A Phenomenological Study of Health-risk Behaviors among Thai Adolescents who Drop-out from School

Suree Jinruang, Rutja Phuphaibul, Uthaithip Jiawiwatkul, Rungnapa Panitrat*

Abstract: This study explored the lived experiences of adolescents residing in a slum area in Thailand who had dropped out of school. Giorgi's phenomenological methodology was used, and data gathered through focus group discussion and semi-structured interviews with 14 participants. Data were collected from July 2011 to June 2012. This study illuminated the lived experiences of the adolescents who engaged in health-risk behaviors.

Three phenomenological themes emerged: *encountering life adversity, my health-risk behaviors,* and *bounced back effects*. The participants explained their attitudes to the factors that lead them to health risk behaviors or encountering life adversity meant living with at-risk families and being forced into premature adulthood, which were all self-reported health-risk behaviors. They indicated that they had an ability to bounce back from the problems related to these behaviors. In order to encourage and promote health among adolescents who drop out from school, nurses have to concentrate on assessment and care planning of adolescents' risk behaviors and the determinants to these, including adolescents' friends and families.

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Introduction

Adolescent health-risk behavior is seen as an important part of the learning process of this age group who are at-risk amidst social and cultural factors that are also seen to force them into risk-taking behaviors.[1,2,3,4] In Thailand, the increase in health-risk behaviors cause problems among Thai adolescents, and are mainly the result of behavioral and social influences which have profoundly affected their social outcomes. They represent social challenges and remain an issue particularly from health promotion and prevention perspectives.[5,6] Previous research surveying risk behavior among Thai adolescent students in school found drug abuse, alcohol drinking, cigarette smoking, unsafe sexual practices and behaviors which result in unintentional injuries such as reckless driving, drinking and riding, and delinquency, and these have become major health-risk behaviors.[5,6,7,8] The factors which are strongly

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implicated in causing and influencing health-risk behaviors among adolescent students were individuals, peers, and social norms.[7,8,9,10] The number of children and adolescents who drop out of school each year in Thailand is a social challenge. In 2013, there were around 10,000 such students aged 12-18 years old.[11]

Schools have a significant role in sustaining adolescents' well-being and for acting as safeguards against health risk behaviors and their consequences. Children and adolescents who perceive their school as supportive are more likely to engage in positive health behaviors and have better health outcomes.[12] However, the Problem Behaviors Theory and Dynamic of Protective and Risk supposes that adolescents' risk behavior results from both risk and protective factors comprising biological factors, the social environment, the perceived environment, personality and behaviors.[13] In Thailand adolescents who drop out of school represent an under-studied population in terms of health-risk behaviors, risk factors and protective factors, and understanding or studying these can lead to the designing of interventions for them.

Literature Review

Health-risk behavior can be defined as any activity undertaken by people with a frequency or intensity which increases the risk of disease or injury, which can interrelate with and lead to the risk of developing chronic diseases in adulthood.[14] In Thailand, previous studies have found that health-risk behaviors among adolescents are associated with social factors[8] and cultural factors.[9] However, a conceptual framework for adolescents' risk behavior, protective behaviors, risk behaviors and risk outcomes has presumed that adolescents' risk behavior results from risk factors and protective factors. However, the conceptual domains of risk factors and protective factors are interrelated. The conceptual role of protective factors is to moderate, defend, protect against, and alleviate the impact of risk on adolescents. These play a role in decreasing the impact of exposure to and experiences of risk factors and significant predictors of change in risky behaviors overtime.[13] Moreover, the Youth Resilience Framework describes a model for the prepared intervention that can be intended to lessen health-risk behaviors and associated negative results in adolescents who engage such behavior.[15]

Adolescents who drop out from primary school, secondary school and vocational college program, without either completing their courses of study or transferring to another educational institution. Previous studies have found numerous variables responsible for health-risk behaviors among Thai adolescents studying in schools and colleges.[6,7,8,9,10] A study of the factors which influenced health-risk among adolescents who were put on probation by the Department of Juvenile Observation and Protection found these included health disparity in the family, parents with low socioeconomic status, a low level of adolescent and parent relationship and parent monitoring, peer pressure, and peers who engaged in negative behaviors.[16] However, studies related to health-risk behaviors among adolescents who drop out of school are limited.

