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HEALTH AWARENESS OF YOUNG PEOPLE WITH MODERATE INTELLECTUAL DISABILITIES*

Introduction: Human health awareness is defined as a complex cognitive structure responsible for directing and organizing health behavior. Due to the nature of intellectual disability, including the frequent co-occurrence of health problems, it seems crucial to understand this structure in people with moderate intellectual disabilities.

Research Aim: The aim of the research was to present the level of knowledge of health and disease in the study group of young people with moderate intellectual disabilities and the place of health in the hierarchy of their values, which are elements of health awareness. The study included a total of 27 people (16 women – 59.26% and 11 men – 40.74%). The respondents were aged 13 to 19.

Method: The diagnostic survey method was used, with a standardized interview technique in the form of a guided conversation. In order to measure the place of health in the respondents' hierarchy of values, a modified questionnaire Personal Values List – PVL was used, adapted to the cognitive abilities of people with intellectual disabilities.

Results: The results show that the majority of the people with moderate intellectual disabilities taking part in the questionnaire achieved high knowledge scores in the following categories: health and disease, physical activity, body hygiene, nutrition, safety. Two categories were at the average level: rest and medical assistance. In addition, for two of the respondents, good health was the highest value, next to love, friendship, nice appearance, wealth, knowledge and wisdom, courage and kindness.

Conclusions: The present research results provide an important rationale for systematic health promotion activities among students with moderate intellectual disabilities in order to prevent and eliminate undesirable health behaviors.

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INTRODUCTION

Health awareness is a complex cognitive structure that plays a regulatory role in human health behavior, directing and organizing it. Health awareness is divided into three components. The first one includes structures that enable the perception of signals that threaten health (the perceptual model is relatively constant). The aforementioned structure allows us to distinguish alert individuals, who notice even small signals of danger, and avoidant people, who overlook or ignore them. The second component of health awareness concerns knowledge of health and disease, acquired through observation of other people's behavior, as well as from information obtained from entities responsible for this task (e.g. schools, mass media). The third component of the described category is the place of health in the hierarchy of other values of an individual. Values are assigned different regulatory power (Ratajczak, 1997; cf. Gaweł, 2011; Woynarowska, 2017; Kosycarz and Walendowicz, 2018). Health awareness is also associated with subjective concepts of human health, which include beliefs about health criteria and its determinants (Gaweł, 2021). As Gaweł (2011) notes, health awareness cannot be the only factor explaining human health behavior. A significant role is attributed to the non-health elements of areas of consciousness, personality traits, and also intermediary variables of a demographic, social and situational nature. The concepts of health awareness also emphasize the need to direct it towards the future, referring, for example, to Nurmi's future orientation model, which distinguishes three fundamental processes: motivation, planning, assessment/valuation (Łukasik, 2018).

The amount of knowledge of health and health beliefs are considered to be one of the most important determinants of human health activity (Boczkowska, 2015). The amount of knowledge and acquired experience constitute the foundations of independent choices made in the future, which should promote maintaining and increasing health (Leksy, 2019). According to Boczkowska (2015), a large amount of knowledge of the harmfulness of certain health behaviors is not a sufficient factor to change them. Despite this, the impact of knowledge on the formation of health beliefs cannot be denied. The assumptions of health promotion emphasize the need to enable people to acquire skills important for health throughout their lives. These issues were raised by the WHO and UNICEF, where the need to develop people's life skills was emphasized. They enable a person to use knowledge, attitudes and values in activities that allow him or her to engage in health behaviors (Borzucka-Sitkiewicz, 2009; cf. Boczkowska, 2015; Wenclawek and Wojnowski, 2019; Kamecka-Krupa, 2023). From an educational perspective, the following aspects should be remembered in raising health awareness: the need to perceive

health problems in an objectified reality; the accumulation of health knowledge and its reception in intellectual and emotional dimensions; the internalization of this knowledge; the ability to verbalize health needs and health-related opinions; the ability to use health knowledge in everyday situations; the anticipation of phenomena, processes and human activities and the ability to make appropriate decisions (Śliwa, after: Leksy, 2020; see Mach, 2017).

As Buczak (2014, p. 43) points out, “childhood experiences are a source of value preferences and ways of their realization. They are a representation of events, consciously realized by the subject, in which he or she participated together with the parents (or other significant persons), who interact through the transfer of information and the use of appropriate reinforcements”.

