

Confirmatory Dimensions of the Attitude Toward Occupational Health

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1. Abstract

In the context of health policies, the psychological processes of identity and stigma are a team that tries to explain assessment processes lifestyles related to vulnerable groups. Indeed, the aim of this study is to establish the validity and reliability of an instrument that measured four dimensions on a scale of attitudes. A cross-sectional and correlational study was conducted to establish the psychometric properties of the instrument with a non-probabilistic intentional sample of 100 students from a public university. The results show both dimensions as preponderant factors of attitude, but their inclusion in the construct was taken as part of a process of spontaneous activation; actions and risks that only carriers close to group can perform.

2. Introduction

The health occupational is a public health problem due to the process of development. Occupational cycle comprises a standard period of 10 years that are still infected risky life styles as they do not change their behavior because of a symptom that requires them to self-care.

Thus, 30.1 million cases are adults, 16.8 million women and 1.5 million children. Sub-Saharan Africa has the largest number of carriers with 22'900,000 while North Africa recorded 470,000 cases. In Latin America there 1,500 thousand carriers and in Mexico only 200 thousand cases.

Both aspects, the process disproportionate increase in the regions seem to indicate that the problem originates in risk behaviors same as being influenced by the identity of carrier groups and non-carriers

make a public health problem on the stigma.

In health sciences, close to sick groups are known as social support and are predominant factor in adherence to treatment, the main determinant variable of hospital health [1]. In the case of nearby groups with not only styles are associated with risk, but risk attributed identities [2].

Identity and stigma are two psychosocial processes for purposes of this work will be understood as powers and biased in favor of a group of belonging with respect to another reference group (Cañizo and Salinas, 2010) elections.

Both definitions underlie consider a public health problem, which makes sense in a context; economic, political, social, welfare, symbolic, institutional, organizational, professional (Table 1).

Referring to attitudes, identity is a consequence of a deliberate, planned and systematic election [3]. In this sense, there are three attitudinal theoretical frameworks that explain ingroup favoritism to the detriment of the outgroup known as ethnocentrism, although a conflict within the group of belonging generate an altercentrismo [4].

The Theory of Reasoned Action (TAR) argue that identity and stigma are products processing general information about a group of belonging in contrast to the allocations to a reference group [5]. In this conceptual model, beliefs surrounding process the information, but are biased attitudes who will determine the choice of a group [6]. These are categories in which the information is concentrated to perform a specific action that celebrates the in group and the out group circumvented [7].

However, the deliberate action resulting, categorized general information, not always anticipate specific behaviors and perceptions rather require control or perceived behavioral controls [8].

Thus, the Theory of Planned Behavior (TCP) assumes that only the defined information and processing both beliefs and perceptions specify the information in such a way that anticipate specific behaviors [9].

Thus, the TAR and TCP, identity and stigma are consequences of having deliberately processed, planned and systematic information concerning a group close to an individual after being contrasted with information on other distant groups to the same individual [10].

Although attitudes have been considered associations between evaluations from group categories, Espontaneo Processing Theory (TPE) argues that it is rather the arbitrary processes attitudes, spontaneous or semi [11].

TPE, unlike the TAR and TCP posed a deliberate, planned and systematic, considers that this information is maintained in memory long and short term, as well as its procedural phase [12]. Thus, the information is stored and is in a dormant state to be activated when some stimulus recovers and associated with an improvised behavior [13].

The identity and stigma from the perspective of the TPE, are part of arbitrary, spontaneous or semi - automatic process that characterizes attitudes [14]. In this regard, it is noted that identity is a negative or positive attitude for or against a group and stigma is a biased evaluation of the attitudinal and identity process, but for some reason is dormant and does not materialize as behavior until a stimulus reactivates the discretion of the individual to categorize related to carriers of a disease [15].

Since the TAR, TCP and TPE is possible to construct a theoretical framework in which coexist both deliberate processes with spontaneous, planned discretionary, systematic with semiautomatic [16]. In this model, information does not flow from one side to another or interconnects from one end to another but is in all the cognitive structure of the individual showing the formation of a network [17].

Attitudinal Theory Network (TRA) argues that both identity and stigma are not only correlated with attitudes, but also are structural nodes from which the information is renewed to form new nodes; associations between categories and evaluations about information concerning the ingroup and outgroup [18].

Psychological studies of attitudes, identity and stigma pose a cognitive network to explain the relationships between groups and people living with occupational health [19].

