

Health Perception and Feeling of Health Efficacy among Deprived Adolescents in Jordan

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Abstract. This paper reports the findings from a study of some adolescents in Jordan, the sample has been selected from Palestinian refugee camps in Jordan, which are considered economically distressed (deprived) social environments. Variables of interest included gender, as well as attitudes toward health and health efficacy feeling. The study sample size was 272 males and 280 females from several Palestinian refugee camps located in Jordan. Results indicate that there are some serious health problems that need a clinical visit, such as: back pain, continuous cough, difficulty in breathing, chest pain, abdominal tumor and obesity as attitudes toward health. The gender factor was affecting these attitudes; males did perceive some health problems which were more serious and required medical attention, than other problems, while females perceived other health problems that are more important and need a clinical visit. The health efficacy feeling of this population is moderate to negative. The overall quality of family life in these areas started to become diminished. The results are discussed in reference to socio-cultural characteristics.

Introduction

The term adolescence denotes a period of transition, accompanied by biological changes, physical growth, changes in bodily proportions, and the attainment of sexual maturity. The changes in adolescent bodies contribute in important ways to social and economic changes from dependence on ones family to a legally and morally sanctioned independence. There are numerous psychological changes as well. These include the progressive maturing of sexual attitudes and behaviors that will ultimately allow adolescents to acquire many social skills that enable them to become well socialized adults. In effect, adolescence for humans is simply a protected form of what in many animals is rather the transition point at which pups or fledglings must leave or are ejected from the nest to make their own way (Spirito *et al*, 1995).

Psychologically and emotionally, adolescence has been considered as a period of great stresses as mentioned by most of psychologists (Maki, 1993). Children and adolescents with illness have to cope with developmental tasks and everyday stressors. In addition to their healthy contemporaries, they have to deal with illness-related stressors. Predominantly, adolescent patients are confronted with restrictive treatment regimens, frequent hospitalizations, painful medical procedures, and social rejections (Boekaerts and Roder, 1999). Adolescent patients with entopic dermatitis have to cope with restrictive diet recommendations and changes in appearance causing stigmatization by healthy peers (Hampel *et al*, 2000b). Similarly, adolescent patients with asthma have to adhere to very strict therapeutic regimens, and to deal with social isolation (Williams, 2000). Adolescent patients with cancer have to cope with painful medical procedures. Due to frequent school absence, children and adolescents with cancer are more isolated than healthy peers; while in remission they have to face the return to school and their social network. Thus, it can be assumed that children and adolescents with these chronic conditions are a high risk of development of psychological maladjustment (Vance and Eiser, 2002).

Previous findings on psychological adjustment among children and adolescents with chronic illness have been contradictory. These inconsistent findings may be primarily due to methodological differences (Boekaerts and Roder, 1999). In sum, there is a growing body of evidence that most children and adolescents with chronic illness are able to adjust to their chronic condition, while a subset of this population was identified with impaired psychosocial functioning. Focusing on children and adolescents with cancer, Sanger and her collaborates (1991) stated that although the prevalence and severity of psychosocial disturbances are controversial, the significant moderating role of coping capacities in children's and adolescents' psychosocial functioning is widely accepted. The majority of research addressing the relationship between coping and psychological adjustment has focused on coping with medical procedures (Spirito *et al*, 1995). However, some studies have been conducted to investigate children and adolescents' coping with illness-related stressors. Compared healthy counterparts as well as those with acute diseases, chronically ill children and adolescents were characterized by low levels of avoidant behavior, self-criticism, and distraction (Spirito *et al*, 1994). In comparison with healthy controls, children with chronic illness (asthma, diabetes, and juvenile rheumatoid arthritis) consistently endorsed more cognitive coping strategies in response to venepuncture (Olson *et al*, 1993).