Reflecting on the category of health as a value, it is worth mentioning two approaches in this area. We find them in the concepts: 1) “the value: health”, 2) “the value of health”. The two terms are interrelated. In explorations of the value of health in social awareness, the second of the variants is frequently adopted, showing the position of health in the hierarchy of values of the study group. Research conclusions suggest that the high position of the value of health is declarative in nature, and not necessarily implementation-related (Woynarowska, 2017; see Liberska, 2017). The concept of “the value: health” places health in the cultural aspect. It refers to the sphere of beliefs, not goals. “The value of health” manifests itself in attitudes related to the desire for health. In other words, a person sets health-promoting goals and then pursues them (Buczak, 2014). The different regulatory power of the value of health towards behaviors is dependent on the type of value that can be declared, accepted, desired or practiced. An autotelic approach to health promotes the tendency to health-promoting behavior. An instrumental approach to health enables the acquisition of other values, which in turn translates into inconsistent and even unfavorable activities towards health (Zadworna-Cieślak and Ogińska-Bulik, 2011). Górnik-Durose et al. (2020, p. 34) explain that “taking care of one’s health can be understood not only as an autotelic value, but may also become a rationalized and measurable activity, allowing for the performance of mental »business« operations, for which health behavior is a »means of payment«”. According to the authors, one may wonder to what extent consent to the loss or reduction of health in one sphere may be compensated by other activities, and whether in a given situation, sacrificing or maintaining health becomes profitable (assessment of gains and losses of other types of resources) (Górnik-Durose et al., 2020). It is worth noting, following Ratajczak (1997), that the ineffectiveness of various health-promoting interactions may result from the erroneous assumption of an individual’s unequivocally positive attitude towards his or her own health. As the author points out, health is sometimes neglected, endangered, and subjected to self-destruction. Horbowska (2017; Siedliska, 2017) notes that health is the most important value for adults, in contrast to its position

in the hierarchy of values of youth. Young people who do not have health problems may not see the connection between health and other values.

The issue of health awareness seems to be particularly relevant in the context of people with intellectual disabilities, especially those with more profound (moderate and severe) and profound disabilities. This is associated with the frequent occurrence of developmental defects, internal organ dysfunctions and comorbidities in this population. Therefore, health education is becoming a key challenge not only for the medical community, but particularly for teachers and special educators working with children and young people with intellectual disabilities. The formation of proper health habits is one of the most important elements that are part of the process of self-determination and influencing one's life choices.

Young adults with intellectual disabilities are at risk of adverse health outcomes (Young-Southward et al., 2017; Tyrer et al., 2019). They face numerous health problems, despite increasing societal initiatives to raise health awareness (Emerson, 2005; Emerson et al., 2016; Hughes-McCormack et al., 2018). When studying the literature on the subject, there are few publications presenting explorations in the field of health and its values from the perspective of people with intellectual disabilities themselves. Caton et al. (2012) in their research focused on the issue of people with intellectual disabilities' understanding of what health is, what being healthy means to them and what actions they take in terms of a healthy lifestyle. In semi-structured interviews with 13 respondents, several questions were also asked about healthy eating, the dangers of alcohol abuse and the benefits of physical activity. The research results showed that people with intellectual disabilities generally understand what a healthy lifestyle is and what the consequences of risky health behaviors are. Another research team led by Young-Southward et al. (2017) conducted 17 semi-structured interviews with 17 young people with mild, moderate and severe intellectual disabilities aged 16–27 and their parents. The significant problems identified by the researchers included: lack of physical activity, obesity and the inability of people with intellectual disabilities to perform various social roles, which may negatively affect a person's psychophysical sphere. Health and well-being were an important issue for the young people and young adults with intellectual disabilities, as well as for their parents. The research in question showed common occurrence of early deaths, which are, for instance, the result of undiagnosed diseases. Zwack et al. (2022), on the other hand, examined the relationship between modifiable risk factors and the cardiometabolic health profile in adults with intellectual disabilities aged 18–45. The authors undertook a clinical assessment of cardiometabolic parameters and the level of physical activity, diet and knowledge of health. Thus, the study subjects with intellectual disabilities had increased obesity compared to the control group, were less likely to engage in physical activity, and food products were scarcer in their total daily diet. According to the researchers, health knowledge,

nutrition, and physical activity seem to be an important predictor of the risk of various diseases in the study population. If people with intellectual disabilities are to properly influence their health, it is impossible to ignore the issue of education that takes into account their cognitive abilities and the adaptation of the form of content transmission.

This research falls within the scope of explorations by other Polish researchers. It is worth citing here the studies by Gunia and Trojańska (2007), Dyduch (2010), Rusinek (2014) and Mach (2015). The researchers focused on students with mild intellectual disabilities and the values held dearly by the respondents. The conclusions varied, as did the demographic variation in the groups. To some of the students, love ranked first in the hierarchy of their values, while other students with intellectual disabilities rated the value of health highly, after family and love.

RESEARCH AIM

The author's own research was to aimed to determine the level of knowledge of health and disease and the place of health in the hierarchy of values, that is, selected elements of health awareness of young people with moderate intellectual disabilities. The intentions of the explorations were achieved by answering the main research question: What is the health awareness of the study group of young people with moderate intellectual disabilities? Two detailed questions were selected from the main question:

1. What is the level of knowledge of health and disease in the study group of young people with moderate intellectual disabilities?
2. What place in the hierarchy of values does health occupy in the study group of youth people with moderate intellectual disabilities?

Due to the diagnostic nature of the questions, no hypotheses were formulated (Maszke, 2008).