[20] considers the cognitive network is a process of social responsibility in which carriers not only show a self-care, but also spread their experiences to prevent re-infections or infections that lead

to a public health problem. [21] found in the expression of the disease a network structure associated with social responsibility and solidarity with carriers in terminal phase, but [22] showed a network of determining symbols recruitment of victims of sexual exploitation who developed behaviors of underestimation, risk and recidivism. Among the risky sexual behavior is coitus interruptus Petracci (2011) associated with a network of beliefs about invulnerability.

In this sense, Serrano (2011) warns that when couples establish a communication network, its decisions are carried out by consensus, but when only one - way communication is established, men women delegated the responsibility for contraception. Meanwhile, [23] found that when a group is exploited by pimps, the latter set speeches legitimizing the superiority of residents or natives regarding migrants. In this sense, [24] through an inventory of experiences of sexual assault established a link with current sexual experiences, but [25] found that victims are not always considered and exploited rather their religious beliefs around sin which affect their sexual behavior.

3. Method

Design: An exploratory, transversal and correlational study was conducted.

Sample: A nonrandom selection of 100 students from a public university in the State of Mexico was conducted. The criterion of choice was to have enough knowledge occupational health and have interacted with carriers, their relatives or friends.

Sex: The 49% of respondents were women (M = 339.45 dollars monthly income and DE = 21.37 dollars), 48% were male (M = 384.58 dollars and DE = 19.36 dollars) and 3% did not answer.

Age: The 51% are between 22 and 29 years (M = 326.38 dollars monthly income and SD = 21.25), 37% are between 18 and 22 years (M = 273.29 and DE = 18,0), 9% are under 18 years (M = 220.13 and DE = 10.6), 3% did not answer

Group. 63% said they did not belong to any group (M = 257, \$ 27 of monthly income and SD = 19.08), 34% said that if they belonged to a particular group (M = 345, 24 and DE = 17.20), 3% did not answer.

Instrument: The Attitudes Scale Towards Occupational Health was used [26] which includes 28 statements about negative or positive, favorable or unfavorable to nearby groups occupational health and their lifestyles provisions behaviors risk and vulnerability. Each statement includes six response options ranging from 0 = "not at all likely" to 5 = very likely. The dimension of identity measures attitudes toward a group close to people living occupational health compared to groups considered distant and reached a reliability (alpha = 0.718) higher than the minimum necessary. The dimension of stigma measures attitudes toward lifestyles and risk behaviors and vulnerability to sexual exploitation associated

with nearby groups with occupational health with respect to distant groups reaching reliability ($\alpha = 0.702$) than required. The overall scale had an internal consistency ($\alpha = 0.780$) than the subscales of identity and stigma.

Procedure. Adjust the original instrument at the university level considering the findings reported in the state of knowledge and public health context. Students were surveyed in the lobby of the medical and sexual orientation prior informed consent and warning that the study results would not affect their academic status. Data were processed in SPSS version 20 and AMOS version 4.0

Measures of central tendency and dispersion measures for descriptive instrument data and alpha coefficients were estimated for reliability and values exploratory factor analysis of principal components with varimax rotation, adaptation and sphericity. The values above 0.70 were considered as evidence of internal consistency and the top 0,600 KMO values were taken as evidence of suitability with significant levels less than 0.05 sphericity case were considered. The above 0.300 factor weights were assumed as evidence of construct validity.

4. Results

Table 2 shows values above 0.70 for the items that were measured by two subscales concerning the identity and stigma as preponder-

ant factors attitude towards occupational health which was established above 0,300 same factor that explained 43% and 57% of the total variance.

The internal consistency and construct validity show that the instrument can be replicated in other contexts with other samples, but the latter must be university students since the selection of the sample was not random.

Once the factors that explained 60% of the total variance explained were explained, we proceeded to observe the linear relationships between them in order to anticipate their structure and the emergence of a second order factor common to the four relative first-order factors to the identity, the image, the reputation and the stigma of groups around occupational health (Table 3).

The values of association between the factors, together with the percentage of total variance explained, suggest a common factor of second order that would explain the formation of attitudes towards occupational health, but the adjustment and residual parameters [$\chi^2 = 324,3$ (54gl) $p < ,01$; GFI = ,997; CFI = ,995; RMSEA = ,008] warn the non-rejection of the relative null hypothesis to the significant differences between the theoretical relations of the variables with respect to the empirical relationships, suggesting the inclusion of explanatory constructs of attitudes such as beliefs and perceptions (Figure 1).