Research on how chronically ill children cope with common stressors has been widely neglected (Wallander and Varni, 1995), although studies have shown that common stressors such as academic problems predict poor psychological adjustment in children and adolescents with cancer (Kupst *et al.*, 1995). Moreover, Bull and Drotar (1991) found that among children and adolescents with cancer, general life stressors rather than cancer-related stressors contributed mainly to their perceived stress. Derevensky, Tsanos, and Handman (1998) found, when examining mothers' reports, that children with cancer were characterized by more flexible coping with common stressors than healthy controls. In contrast, the study reported by (Olson *et al.*, 1993) failed to ascertain significant differences between chronically ill and healthy controls in

coping with common stressors. In another study, middle and late adolescent patients with diabetes mellitus showed a non-reflective coping style and used their social network less frequently than the healthy peers (Seiffge-Krenke, 1993).

Many adolescents in Jordan are living in poverty especially those who are living in poor areas such as Palestinians Refugee camps. About 25% of children and youth are living below the poverty line (Department of Statistics, 2006). These percentages present an affirmative mandate for an increased research effort aimed at understanding the full spectrum of possible effects of economic disadvantage on families and adolescents of all age groups, including the family effects and human developmental consequences of socialization in an impoverished environment. However the Arab Family can be described as authoritarian with regard to the decision making process, (Smadi, 2002).

An environment of economic deprivation is one in which unemployment is higher and family is facing social isolation, as reflected by a plethora of social supports and social resources, (Al-simadi *et al.*, 2000). Few studies have examined adolescents' attitudes toward illnesses and physicians, and fewer still have utilized some questions for doing so. Previous studies have involved health and illness classroom subjects whose description of their general practitioner coincided with stereotyped media images. In addition, most of the studies have relied on conventional self-reported measures which in adolescence may be susceptible to distortion due to adolescent need for social approval and difficulties expressing negative opinions about authority figures. Projective art drawings were chosen for this study because for many adolescents it is easier to open up grammar or pronunciation and little need for intense eye – contact. Expressing emotions and thoughts on paper provides validation and puts some distance between the doctors, and themselves.

Emphasis was placed on the fact that there isn't right or wrong way to complete the attitudes questionnaire. By using these attitudes scales studies of adolescents and their health and illnesses, many socio-demographic variables have been used to explain these attitudes. Simonian, (1993) mentioned that gender was very effective on these attitudes; he found that females have more satisfaction about their health than male adolescents.

Levenson *et al.*, (1984) have reported in their study that students attributed more importance to their health, showed a better personal health status, expressed more worry about personal health and becoming sick and more concern about being sick, showed more feelings of responsibility for their health, and exhibited less frequent practice of harmful behaviours than adults anticipated that the students would report. Adults differed in their perceptions of the students' reported health status and the frequency of student worry about personal health and being sick.

This paper reports the findings from work aimed at examining further effects of poverty on attitudes of adolescents toward their health. Moreover, the present paper explores issues such as a psychological and physical health of population of Palestinian refugee camp adolescents living in a region identified as being socially isolated and economically deprived.

The importance of the present study stems from the desperate need to explore the psychological status in terms of health perception of adolescents living in a deprived environment in order to provide data-base for organizations involved in under development in such areas. Furthermore, little research interest has been shown in such populations especially as regards in psychological and social studies. For this research, social Isolation was defined as “lack of social support, medical and social services and transportation – and low frequency of opportunity for social inter action. Economic deprivation was defined according to the rate of unemployment, media, family income and educational attainment of the head of the household.

The guiding assumption of the study is that an environment of chronic economic distress and resulting diminished quality of life experience available to those adolescents and the impact of that on their attitudes toward their health.

The present study attempts to answer the following questions:

- 1- What is the level of attitudes toward the health of deprived adolescents in Jordan?
- 2- What is the effect of gender on the attitudes of deprived adolescents towards their health in Jordan?
- 3- What is the level of health efficacy feeling among deprived adolescents in Jordan?

Method

Population

The population consisted of all adolescents in poor and deprived areas such as Palestinian refugee camps in Jordan. The characteristics of the general population of these areas are high rates of unemployment, low level of educational attainment and low median family income. The estimated rate of unemployment was around (25%).

Median family income was estimated at (200) Jordanian Dinars monthly (300\$). the average level of educational attainment of all adults in the regions was 10 years. Demographic data for the camps indicated that these environments are considered to constitute persistent economic deprivation (Department of Statistics, 2006).

