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長期照顧機構老年歧視之現況研究—以臺中地區護理之家與老人福利機構為例

陳伊如* 邱怡玟**

摘要

目標：「老年歧視」是僅次於種族與性別歧視的第三大歧視，負向的認知、態度與行為，皆會影響老人生理、心理及社會的發展。長期照顧機構人員倘若存有老年歧視，可能對老人產生身心危害，甚至不公平的對待老人，帶來更大的負面後果。故本研究旨在探討長期照顧機構之護理人員老年歧視現況及影響因素。

方法：採橫斷式研究方法，以臺中地區護理之家與老人福利機構之護理人員為收案對象，研究工具以翻譯之弗拉博尼老年歧視量表 (Fraboni Scale of Ageism, FSA) 進行問卷調查，共發放103份問卷，回收98份有效問卷，有效回收率達95.1%，統計方法以SPSS 25.0版進行描述性與推論性統計分析。

結果：護理人員曾修習老年護理學課程者，老年歧視分數較低 ($p < .01$)；與老人同住時間和老年歧視總分 [$r(-.21)$，$p= .041$] 呈現負相關，表示

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與老人同住時間越久，老年歧視分數也越低。

結論：建議長期照顧機構護理人員皆應於在學時修習老年護理學的教育課程，在職教育課程規劃也應納入老年歧視相關議題，以培養及發揮正確的態度，提升長期照顧機構老人的生活品質。

關鍵詞：老年歧視、長期照顧機構、護理人員、教育訓練

壹、前言

世界衛生組織 (World Health Organization, WHO) (2018) 年推估2015-2050年全球60歲以上人口將由12％上升至22％，呈倍數成長。2023年中華民國內政部戶政司全球資訊網人口統計資料顯示，臺灣地區65歲以上老人人口高達4,217,423人，占總人口18.02％，國民老化指數達149.9；高齡化所帶來挑戰包含，老人與家庭經濟壓力上升、醫療與照護需求增加，以及對老年的歧視，這些問題都會影響老化的過程（楊志良，2010）。我國高齡社會福利白皮書提到，人口老化是全球要面臨的一大問題，因此世界衛生組織提出活力老化，強調老人應能在公平且被尊重的環境中發揮自己的潛能（衛生福利部社會及家庭署，2021）；但2022年國內老人狀況調查報告中，有14.4%的65歲以上的老人認為社會大眾對老人態度是不尊重的（衛生福利部統計處，2024）。

老年歧視 (Ageism) 是1969年由Robert N. Butler, M.D.創立的名詞，其觀點來自種族歧視及階級偏見所引發對年齡反抗的態度，也就是以年齡作為標準對老人產生偏見的態度及行為（蔡等，2010；Achenbaum, 2015）。對老人的刻板印象大多來自過去的經驗、知識及媒體渲染，受年齡、性別、教育程度、婚姻狀態及收入所影響，尤其年齡對於老年刻板印象的影響最為顯著（呂以榮，2006；蔡等，2010），從刻板印象延伸出以偏概全的負面印象即為偏見，其乃屬於一種消極的態度（Peter McLaren、彭秉權，1999；林明幟，1999），進而可能對老人產生歧視或偏見的行為，如：以不適當的方式進行溝通、採用保護性語言、美其名為老人好的假正向態度、以老人退化作為題材的公開嘲諷、先入為主合理認為老化應帶來的各種症狀，以及老人虐待等（蔡等，2010）。

根據聯合國 (2021) 的調查，全球每兩個人當中就有一個人對老年人持有年齡歧視的態度，年齡歧視 (ageism) 是一種基於年齡的偏見和刻板

印象 (WHO, 2018)，研究發現77％的老人都經歷過老年歧視 (Palmore, 2001)。老年歧視會影響其社會福利的權益，並且容易產生世代隔閡（黃俐婷，2021）。而當提供照顧服務者，若對老化存有負向認知，當其同時面臨其他經濟、生活等壓力時，容易在照顧時產生言語的威嚇，或刻意忽略老人需求及老人虐待的情形（廖婉君、蔡明岳，2005）。

長期照護機構的老人，因身體及心理的衰退，對機構的生活與文化適應困難（許旭緯，2014）。孤寂與憂鬱是機構住民最為嚴重的心理問題，住民認為自己缺乏影響力、不具獨立性、生活缺乏意義，沒有貢獻力，以及照護提供者慣用之上對下的溝通模式，因此容易讓機構住民在生活中感到挫折 (Theurer et al., 2015)。

護理人員在長期照護領域中扮演著影響照護品質的關鍵角色，除了直接提供照護、跨專業團隊的溝通協調外，更肩負了對住民、家屬以及照顧服務員的指導和教育（林碧珠，2017）。醫療人員對老化的知識是優於一般人，但仍會出現出對老人歧視的態度，且照護老人的數量越龐大，更容易出現老人歧視的行為 (Lee et al., 2020)。研究顯示87.3%的護理師有歧視行為，但教育程度較高的護理師則老人歧視較低 (Rababa et al., 2020)；教育程度與老人照護相關教育是有助於改善老年負向態度與行為的策略 (Lee et al., 2020, Rababa et al., 2020)。

在對待老人態度的研究顯示，年齡越大、教育程度越高者在老化態度上較為正向 (Özdemir & Bilgili, 2016; Reyna et al., 2007)；女性在老年歧視行為上較男性正向 (Shiovitz-Ezra et al., 2016; 李等，2017)；收入越高者，對老化也有較正向的態度 (English, 2019)；此外，曾有與祖父母同住之經歷者，對老人的態度也較正向 (Luo et al., 2013; Özdemir & Bilgili, 2016)。許多照顧機構的護理人員與老人進行溝通時常會表現出幼稚性言語溝通，或是不恰當的稱呼，這些舉動均可能隱含認為老人是無能的認知，進而會造成老人的退縮、自尊下降及憂鬱 (Williams et al., 2017)。Doherty et al. (2011) 指出，健康照護工作者因為接觸大量的病患或依

賴的老人，特別容易產生老年歧視態度，照顧者若對老人有不正確的認知、帶有偏見情感，以及不適當的對待或行為，將會為老人生活帶來嚴重不良影響，尤其是接受長期照顧機構照顧的老人，其生理上的失能、缺乏控制力，因此所產生的無力感及生活中的威脅就更多（謝伶瑜、王靜枝，2008）。

老年人口逐年攀升，各項身心健康議題也陸續被重視；老年歧視會影響到老人的健康狀態，醫療照護需求高的老人遭遇到不公平的對待，無疑更是雪上加霜。故本研究目的旨在了解長期照顧機構護理人員對老年歧視自覺現況，分析不同背景之護理人員對老年歧視的差異性，期望能對於找出影響老年歧視之相關因素，進而研擬相關建議或策略，以提升長期照顧機構照護服務品質。

貳、材料與方法

本研究採用橫斷式研究 (cross-sectional study)，針對長期照顧住宿式機構護理人員，以立意取樣、結構式問卷收集資料，探討其在老年歧視的現況。研究場域以臺中市衛生局核可立案之護理之家及臺中社會局核可立案之老人福利機構。因臺中地區護理之家與老人福利之機構數相近，故採護理之家和老人福利機構以1：1抽樣原則，並以亂數表隨機抽取，抽取到的機構內所有護理人員均納入收案對象，直到樣本數額滿為止。研究對象人數推估，採用G-power 3.1版，以Multiple Regression計算樣本數，設定 α 值為 .05，power為 .8，effect size依中等檢定效力設為 .15，推估需達92人。

本研究對象收案條件須為表達能力清楚，且願意填寫問卷者之護理人員，並且需具有護理證照（護士或護理師），執業登錄於該機構，且有實際執行護理工作者；因機構規模及工作人員人數不同，收案對象採累計方式收案達到預估之樣本數則停止收案。本研究共進行兩階段抽樣，第

一階段抽取護理之家10家其中4家不同意參與研究，老人福利機構10家其中5家不同意參與研究，有效總樣本數為52人，因未達有效樣本數，故進行第二階段抽樣，抽取護理之家10家其中6家不同意參與研究，老人福利機構10家其中7家不同意參與研究，共取得有效總樣本數為46人，有效樣本總數達98位護理人員（表1）。本研究於取得研究對象同意後始進行研究調查，共發放103份問卷。經兩階段資料整理，刪除無效問卷及填答不全資料後，得有效樣本為98人，總有效問卷率95.1%。

表1

階段性抽樣結果 (n=98)