Study Aim:

To explore the lived experiences of Thai adolescents who dropped out from school and engaged in health-risk behaviors.

Methods

Study Design:

A qualitative approach was used, and data collected through focus group discussion and semi-structured interviews. Giorgi's phenomenological methodology[17] was adapted for exploring data to extract the meaning of the lived experiences of the adolescents.

Participants and Setting

The study site was a congested urban community within a district, and had around 25 adolescents who had dropped out of school and lived within 20 vulnerable families. There were around 800 households and approximately 3,400 individuals in this community. The original settlers had no land or houses. They had rented a piece of land from a landlord 35 years ago. Around 25 years ago, the newcomers were migrants from rural areas to this area seeking employment opportunities. Some of them had migrated from other provinces and lived with relatives or friends.[18] The community was a practical training area for nursing students to learn health promoting practice. The researcher was a nurse instructor in this community and acquainted with two volunteers who lived in community for twenty years and worked as health volunteer for ten years. They were familiar with all children and adolescents, and those who had dropped out of school. The volunteers referred potential participants to researchers. Eligible criteria were: (a) 13-19 years of age, (b) had experiences with health-risks, (c) had dropped out from school and lived in the study community, (d) Thai speaking (e) willing to be interviewed and digitally recorded, and (f) provided informed consent. Exclusion criteria were: (a) left the community and went to other province during the study and (b) cognitive impairment.

Data Collection:

Occurred from July 2011 to June 2012. Four focus group discussions took place in a community setting and ranged in length from 60-120 minutes, whilst 14 semi-structured interviews were conducted in adolescents' homes and ranged in length from 30-60 minutes. The researchers conducted 4 focus group discussion sessions, each session comprised three to four adolescents at their convenient times. The interview guide was developed and modified from a previous study[19], as outlined in Table 1. There were 14 participants who provided perspectives on life experience through FDG, but during the data collection, some adolescents said little and could not be encouraged to contribute to the discussion. All participants engaged in multiple in-depth interviews and the same questions were used for in-depth interviewing.

Table 1. Interview Guide

1. Would you like to talk about how do you engage in health-risk behavior?
2. What concerned you about your health-risk behavior?
3. Would you like to talk about how do you feel about your health-risk behavior?
4. How do you deal with your health-risk behavior problems?

Ethical Considerations:

Approval was gained from the Research Ethics Committee of the Faculty of Medicine at Ramathibodi Hospital, Mahidol University Institutional Review Board on Human Rights (Reference No. 11-53-16), prior to data collection, which was designed to protect all the participant rights. To ensure confidentiality, care and sensitivity among participants, the researcher protected the anonymity of participants. All information acquired was highly confidential. Those who agreed to participate in the study gave assent and informed consent also obtained from their parents or guardian.

Data analysis:

All data were digitally recorded and notes taken. The recording was transcribed by a research assistant. The interviewer checked for accuracy by listening to the recording and reading the transcripts[17] to try to extract meaning of the lived experience of adolescents who dropout from school and engage in health-risk behaviors. In order for this to occur a researcher has to "bracket" their thinking and biases in order to analyze

a person's phenomenal condition.[17] The data analysis procedure included reading all of the transcriptions, rereading the descriptions, confirming the lived experiences transcribed in all transcripts, carefully clarifying, and vigilantly connecting the relationships, cautiously considering what was mentioned by all interviewees, translating what was said by all interviewees into concepts, merging all observations into meaningful description of all lived experiences, and grouping similar meaningful experiences from the transcripts into key words. The key words with similar concepts or relate meaning were then grouped into a subtheme, and the core meaning behind each of these subthemes were outlined into themes.

Rigor and Trustworthiness:

This study adhered to credibility, dependability, and confirmability[20] for maintaining the rigor of study. Each interview was performed by the first author who was not a health care provider working with the participants, had no relationship with the participants, and did not live in the same community as the participants lived. The interviewer had seven years experiences as a pediatric nurse, 17 years' experience as a nursing lecturer and qualitative research training in her PhD course. To ensure credibility, the interviewer avoided using ideas and experiences to lead or direct the participants to express their experiences and feelings. All the transcripts, the data coding and themes formulation were reviewed by participants who read their individual transcripts and verified the findings.