Sample

Data was obtained from (280) female and (272) male adolescents selected from (9th) grades students from several Palestinian refugee camps (Azmi, Al-Mofti, Jerash, Wihdat and Bagaah). Sixteen sections of (9th) grade were chosen randomly, and all students in the chosen sections were asked to fill out a written questionnaire that contains the two scales (Problems needing doctor visit, and feelings towards health). (9th) grade students were the focus sample because this age (15 years) most of the physical and psychological changes during adolescence stage.

Instrument

The problems requiring doctor visit Questionnaire. This scale was used to describe the health problems which need a visit to a clinic. Score for each item took 1 or 2, 1 if

this health problem does not need a clinical visit and 2 if this health problem does need a clinical visit, lower scores would indicate a lower need to visit a doctor and higher number would indicate a higher need for a visit to a doctor.

To conduct the validity and reliability of this scale, 3 psychologists examined the scale and appropriate changes were made to satisfy all their remarks, also the internal consistency of this scale, made by using results of the study sample, results showed an alpha value was .82 for this scale. Feeling of health efficacy was measured by using a scale which is designed by the researchers. The item score ranged from (0- 4) requesting the subjects to indicate how much each item applied to them. Scores of 0 indicated that the item did not apply at all; a score of (1) that it applied rarely, a score of (2) that it applied some time, while score (3), indicated to often and (4) indicated to always. Negative items were reversed for scoring, so that lower scores are interpreted as being negative (low feelings of health efficacy) and higher scores are interpreted as being positive (high level of health efficacy feeling). The researchers tested the content validity of this scale through systematic examination in terms of representation of the behaviour domain to be measured and language clarity, the internal consistency of this scale using the study sample, showed an alpha value of .91.

Instructions

After the researchers had chosen the selected sections of the (9th) grade students, they visited each section individually to inform the students about the purpose of the study and to ask for their participation in filling out the questionnaires for the study. Instructions for answering the questionnaires were explained and students were to ensure that their responses were confidential. Questionnaires were completed during the home-room class period and collected by the researchers. Afterwards, the students were debriefed and thanked.

Results

Data were collected from (280) females and (272) males students (average age – 15 years) selected from (9th) grade students from several Palestinian refugee camps. Household and family structure data indicate that more than (80%) of the respondents lived in two-parent families and families averaged (5) children per household.

To answer the first question regarding the health problems which required clinical visit (Health perception), twenty questions were used to assess which problems are more serious and require a visit to the doctor. Findings indicated that most serious health problems were: chest pain (86%), muscle pain (80%), powerlessness (74%), back pain (73%), chronic cough, (71%). difficulty in breath (68%), , abdominal tumour (66%), and obesity (60%), while the problems of insomnia (36%), weight loss (34%), bloody stool (33%), skin rashes (30%), bloody urine (29%), high fever (29%), foot tumour (24), pale face (24%), eyes pain (20%) and headache (16%) were not perceived that a clinical visit needed (See table 1).

Table (1). Frequencies and percentages of the sample on health perception scale ite.

Item	Frequencies		%	
	Need	No need	Need	No need
Back Pain	401	151	73	27
Continuous cough	390	162	71	29
Muscle pain	442	130	80	20
Bloody Stool	180	372	33	67
Bloody urine	161	391	29	71
Foot tumour	130	442	24	76
Weight loss	191	361	34	66
Powerlessness	411	141	74	26
Breathing difficulties	376	176	68	32
Continuous headache	090	462	16	84
Daisy	220	332	60	60
Chest pain	475	007	86	14
Abdominal tumour	361	191	66	34
Skin rashes	184	388	30	70
Eye pain	111	441	20	80
Pale face	131	421	24	76
High fever	160	392	29	71
Insomnia	201	351	36	64
Obesity	330	222	60	40

In the answer of question 2, Gender differences in adolescent perception of serious problem which need a clinical visit (χ^2) tests were used to test the difference between males and females in the perception of seriousness of health problems. The result (table 2) showed that males (positive values) perceived that back pains (3.19), chronic cough (3.02), bloody stool (4.3), bloody urine(4.03) and chest (4.02) pain required a clinical visit, while the females (negative values) did perceive that, difficulty in breathing (-4.03), daisy (-4.10), skin rashes (-4.11, high fever (-4.11) and obesity (-7.01) were the most serious health problems and needed a clinical visit.