抽樣	機構類型	抽取家數		有效樣本數 護理人員
		同意	不同意	
第一階段	護理之家	6	4	33
	老人福利機構	5	5	19
第二階段	護理之家	4	6	24
	老人福利機構	3	7	22
總計		20	20	98

本研究之老年歧視量表採用Fraboni & Saltstone於1990年所發展的Fraboni Scale of Ageism (FSA) 弗拉博尼老年歧視量表，此量表共有29題，用於測量老年歧視之情感態度，量表共有三個面向，一為對老人的誤解、錯誤資訊及迷思，也就是所謂的負向慣性思維或刻板印象；二為偏見，是一種沒有直接造成傷害的行為與偏見，意指刻意避免與老年人的社交；三是一種極端行為的表現，反應出更多對老人偏見的行為意向，此三面向量表中分別以仇恨言論、逃避及歧視為標題 (Fraboni et al., 1990)。

此外，因原量表「老年歧視」名稱的敏感性可能使研究對象產生社會規範或道德的測量偏差，故本研究在施測時將老年歧視量表之「仇恨言

論」、「逃避」和「歧視」調整為「認知」、「態度」和「行為」作為替代名詞，並將量表名稱修正為「老年認知、態度和行為量表」。量表採李克特四點式量表 (Likert Scale) 計分，分別為「1」非常不同意、「2」不同意、「3」同意以及「4」非常同意，題目中共有六題為正向題，計算分數時反向計分，總分從29到116分，分數越高，代表具有較高的老年歧視 (Fraboni et al., 1990)。FSA問卷經取得原作者同意授權，並進行雙向翻譯後使用。研究問卷之個人屬性資料包括基本資料、教育訓練及同住經驗三面向；基本資料包括年齡、性別、收入以及教育程度；教育訓練涵蓋在學正式課程及在職教育訓練；同住經驗則包括與老人的同住經驗和與老人相處同住時間。

在問卷效度檢定方面，本研究延請五位老人醫學、長期照護及社會工作等相關領域專家，採李克特4點式量表進行問卷專家表面效度檢視，審查問卷內容文字的適切性、問題之清晰度與合宜性，五位專家對本研究問卷各題評分均為3-4分，CVI為1.0。在信度方面，原Fraboni Scale of Ageism (FSA) 弗拉博尼老年歧視量表內在一致性Cronbach's α 值為 .86 (Kutlu & Findik, 2012)，本研究之Cronbach's α 分析，其數值為 .87，顯示本量表具有良好的內在一致性，量表中各面向Cronbach's α 值分別為：仇恨言論 .80、逃避 .77及歧視 .56。

本研究經由中部某醫學中心人體試驗委員會審查通過（編號CS2-19070）。於取得機構負責人同意後，並確認研究對象皆已充分了解研究目的、方法、權益與義務，始進行填寫問卷。每份問卷皆以信封袋裝入，採不記名方式填寫，研究對象完成問卷後立即彌封信封並繳回，資料採用匿名編碼方式處理，以確保研究對象及機構之隱私。本研究以SPSS 25.0統計軟體進行問卷資料分析。資料以描述性統計計算個人屬性和老人歧視量表得分的分佈情形，並以獨立樣本t檢定 (Independent-Sample t Test)、單因子變異數 (One-Way ANOVA) 分析不同個人屬性（基本資料、教育訓練及同住經驗）與老年歧視得分之差異性，另外採用皮爾森相關

(Pearson Correlation) 探討老年歧視與基本資料之相關性，再以簡單線性迴歸解釋老人同住時間與老年歧視的變化。

參、結果

本研究共98位護理人員參與，其中92.9%（91人）為女性、97.9%（96人）薪資收入在3-4萬元以上、58.2%（57人）為大學以上之教育程度；平均年齡為40.5歲，以31-40歲比例最高（40.8%）；護理人員在該機構年資以1 ~3年者為主，占39.8%，平均年資為51.2個月（約4.3年），且有超過一半（52%）的人員過去有醫療機構工作的相關經驗；在學習歷程方面，89.8%在學時都有修習過長期照顧的相關課程；99.0%已完成長照Level Ⅰ的在職課程；有67.3%的護理人員近一年曾參與至少2小時以上的老人照顧講座；研究對象中曾經及現在與老人同住者占65.3%，與老人同住時間最短為0.5年，最長40年，平均為10年（表2）。

表2

基本資料分析 (n=98)

變項	人數	%	變項	人數	%
職稱			長照機構年資		
護士	28	28.6	無	50	51.0
護理師	70	71.4	有	48	49.0
性別			醫療機構年資		
男性	7	7.1	無	47	48.0
女性	91	92.9	有	51	52.0
學歷			在學正式課程		
專科含以下	41	41.8	無	10	10.2
大學含以上	57	58.2	有	88	89.8

（續下表）

表2 （續）

收入(萬元)			在職訓練課程		
3含以下	2	2.1	無	1	1.0
3~4以下	61	62.2	Level Ⅰ	43	43.8
4以上	35	35.7	Level Ⅰ＋Ⅱ	27	27.6
年齡(歲)			Level Ⅰ＋Ⅱ＋Ⅲ	27	27.6
30以下	17	17.4	一年內參與相關講座		
31-40	40	40.8	無	32	32.7
41-50	20	20.4	有	66	67.3
51-60	15	15.3	與老人同住經驗		
60以上	6	6.1	無	34	34.7
本機構年資(年)			曾經	40	40.8
＜1	15	15.3	現在	24	24.5
1~2.9	39	39.8			
3~5.9	19	19.4			
6~9.9	12	12.2			
＞10	13	13.3			

整體護理人員老年歧視平均分數為64.3分，因此量表起始分數為29分，將其標準化調整為1-100分後得知，護理人員在老年歧視的標準化平均得分為40.6分，顯示其對老年歧視為低等程度。各項基本資料的分析顯示，女性得分略高於男性、專科以下教育程度者得分高於大學以上學歷者、收入3萬元以下者、年齡61歲以上者和在該機構年資未滿一年者的老年歧視得分高於該類其他分組，但經過統計檢定分析後均無顯著差異；且護理人員之各項基本資料亦與老年歧視的仇恨言論、逃避及歧視三個面向得分無統計學上的顯著差異。

在學習歷程方面，護理人員在學時是否曾修習過相關課程、是否上過Level Ⅱ、Ⅲ課程和最近一年是否參與過老人相關講座課程和其老年歧視

總得分均無統計學上之顯著差異；但是，護理人員在學曾修習「老年護理學課程」課程者，老年歧視分數則顯著低於修習其他課程者 (p= .001)，可見老年護理學課程可以改善老年歧視態度；現在與老人同住者的老人歧視得分略高於曾經與老人同住經驗和不曾與老人同住者，但經過統計檢定分析後發現亦無顯著差異（表3）。

表3

護理人員之個人屬性資料與老年歧視分數分析 (n=98)

	老年歧視總體分數	老年歧視各面向分數		
		仇恨言論	逃避	歧視
變項名稱	Meam(SD)	Meam(SD)	Meam(SD)	Meam(SD)
護理職稱				
護士	65.5(11.6)	25.4(5.2)	22.7(5.0)	17.4(2.9)
護理師	63.8(9.8)	24.1(4.7)	21.6(3.9)	18.1(2.8)
性別				
男性	63.5(7.5)	24.0(2.9)	21.1(3.8)	18.4(1.9)
女性	64.3(10.5)	24.5(4.9)	22.0(4.3)	17.8(2.9)
學歷				
專科含以下	65.8(10.9)	25.1(4.7)	22.5(4.8)	18.2(2.8)
大學含以上	63.2(9.7)	24.0 (4.8)	21.5(3.8)	17.7(2.9)
收入(萬元)				
3含以下	68.5(2.1)	24.5(2.1)	24.5(3.5)	19.5(0.7)
3~4以下	63.9(11.2)	24.1(5.1)	21.9(4.5)	17.9(3.0)
4以上	64.6(8.9)	25.0(4.3)	21.8(3.9)	17.8(2.6)
年齡(歲)				
30以下	64.2(11.3)	23.8(4.8)	22.5(5.1)	17.9(2.6)
31-40	65.2(11.2)	25.1(5.1)	22.1(4.6)	18.0(3.4)
41-50	65.6(7.9)	25.7(3.3)	21.9(3.3)	18.0(2.3)
51-60	58.6(9.5)	21.4(5.1)	20.1(3.7)	17.1(2.5)
61以上	68.0(7.2)	25.8(3.4)	23.3(3.2)	18.8(2.6)

