



## Research Article

# Health Behaviors and Related Demographic Factors among Korean Adolescents



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## SUMMARY

**Purpose:** The purposes of this study were to explore health behaviors, examine health behaviors in relation to demographic factors, and investigate the relationships between health risk behaviors (e.g., tobacco use, alcohol consumption, and sexual experience) among Korean adolescents.

**Methods:** The study used a cross-sectional descriptive relational design and a population-based data collection of 1,716 middle and high school Korean adolescents. The 72-item Korean Adolescent Health Behavior Scale was used for data collection, while descriptive statistics, *t* test and chi-square test were used in the data analyses.

**Results:** Females were doing better on weight control, hygiene, safety, and computer use than were males. Males were doing better on physical activity. Adolescents living in cities were more likely to be addicted to computer but were consuming alcohol and using tobacco less than adolescents in rural areas were. In addition, religion, grade level, and living area also made the adolescents' health behavior significantly different.

**Conclusion:** As the result suggested, gender, religion, grade level, and region need to be considered when designing health promotion interventions among Korean adolescents.

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## Introduction

In the past, many researchers have asserted that adolescent health is critical because this period is a transitional phase, with numerous external factors affecting individual health from puberty to early adulthood (Neilson, 1991; Singer, 1984). In addition, adolescents shape their own behavioral lifestyles at a young age, and those behavioral patterns can influence their lifelong health. Given the importance of adolescent health, understanding adolescent health behaviors and related factors is the initial step in improving lifelong health, as well as in determining which adolescent health behaviors require interventions.

The health behaviors of adolescents have been studied in several countries, including Lithuania, Finland, Taiwan, Vietnam, and various African countries (Grabauskas, Zaborskis, Klumbiene,

Petkeviciene, & Zemaitiene, 2004; Kaplan et al., 2003; Katja, Päivi, Marja-Terttu, & Pekka, 2002; Page & Suwanteerangkul, 2009; Yang, Wang, Hsieh, & Chen, 2006). These studies have focused on components of health behaviors similar to those considered by researchers in the U.S. and Korea. In two studies, demographic characteristics such as gender, grade level, and family structure, as well as psychosocial factors such as self-efficacy, self-esteem, and knowledge, were found to be closely related to health behaviors (Spear & Kulbok, 2001; Thunfors, Collins, & Hanlon, 2009). However, the results were not always consistent, and the evidence regarding health behaviors among Korean adolescents was limited. The present study was undertaken to fill a gap in the literature by focusing on Korean adolescents and to provide implications for nurse educators and a basis for future intervention studies.

Health-promotion interventions aimed at adolescents have focused mainly on reducing risk-taking health behaviors and encouraging health-promoting behaviors. These studies have shown positive effects on the health of adolescents. Health risk behaviors such as tobacco use, alcohol consumption, and sexual contact are common risk behaviors among adolescents and frequently co-occur (Spring, Moller, & Coons, 2012). Therefore, the foci of

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intervention have included tobacco use, alcohol consumption, drug abuse, and sexual health (Bottorff et al., 2004; Leavy, Wood, Phillips, & Rosenberg, 2010; Park, & Jung, 2013; Werch, Moore, DiClemente, Bledsoe, & Jobli, 2005; Winters, Fahnhorst, Botzet, Lee, & Lalone, 2012).

In Korea, some studies have explored adolescents' health behavior using the translated version of the Youth Risk Behavior Survey from the Centers for Disease Control and Prevention (An & Tak, 2006; Byun & Lee, 2005). Some studies have used a Korean version of the Youth Risk Behavior Survey, but the research focused either on oral health behavior (Jung, Tsakos, Sheiham, Ryu, & Watt, 2010) or on nutrient intake (Cho, Nam, & Kim, 2011). Cultural differences and health beliefs need to be incorporated into health education programs in order to develop culturally sensitive health education (Chen, James, & Wang, 2007). Likewise, in developing or revising survey instruments, cultural elements need to be considered. Shin (2010) incorporated cultural components of Korean adolescents when developing the Korean Adolescent Health Behavior Scale (KAHBS). For instance, item about carrying a weapon was deleted and item about eating salty and spicy foods was added.