Table (2). Frequencies and percentages of the sample on health perception scale items in terms of Gender.

Gender	Item	Frequencies		Percentages %		χ^2
		Need	no needed	Need	no need	
Male	Back pain	200	72	74	26	3.19
Female		160	120	57	43	
Male	Continuous cough	190	82	70	30	3.02
Female		135	145	48	52	
Male	Bloody stool	175	97	64	36	4.2
Female		109	171	38	62	
Male	Bloody urine	180	92	66	34	4.03
Female		150	130	53	47	
Male	Chest pain	173	99	63	37	4.02
Female		146	134	52	48	
Male	Breathing difficulties	175	105	64	36	-4.03
Female		195	85	70	30	
Male	Daisy	170	102	62	38	-4.10
Female		203	77	73	27	
Male	Skin rashes	132	140	31	69	-4.11
Female		70	210	25	75	
Male	High fever	84	188	31	69	-4.11
Female		64	216	33	77	
Male	Obesity	100	172	36	34	-7.01
Female		235	50	84	16	

Table (3). Results of the sample on health efficacy feeling scale.

Items	X	SD
Has a bad thing happened to you last month?	1	0.96
Did you feel that your life events were out of your control since last month?	1.60	1.85
Were you nervous through last month?	2.7	1.35
Were you succeeding in dealing with bad daily life events?	3.3	1.21
Were you effective in dealing with your life?	3.1	1.11
Have you felt confidence in taking your responsibility through last month?	3.3	.98
Have you felt that every thing is going good through last month?	3.5	1.29
Have you felt that you can not adapt with the events through last month?	1.3	.91
To which level have you felt able to control the events through last month?	3.0	1.41
Have you felt aggressive because some events were out of your control?	3.3	1.43
Have you felt there are something has to be achieved through last month?	2.2	1.15
Have you felt that you control the leisure time through last month?	2.7	1.29
Average score	2.58	1.22

To answer the third question regarding exploring the level of an adolescent's feeling of health efficacy, data on the efficacy scale were analyzed as shown in Table (3). The health efficacy feeling scores (Range= 0-4) were generally moderate ($X= 2.58$, $SD= 1.22$). This indicates a moderate level of efficacy since the average is a little higher than the median score (2).

Items reflecting a particularly low and moderate self efficacy included: nervous feelings (2.7), dealing with bad events (3.3), level of control of events (3), aggression (2.2), while there is more efficacy in some items of high feeling of efficacy in dealing with life events (3.1), responsibility (3.3), feeling good (3.5), controlling the events (3.3), feeling of achievement (2.9) and controlling of leisure time (2.7), finally tests of gender differences were not significant.

Discussion

It is well known that adolescence, as a developmental stage has huge psychological and physical changes, which are producing serious problems (behavioural, physical and psychological), such as crises of identity, body changes and behavioural delinquency.

Results from the health perception scale indicated the following: the answer of question 1, the internal diseases were not important or they do not need a clinical visit, while the diseases which are affecting the physical power of the body such as back pain, muscles pain, continued cough, powerlessness and obesity, were very important and these problems need a clinical visit. These results are expected, because such health problems are affecting the body directly. It is well known that these people are economically deprived and they are manual labourers and unskilled workers, depending on the muscles and power of body (Al-Simadi 2000). Moreover, these adolescents are coming from deprived areas (educationally and economically), and family backgrounds (refugee camps), these families are careless about health and education; if they are curious about the kids' health, they will not have a financial capability to get an appropriate treatment (Spirito *et al.*, 1995). As well as, some of these problems such as chronic cough, chest pain, abnormal tumour, are considered by the subjects as correlated to the cancer, so they were afraid seriously from these symptoms, this, they

felt that they have to visit the clinic, when they have such symptoms (Dercvensky *et al.*, 1998). While the other problems such as bloody urine and stool, headache, skin rashes, eyes pain, pale face, high fever, weight loss and insomnia, were not considered as serious and important health problems and they do not need clinic visit, because they are not correlated to serious illnesses such as cancer or heart attack (Bull and Drotar, 1991).