（續下表）

表3 （續）

本機構年資(年)				
＜ 1	66.0(13.3)	24.4(6.2)	23.4(5.5)	18.1(3.0)
1~2.9	65.3(10.6)	24.8(4.8)	22.0(4.2)	18.5(3.0)
3~5.9	62.8(8.5)	24.2(4.2)	21.2(4.3)	17.4(2.7)
6~9.9	61.5(11.3)	23.5(5.4)	21.0(4.1)	16.5(3.0)
＞ 10	64.7(5.5)	24.9(3.0)	21.7(2.6)	18.0(2.2)
長照機構年資				
無	65.6(10.4)	25.1(5.0)	22.4(4.3)	18.1(2.9)
有	63.0(10.1)	23.9(4.5)	21.4(4.2)	17.7(2.9)
醫療機構年資				
無	64.8(11.1)	24.7(4.7)	22.2(4.8)	17.9(3.0)
有	63.7(9.4)	24.2(4.9)	21.6(3.6)	17.9(2.8)
在學正式課程				
無	66.4(13.1)	25.1(6.9)	22.4(4.3)	18.9(3.2)
有	64.1(10.0)	24.4(4.5)	21.9(4.3)	17.8(2.8)
在學正式課程分類				
1.老年護理學	**	**	***	*
無	67.7(10.8)	25.7(5.1)	23.4(4.3)	18.6(3.1)
有	60.6(8.3)	23.1(4.1)	20.3(3.7)	17.2(2.4)
2.老人樂齡照護				
無	64.5(10.7)	24.7(4.9)	21.9(4.5)	17.9(3.0)
有	63.6(8.6)	23.7(4.6)	22.0(3.4)	17.9(2.3)
3.長期照護				
無	66.5(11.6)	25.8(4.9)	22.4(5.3)	18.3(2.8)
有	63.4(9.7)	24.0(4.7)	21.7(3.8)	17.7(2.9)
4.老年社會學				
無	64.2(10.7)	24.4(4.9)	21.9(4.4)	17.9(3.0)
有	65.5(5.5)	25.0(3.2)	22.2(2.9)	18.3(1.3)

（續下表）

表3 （續）

5.老人學				
無	64.9(10.7)	24.7(5.0)	22.2(4.4)	18.0(2.9)
有	61.2(7.4)	23.4(3.5)	20.5(3.2)	17.3(2.7)
6.高齡體驗				
無	64.8(10.5)	24.7(5.0)	22.0(4.4)	18.1(2.9)
有	61.1(8.1)	23.2(3.3)	21.0(3.2)	16.9(2.4)
在職訓練課程				
1.長照Level Ⅰ				
無	56.0	21.0	20.0	15.0
有	64.3(10.3)	24.5(4.8)	21.9(4.3)	17.9(2.9)
2.長照 Level Ⅰ＋Ⅱ				
無	64.8(10.4)	25.0(4.8)	21.8(4.5)	18.0(2.8)
有	63.9(10.2)	24.0(4.8)	22.0(4.1)	17.9(2.9)
3. 長照Level Ⅰ＋Ⅱ＋Ⅲ				
無	64.2(10.1)	24.6(4.7)	21.7(4.2)	21.7(4.2)
有	64.6(10.9)	24.3(5.1)	22.5(4.4)	22.5(4.4)
一年內參與老人照顧講座				
無	64.5(7.9)	24.7(3.9)	21.9(3.2)	17.9(2.5)
有	64.2(11.3)	24.4(5.2)	21.9(4.7)	17.9(3.0)
同住經驗				
無	64.6(11.4)	24.6(5.2)	22.1(4.5)	17.9(3.1)
曾經	62.7(7.8)	24.0(3.8)	21.2(3.7)	17.5(2.5)
現在	66.5(12.1)	25.0(5.7)	22.9(4.7)	18.6(3.0)

$^{*}p < .05$、$^{**}p < .01$、$^{***}p < .001$

將護理人員個人屬性之連續變項與老年歧視總分（三面向總和）和其三面向各別分數進行皮爾森相關分析發現，與老人同住時間和老年歧視總分 [r (-.21)，p= .041] 及仇恨言論面向 [r (-.22)，p= .032] 呈現負相關（表4）。再進一步以簡單線性迴歸分析，逐一分別以老年歧視量表三

面向總和分數及其仇恨言論、逃避、歧視三面向各別分數為依變相，與老人同住時間為自變相，個別迴歸係數邊際檢定顯示老年歧視總分 [β = -.140, p= .041]，而老年歧視之仇恨言論面向 [β = -.217, p= .032]，均與和老年同住具有顯著關係，表示與老人同住時間越久，仇恨言論分數隨之降低，老年歧視總體分數也越低（表5）。

表4

連續性個人屬性資料與老年歧視總和分數及三面向分數之相關性 (n=98)

項目	1	2	3	4	5	6	7	8	9	10
1老年歧視總和分數	1									
2仇恨言論面向分數	.88***	1								
3逃避面向分數	.90***	.65***	1							
4歧視面向分數	.77***	.49***	.61***	1						
5年齡	-.04	-.03	-.07	.01	1					
6本機構年資	-.05	-.02	-.05	-.05	.31**	1				
7長照機構年資	-.11	-.11	-.12	-.04	.40***	.03	1			
8醫療機構年資	-.06	-.04	-.11	.05	.20	.46***	.15	1		
9總年資	-.12	-.10	-.15	-.02	.47***	.58***	.76**	.68**	1	
10同住時間	-.21*	-.22*	-.20	-.08	.27**	.01	.04	.20	.11	1

*p< .05、**p< .01、***p< .001

表5

同住時間與老年歧視量表總和分數及三面向分數之簡單線性迴歸分析 (n=98)

依變項	自變項：同住時間							
	R	R^2	Adj R^2	F	B	β	*t*	*p*
老年歧視	.207	.043	.033	4.297	-.237	-.140	-2.073	.041*
仇恨言論	.217	.047	.037	4.723	-.1161	-.217	-2.173	.032*
逃避	.198	.039	.029	3.905	-.095	-.198	-1.976	.051
歧視	.081	.006	.004	.627	-.026	-.033	-.792	.430

*p < .05

肆、討論

本研究長期照顧機構護理人員，老年歧視總平均分數為64.3分，仇恨言論24.5分、逃避21.9分、歧視17.9分。中國地區李依等人（2017）的研究中，老年歧視總平均分數為65.4分，及韓國 Lee (2020) 的研究中，護理人員的老年歧視總平均分數為64.8分，均與本研究分數相近；而 Fraboni et al. (1990) 原量表之老年歧視總平均分數為57.8分，相較於其他研究有更低分的情形。李依等（2017）、Fraboni et al. (1990) 及本研究結果均發現在老年歧視三面向中都是以歧視面向分數較低，仇恨言論及逃避面向較高分（李依等，2017；Fraboni et al. 1990），顯示在負面刻板印象及逃避的情感是人們比較容易產生的部分，而不公平對待的情緒行為比較不會發生。推測可能是社會的價值觀，形成一種共同認可及遵守的道德規範，一旦超越道德的界線，可能會帶來爭議、輿論及撻伐，而這樣的道德建立了秩序，進而約束了個人的行為，所以可能會出現對老人負面看法或不滿的情緒，但卻較少出現對老人不公平對待情緒表現。

本研究發現，老年護理學課程有助於弱化老年歧視；此課程結合老化與長期照護之概念，並教導如何因應老人生理及心理的變化，給予合適的照護，也涵蓋許多有關老化的健康議題。而與中國李依等（2017）及韓國 Lee (2020) 之研究對象背景相似的研究相較下，本研究護理人員亦呈現較低的老年歧視分數。

研究結果中曾有與老人同住經歷者，老年歧視得分比較低，且同住越久歧視越低。呂怡慧（2016）表示老人與年輕世代藉由互動的增加可以提升世代之間的連結，進而改變年輕人對老人的負面印象與偏見，故與老人同住或許即為一種好方法，這樣的經驗可以幫助世代之間的溝通與相互了解，改善對老人的負向概念與態度；但本研究中卻也發現，現在仍與老人同住者之老年歧視情形反而比較高，雖然未達顯著差異，但仍值