Findings

Participant Characteristics:

Fourteen participants participated in the study and all were exhibiting at least two health-risk behaviors. There were eight males and six females.

Findings

Three phenomenological themes emerged: *encountering life adversity*, *my risky health behaviors*, and *bounced back effects*.

Theme 1: Encountering life adversity

This theme revealed the lived experienced of participants encountering life adversity, described as an antecedent of health-risk behaviors. They considered that being faced with unhealthy circumstances in their families linked with their being forced into premature adulthood. Two subthemes emerged as factors that lead participants to risky behaviors: living in a family at risk and entering premature adulthood.

Living in a family at risk.

All of them lived in families that were at risk and vulnerable. Their parents had low incomes, were unemployed, and had health-risk behaviors as well. Six lived with daily family violence. They had no significant person who could help them to encounter these difficulties and the complexity of their lives. For example: a 16 years-old-girl expressed:

> *My mother has been using amphetamine and she is a cigarette addict. My father is an alcoholic. Dad is always shouting at Mom and sometimes beats my brother and me when he is drunk. This is normal for us, and it brings me down.*

Entering premature adulthood

Participants were living in the community all the time. They felt they had no friend their age as they had dropped out from school and stepped into adult life before time. They had to change their role suddenly and were being forced into premature adulthood. Their voices reflected their hard life and difficult experiences, for example, a 16 year-old boy expressed:

> *I was in school. I was a volleyball player. I was a student and played in the student team. After I dropped out from school, at that time, I stayed all the time at home. I had nothing to do. I worked in a heavy factory. It was a very great strain for me, so at around three months, I quit and went back home, and all day, all night I have to talk with an old man who lived near*

my home. It's bad. Now I mingle with adults who come into my neighbor's house for playing cards. They did not give me money for playing card with them, but they give me some money for buying them food or drinks.

A 16 year-old girl said:

In the past, I used to avoid the stress by getting out of my house, but later I couldn't do that because I have a baby. I have to raise my baby. Before I had baby, I walked out of my house and lived in my boyfriend's house. He is older than me. He drinks alcohol sometimes. I try to drink with him and then use amphetamine, because my friend who is older than me does. She lives in the same alley. She persuaded me. She is a drug (amphetamine) *seller. I want someone to talk to and inhale amphetamine with me, while my boyfriend works for his family, not me. I have to be a drug seller for money to raise my baby.*

Theme 2: My health risk behaviors

All the participants' health risk behaviors derived from the mutual influences of personal factors and those stemming from other adolescents like themselves. These behaviors had six subthemes:

Alcohol consumption

They were active drinkers and had experienced being "dead drunk" (five alcoholic drinks in two hours). They had drunk alcohol four to five times in the past 30 days. As a 16 year-old male participant said:

I drink when I go out at night, around 20 times per month. In the past 30 days, I was dead drunk many times. Once, I was drunk and rode a motorcycle. I had an accident and someone brought me to the hospital. I almost died.

Unsafe driving

Unsafe driving was a harmful behavior which led to unintentional injuries. They experienced street accidents. They did not wear the helmet when they rode a motorcycle or sat behind a motorcyclist and also sat behind a motorcyclist who was drunk. As a 19 year-old male said:

At fourteen years old, I was in a hospital at midnight because I drank and drove. My leg was broken and I stayed in hospital for around one month.

No concern for unsafe sexual practice.

The pattern of sexual behaviors among them led to unwanted pregnancy, but they were not concerned. They had been sexually active and seldom used protective barriers. They had experienced teenage pregnancies and criminal abortion: For example: a 17 year-old girl said:

I slept with men since I was 14. I have had criminal abortions two times. Around two years ago, I was a pregnant girl, now my daughter is one year and four months old. Now, I do not have any real husband.

I am a man. I have had active sexual intercourse with two boyfriends and, sometimes, I did not have and did not use any condom.

Violence

The participants were always in troubled situations in their homes and the community. They stressed the frequent verbal and physical abuse in their families and responded in different ways. The data reflected the violence in their homes. A 19 year-old female said:

I have quarreled frequently with my boyfriend, and sometimes have a severe fight.