Table 1: Social Context of public health

<i>Context</i>	<i>Dimensions</i>	<i>factors</i>	<i>interventions</i>	<i>Indicators</i>
<i>Political</i>	Commitment	Construction schedule	Establishing agreements	Percentages of social and agreements established under local conditions
<i>Symbolic</i>	Norms, meanings, ideologies, visions	Power, stigma, discrimination, influence	Media coverage, framing, awareness, advocacy, transformation	Around percentages related to the action of the other beliefs nearest
<i>Material</i>	Economy, praxis	Poverty, capabilities, criminalization	Production, redistribution, capacity,	Percentages of exclusion and marginalization care
<i>Relational</i>	Intra- and inter communities, organizations, bodies	Capital participation	education initiatives, mobilization	Percentages of organization and consultative, deliberative or consensual participation
<i>Institutional</i>	Structure, incidence, prevalence	Vulnerability, marginalization, exclusion	Specialized care, focused treatment	Costing and financing, hospital structure and modern facilities, mortality, orphanhood and risks; percentage of cases diagnosed in specific sectors with standardized procedures
<i>organizational</i>	Provision, capacity, quality	Climate relationships and tasks	Reengineering, synergy	Strategic alliances in training volunteer management and promotion processes, percentage of applicant's diagnosis and monitoring of cases, risk communication and health promotion
<i>Asistencial</i>	Knowledge, behavior, adherence, representation, happiness, influence	Promotion, management, quality of life and subjective well – being	Channeling, monitoring, mediation, promotion, management	Percentage of self - care and coping around the problem, forming positive attitudes

Source: Mannell, Comish and Russell (2014)

Table 2: Psychometric properties of the instrument

<i>R</i>	<i>M</i>	<i>S</i>	<i>K</i>	<i>A</i>	<i>F1</i>	<i>F2</i>	<i>F3</i>	<i>F4</i>
<i>R1</i>	2,48	0.17	0,134	0.713	0.482			
<i>R2</i>	2.3	0.13	0,143	0,729	0.493			
<i>R3</i>	2.94	0.18	0,176	0.794	0.493			
<i>R4</i>	2.6	0.09	0,187	0,739	0.491			
<i>R5</i>	2,64	0.11	0,198	0.712	0.402			
<i>R6</i>	2.83	0.1	0,132	0,739	0.536			
<i>R7</i>	2,49	0.13	0,174	0.725	0.406			
<i>R8</i>	2.83	0.15	0,143	0,739		0.514		
<i>R9</i>	2.96	0,94	0,175	0.748		0.578		
<i>R10</i>	2.77	0.85	0,164	0.745		0.351		
<i>R11</i>	2,49	0,71	0,143	0.741		0.362		
<i>R12</i>	2,61	0,39	0,132	0.756		0.462		
<i>R13</i>	2.84	0,31	0,145	0.772		0.468		
<i>R14</i>	2.9	0,48	0,175	0.704		0.591		
<i>R15</i>	1,04	0,57	0,187	0.714			0.493	
<i>R16</i>	1.05	0,26	0,198	0.726			0.491	
<i>R17</i>	1,92	0,83	0,134	0.701			0.384	
<i>R18</i>	1,06	0,93	0,154	0.735			0.412	
<i>R19</i>	1,07	0.99	0,134	0.794			0.485	
<i>R20</i>	1.01	0.8	0,176	0.752			0.384	
<i>R21</i>	1,82	0,74	0,174	0.734			0.461	
<i>R22</i>	1,16	0,69	0,131	0.705				0.401
<i>R23</i>	1,19	0.36	0,145	0.772				0.493
<i>R24</i>	1,06	0,46	0,175	0,785				0.524
<i>R25</i>	1.01	0,51	0,197	0.705				0.395
<i>R26</i>	1,07	0.55	0,135	0,715				0,330
<i>R27</i>	1,49	0,64	0,162	0,762				0,536
<i>R28</i>	1,53	0,52	0,143	0,784				0,531

Note: Elaborated with data stud: R = Reactive, M = Median, S = Standard Deviation, K = Kurtosis, A = Alpha removed value item. Multivariable Bootsrtrap = 0,000; Multivariable Kurtosis = 1.304; KMO = 0.721; Bartlett [$\chi^2 = 18.33$ (18gl) $p = 0.000$], Factor 1 = Attitude towards the identity (23% of the total variance explained), Factor 2 = Attitude toward stigma (17% of the explained variance), Factor 3 = Attitude toward image (13% of the explained variance), Factor 4 = Attitude toward reputation (7% of the explained variance).