得注意此現象可能是因為本研究之護理人員平均40.5歲，以女性居多，是屬於上有老、下有小的三明治世代，面臨到照顧父母與兒女所帶來的壓力，較容易產生照顧負荷而有負面情緒之故。而陳等（2018）研究中指出，七成的失能者之家庭照顧者在照顧時感到有負擔沉重，甚至有三成的人覺得有壓力，其中又以女性為家庭照顧者時，其有一半的人因照顧家中失能者而感到沉重，與男性相較下，女性易產生照顧壓力。

本研究僅在臺中地區進行抽樣調查，且研究對象的數量僅98人，無法推論至全臺灣長期照顧機構的護理人員，建議未來可以針對不同地區、不同工作場域或是不同職類的工作人員，進行大規模或是比較性研究，以了解老年歧視的現況和差異性。

伍、結論

護理人員在長期照顧中扮演重要的角色。學校養成教育或是執業期間的在職教育，加強教導對老化的知識、態度的正確認知，避免錯誤的行為，能夠減少老年歧視造成的隔閡與摩擦，也可讓老人感受到更多的重視與尊重。長期照顧機構的護理人員，建議接應接受老年護理學課程，具備老人照護的專業能力，以滿足最基本的需求，亦需要持續的接受教育訓練，並能對老人保有良好的態度。而在護理教育中，情意、知識與技能應要並重培養，並非著重在照顧的知識與技能之上，求學過程中，藉由老人護理學課室與實作課程整合，透過直接觀察、接觸、練習與反思，提前瞭解自己的優劣勢，補充及修正自己的不足，亦能銜接畢業後就職領域；老人護理學以及相關實作課程，應列為必修課程之一，在職之長期照顧專業課程亦須將老年歧視議題納為課程主題。

面對現今少子化的社會結構，增加與老人同住的時間來改善老年歧視，實在不容易達成，必須透過多元方式來降低老年歧視。國民健康署（2019）持續推動高齡友善城市，其八大面向都是讓高齡者能增加與社會

的連結與互動，讓不同世代可以有更多機會互相理解。教育及觀念培養是要從小做起，透過代間學習於基礎教育中，讓不同世代族群有更多互動與認識，以破除迷思。營造友善的老人生活環境是需要全體有共同意識才能達成。

本研究僅作為拋磚引玉，希望在逐漸越來越老化的臺灣社會中，老年歧視的議題能受到重視，社會也能重新省思「老」的意涵，不再仇老，並發展相關老人照護模式與因應對策，讓每位長者安享晚年成為臺灣最美的風景。

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Current Status of Ageism in Long-term Care Institutions – A Study in Nursing Home and Senior Citizens' Welfare Institutions in Taichung City

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Abstract

Objectives: "Ageism" is the third largest discrimination after racism and sexism discrimination. Negative perceptions, attitudes and behaviors will affect the physical, psychological, and social development of the elderly.

If the staff members have ageism, they may cause physical and mental harm to the elderly, or even treat them unfairly, which will bring greater negative effects. This study aims to explore ageism and its impact factors among the nursing staff in long-term care institutions.

Methods: This study is a cross-sectional research which was conducted in nursing home and senior citizens' welfare institutions in Taichung City. A questionnaire developed from Fraboni Scale of Ageism (FSA) was used. A total of 103 questionnaires were distributed, and 98 valid questionnaires were recovered, with an effective recovery rate of 95.1%. The statistical method was SPSS version 25.0 for descriptive and inferential statistical analysis.

Results: This study found that nursing staff who had taken courses related to elderly care were less likely to have ageism ($p < .01$). There is anegative correlation

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between the length of time living with the elderly and the total ageism score [r (-.21), p= .041], which means that the longer a person lives with the elderly, the lower his/her ageism score.

Conclusions: Nursing staff in long-term care institutions are required to take education courses in geriatric care during school. On-the-job education planning should also incorporate issues related to ageism to cultivate and develop the right attitude towards the elderly, thereby improving the quality of life of the elderly in long-term care institutions.

Key words: ageism, long-term care institution, nursing staff, education

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國中特殊專長學生壓力及因應探討

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摘要

目標：近年來教育推動目標，強調讓學生依專長興趣發展。然而，統計數據調查，高中專長招生的學生數量顯著減少，導致國中專長學生在升學中面臨更大的競爭。因此，本研究探討國中專長學生的壓力與因應方式，來進行主題分類與歸納。旨在提供具實務價值的見解，特別是不同專長學生在面對壓力時的差異。

方法：質性深入訪談，對象為新竹區的國中美術、音樂、體育專長學生、家長各9位，以及指導老師3位。

結果：研究發現，專長學生的壓力主要來自於學業與才能表現的落後。學生感受到自身才能未能達到自我和師長的期望，隨著學業難度增加，在學業與才能發展間的時間分配困難。面對壓力，部分學生採取積極調適情緒，嘗試解決問題；另一部分學生則選擇消極逃避，避免面對挑戰。家長在壓力因應中提供了重要支持，透過正向情感連結和提供物質資源幫助學生增強心理安全感。指導老師則探索學生才能發展、提供具體策略和心理輔導，克服壓力。

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結論：專長學生的壓力來自家長期望和學業表現不佳，進而引發負面情緒。有效的因應策略能幫助學生平衡學業與才能壓力。家庭支持及指導老師的輔導對學生的發展和未來規劃至關重要。

關鍵詞：家庭支持、特殊專長學生、輔導、壓力因應

壹、前言

近年來，教育部推動新課綱教育，旨在達成「適性揚才」的願景，除了傳統的單一入學方式，還採取了多元的入學管道，特別是針對具有特殊專長的學生，設立了美術、音樂等藝才班以及體育班，以幫助具有藝術和運動潛能的學生發展（教育部，2023）。然而，在這種趨勢下，特殊專長學生在升學過程中面臨的壓力和挑戰也日益凸顯。根據110學年度的學校體育統計年報，國小體育班學生數為6566人，國中為20976人，高中則降至10555人（教育部體育署，2023）；此外，中華民國特殊教育統計年報顯示，藝術才能班在國小階段學生數為11270人，國中為14117人，高中則僅有4388人（教育部特殊教育通報網，2023）。這些數據顯示，隨著教育階段的提升，專長班學生人數顯著減少，尤其在高中階段，反映出專長學生在升學過程中面臨的競爭加劇和壓力增加。本研究將探討國中特殊專長學生所面臨的壓力來源及其應對策略，並分析家長與指導老師等重要他人對學生的支持方式，以期找出影響這些學生心理和學習表現的關鍵因素，並提出有效的支持策略來幫助他們妥善應對升學壓力和挑戰。

從本研究運用壓力和因應的交易模型理論，主要是評估應對壓力事件過程的框架，說明壓力和因應是每個人生活都必須會面對的挑戰，適度的壓力可以是助力，反之，過度壓力是阻力 (Lazarus & Folkman, 1984)。在特殊專長學生的壓力的生活現況，先前藝術領域學生研究提到，會面臨困難與挑戰為：興趣不被支持或能力不受肯定，枯燥的制式練習以及考試帶來的壓力與挫折，與對未來職業發展的憂慮等（王麗雁，2015）。同樣地，在體育領域學生研究也提到，在專長生活面臨的壓力為：教練的期待、同儕的競爭、家人的期望、受傷的困擾、生理發育的壓力、課業的壓力、運動成就的追逐、訓練環境不佳的壓力、未來就業不確定的

壓力等。與運動員角色的衝突，當訓練營與學校的考試時間相衝時，體育教練可能希望青少年運動員優先考慮體育，而導師則可能希望將學業置於體育之上；以及身心負擔過重的衝突，身體和精神活力的耗盡、自我效能感的喪失、社會支持和時間的耗盡等（黃文成，2012；Van Rens et al., 2016）。此外，在國中特殊專長學生來說，他們必須在專長領域表現出色，同時兼顧學業表現所面臨的壓力，在相關學業成績的研究表明，壓力與成績之存在著負面的關係 (Ye et al., 2019)。綜合前述研究，專長生活壓力都有可能導致學生失去對學業和專長的創造力和表現力。