He hit me more than I hit him. It's always, I don't know why but when my mom was upset, she usually shouted at me and sometimes she beat me. Therefore, when I'm upset, I frequently beat my boyfriends. More when my friends and I go out at night, drinking alcohol leads to entering

into conflict with other people, resulting in fighting. I go to a bar with my friend at night and I usually argue with the others there. They hate me, end with fight often.

Amphetamine use

Amphetamine use was a health risk behavior, although they tried to quit, and adults who knew about their problem helped them. A 19 years-old male said:

I have to use amphetamine every day. Sometimes I have no money. It is very bad for me. I myself feel bad for using drug, but I try to quit. Uncle Wan tried to help me. He advises me to reduce the amount of drug. I believe in him and now I try to quit.

A 16 year-old female said:

I use it almost every day, around twenty times per month. I am a smoker two year ago. I crushed into powder, put down on aluminum foil and burn it, then inhale vapor sometimes.

No one works out

All of participants had sedentary lifestyles which may be from less healthy environments. For example, a 16-year old female said:

I don't see anyone in my community, work out or participate in any physical activities and I have no idea how to work out. I have more free time, but I like to play Internet games. I play two to three hours a day, three to four days a week. No one tells me, you have to work out.

Theme 3: Bounced back effects

These were the influential factors which lead participants to overcome the health-risk behaviors. There were seven subthemes that emerged as discussed below:

Fixing myself

They expressed the idea of overcoming risky problems by a self-correction strategy, for example, a 16 year-old boy said:

Correcting is the most important and I think I have to do it by myself. Now I'm a bad guy, but I can be a good guy. However, my mom would not get mad at me. I want her to support me if she can. I think correcting by myself is the answer. I do bad things. I do it by myself. To fix it, I have to do it by myself. Anyone knows me more than I know myself? Nobody can lead me if I do not let myself change. There is no one who can help me except myself.

Seeking helping:

The participants also needed help from their parents or other adults to deal with their bad habits. Consider this case: a 18 year-old male said,

Mom must not blame and shout to me, just calmly talk to me. Tell me what she wants. I wanted to do jobs for money. I needed an employer to hire me. Now my brother in-law persuaded me to do a job. I work as his assistant. It's helpful.

I just say no

Almost all of the participants had experienced with drug abuse. One third of them were drug addicts. They tried to refrain from problems and bad situations that motivated them to engage in risky behaviors. For example, a 19 year-old male said:

I experienced being in jail [Probation by the Observation and Protection Department] for three months. It was good for me at that time, but I would like to live out of jail more than in jail, therefore, I have to quit [drugs]. Refusal is the best, even though you may lose a friend.

Information seeking by watching television

Participants tried to seek information related to fix their health-risk behaviors. They sought health information by watching soap operas, the television programs such as a documentary related to alcoholism and advertisements. A 16 year-old boy said,

I remember a television ad launched a "Don't Drive Drunk" campaign. I got it. I also have seen a documentary program related to alcoholism, it's a bad life. Alcoholism and adultery, having sex without protection like an actress in a soap opera in TV programs is so bad. She was always drunk and finally she got a sexual-transmitted disease, very awful. In an advertising spot, I saw a young, disabled man move by wheelchair because he was hit by a drunk driving a car. I remembered it until now.

Made a resolution

Made a solution describes the participants' ways of trying to overcome hardship. All of participants who succeeded in refraining from health-risk behaviors and who did not initiate other health-risk behaviors expressed an idea that reflected making a resolution. For example: a 19 year-old male said:

I have to stop drinking in order to be a healthy guy. When healthy, I have to find a job. Quitting drugs is up to me, not others. I made my decision to stop using drugs after my Mom asked me and she cried at that time. I think my goal is up to me. Now I'm a father, and my wife has been away from home around one year. I have to raise my boy. I stopped drinking and stopped nightlife lifestyle for one year ago. I have to do it for my boy.