Table 3: Correlations and covariations

	<i>F1</i>	<i>F2</i>	<i>F3</i>	<i>F4</i>	<i>F1</i>	<i>F2</i>	<i>F3</i>	<i>F4</i>
<i>F1</i>	1,000	,327*	,439**	,320*	1,896	,453	,435	,439
<i>F2</i>		1,000	,314*	,431***		1,865	,325	,471
<i>F3</i>			1,000	,345**			1,984	,327
<i>F4</i>				1,000				1,943

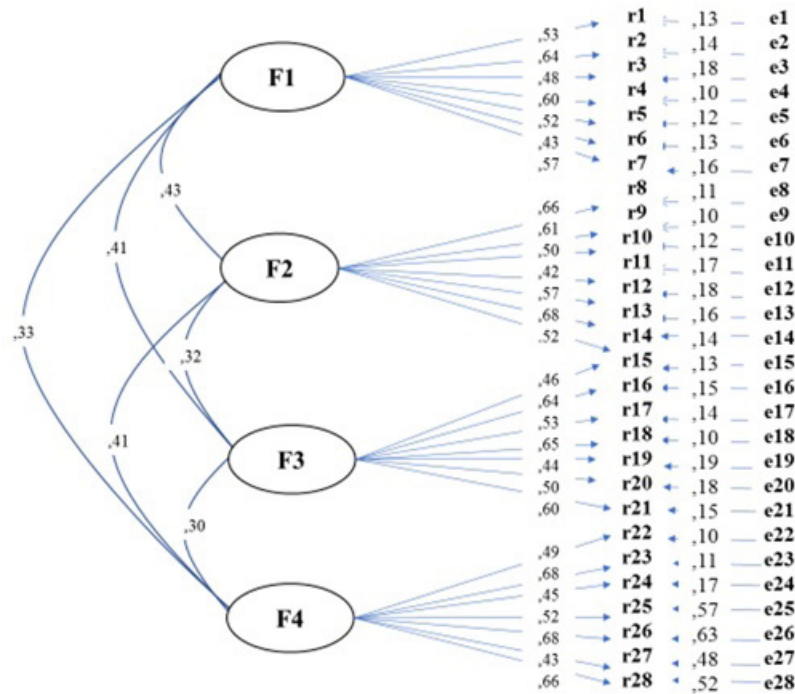


Figure 1: Structural Equation Modelling

Source: Elaborated with data study

5. Discussion

This study has established the validity and reliability of an instrument that measures attitudes toward identity and stigma of nearby groups with occupational health in a context in which the media, especially television was assumed as the source more prominent in terms of lifestyles and risk behaviors and vulnerability to sexual exploitation by those who interact with people living occupational health information.

However, the report [27] noted a bias concerning gender identity at the time of between parents and children and concluded that not only the sexual subject was taboo but was also guided by a gender female rather than a male gender identity. In this sense, the present study warns that gender identity would be linked with the stigma, as it is two information nodes that although they were influenced by media guide the formation of attitudes towards the occupational health.

Thus, Hurtado, [28] argue that teens who start their sex are more influenced by their peers than by their parents, teachers, social groups or digital networks. That is, the identity seems to be a process that not only explicit sexual preference, but also practice and frequency of it when improvising or planning a laboral act. In the present study only established that respondents not only distinguish their group belonging to the reference group in question (family and friends), but also warn a trend of attributes that makes them evaluate these groups as different to associating lifestyles and risk behaviors themselves a vulnerable to sexual exploitation

sector.

Finally, with regard to the study by [26] Garcia (2013) in which the group of health professionals stigmatized attention to families and people living occupational health as a vulnerable group that is owed to respond differently to other groups of relatives and patients, this paper considers the identity not only is evaluated by respondents but is also linked with associations that put vulnerable groups at risk practices and labours.

However, this paper does not explain how the identity and stigma are nodes attribution information concerning lifestyles and risk behaviors in an environment, but if evidence both identity and stigma are components a construct on attitudes towards groups related with occupational health. That is, the study may or may not verify the identity and stigma are nodes where it is concentrated or generates information, but it opens the discussion on the importance of observing the relationship between vulnerable groups, marginalized or excluded around carriers as these are part of a social support largely determines adherence to treatment.

6. Conclusion

The contribution of this work is the state of knowledge have established the validity and reliability of an instrument that measures two preponderant psychosocial factors in shaping attitudes towards close groups with occupational health. According to the theory of spontaneous processing, memory not only protects information concerning occupational health, styles and risk behaviors of vulnerable groups, but also such information is activated spon-

taneously or arbitrarily to carry out impromptu behaviors that explain the self watch out. In this sense but indicate the emergence of a psychosocial process relating to power or social influence around sexuality.

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