然而，在特殊專長學生的壓力生活因應情境之下，在相關研究所使用積極因應來解決問題如：身心策略、情感調節和支持；以及消極因應來逃避問題如：過度上網、異常不良的健康行等方面的相關因應 (Schäfer et al., 2017)。尤其在音樂專長學生研究中，最常的焦慮管理解決策略包括：增加練習、自我激勵、參加非正式表演、冥想或呼吸練習，或者依賴藥物和酒精等。所運用的外部資源包括：心理支持、表演心理學的課程、參與該專家領域工作、多參加表演的活動，並研究專業書籍等（王麗雁，2015；Cornett & Urhan, 2021）。在體育領域學生研究中，不同才能的自信的能力和競爭的增強，對運動情況的反應等有效適應的心理訓練關鍵 (González-Hernández et al., 2020)。並從學業生活壓力的相關因應研究，青少年在身體活躍策略，以體育俱樂部活動和慢跑；在積極的策略，以聽音樂、上網和寫文章；在消極調適的逃避，像過度使用網絡遊戲和社交異常行為；在精神力量，依靠祈禱和聖經 (Park & Kim, 2018)。以及其他相關具體的研究介入方法，如：放鬆練習、冥想、與親人和朋友共度休閒時光等 (Alexopoulou et al., 2019)，為特殊專長在生活壓力調適的相關因應策略。

綜合前述研究文獻回顧，從本研究目的來探討國中特殊專長學生面臨的壓力及其因應，然而，在各專長的背景學生壓力與因應的異同之處，及因應策略對各專長的壓力有效性為何來探討，是目前文獻中所欠缺部

分。藉由研究設計所設定問題，針對特殊專長班學生壓力因素 所使用的因應、家庭支持和指導老師的輔導策略，進行評估和分析各專長學生壓力因應來補足文獻的缺口，並對本研究提出實務上貢獻和建議及未來研究方向。

貳、研究方法

一、研究設計

質性研究中常用資料蒐集的訪談法，依據結構化程度可分為結構式、半結構式和非結構式訪談（林淑馨，2010；陳向明，2002）。本研究採用深入訪談法，以半結構式訪談為主要方法，旨在了解國中特殊專長學生的壓力及因應經驗。研究者藉由訪談大綱的指引，並在開放的情境中讓受訪者自由表達其主觀觀點，探索專長學生的壓力來源及因應方式，並分析其行為背後的社會文化因素。

二、研究受訪者

本研究採用立意取樣，在新竹地區選取國中特殊專長班的學生、其家長及專長教師，共計21人。受訪者包括美術、音樂及體育專長班的學生及其家長和教師。此樣本對象考量了多樣性、典型性及專家建議。受測受訪者背景基本資料編如表1所示。為確保受訪者在訪談過程中感到舒適，本研究依受訪者所選擇學校、教室及咖啡廳作為主要訪談地點，單獨訪談約40-60分鐘。

表1

受訪者背景基本資料

編碼	稱謂	年級	年齡	性別	學區	教育程度	專長種類
AS1	學生	八	14	女	竹東	國中	美術
AS2	學生	八	14	男	竹東	國中	美術
AS3	學生	八	14	男	竹東	國中	美術
MS1	學生	七	13	女	新竹	國中	鋼琴、長笛
MS2	學生	八	14	女	竹北	國中	小提琴、鋼琴
MS3	學生	七	13	女	竹北	國中	鋼琴、低音管
PS1	學生	八	14	男	竹東	國中	跆拳道
PS2	學生	八	14	男	竹東	國中	標槍、鉛球
PS3	學生	八	14	女	竹東	國中	跑步
AP1	家長	-	49	女	竹東	大學	美術
AP2	家長	-	45	女	竹東	研究所	美術
AP3	家長	-	50	女	竹東	高中	美術
MP1	家長	-	43	女	新竹	大學	音樂
MP2	家長	-	42	女	竹北	研究所	音樂
MP3	家長	-	45	女	竹北	研究所	音樂
PP1	家長	-	39	女	竹東	國中	體育
PP2	家長	-	42	女	竹東	高中	體育
PP3	家長	-	51	女	竹東	高中	體育
AT1	教師	-	40	女	竹東	研究所	美術
MT2	教師	-	37	女	竹北	研究所	小提琴、鋼琴
PT3	教師	-	37	女	竹東	研究所	體育

資料來源：本研究整理

三、研究者背景

研究者具備質性研究相關課程和理論知識訓練，並擁有護理專業背景和專長學生家長的身份，有助於在研究中處理不確定性和建立信任，確保分析過程的客觀性和可靠性。

四、研究工具

(一)訪談大綱

在進行針對特殊專長班學生的深度質性研究之前，為了確保研究的有效性和結構性，首先擬定了研究學生、家長、老師訪談大綱如表2所示。這份大綱明確列出了要探討的開放式問題，根據受訪者的專長學習經驗、面臨的壓力及因應策略，進行問題調整以適應討論的需要。

(二)錄音筆記

訪談過程全程錄音並進行筆記記錄，詳細說明錄音的原因和保密原則，確保受訪者的隱私權。錄音和筆記有助於捕捉訪談內容的完整性和準確性，並補充非語言訊息的資料分析。

表2

學生、家長、老師訪談大綱

研究目的	訪談問題
瞭解不同特殊專長學生的壓力來源因素	一、學生 1.自己是出於什麼原因來學習這專長？會讀這所學校藝(技)班原因？請您說明專長學習過程內容？ 2.自己從練習這專長方面時遇到什麼困難?當時發生什麼事情？ 3.自己於學校學業方面時遇到什麼困難?當時發生什麼事情？ 4.請描述專長和學業最煩問題，你覺得是什麼原因造成的？ 5.專長和學業能力所期待的和現在有怎樣不同？
瞭解不同特殊專長學生的因應	一、學生 1.當自己遇到專長和學業瓶頸，請舉例說明排解內容和方法？ 2.當自己面臨壓力時，請舉例說明是如何轉移注意力，找到紓壓的策略？

（續下表）

表2 （續）

研究目的	訪談問題
瞭解不同特殊專長學生的家庭支持策略	一、學生 1.當自己碰到壓力時，家庭方面有提供那些幫助？ 2.當自己碰到壓力時，最期待家庭方面有何幫助？ 二、家長 1.請您描述在面臨孩子才能瓶頸，所使用過家庭支持策略有哪些？ 2.當孩子碰到學業壓力時，您在家庭支持策略哪些方面是有幫助？哪些是沒幫助？ 3.您覺得在家庭支持策略哪些是需要協助？孩子最期待您哪些幫助？
瞭解不同特殊專長學生的指導老師的輔導策略	一、學生 1.自己碰到壓力時，指導老師輔導有那些幫助？ 2.自己碰到壓力時，最期待指導老師有何幫助？ 二、家長 1.孩子碰到才能瓶頸的問題時，指導老師有協助您那些幫助？ 2.孩子碰到升學壓力時，最期待指導老師有何幫助？ 三、老師 1.請您描述在面臨學生才能和學業中，最讓學生煩惱的問題是？覺得是什麼因素造成的？ 2.當學生碰到才能和學業壓力時，您有協助那些方面輔導?哪些是有幫助？哪些是沒幫助？ 3.您覺得自己在輔導方面經驗哪些是不足的部分？學生最期待您哪些輔導？ 4.當學生碰到才能瓶頸的問題時，學校有協助您那些資源？ 5.當學生碰到升學的選擇時，您給學生建議有哪些？

資料來源：本研究整理

五、資料分析

訪談資料的蒐集自112年進行，每次訪談約40-60分鐘，訪談內容經

詳細閱讀和熟悉後進行逐字稿編碼，歸納要素並發展次主題，最終詮釋整體研究主題。

(一)主題分析的步驟組成

主題分析是一種對訪談資料或文本進行系統性分析的方法，旨在從大量的材料中抽絲剝繭，歸納和研究與問題相關的核心意義。（吳啟誠、張瓊云，2020；Braun & Clarke, 2006, 2012；Clarke & Braun, 2013）。這個六步驟過程，首先，將轉錄錄音檔為文字稿，逐字閱讀和熟悉文字稿，確保轉錄的準確性。第二步驟是開始進行逐字稿編號，標記和分析資料中顯著概念，避免遺漏。第三步驟是歸納要素，檢視相似或重疊的編碼並分類，扣住研究問題的關鍵。第四步驟是初步發展次主題，反覆檢視和確認主題。第五步驟是詮釋整體研究主題，檢視和命名主題之間的關聯性。最後步驟，撰寫研究報告，說明專長經驗歷程並加入研究者的省思。

根據上述第四、五、六項的步驟操作，整理主題歸類編碼範例，如表3。

表3

主題歸類編碼範例

壓力源	主題	次主題
專長學生才能與學業能力表現的落後	一、學生感受才能未達到自身及師長期望水平	(一)家長要求 (二)表現不佳

資料來源：本研究整理

(二)研究結果的檢核

研究夥伴首先獨立進行資料分析，然後與研究者比對分析結果，確認一致性與準確性。為確保資料分析的嚴謹性，研究者與研究夥伴進行了多次深入討論，特別是在資料編碼、主題和詮釋過程中進行逐步討論，以處理意見不一致的情況。當有分歧時，雙方共同審視原始資料，必要時徵詢外部專家的意見。整個檢核過程有徵求具有質性研究專長教授的