This instrument has two major advantages. First, the total scores for the subscales made it possible to prioritize the types of health behaviors needing reinforcement or modification. Second, the use of KAHBS that recognizes cultural awareness as appropriate to adolescents' perceptions which made the study culturally sensitive. These advantages have the potential to contribute to developing health behavior interventions aimed at Korean adolescents. Furthermore, the results should be relevant to research among Koreans living abroad through better understanding of cultural differences and health practices as well.

The purposes of this study were to (a) explore health behavior practices; (b) examine those health behavior practices in relation to demographic factors; and (c) investigate the relationships among health risk behaviors (e.g., tobacco use, alcohol consumption, and sexual experience) in Korean adolescents.

## Method

### Study design

This study used a cross-sectional relational descriptive study design with a self-report questionnaire.

### Setting and sampling

In order to have representative sample, a population-based data collection through proportionate stratified sampling was conducted. For example, 20.75% of population were living in Seoul area, so the target sample size in Seoul were 21% of the total sample. Within the cities and provinces, middle and high schools were randomly selected from schools registered in the Office of Education. Thirty-five Korean middle and high schools were finally selected and a total of 1,769 students completed the survey.

### Ethical consideration

This study was approved by the Institutional Review Board at the researcher's institution. To ensure that students responded candidly, all participants were kept anonymous, which is critical when questions are of a personal or private nature (Polit & Beck, 2004) such as the sexual behavior questionnaire. To ensure the anonymity, no name or number were written in the paper survey, and nickname was created by the students for the computer-assisted survey (CAS). In the beginning of the survey, a cover letter explaining privacy protection was provided. Both the informed

consent from the participants and the approval for the survey from the parents were received.

### Instruments

Participants were asked to provide demographic characteristics such as gender, age, grade, religion, and living area in the first part of the survey. The second part consisted of the KAHBS (Shin, 2010). Of the 72 items on the KAHBS, 48 are measured on a 4-point Likert scale (1 = *not at all*, 2 = *usually not*, 3 = *usually*, and 4 = *always*). In order to understand and compare the health practices, the average scores for each Likert-type subscale were calculated. Negative items were reverse-coded, meaning high scores representing optimal health behaviors.

The KAHBS comprises subscales for 14 health behaviors: stress and mental health (10 items), sleeping habits (5), dietary habits (12), weight control (4), physical activity (4), hygiene habits (5), tobacco use (5), substance abuse (2), alcohol consumption (4), safety (4), sexual behavior (9), computer use (3), health screenings (4), and posture (1). Among 14 subscales, 3 subscales, tobacco use, alcohol consumption, and sexual behavior, were measured by one polar question and more questionnaires for additional information. For example, tobacco use was measured by the questionnaire "I am smoking these days." Additional questionnaires were the initiating age of the smoking, number of cigarettes smoked past week, number of days smoked past week, thinking about quitting, and the experience of smoking cessation education with the place where they received it. For alcohol consumption, after a polar question asking the experience of alcohol consumption, initiating age, days of alcohol consumption past month and the amount, and the experience of receiving the education about alcohol consumption were followed. For sexual behavior, after the questionnaire about the experience of sexual intercourse, initiating age, contraceptives usage, method of contraceptives, experience of pregnancy and abortion, experience of sexually-transmitted disease with the treatments received, and the experience of sexual education were followed. An average of 10 minutes was required for answering all questions.

The face and content validity of the questionnaire were established through a review process involving six experts and four school teachers. The reliability coefficient (Cronbach's alpha) of the current study questionnaire was .82, and the coefficients of each health behavior subscale ranged from .59 to .96. The reliability coefficients for the subscales in this study were as follows: stress and mental health, .73; sleeping habits, .59; dietary habits, .72; weight control, .73; hygiene habits, .73; substance abuse, .96; safety, .62; computer use, .71; health screenings, .78.

Self-reported height and weight were used for body mass index (BMI; kg/m<sup>2</sup>) which was calculated as weight in kilograms divided by height in meters squared. All subjects were divided into five groups according to BMI: underweight, normal, overweight, mild obese, and moderately obese (Korean Society for the Study of Obesity, 2010).

### Data collection

Data collection was conducted using the KAHBS survey throughout South Korea from September 2009 to December 2009. Cooperation letters were sent to school nurses for purposes of recruitment. When permission was obtained by the schools, the researcher requested the designated number of surveys to the local school nurses based on the gender differences by each grade. Surveys were answered via either hard copy or CAS which were developed within the University Web System. The survey could be answered either at school or at home, but most of the surveys were

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