RESEARCH AIM AND QUESTIONS

Based on the purposive selection, the study included 27 students (16 women, 11 men) with moderate intellectual disabilities, from the second (older grades) and the third level of education in special schools. The subjects were aged 13 to 19. In terms of place of residence, the largest group were students from rural areas (19 people, 70.37%). The study was conducted in two special schools in the Podkarpackie province and one in the Lubelskie province. In the presented group of subjects, 5 people (18.52%) were diagnosed with Down syndrome, 2 people (7.41%) with cerebral palsy and one person (3.70%) with Pfeiffer syndrome.

The research procedure used the diagnostic survey method, with the standardized interview technique in the form of a guided conversation, using the author's own questionnaire on knowledge of health and disease. For questions on "body hygiene", "nutrition", "safety", pictorial material was prepared, presenting appropriate cosmetic accessories, food products, as well as information and warning signs. It served as an aid in providing answers by the study group with more profound intellectual disabilities. It should be noted that the interview was conducted with each student individually. It was based on the same pattern, which consisted of specific questions asked in the order previously adopted by the researcher. The content of the interview was consulted with the educators and teachers who had direct contact with the subjects. The conditions in which the interviews were conducted were the same for all the participants, which made it possible to compare and generalize the research results. The duration of the interview, depending on the communication capabilities of a respondent, was about 60 minutes.

The interview questionnaire included seven categories, i.e. health and disease, physical activity, body hygiene, rest, nutrition, medical assistance, and safety. The questions assigned to individual sections allow us to determine the respondents' level of knowledge. The answers to the questions were presented on a 3-point scale (low, average and high level). The questionnaires for both sexes were the same with a small exception. In the section on body hygiene, female respondents were additionally asked to respond to issues related to menstruation.

The respondents' level of knowledge of the phenomenon of health and disease was assessed as high when they correctly identified (three out of four issues): what health is, what it means to be sick, what actions should be taken to maintain health. It was also necessary to identify those factors that lead to disease and those because of which people get sick. The respondents' level of knowledge was assessed as average when they had difficulty in responding to the above questions (two out of four). The respondents' level of knowledge of health and disease was assessed as low when they were unable to define the concepts of health and disease at all, or defined it insufficiently, did not provide the reasons why people get sick, and did not know what actions should be taken to maintain good health.

It was found that the respondents' level of knowledge of physical activity was high when the respondents were able to define in three out of four cases: what physical activity is and what activities are conducive to maintaining good health, explain what the saying "movement is health" means, and determine how often and for how long physical exercise should be taken in order to maintain health. An average level was awarded when they correctly answered two out of the four questions above, and a low level was awarded when they were unable to address the content of the questions.

The respondents' knowledge of body hygiene was defined as high when they were able to correctly respond to seven of the ten statements regarding: frequency

of brushing teeth, indication of oral hygiene accessories, toiletries and cosmetics, indication of those personal accessories that belong to only one person, reason for visits to the dentist's office, head hygiene, frequency of hand washing and the whole body, frequency of changing underwear and behavior in public restrooms. The level was defined as average when the respondents correctly responded to five of the ten questions described above, and defined as low when they were unable to respond to any of the questions, were unable to identify and explain what body hygiene activities consist of. Additionally, the women had to explain correctly four reasonable behaviors during menstruation.

The respondents were able to score high on their knowledge of rest when they were able to correctly identify: what stress is and how to deal with it, how to rest properly, how many hours of sleep a person needs, and what activities should be undertaken before sleep to make it restful. The knowledge of rest was considered average when the respondents, despite errors and failure to give a complete answer, were aware of what stress is, how to deal with it and why rest is important in a person's life. The knowledge of rest was considered low when the respondents were unable to relate in any way to the content of the questions.

The scores in terms of knowledge of nutrition were considered high when the respondents were able to list correctly (within five issues): the number of meals consumed during the day; products that should be eaten daily; examples of snacks; products that are unhealthy, and were able to imagine that you are at a scout camp and together with the cook you should suggest a sample breakfast/dinner. An average level was assumed when the respondents correctly answered three out of six of the questions above, and a low level was assumed when they were unable to relate to the content of the questions.

High scores on the knowledge of issues related to medical assistance could be obtained by the respondents if they were able to correctly identify and explain: when to go to the doctor, what the symptoms of a cold are, what are the discomforts experienced during the flu and what to do, what a given specialist doctor does (dentist, dermatologist, neurologist, ophthalmologist, psychiatrist, cardiologist, gynecologist, otolaryngologist, orthopedist) and what preventive examinations there are and why you should be examined, what the negative health effects of prolonged exposure to the sun are, how you can protect yourself from excessive sun exposure. The respondents could also receive high scores if they were able to correctly provide ways of behaving in example situations, i.e.: what to do after returning from a walk where it rained, you are wet and cold; what to remember when going to the swimming pool; what to do when a friend feels worse and faints (loses consciousness) and there is no adult nearby; what to do when evening is approaching, it is getting darker outside and you have to do some art work, what to take care of then; how to prepare for a doctor's visit when sick (your head and throat hurt, you have a runny nose). The knowledge of medical assistance was considered average when the re-

spondents had difficulty in providing precise answers to the questions. Low scores could be given to students who were unable to relate to any of the questions, were unable to identify or explain what medical assistance activities involve.