專業意見，通過多方交流和討論，提升資料分析的嚴謹性和研究結果的整體品質。

六、研究倫理和信實度

為提升研究信實度，本研究遵循倫理規範與資料驗證程序，進行受訪者檢核，確保解釋的準確性。提供受訪者訪問的建議與感想的檢核回饋表單並使用反身性日記識別個人偏見。保護受訪者隱私，也將所有資料均以編號處理，並與受訪者簽訂知情同意書，確保研究的倫理性和資料的可靠性。

參、研究結果

本研究採用主題分析法進行質性資料的系統性處理與分析，嚴格依據 Braun & Clarke (2006, 2012) 的理論框架。為了確保研究結果的信實度和客觀性，研究過程中進行了逐字編碼，標記關鍵概念，形成次主題，最終整合形成核心主題。隨後，將本研究結果以國中特殊專長學生壓力及因應的主題，透過二十一位受訪者資料的綜合分析，從研究問題中進行主題編碼整合出影響不同專長相關因素的次主題。進一步通過交叉比對的方式，找出不同專長之間的共同點和獨特性。

一、特殊專長學生的壓力來源因素

本研究旨在探討不同特殊專長學生在學習過程中所面臨的壓力來源。通過對美術、音樂、體育九位專長學生的深入訪談，研究總結了專長學生所面臨的主要壓力來源「才能與學業能力表現的落後」，並進行了詳細分析。研究結果顯示，這些壓力來源主要集中在以下幾個方面：

(一)才能未達到自身及師長期望水平

多數專長學生反應，專長才能未達到自身及師長期望水平，這成為了

主要的壓力來源。首先，家長對學生的高期望是壓力的重要來源之一。學生普遍感受到來自家長的高期望，部分學生的專長選擇甚至是基於家長的意願，而非自身興趣。例如，AS1提到：「媽媽從小讓我去美術社學畫畫和美勞」，這顯示出家長對其專長的強烈期望。然而，當學生在術科的表現未達預期時，會在專長領域感到自信心不足。例如，MS1表示：「術科考試花很多時間練習，也沒有達到老師要的結果」，這進一步加劇壓力感。因此，家長的高期望和術科表現不佳共同構成了專長學生面臨的主要壓力來源，影響了專長學生的心理健康和學習體驗。

(二)學業難度增加

專長學生除了需要在專長領域不斷精進外，還需面對學校的學業要求。隨著學業難度的增加，感到巨大的壓力。首先，許多學生感受到學業進度跟不上的無力感。例如，PS1提到：「學業方面的問題，大部分的科目都得補習」，顯示出這些學生在跟上學業程度方面面臨的困難。此外，考試成績的不理想也讓學生感到焦慮和挫敗。例如，PS2表示：「學業就是第一次考不好，有點嚇到為什麼會這樣」，反應了學生對考試成績的擔憂和無助感。因此，學業難度的增加不僅讓專長學生在專長領域的精進變得更具挑戰性，也使專長學生在學業方面承受著更大的壓力，這雙重壓力進而影響了心理健康和學習效果。

(三)學習才能和學業分配時間不足

專長學生在學習才能和學業之間的時間分配困難，面臨時間管理上的巨大挑戰。首先，術科功課和練習佔用了大量時間。例如，AS2提到：「水彩每天要練，要是畫不好的話，可能就要重新打基礎」，這顯示出術科訓練對時間的高度要求。其次，讀書時間不夠也成為一個重要問題。例如，PS1提到：「術科練習完很晚，補習上課要到晚上7-9點會來不及，也會累死」，反應了學生在術科練習和學業補習之間的時間安排困難。此外，術科活動和學業時間順序衝突也是一大挑戰。例如，AS1提到：「遇

到要繳交美展作品和學校考試同時發生」，顯示出術科活動與學業時間的衝突問題。專長學生在時間分配上的困難，不僅影響了在專長領域的發展，也對學業成績造成了負面影響的壓力。

(四)才能和學業競爭壓力

專長學生在學習過程中，除了學業和才能上的壓力外，還面臨著來自同儕的競爭壓力，這種壓力在演出和比賽等場合尤為突出。首先，許多學生擔心自己跟不上同學的步伐。例如，AS2提到：「學校老師比較注重那些差或者比較好的學生，我在中間可能就是少建議啦」，這顯示出學生在競爭中的不安感和被忽視的情緒。其次，學生對自己的演出和比賽能力感到不夠自信。例如，PS1提到：「跆拳的話就是比賽的壞習慣動作，在場上打太累就變成大動作」，這反應出學生對自身能力不足的擔憂。這種競爭壓力不僅影響了學生的心理健康，還可能削弱學生在專長領域的表現。總之，同儕競爭壓力加劇了專長學生的焦慮，進而影響了學習和專長生活。

綜合前述的研究結果說明，特殊專長學生在學習過程中面臨的壓力主要來自專長才能與學業能力的落後、學業難度增加、學習才能和學業時間分配不足，以及才能和學業的競爭壓力。這些壓力因素在不同程度上影響著學生的學習和心理健康。以下為美術、音樂、體育專長學生的壓力源之整理，如表4所示。

表4

美術、音樂、體育專長學生的壓力源

壓力源	主題	次主題	編碼
專長學生才能與學業能力表現的落後	一、學生感受才能未達到自身及師長期望水平	(一)家長要求	1.媽媽讓我去學畫畫 2.媽媽說準備美術班考試 3.媽媽要我讀美術班 4.我媽希望我有個專長 5.媽媽讓我去培養興趣

（續下表）

表4 （續）

壓力源	主題	次主題	編碼
專長學生才能與學業能力表現的落後	一、學生感受才能未達到自身及師長期望水平	(二)表現不佳	1.畫不到自己的期許 2.老師會說怎麼畫成這樣 3.術科考試沒達到老師要求 4.教練講我都沒做到 5.受傷和確診的表現受影響 6.練習長跑過程中會吐
	二、學生感受到學業難度增加	(一)學習程度跟不上的無力感	1.大部分的科目都得補習 2.英文的程度可能就是小六 3.數學也去補習班 4.現國中比國小難 5.學科困難就是要去理解 6.老師講什麼都聽不懂 7.上課就是聽不懂會分心 8.讀書沒方法、不認真聽講
		(二)考試成績不好	1.成績仍然不好 2.在班上的成績就是中下 3.考試錯的比較多 4.班排前面掉到中間 5.每科平均的分數都很爛分 6.學業就是考不好
	三、學生在學習才能和學業分配時間不足	(一)術科功課和練習花很多時間	1.美術需要時間反覆練習 2.水彩每天要花時間練 3.術科平均是三週交作業 4.音樂會花很多時間練習 5.樂理等作業寫不完 6.有難度要練很熟悉為止 7.每週一、三有夜訓 8.晨間訓練和下午六七節
		(二)讀書時間不夠	1.一年級就有第八節課 2.利用下課時間有先讀 3.晚上有術科對練時間 4.術科練很晚，補習來不及

（續下表）

表4 （續）

壓力源	主題	次主題	編碼
專長學生才能與學業能力表現的落後	三、學生在學習才能和學業分配時間不足	(三)有術科活動和學業時間順序衝突	1.美展作品和考試同時發生 2.要優先把比賽曲子先練好 3.會以全國賽為優先於功課 4.家人會說不能只有田徑
	四、學生面臨到才能和學業面臨競爭	(一)怕跟不上同學	1.注重比較好的學生 2.同學都交出好的作品 3.主副修成績在中間 4.彈鋼琴會有比較
		(二)怕演出和比賽的能力不夠	1.樂團表演會找厲害的人 2.比賽被抓到缺點輸掉 3.未達標全中運成績

資料來源：本研究整理

二、特殊專長學生的壓力因應策略

本研究旨在探討不同特殊專長學生在面臨學業和才能壓力時的因應策略。通過對美術、音樂、體育九位專長學生的深入訪談，研究總結專長學生所採取的主要「才能與學業的啟發和情緒壓力」的因應策略，並進行了詳細分析。研究結果顯示，這些因應策略主要集中在以下幾個方面：