Feel good about myself

From the bounce back from bad behaviors, participants had a sense of feeling good about themselves. For example, a 17 year-old male said:

I feel good when I can reject my friend who lures me to smoke drugs [amphetamine], even though I am afraid she gets mad at me. I strengthen myself and learned from my past. I got sick because of drinking. Nobody visited me at that time, but I realized that everyone has to do for themselves. I'm happy. I am proud of myself. I can quit smoking. Do you know? I also never, ever touch alcoholic beverages anymore. It is okay. I am good now.

Be a good person

They were growing into adulthood and thought positively of themselves. "Be a good guy" was another subtheme. The participants expressed their experienced that reflected the positive factor for coping with their past. For example, a 19 year-old male said:

My goal was to be a good guy. I myself have changed. Nobody could help, because everybody has many things to do. However, I used amphetamine for around five years, and then I think my body had worsened. Amphetamine is not good for anyone. Smoking it could make me die. I do not want to die before I am a good guy, I told myself.

Likewise, a 19-year-old female said,

I used to smoke amphetamine for two years. Now I have quit, because it made me nervous, sometimes I felt drowsiness. It is truly bad. Also, my best friend was arrested by police. I was scared, so I told myself that I have to be a good person.

Discussion

This study offered participants' lived experiences related to their health-risk behaviors. The participants felt that they were faced with the difficulties in their life before they engaged in such behaviors. After dropping out from school, they had encounters with adversity. They were unemployed, so they used their available time with adults who were living in a community. The feeling perceived was being faced with unhealthy families and linked to being forced into premature adulthood. Their lived experiences were expressed as a risk factors affecting health-risk behaviors. This is similar to a previous study that found a perceived family atmosphere, entering premature adulthood and

peer relationship were associated with health-risk behaviors.[21] On the other hand, adolescents' perception of family caring has an effect on not engaging in health-risk behaviors. Another study's findings were consistent with the results of this study; it was found that adolescents' perceptions of caring behaviors in their parents were correlated with adolescent's health-risk behaviors[22]. A review of evidence-based family interventions recommended that the most useful approach for preventing adolescent substance abuse and delinquency was a program that can strengthen the family and be adopted culturally[23].

The participants expressed their attitudes and concerns about their health-risk behaviors. Data showed that they had experiences in six subthemes of health risk behaviors including alcohol consumption, unsafe driving, no concern for unsafe sexual practice, violence, amphetamine use, and sedentary lifestyles. However, when these findings are compared with a previous study conducted by interviewing teachers and adults regarding health problems among Thai children and teenagers who dropped out from school, drug abuse and malnutrition were identified as the two health-risk problems.[24]

A last theme which emerged in our study reflected on how adolescents overcame their health-risk behavior problems by themselves. This theme was called *bounced back effects*. Participants explained that they were successful in adapting or bouncing back from the health-risk behaviors and engaged in healthy behaviors. They also described their feeling of overwhelming experiences. The personal skill, the connectedness with adults and friends, and their positive attitudes were found in this study. This is consistent with a study that found that individual protective resources are part of the core domain of resiliency and were explained in the youth resilience framework.[15] Our findings are also consistent with a study where high optimism and self-efficiency were the part of a positive personality factor and where a predictor of high resilience adolescents.[25] On the other hand, a previous study on adolescents aged 13-17 years old living in governmental residential care facilities in Iran found that adolescents who perceived they had resilience always trusted God in the face of complexities; they looked forward to a better future and experienced resilience by keeping themselves physically and mentally away from complicatedness.[26]

Limitation

This study is limited as it was conducted with adolescents who lived in an urban area, thus, may not reflect the perceptions of adolescents who lived in rural areas.

Conclusion and Recommendation

This study used a phenomenological approach to illuminate the lived experiences of Thai adolescents who dropped out of school, and engaged in health-risk behaviors. Three phenomenological themes emerged: *encountering life adversity*, *my health-risk behaviors* and *bounced back effects*. The interviewees described the risk factors that led them to health-risk behaviors or encountering life adversity which meant living with at-risk families and being forced into premature adulthood. All expressed how they engaged in health-risk behaviors. Interestingly, participants indicated that they had an ability to bounce back from the health risk behaviors and problems. They had individual protective resources which encourage them to have resilience, such as connectedness and cognitive coping skills. Interventions or plans for reducing the health-risk behaviors among them can be addressed by health care providers, who should assess their resiliency and empower them to use protective factors. Moreover, to help adolescents achieve positive life experiences, nurses can be involved in following those who drop out from school. To encourage and promote healthy lifestyles, nurses and others health care providers also need to concentrate on the determinants of adolescents'

health-risk behaviors, including the protective factors such as peers, parents, family members, and neighbors.