In the category of safety, it was assumed that the level of the respondents' knowledge was assessed as high when they were able to correctly provide (three out of four issues) emergency numbers and explain in what situations they should be used, how to cross the street safely, explain the meaning of the symbols presented (i.e. hospital, beware of the vicious dog, slippery surface, drinking water, no crossing, not drinking water – non-potable water, no cell phone use, wash your hands, fire hazard – flammable materials, emergency exit door, no bathing, no lighting fires, do not pick fruits, seeds and forest floor, no rollerblading, no jumping into water) and how to behave (how to react) in a situation when a stranger wants to give us a treat. The level was average when the respondents correctly answered two out of four of the questions above, and a low level when they were unable to relate to the content of the questions on safety.

In order to measure the value of health, a modified questionnaire Personal Values List – PVL, authored by Juczyński (2012) was additionally used in the study. This list refers to the measurement of values presented by Rokeach (1973, after: Juczyński, 2012), where health is one of the values and should be compared with other values. The focus was on keeping the inventory simple due to the study group, which consisted of people with moderate intellectual disabilities. Illustrations and a situational description of individual values were prepared for this purpose. Nine values were used, not 10. The fourth value in order, i.e. intelligence, sharpness of mind, was omitted. For the respondents, it could have been identical with knowledge and wisdom. The possibility of selecting 5 values by the respondents and assigning them points (from 1 to 5) was abandoned. Instead, the respondents were asked to order the values from the most to the least important. The procedure of the study is as follows. The researcher arranges nine pictures illustrating individual values on a table in front of the subject. "The pictures show people, objects, situations. They represent values, that is, what is important to a person. In this picture (the researcher points to a picture symbolizing kindness, helpfulness) there is a boy helping an elderly lady carry a heavy shopping bag. We can call this picture KINDENESS. Someone is good when he or she helps other people without expecting a reward for it. A good person is willing to share something, lend something, e.g. when someone is hungry, he or she shares the food, or when someone has no money, he or she lends his or her own. A good person has time for others, e.g. when someone is sad, a good person tries to comfort him or her. Look at the other pictures and say what values they represent". The researcher points to the next pictures. If the student has any doubts, he or she explains the meaning of the values presented (see below). After defining each of them, he or she reminds them the name of the value again. At the end of the presentation of all nine values, the researcher points to the next

pictures with the name. Then, the student is asked to list the values and point to the pictures. When it is determined that the student understands the essence of all the values presented and associates the concept with the picture symbol, we ask him or her to create a “ladder of values”. “This is a ladder of values. On the highest rung, that is, at the very top of the ladder, put a picture with the value that is the most important to you”. The subject follows the instruction. “Think about it and point to the next value that is very important to you. Place it on the second rung of the ladder”. The subject follows the instruction. “Think about which of the remaining values is important to you and place it on the ladder”. If the researcher is certain that the subject understands the essence of the task, he or she can be allowed to complete it on his or her own. Once the “ladder of values” is created, the researcher asks the student to verify the completed task and “read” the hierarchy of his or her values. To check understanding of the task, the researcher can be asked which value is the least important to him or her, which is the most important, and which is of average importance. Finally, the researcher enters the order of values indicated by the examinee into the sheet, assigning numerical values from 1 to 9.

The research was made possible by obtaining the consent from the principals of special schools in the Podkarpackie and Lubelskie provinces. The research procedure fully respected the recommendations included in the Helsinki Declaration, with respect for the research participants. The respondents were guaranteed conscious, anonymous and voluntary participation in the study. They were able to refuse further participation in the study at any point. During the study, the respondents did not have to answer all the questions. The construction of the research tools allowed them to omit questions they did not want to answer, for example, for personal reasons. It should be emphasized that the research problem corresponds to the issues specified in the core curriculum of general education for students with moderate or severe intellectual disabilities in elementary schools.

DATA ANALYSIS PROCEDURE

Data analysis included a group of 27 subjects, within which the level of knowledge in the categories indicated in the interview questionnaire was determined, as well as the place of health in the hierarchy of other values.

RESULTS

In response to the first detailed question, the respondents’ statements were analyzed in the following categories: health, physical activity, body hygiene, rest, nutrition, medical assistance, and safety (Table 1).

Table 1.

Number of young people with moderate intellectual disabilities who achieved a specific score (high, average or low) in the analyzed categories

Categories	High scores		Average scores		Low scores	
	<i>n</i> respondents	%	<i>n</i> respondents	%	<i>n</i> respondents	%
Health and Disease	23	85.19	0	0	4	14.81
Physical Activity	22	81.48	5	18.52	0	0
Body Hygiene	27	100	0	0	0	0
Rest	0	0	27	100	0	0
Nutrition	27	100	0	0	0	0
Medical Assistance	0	0	27	100	0	0
Safety	27	100	0	0	0	0

Source: Authors' own study.