(一)學生在才能和學業問題的解惑

多數專長學生反應，在面對才能和學業問題時，會尋求有經驗的指導者的幫助，以提升自己的能力和成績。首先，學生會尋求擁有指導經驗的老師或學長姐的幫助。例如，AS1提到：「術科有在地刊物採訪編輯活動，也會在老師規劃下，請畢業的學長姐指導我們」，這顯示出學生在術科訓練中獲得的支持和指導。接著，學生採取各種有效的讀書方法來提高學業成績。例如，MS1提到：「數學比較不好，通常就是爸爸幫我就一起複習」，這表明家庭成員在學生學業中的支持角色。因此，尋求有經驗的指導者和採用有效的讀書方法，成為了專長學生解決才能和學業問題

的主要策略，這不僅提升了學業成績，也增強了在專長領域的自信心。

(二)學生用積極調適來轉移情緒

專長學生在面臨壓力時，會採取積極的調適策略來轉移情緒，減輕心理負擔。首先，體能運動成為學生宣洩壓力的一種有效方式。例如，PS2提到：「自己去跑步放鬆」，這顯示出運動在情緒調節中的作用。其次，學生通過娛樂休閒活動來暫時放空，緩解壓力。例如，AS1提到：「不想念時會先放下書本，看半小時卡通」，這反應了學生通過休閒活動來放鬆身心。此外，學生在壓力時期需要他人的同理和陪伴來獲得心理支持。例如，MS2提到：「偶爾會陪我外出逛逛，讓我把自己心裡話講出來」，這顯示出社交支持在情緒調節中的重要性。因此，專長學生在面對壓力時，透過體能運動、娛樂休閒活動和他人的心理支持來積極調適情緒策略，有效地減輕心理負擔。

(三)學生用消極處理來逃避困難

部分專長學生在面對困難時，會選擇消極的應對方式，以逃避壓力源。首先，有些學生在面對困難時會選擇放棄努力。例如，MS3提到：「會有撞牆期，練到有點想放棄了」，這反應了學生在壓力面前的退縮，無法克服學習和才能上的挑戰，最終影響了專長的表現和自信心。此外，極少數學生會選擇用自殘的方式來面對壓力。例如，PS3提到：「之前壓力過大，在教室時，有用美工刀自殘的方式」，這表明部分學生在極端壓力下的負面應對方式。這些消極的應對策略不僅無助於解決問題，反而可能對學生的身心健康造成更大的傷害。因此，專長學生在面對困難時，採取消極應對方式逃避壓力源，對學生的長期發展和心理健康造成了不利影響。

綜合前述的研究結果說明，特殊專長學生在面臨壓力時採取了積極的解惑與調適策略以及消極的逃避策略。具體來說，學生在才能和學業問題上會尋求有經驗的指導者幫助，並採用有效的讀書方法來提高學業

成績；在情緒調節上，專長學生通過體能運動、娛樂休閒活動和他人的心理支持來疏解壓力；但在極端壓力下，部分學生會採取消極的逃避行為，如放棄練習或自殘。這些因應策略的多樣性反應了專長學生在應對壓力時的複雜性和多面性。以下為美術、音樂、體育專長學生的因應策略之整理，如表5所示。

表5

美術、音樂、體育專長學生的因應

壓力因應	主題	次主題	編碼
才能與學業的啟發和情緒壓力的因應	一、學生在才能探索和學業的解惑	(一)擁有指導經驗的人	1.術科請畢業學長姐指導 2.外面老師會指導加強 3.刊物發想老師會指導 4.尋求主副修老師來加強 5.小提琴老師會教技巧 6.找同學或跟學長學姐 7.教練有告訴我補強之類
		(二)有效率的讀書方法	1.尋求同學的幫助和解答 2.學業問老師、同學 3.爸爸幫我複習、補習班 4.老師講解或讀懂詳解 5.有空就要先讀 6.問老師或聰明的同學 7.問姊姊功課要怎麼讀
	二、學生用積極調適來轉移情緒	(一)體能運動的疏壓宣洩	1.跟國小同學打球 2.和家人一起戶外運動 3.自己去跑步放鬆
		(二)娛樂休閒活動的暫時放空	1.看卡通、畫畫、聽音樂 2.玩遊戲 3.看小說、會吹樂器 4.逛街抒發壓力 5.看電視 6.看手機、出去玩 7.看IG跟不認識的人聊天 8.跟表姊聊天

（續下表）

表5 （續）

壓力因應	主題	次主題	編碼
才能與學業的啟發和情緒壓力的因應	二、學生用積極調適來轉移情緒	(三)同理和陪伴的心理支持	1.媽媽說有盡力就好 2.老師就會給鼓勵、支持 3.媽媽會幫我 4.會說不用太在意 5.把自己心裡話講出來稱讚 6.陪伴、鼓勵、加油 7.就鼓勵、說訓練上壓力 8.受傷姑姑就有安慰我 9.教練開導和調整我的心情
	三、學生用消極處理來逃避困難	(一)放棄不想練習	1.不想特別符合老師標準 2.就沒有把它練好 3.會有撞牆期，想走社團 4.跟教練說想要轉班
		(二)美工刀自殘	1.在教室時用美工刀自殘

資料來源：本研究整理

三、家庭面對特殊專長學生的支持策略

本研究旨在探討不同特殊專長學生在面臨學業和才能壓力時，家庭所提供的支持策略。通過對美術、音樂、體育九位專長學生之家長的深入訪談，研究總結了家長所採取「提供強大的後援和支出」為主要家庭支持策略，並進行了詳細分析。研究結果顯示，這些支持策略主要集中在以下幾個方面：

(一)家長給予正向情感連結

家長在支持孩子的過程中，給予了大量的情感支持，這些情感連結對學生的心理健康和學習效果產生了積極影響。首先，家長通過與孩子的交流和陪伴，給予小孩心理上的安全感。例如，AP1提到：「睡前陪她聊天，讓她說一說舒緩壓力」，這顯示出家長在情感支持中的重要作用。其

次，家長尊重孩子的學習發展，鼓勵小孩按照自己的興趣和能力發展。例如，AP1提到：「傾聽小孩的想法，不用大人的角度給意見」，這表明家長在支持孩子自主發展方面的態度。最後，家長給予孩子充分的休息和放鬆時間，幫助平衡學習和生活。例如，AP2提到：「偶爾讓他找同學出去打球，或給他線上打電動時間」，家長透過這些策略，不僅提升了孩子的學習效果，也增強了小孩的心理健康和自信心。

(二)家長投入學習所需的物質環境

在支持孩子學習方面，家長投入了大量的物質資源，這些資源對孩子的學習和才能發展提供了重要保障。首先，家長通過尋找外部的教育資源，為孩子提供更好的學習條件。例如，AP1提到：「請外面的美術老師協助指導孩子全縣美展作業」，這顯示出家長在尋找外部支持方面的努力。同樣地，MP2提到：「我們請了一位鋼琴老師，每週來家裡上課，幫助孩子準備音樂比賽」，這顯示出音樂領域家長在支持孩子專長發展的投入。體育領域的家長也有類似的投入，如PP2提到：「購買了專業的體育設備，讓孩子能夠完善的練習」，這反映出家長對孩子在體育專長發展上的支持力度。這些投入不僅幫助孩子在專長領域取得進步，也減輕了他們的學習壓力，讓孩子能夠更加專注和自信地面對學業和才能的挑戰。通過這些物質資源的支持，家長為孩子創造了一個良好的學習環境，促進了他們的全面發展。

綜合前述的研究結果說明，家庭在支持特殊專長學生的過程中，通過提供正向情感連結和投入學習所需的物質環境，幫助學生更好地應對學業和才能的壓力。家長在情感和物質兩方面的支持，不僅提升了學生的學習效果，還增強了他們的心理健康和自信心。以下為美術、音樂、體育專長學生的家庭支持策略之整理，如表6所示。