Further research aimed at health-risk reduction among adolescents who drop out from school should focus to explore their abilities to bounce back from risky behaviors to healthier lifestyles, and encourage adolescents in ways aimed at refraining from or reducing their health-risk behaviors. Interventions should be designed to encourage individual protective resources and other protective factors such as family functioning. Giorgi's phenomenological methodology is practical as a research process for vulnerable groups. To hear their voices, researcher can utilize this methodology to explore the meaning of lived experiences related to health-risk behaviors. However, we recommend individual interviews would be better for this topic in future, rather than focus group interviews.

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การศึกษาเชิงปรากฏการณ์วิทยาเรื่องพฤติกรรมเสี่ยงต่อสุขภาพของเด็กวัยรุ่นไทยที่ออกจากโรงเรียนกลางคัน

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บทคัดย่อ: การศึกษาเชิงปรากฏการณ์วิทยานี้เป็นการศึกษาการให้ความหมายของพฤติกรรมเสี่ยงต่อสุขภาพตามประสบการณ์ของเด็กวัยรุ่นทีออกจากโรงเรียนกลางคันและอาศัยอยู่ในชุมชนแออัด ระเบียบวิธีวิจัยเชิงปรากฏการณ์ตามวิธีของจิออจิถูกนำมาใช้ในการเก็บรวบรวมข้อมูลโดยการสนทนากลุ่มและการสัมภาษณ์แบบกึ่งโครงสร้าง ผู้เข้าร่วมศึกษาคือวัยรุ่นทีออกจากโรงเรียนกลางคัน มีพฤติกรรมเสี่ยงต่อสุขภาพและอาศัยอยู่ในชุมชนแออัด จำนวน 14 คน เก็บข้อมูลระหว่างเดือนกรกฎาคม 2554-เดือนมิถุนายน 2555

การศึกษาครั้งนี้เด็กวัยรุ่นที่มีพฤติกรรมเสี่ยงต่อสุขภาพให้ความหมายที่เป็นแก่นแท้ของประสบการณ์ไว้ 3 ความหมาย ได้แก่ เส้นทางชีวิตที่ยากลำบาก พฤติกรรมเสี่ยงต่อสุขภาพของฉัน และปรากฏการณ์ของภูมิคุ้มกัน กลุ่มตัวอย่างอธิบายทัศนคติและปัจจัยต่างๆที่ชักนำพวกเขาเข้าสู่การมีพฤติกรรมเสี่ยงต่อสุขภาพหรือเส้นทางชีวิตที่ยากลำบากที่หมายถึงการมีชีวิตอยู่ในครอบครัวที่มีความเสี่ยงและการที่ถูกผลัดดันให้เข้าสู่การเป็นผู้ใหญ่เร็วเกินไป กลุ่มตัวอย่างได้ให้ความหมายพฤติกรรมเสี่ยงของตนเอง รวมทั้งได้อธิบายประสบการณ์ของตนเองว่าสามารถข้ามผ่านปัญหาพฤติกรรมเสี่ยงต่อสุขภาพมาได้อย่างไร ในการวางแผนการดูแลเพื่อส่งเสริมสุขภาพและป้องกันโรคเด็กวัยรุ่นที่ออกจากโรงเรียนกลางคันและมีพฤติกรรมเสี่ยงต่อสุขภาพ พยาบาลต้องให้ความสำคัญกับการประเมินสภาพโดยการสัมภาษณ์วัยรุ่นและประเมินสิ่งที่มีอิทธิพลต่อพฤติกรรมเสี่ยงต่อสุขภาพ คือเพื่อนและสมาชิกในครอบครัวของเด็กวัยรุ่นด้วย

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คำสำคัญ: เด็กวัยรุ่นที่ออกจากโรงเรียนกลางคัน พฤติกรรมเสี่ยงต่อสุขภาพ ระเบียบวิธีเชิงปรากฏการณ์วิทยาของจิออจิ

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