The results of gender differences (question 2) showed that the males were focusing on the diseases which are affecting the physical function of the body. While females were focusing on the internal diseases, these results were consistent with results of Simonian *et al.*, (1993). These results are consistent with the psychological literature, which is indicating that females are having a higher level of sensitivity to their health than males, at the same time the family in these areas are more caring for their daughters' health than their sons because daughters marriage is more difficult than males, moreover the daughters' marriage decision to select her spouse still with her family not with her, while the males are having better chances to get married than their sisters, because Jordanian society is still traditional which means its individuals do not have large margin of selectivity specially in the marriage process (Smadi, 2002).

Results from the feeling of health efficacy scale (question3) indicated that the average score ($X=2.58$, Range= 0-4) is within the normal limits established by previous studies (Boekaerts and Roder, 1999; Vance and Eiser, 2002). The results indicated moderate to high levels of feeling of efficacy. However, some of the items showed high health efficacy feeling in several studies. This level of health efficacy feeling may be related to their self concept in positive direction, because like these adolescents usually are considering themselves, that they are adult, so they have to feel independent from the family and become workers to earn income. At the same time they have to feel positively toward their health and themselves to be adjusted psychologically and physically with their life requirements, because these aspects are very important in their work environment and their family relations (Al-Smadi, 2000).

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الإدراك الصحي والشعور بالفعالية الصحية لدى المراهقين في المناطق المحرومة في الأردن

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المستخلص. هدفت هذه الدراسة إلى التعرف على مدى إدراك المراهقين المحرومين في الأردن لمشكلاتهم الصحية، عن طريق تصنيفهم للمشكلات التي تستوجب الذهاب للعيادة والعلاج، والمشكلات التي لا تستحق الذهاب، وهدفت الدراسة أيضاً إلى التعرف على مدى شعورهم بالفعالية الصحية. لتحقيق هذين الهدفين، أجريت الدراسة على ٥٥٢ مراهق من الجنسين (٢٧٢ من الذكور و٢٨٠ من الإناث) في المخيمات الفلسطينية في الأردن لكونها الأشد حرماناً وفقراً. استخدمت الدراسة مقياسين: الأول، لقياس الإدراك الصحي والثاني، لقياس إدراك الفعالية الصحية. أشارت نتائج هذه الدراسة إلى أن أكثر المشاكل الصحية الجدية، والتي تحتاج لزيارة الطبيب هي المشاكل التي تتسبب في تعطيلهم عن العمل، والتي ترتبط بالقدرة الجسمية مثل: آلام الظهر والسمنة وكذلك الآلام المرتبطة بالأمراض الخطيرة كالسرطان وما يرتبط بتلك الأمراض كالسعال والأورام وكذلك أمراض القلب، وآلام الصدر. أما النتائج المتعلقة بالفروق بين الجنسين فقد أشارت النتائج إلى أن الذكور ركزوا بشكل أكبر على بعض الأعراض المرضية، مثل: آلام الظهر والسعال والنزيف الدموي، بينما ركزت الإناث على آلام السمنة وارتفاع الحرارة وأمراض الصدر. أما نتائج اختبار الشعور بالفعالية الصحية فقد بينت نتائج العينة ككل أنها تراوحت بين المنخفضة والمتوسطة، فقد عبر المشاركون في البحث عن العصبية الزائدة وعدم القدرة على التحكم في الأحداث الكبيرة، وخصوصاً السلبية منها، والشعور بالعدوانية، وكان شعورهم أفضل في قدرتهم على التعامل مع الأحداث اليومية الروتينية والشعور بالمسؤولية والشعور بالإنجاز. وأخيراً لم تشر نتائج هذه الدراسة إلى فروق ذات دلالة بين الذكور والإناث في شعورهم بالفعالية الصحية.