In the category of health and disease, the results indicate the respondents' high level of knowledge. Here, the vast majority of the respondents, 23 (85.19%), were able to accurately define what it means to be healthy (from the respondents' statements: it is a person who feels good; is cheerful; has more immunity; is a strong person; a person who does not get sick; it is a person who can go for walks and to school; a person who eats a lot of healthy things, goes to the gym) and sick (from the respondents' statements: a person who eats a lot of candy; lies in bed and does not get up; such a person is sad; has a sore throat and stomach; sleeps a lot, or is pale and sweaty; when you are sick, you do not go to school, but to the doctor; such a person may have a fever and feel unwell). The respondents also indicated activities that are supposed to help maintain health. They mentioned that you should: eat healthily; drink a lot of water and juices; eat a lot of fruits and vegetables; salads; you should do gymnastics, you should walk a lot; move and go to the doctor; you can play sports; play soccer; you need to lie down and sleep at night; ensure a good night's sleep; rest). They also identified the factors that lead to disease (from the respondents' statements: your throat hurts when you eat cold ice cream or drink cold drinks; from eating crisps; drinking cola; from the cold; from not getting treatment; when it is cold outside and you go out in just a T-shirt; from low or high temperatures; from changes in temperature; from a strong wind, from a draft; sometimes from the air if there is pollen in it, then we have trouble breathing; when someone infects us; when we are allergic to something; from a long and heavy cold, then our sinuses hurt). Far fewer students (four respondents, 14.81%) had difficulty answering questions from the health category. Their knowledge was at the level of low scores. These were incomplete and insufficient answers.

Analysis of the interviews revealed a high level of the respondents' knowledge of physical activity. The questions were answered by 22 respondents (81.48%), who were able to define what physical activity is and what activities are conducive to maintaining good health (from the respondents' statements: doing various exercises; walking; running; walking with poles; swimming in the pool; cycling; rehabilitation; dancing; physical education classes; aerobics, including sit-ups and squats; sometimes cleaning the room; raking leaves; playing volleyball). They also explained what "movement is health" means (from the respondents' statements, these include: staying in shape; burning more calories; watching your figure; we move so as not to be sick; to lose weight, we have to run a lot; it is health and strength; the muscles are exercised then). This area was complemented by the following statements from the respondents: "Because if we do not move, we will have health problems, [...] we can become, I don't know, invalids like that, I don't know, that's how I see it. Movement, posture, healthy eating, rest" a woman said. "I am obese..." "Do you think you are obese?" "Yes. Here I have fat and a belly, and I have to lose it, because I look bad like this and in general, I feel bad. Except that there are probably others, you know. I would like to be thinner. Because I weigh a lot, around 80, something like that". [...] "Boyfriends, boys are leaving me and nobody wants me. I would like to be smart for boys, so that I would be a pretty, shapely girl", another respondent said. "Because muscles need movement, because if you don't move, then these muscles, um, if someone sits or lies down and doesn't move, then these muscles already know that they don't need it anymore, and someone knows that, that they have to". "So our movement makes us have strong, powerful muscles?" "And thanks to having strong muscles?" "More strength to run, to live" – a statement from one of the men. The respondents also had no problem in determining how often and for how long physical exercise should be taken in order to stay healthy. Their statements indicated that physical activity should be taken every day, or at least once a week, or four times a week, for an hour, for 30 minutes, or until all calories are burned, sometimes even without taking a break, and that you should exercise with the whole body. Far fewer students (five respondents, 18.52%) had trouble answering two questions from this category. Their knowledge was at the level of average scores.

In terms of body hygiene, all the respondents demonstrated a high level of knowledge. They were able to determine how often teeth should be brushed. They answered that it should be done in the morning and in the evening, every day, after every meal. One of the respondents explained: "You should always brush your teeth because you don't want them to fall out, you don't eat unhealthy things, you can't even use your teeth for pens, duct tape, or for keys". "Kryisia, when should you brush your teeth?" "Well, you have to brush your teeth every day". "But when, in the morning, in the evening?" "You have to brush your teeth every day because if you want to have healthy and strong gums in your teeth, you have to brush

