondents in this case are markedly lower than those for value-motivational and cognitive components. Median estimates in nine cases out of 14 fall into the range of "do not know" ratings "rather disagree" (4-3 points). Most teenagers confidently confirm that they avoid bad habits (only 20% of adolescents from each group to a greater or lesser extent, deny it). If we analyze the expression of confidence consent, i.e., 6-7 points in the answers that the evaluation of concrete actions is more logical, then engaged in exercise only 43.3% of chronic patients and 30% of healthy adolescents; go to sports clubs, respectively 53.3% and 40%; control their weight, respectively 30% and 40%. The remaining proposed to assess the action carried out by teenagers of both groups even more rarely (diet, hardening, sleep and rest).

In case of indisposition adolescents of both groups often seek the advice of a native or treated yourself. So do 83.3% of chronic patients and 80% of healthy children (answers 5-7 points). Chronically ill adolescents are much more likely themselves take measures: 89.1% of them estimated the response in 5-7 points. Healthy teens chose this answer in 66% of cases. Try to ignore the discomfort, only 30% of adolescents in each group. The most rare agreement with the reference to the doctor in 23.3% of chronic patients and 13.3% of healthy adolescents (Table 9 and 10).

Correlation analysis: In the current analysis, we focus on a comparison of significant correlations (rs 0.05 = 0.36; rs0.01 = 0.47), between the observed parameters in chronically ill teens and their healthy peers. In both groups there was a significant correlation between the intensity of the whole value-motivational and cognitive components related to health as described in HAQ (rsHIA = 0.54, $p<0.01$; rsHA = 0.65, $p<0.01$) as well as between the severity of the overall emotional and behavioral components (rsHIA = 0.59, $p<0.01$; rsHA = 0.59, $p<0.01$). In addition, the healthy adolescents was significantly linked their health self-assessment by the method of Dembo-Rubinstein and cognitive component of attitude to health at Berezovskaya (rsHA = 0.40, $p<0.05$). Results of the study show that, in general between the two groups of chronically ill and healthy adolescents in their relation to health there are more similarities than differences. Teenagers appreciate the terminal value of health which was confirmed repeatedly in earlier studies Kabaeva, Sramova. In assessing the value of a functional health Opinion healthy and chronically ill adolescents diverge. In our opinion, the lower estimate of functional value of health of chronically ill adolescents is associated with the fact that they operate not only the assimilation of social assessments but also attract our own experience: they already know that their health and the level of success you can achieve. Indirectly, this interpretation is confirmed by the fact that chronically ill adults evaluated more positively and inadequate levels of health in comparison with healthy people Badia *et al.* (1998).

Analysis of responses to ascertain the motives of insufficient care of their health shows that chronically ill adolescents in this matter much more active. In fact, more than 50% of chronically ill adolescents selected all "exculpatory" motives but motives "there are more important things." In healthy teens this rate only reaches agreement with the motive of "not enough time". In our view, this indicates a higher level of obligation and perhaps guilt, in chronically ill adolescents regarding the care of their health. It is noteworthy that the chronically ill teens tune of "I do not know what to do," appears in almost 70% of cases, ranking in second place ranking, while in healthy adolescents it is on the last place and is about 30%. This may indicate a preceding negative experience of the treatment of their chronic disease which does not lead to recovery in spite of the effort. When

considering the assessment of cognitive health component results attention is drawn to the following facts. The median self-rated health among chronically ill adolescents below 11.5 points in comparison to that of their healthy peers. At first glance, these results are natural. However, according to the authors of SRH techniques, scores above 75 points are considered as high self-esteem. In healthy adolescents such self health found in 50% of cases, ie three times more likely. This suggests that chronically ill adolescents due to ill health experience more realistic in their self-rated health. This conclusion is confirmed by the presence of a significant association between the cognitive component of attitude to health (in fact, the social representations about health) and self-assessment of health is in healthy adolescents When comparing various indicators of cognitive component of attitude to health in both groups there is agreement between the dominance of the internal health locus and high estimates of factors such as a healthy lifestyle and taking care of their health as well as between the lower assessment of control by powerful others (doctors) and the impact on quality of care health (Table 3). In our view, this indicates that the teenagers' knowledge about health sufficiently consistent and consistent. Chronically ill teenagers show great interest in health information. They are less convinced that eating habits affect their health. Given that about 57% of chronically ill adolescents have gastrointestinal disease, it can be assumed that in this case we are again faced with the fact that chronically ill adolescents base their estimates on the experience, while the healthy adolescents are guided by the "book knowledge". We assume that the difference by a factor of bad habits which is listed after the power factor are the differences between for the same reason groups. For ongoing research of particular interest are identified by the correlation between the individual components related to health. In both groups, a fairly strong correlation between the value-motivational and cognitive components of attitude.

These results are consistent with the findings of other researchers that teenagers increasingly operate knowledge about health, lessons from society and declare the value of health (<2010). Our assumption is that the chronically ill adolescents are more likely to turn to their assessments of personal experience, confirmed by the fact that the discussed correlation expressed them to a lesser extent. Emotional attitude of adolescents to health demonstrates the paradoxical pointed to RA in their studies Bereza and many other researchers: people tend to their health for granted until then, until you feel malaise Berezovskaya (2011). This explains the somewhat more pronounced emotional attitude to the deterioration of health in both groups, however, can not say that teenagers are showing considerable emotion: they are to some extent concerned and upset by this. At the same time, the chronically ill adolescents tend to deny that their sickness annoying, disturbing or unnerving. Perhaps this is due to the fact that because of a chronic illness are more likely to experience sickness and more accustomed to this state. However, our earlier studies suggest that perhaps in this case, there are difficulties with the processing of negative emotions Dykhan *et al.* (2015). For a more definitive conclusions it is necessary to conduct additional studies. The behavioral component of attitude to health (such as active steps to maintain it) is expressed in both groups to a lesser extent than the evaluative and cognitive which is consistent with other studies Zhuravlev (2002). It may be noted that in some cases patients are often young people tend to take actions to maintain their health but against the background of this trend can not be considered significant. In cases of sickness adolescents of both groups are more inclined to ask for help from family or help themselves. In this regard, attention is drawn to the fact that in this case, teens evince distrust of the health care system. Score as emotional and behavioral component in the nature of the issues facing the life experience of teenagers. Note that in this case, the correlation between the components in the two groups was virtually identical. Of course, the presence of a pronounced correlation between emotional reactions and behavior points to the fact that the behavior of adolescent health, more compatible with their emotions. This implies that health education should be built on the internalization of the value of health, ie, transfer it from a neutral outside (declared) in an emotionally-intrinsic value which will have an incentive effect and the positive impact on the behavior of adolescents, health-related.

CONCLUSION

Thus, the attitude to health among the chronically ill and healthy adolescents has more similarities than differences. In general, teenagers demonstrate socially desirable patterns of responses: value, responsible attitude to health, the importance of a healthy lifestyle, etc. Chronically ill adolescents brings in answers and your life experience. They are less sure of the functional value of health, greater doubt of the importance of proper nutrition, etc. In addition, they feel a certain ought to actively engage in their own health and are more interested in learning about health. They are characterized by lower but much more realistic self-assessment of health.Adolescents of both groups have a certain distrust of the health care system. Those and others observed a significant correlation between the value-motivational and cognitive components as well as between the emotional and behavioral components of attitudes towards health. Estimates on the emotional and behavioral components, focused on the life experience of adolescents are significantly lower and approximately the same in both

groups. The findings may help improve the effectiveness of health education which should be based on the life experiences of students, with the active involvement of the affective sphere, promoting the internalization of the value of health.

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