them day and night”. “And before or after eating?”. “You also have to do it before eating and after breakfast, because then your teeth are strong and healthy, and you also have to go to the dentist”. The respondents also had no problem listing oral care products as well as toiletries and cosmetics. They also had no difficulty listing personal items that belong to only one person (these were: comb; panties; bra; hairbrush; toothbrush; towel; nail clippers; nail scissors; roll-on deodorant). They specified the reasons for visits to the dentist’s office. They indicated that usually when: teeth hurt; they are decayed; to fix them; to remove them; to check if everything is okay with them. When asked about the frequency of washing their head, the respondents answered: every other day; in the morning; in the evening; every day; in the evening; as needed; when they get oily; sometimes in the morning, in the afternoon; once a week. Similar answers were given for the frequency of hand washing. The respondents answered: before and after eating; when they are dirty; in the evening and in the morning; every day. In terms of the frequency of washing the whole body, the students indicated: always in the morning and evening; in the morning; in the evening; more than once a week; sometimes at night; on hot days. With regard to the frequency of changing underwear, they stated: when a person sweats and smells bad; panties, socks – every day, bra depending on the need; when going to church, name days; in the evening and in the morning; after each day. They were also asked about behavior in public restrooms. The vast majority answered: remember to flush the toilet and wash your hands; to behave in a cultured and polite manner; not to sit on the toilet seat; not to slip. The women also had to correctly explain four behaviors during menstruation. They were asked about taking care of hygiene during menstruation, how often the body should be washed during menstruation, how often sanitary pads should be changed and what should be done with a used sanitary pad. The women had no problems answering the above questions.

The respondents scored at an average level in terms of knowledge of issues related to rest (4 issues). All of them were able to correctly identify: what stress is and how to deal with it, and in terms of good rest, they mentioned: dancing; gardening; running, cycling, walking; sitting; watching TV; reading; tracing letters; painting; sleeping; lying in water; playing soccer. Problems arose in answering questions related to sleep (how many hours of sleep a person needs and what actions should be taken before sleep to make it restful). They provided incomplete or inadequate answers to the question.

The subjects presented a high level of knowledge of nutrition. The questions were answered by all the subjects, who were able to correctly determine how many meals should be consumed during the day (from the respondents’ statements: breakfast, lunch, dinner; five meals: breakfast, second breakfast, lunch, afternoon snack, dinner), they also listed products that should be eaten every day (these were: bread, fruits, vegetables; juices; snacks for students; yoghurts). To give examples of

snacks, they mentioned those identical to products eaten every day. They also had no problem indicating products that were unhealthy. The students pointed out: candy, because it is bad for your teeth; chocolates, French fries; crisps; candies; cookies; Coca-Cola; soda; ready-made soups; candy bars. In terms of an idea for a sample breakfast/dinner, the respondents suggested: ham, cucumber, tomato, cheese sandwiches; scrambled eggs; cereal with milk, sausages; fish, omelet with peppers; scrambled eggs, ham buns; egg, and to drink: tea, coffee; cereal coffee, espresso; fruit juice, compote.

In the category of medical assistance (10 statements) the respondents' knowledge was at the level of average scores. All the respondents were not always able to fully explain when to go to the doctor. They mentioned the following symptoms of colds and the flu: runny nose, fever; cough; hoarseness; pale skin; sore throat; headache and muscle pain; bone aches and feeling cold; vomiting and diarrhea. During the illness, they knew that they should go the doctor; not leave the house; drink tea with honey; take medicine. When asked what doctors of the above specializations do (i.e. dentist, dermatologist, neurologist, ophthalmologist, psychiatrist, cardiologist, gynecologist, laryngologist, orthopedist), a very small proportion of the respondents provided accurate answers. Faced with the question of what preventive examinations are and why they should be performed, there was a very small share of the respondents providing answers to the questions (the respondents either did not answer or omitted the question). On the other hand, the respondents largely gave correct answers to questions regarding the negative effects of prolonged exposure to the sun (i.e. dehydration; back pain and burning sensation; stroke; fainting). The respondents did not hear about the negative effects suggested by the researcher, such as melanoma or skin cancer. In this area, they were also able to indicate how to protect yourself from excessive sun exposure, they mentioned: sitting in the shade, putting on a hat, protecting yourself with an umbrella, covering yourself with a towel, putting on a hat, sunglasses, wearing shorts and a long-sleeved shirt, applying 50+ sunscreen, remembering to take a bottle of water, going to the shade. Half of the respondents had little difficulty imagining what to do after returning from a walk where they got wet, how to react when a friend faints, how to take care of the conditions when doing homework late in the evening and how to prepare for a medical appointment.

In the category of safety, the respondents' level of knowledge was assessed as high, as all of them were able to correctly provide emergency numbers and justify in what situations they should be used, how to cross the street safely and explain the meaning of the symbols presented. The respondents also had no difficulty answering the question of how they would behave in a situation when a stranger wanted to give them a treat. In order to complete the picture of the issue, it is worth recalling selected statements: "I say thank you and I go. Because I don't know him and he might poison me". "I don't take such things, you don't know what it is,

whether it's some kind of drug or something [...], because with a needle you can stick some kind of drug into a candy bar with such a tool, without saying what it is". Few of the respondents had a problem describing the meaning of the information and warning symbols presented by the researcher.

In response to the second research question, an analysis was carried out of the respondents' choices concerning the ordering of values from the most to the least important. Analysis of the data shows (Table 2) that for only two respondents (7.41%) good health was the highest value, while for three students (11.11%) it was the lowest. A high position of health in the hierarchy of values (from 1st to 3rd place) was found in nine students (33.33%), an average position (from 4th to 6th place) for slightly fewer respondents – only seven (25.93%). The highest number of choices indicating a low position of health in the hierarchy of values was found in 11 students (40.74%). In the first place and with the majority of choices was love ($n = 11$, 40.74%). Few students considered the following values to be the most important: friendship ($n = 4$, 14.81%), nice physical appearance ($n = 3$, 11.11%), wealth ($n = 2$, 7.41%), knowledge and wisdom ($n = 1$, 3.70%), courage ($n = 1$, 3.70%), kindness ($n = 1$, 3.70%). Nobody put joy in the first place.

RESULTS AND DISCUSSION

The present research aimed to determine the level of knowledge of health and disease and the place of health in the hierarchy of values (selected elements of health awareness) in young people with moderate intellectual disabilities. The research results can be expanded in the future with further explorations, thus enriching the area of research investigations, which is rarely explored. In relation to the first detailed problem and the analysis of the respondents' statements, it may be concluded that the majority of the respondents had high scores in the analyzed categories: health and disease, physical activity, body hygiene, nutrition and safety. Four of the respondents had difficulty providing answers in the category of health and disease. It was found that their knowledge was formed at the level of low scores. The knowledge related to the category of rest and medical assistance reached an average level. The research results allow us to conclude that the vast majority of the subjects have elements of knowledge of health and disease, self-protection or taking care of one's own body.

It is worth noting that knowledge of a healthy lifestyle does not always translate into health-promoting behaviors. Lipert and Marciniak's (2015) own research among intellectually disabled adults living in a nursing home showed irregular physical activity of the residents. The authors emphasized that the respondents were aware of health-promoting behaviors, but needed motivation to undertake them. Similar research results were obtained by Celebańska and Gawlik (2013) in

Table 2.
The position of health in the hierarchy of values in comparison with other values in the study group of young people with moderate intellectual disabilities

Value position	Health		Love		Wealth		Friendship		Joy		Nice physical appearance		Courage		Knowledge and wisdom		Kindness	
	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%
1	2	7.41	11	40.74	2	7.41	4	14.81	0	0	3	11.11	1	3.70	1	3.70	1	3.70
2	2	7.41	4	14.81	3	11.11	3	11.11	4	14.81	1	3.70	2	7.41	4	14.81	3	11.11
3	5	18.52	2	7.41	1	3.70	3	11.11	0	0	2	7.41	7	25.93	4	14.81	3	11.11
4	2	7.41	1	3.70	4	14.81	3	11.11	4	14.81	5	18.52	3	11.11	2	7.41	4	14.81
5	3	11.11	3	11.11	3	11.11	3	11.11	2	7.41	2	7.41	3	11.11	3	11.11	5	18.52
6	2	7.41	2	7.41	3	11.11	4	14.81	7	25.93	3	11.11	2	7.41	1	3.70	3	11.11
7	2	7.41	1	3.70	5	18.52	1	3.70	7	25.93	4	14.81	3	11.11	3	11.11	3	11.11
8	6	22.22	1	3.70	1	3.70	4	14.81	2	7.41	2	7.41	3	11.11	5	18.52	3	11.11
9	3	11.11	2	7.41	5	18.52	2	7.41	1	3.70	5	18.52	3	11.11	4	14.81	2	7.41

Source: Authors' own study.

a group of adults with moderate and severe intellectual disabilities, participating in occupational therapy. The respondents led a low-active lifestyle, and half of them were found to be overweight. They also showed a lack of appropriate stimulation from the family environment. Parental knowledge of a healthy lifestyle seems to be an important factor in developing the child's health awareness.

Mach's (2018) research among parents and caregivers of children and young people with intellectual disabilities (mild, more profound and profound) on the health and educational contexts of oral hygiene found that such health aspects are often put on the back burner. There may be various reasons: focusing on other areas of the child's health, insufficient dental care which takes into account the needs of the person with a disability, factors hindering oral care and inappropriate hygiene and eating habits.

It can be assumed that the knowledge of the young people with intellectual disabilities, participating in the study is largely formed at school, mainly through practical activities. The teacher's role is to create situations in which young people not only learn about the models of health-promoting behavior, but are also given the opportunity to create their own ideas for taking care of their own health. Cytowska (2012, p. 355), based on her own research of adults with intellectual disabilities, most of which were moderate, concludes: "Dialogical relationship builds self-awareness, understanding of one's problems (including those resulting from illness and disability), a person with intellectual disabilities learns about his or her body, its needs, reactions to changes (e.g. fits of anger, epileptic seizures, deterioration of condition when not complying with medical and dietary requirements)". Subjective experiences were not insignificant in increasing responsibility for one's own health, behavior and emotions. In contrast, the explorations of Zyznawska et al. (2015) focusing on aquatic exercise of adults with intellectual disabilities showed that at the beginning of the study not all of its participants had sufficiently developed hygiene habits and self-care skills (e.g. ensuring they had cleaning supplies, bathing, order of performing activities related to changing one's clothes). After four years of therapy, positive changes were observed, including adequate behavior in public places such as swimming pools.

With regard to the second research problem, an analysis was carried out of the subjects' choices within the presented values. Analysis of the data and most of the choices made showed that for only two of the respondents good health was the highest value. In the same place there were: love, friendship, nice physical appearance, wealth, knowledge and wisdom, courage and kindness. No one chose joy for the first place.

Similar results were obtained by Rusinek (2014) in a group of young people with mild intellectual disabilities who were students of vocational schools. Family, love, work and happiness were found to be important values. Health was ranked

high in a small group of girls, and the lowest in a group of boys. Bobik (2021), on the other hand, addressing the issue of life plans of young people with mild intellectual disabilities, reports that in the future the respondents would like to have a family, a nice husband/wife, and an interesting job. The subjects also mentioned material aspects, such as their own apartment or car. The author of the study did not cite the category of health in the statements of the study group.

CONCLUSIONS

To conclude, the priority is to draw attention to issues related to health and disease and their importance in special education. Family and school are the main educational environments that are responsible for developing young people's responsibility for their own health. Due to the fact people with a more profound degree of intellectual disability are often diagnosed with disease syndromes, diseases, disorders of organs and systems, health education assumes special importance in the context of the aforementioned population. Pedagogy faces a crucial task of creating a space where there is room for dialogue pertaining to such significant issues as health and its perceived value in human life. It is important to equip young people with the skills in identifying factors that promote and threaten health. It is equally important to take a global view of health issues and to make an integrated effort in order to provide comprehensive and complex support for people with intellectual disabilities and their families, as well as to develop recommendations for educational practice.

STUDY LIMITATIONS

The research sample was selected in a purposeful manner. The research allowed us to identify the knowledge of young people with intellectual disabilities in the analyzed areas: health and disease, physical activity, body hygiene, rest, nutrition, medical assistance, safety. Analysis of the values selected by the respondents enabled us to indicate what place health occupies in the hierarchy of values in their lives. The research results should be treated with caution due to the small size of the research sample and they cannot be generalized to the entire population of people with moderate intellectual disabilities. In the future, the number of respondents should be increased in order to select two groups with an equal number of women and men. The present research results should be treated as a contribution to further research explorations in this direction.

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ŚWIADOMOŚĆ ZDROWOTNA MŁODZIEŻY Z NIEPEŁNOSPRAWNOŚCIĄ INTELEKTUALNĄ W STOPNIU UMIARKOWANYM

Wprowadzenie: Świadomość zdrowotna człowieka jest definiowana jako złożona struktura poznawcza odpowiadająca za ukierunkowanie i organizowanie zachowania zdrowotnego. Ze względu na istotę niepełnosprawności intelektualnej, w tym częste współwystępowanie problemów zdrowotnych kluczowe wydaje się poznanie tej struktury u osób z niepełnosprawnością intelektualną w stopniu umiarkowanym.

Cel badań: Celem badań było przedstawienie w grupie badanej młodzieży z niepełnosprawnością intelektualną w stopniu umiarkowanym poziomu jej wiedzy o zdrowiu i chorobach oraz miejsca zdrowia w hierarchii jej wartości, będących elementami świadomości zdrowotnej. Badaniami objęto ogółem 27 osób (16 kobiet – 59,26% i 11 mężczyzn – 40,74%). Badani byli w wieku od 13 do 19 lat.

Metoda badań: Posłużono się metodą sondażu diagnostycznego, z techniką wywiadu standaryzowanego w formie rozmowy kierowanej. W celu pomiaru miejsca zdrowia w hierarchii

wartości badanych, wykorzystano zmodyfikowany i dostosowany do możliwości poznawczych osób z niepełnosprawnością intelektualną kwestionariusz Lista Wartości Osobistych – LWO.

Wyniki: Otrzymane wyniki wskazują, że większość badanych osób z niepełnosprawnością intelektualną w stopniu umiarkowanym uzyskała wysokie wyniki wiedzy w kategoriach: zdrowie i choroba, aktywność ruchowa, higiena ciała, odżywianie, bezpieczeństwo. Na poziomie wyników przeciętnych znalazły się dwie kategorie: wypoczynek i pomoc medyczna. Ponadto dla dwóch badanych dobre zdrowie stanowiło najwyższą wartość, obok miłości, przyjaźni, ładnego wyglądu, bogactwa, wiedzy i mądrości, odwagi oraz dobroci.

Wnioski: Zaprezentowane wyniki badań stanowią istotną przesłankę do podejmowania systematycznych działań promujących zdrowie wśród uczniów z niepełnosprawnością intelektualną w stopniu umiarkowanym, w celu zapobiegania oraz niwelowania niepożądanych zachowań zdrowotnych.

Słowa kluczowe: świadomość zdrowotna, wartości, wiedza o zdrowiu i chorobach, niepełnosprawność intelektualna