表6

美術、音樂、體育專長的家庭支持策略

家庭支持	主題	次主題	編碼
家長提供強大的後援和支出	一、家長給予正向情感連結	(一)給予孩子安全感的策略	1.讓她說一說舒緩壓力 2.情感上的的支持跟鼓勵 3.心理輔導 4.陪讀和詢問需要哪些幫助 5.聽她抱怨、有問必答 6.我跟爸爸盡量跟他們聊天 7.關心他要注意安全 8.名盡力就好等心理建設
		(二)尊重孩子的學習發展	1.不用大人的角度給意見 2.尊重孩子的想法 3.會隨著他的個性去發展 4.她要做什麼，是不會介入 5.讓她做自己喜歡的事情 6.每一種給她試試看啊 7.支持他的興趣 8.對他有幫助都會主動說 9.看她的興趣找那方面有關
		(三)給予充分休息時間	1.偶爾給他線上打電動時間 2.讓她放空不要規定時間 3.會跟他說好好休息之類
	二、家長投入學習所需的物質環境	(一)供應外部的學習環境	1.外面老師、補習或找網路 2.術科外面畫畫教室加強 3.補樂理、安排音樂欣賞 4.請外面音樂老師、看表演 5.外面音樂教室，準備檢定 6.出國去移地訓練
		(二)添購器材和訓練的費用	1.需要供應美術工具耗材 2.音樂比賽花時間和金錢 3.要投入好多時間跟錢啊 4.跆拳道電子護具需要花錢

資料來源本研究整理

四、指導老師面對專長學生的輔導策略

本研究旨在探討不同特殊專長學生的指導老師在面對這些學生時所採取的輔導策略。通過對美術、音樂、體育三位專長學生之指導老師的深入訪談，研究總結了指導老師在輔導過程中「面對專長學生探索才能的發展」為主要策略，並進行了詳細分析。研究結果顯示，這些策略主要集中在以下幾個方面：

(一)提供學生突破專長才能的策略

術科課程和比賽是指導老師為學生創造發展專長優勢的關鍵方式。美術、音樂和體育老師們一致指出，在設計術科課程時，會協同開設多樣化的課程，以便學生能在實踐中磨練技藝。例如，AT1提到：「會安排學生參加外部比賽，以提高學生的實戰經驗」，也能讓學生在實際操作中學習和成長。其次，例如，AMT2提到：「音樂專長的老師根據每個學生的練習狀況，與相關老師共同討論，制定參賽計劃」，確保了每個學生都能在比賽中發揮最佳水平。此外，例如，APT3提到：「通過外部訓練和比賽，鼓勵學生充分發揮優勢」，同時注重天賦與後天努力的結合，也培養了專長的競爭意識和團隊精神。

在術科方面，指導老師要求學生自我約束並持續努力。例如，AT1提到：「術科學生承受的壓力比一般學生大，需要花費更多時間練習」，有助於學生在技藝上達到更高的水準。例如，MT2提到：「每位學生在技術上都有可能面臨瓶頸，因此需要根據個人情況進行額外的訓練」，能幫助學生突破技術瓶頸，達到新的高度。最後，例如，APT3都提到：「會考慮學生的身體條件差異，進行針對性的輔導」，強調個別化的指導，能讓每位學生在自己的專長領域中取得最大進步。

(二)提供學生專長發展的影響

升學的經驗分享對於學生未來的專長選擇和職涯規劃有著重要的指

導意義。首先，美術老師會邀請相關領域的學長姐，分享在升學和職業發展中的成功經驗，來幫助專長學生確立清晰的目標。例如，AT1 提到：「學長姐們會講述自己在選擇大學專業和職業道路上的經歷」，這些真實的故事讓學生能更具體地了解自己的興趣和能力如何與未來的職業相結合。其次，例如，MT2 提到：「鼓勵學生多元發展，強調興趣的重要性，而不僅僅是現有的技能」。音樂老師會鼓勵學生嘗試不同的領域，發掘自己真正喜歡並願意投入的方向，有助於在未來的學習和工作中保持動力。

然而，例如，PT3 指出：「雖然家長通常非常重視運動，但這種重視對於學生未來專長發展的實際影響有限」，強調家長的支持固然重要，但會與家長和學生共同探討，如何在保持運動專長的同時，開拓更多的發展可能性。學校提供的資源和環境對學生專長發展也有著深遠的影響。例如，AT1 提到：「學校經常與外部資源合作，開展如編輯和繪畫等實踐活動」，這些活動不僅拓寬了學生的視野，還能讓學生了解專業世界的需求和挑戰，為未來的發展打下堅實的基礎。另一方面，例如，M2 提到：「學校在專長培養上仍以學科導向為主，這可能限制了學生在藝術領域的全面發展」，呼籲學校能夠提供更多的支持和資源，幫助學生實現更全面的成長。最後，例如，PT3 強調：「家長對學生學業和未來競爭力的擔憂，往往影響了學校在體育專長銜接上的效果」，這種擔憂使得學校在設計體育專長課程時，面臨諸多挑戰。因此，體育老師建議，學校和家長應該加強溝通，共同支持學生在體育和學業上的平衡發展。

(三)積極心理輔導的策略

輔導老師在輔導過程中，建立學生的自信心和提供專業輔導措施。首先，指導老師提供鼓勵和支持，幫助學生認識自己，提升自信心。例如，AP1 提到：「國八上是探索，然後國八下的話就是有沒有認識自己，然後學生知道自己想要走什麼樣的去向這樣子。」說明在不同階段，老師會引導學生自我探索，找到自己的興趣和方向。例如，MT2 進一步指

出：「學生到九年級之後，就好像會進入到一個封閉時期，反而會鼓勵可以拿起樂器來舒壓，可以稍微遠離一下書本；比較邊緣、沒自信，都會給一點補救機會，然後慢慢建立信心起來。」表明在學生感到壓力或自信心低落時，老師會提供不同的舒壓方式。

接下來是專業的輔導措施，指導老師提供專業心理服務，幫助學生應對挑戰，管理情感。例如，AP1提到：「會先基礎的輔導，教他們怎麼做時間的調配；有特殊的狀況，學校有專業的輔導老師。」這表示老師會首先進行基本的輔導，例如時間管理技巧，並在需要時提供專業的心理輔導。例如，PT3也提到：「藉由運動心理師、諮商師的專門輔導，針對孩子們的比賽的表現去增強選手們的信心，來改善運動表現。」這強調了專業輔導的重要性，通過運動心理師和諮商師的幫助，學生在比賽中能夠表現得更好，信心得到提升。

綜合前述的研究結果說明，指導老師在輔導特殊專長學生時，通過提供突破專長才能的策略、分享專長發展的經驗、以及積極的心理輔導，幫助學生提升能力，應對挑戰。這些策略不僅提升了學生的專長發展，還增強了學生的心理健康和自信心。以下為美術、音樂、體育專長指導老師的輔導策略之整理，如表7所示。

表7

美術、音樂、體育專長指導老師的輔導策略

生涯輔導	主題	次主題	編碼
指導老師面對專長學生探索才能的發展	一、提供學生突破專長才能的策略	(一)術科課程和比賽	1.術科老師會互相開課程 2.專長有比賽或是表演 3.會安排外面訓練和比賽
		(二)在術科的自我要求	1.學生要花時間在練習 2.練技巧學生需要時間 3.身體條件對學生進行分析

（續下表）

表7（續）

生涯輔導	主題	次主題	編碼
指導老師面對專長學生探索才能的發展	二、提供學生專長發展的影響	(一)升學經驗的分享	1.相關科系學長姐的分析 2.升學鼓勵多元發展自己 3.運動對未來發展幫助
		(二)學校對專長的支持度	1.學校有跟外部資源合作 2.目前學校往學科的導向 3.學校對專長銜接不好
	三、積極心理輔導的策略	(一)建立學生的自信心	1.國八探索、認識自己 2.補救機會，建立信心
		(二)提供專業的輔導	1.基礎輔導、專輔老師 2.運動心理、諮商師輔導

資料來源：本研究整理

肆、討論

本研究旨在探討特殊專長學生在學習過程中所面臨的壓力來源及其因應策略。本章節將綜合研究結果，對美術、音樂和體育專長學生、家長以及指導老師的訪談與先前文獻進行分析，討論三方上存在不同感知與經驗的對比，提供研究發現的差異。

一、專長學生的壓力來源

在美術、音樂、體育專長領域壓力來自「才能與學業能力表現的落後」，學生感受到自己的才能未能達到家長和師長期望的水平，主要是因為術科的課程往往是根據家長的要求而安排的。這也與之前的研究相呼應，王麗雁（2015）指出，缺乏興趣的支持和能力的肯定會增加學生的專業壓力。除此，學生在學習才能和學業分配時間方面也面臨著挑戰。這種時間安排上的挑戰與先前的研究相符，指出學校超負荷訓練可能與考

試時間發生衝突，而在學業和專長領域管理上面臨著困難 (Van Rens et al., 2016)。最後，在學習才能和學業方面的競爭也是學生面臨的壓力生活。這種競爭壓力與先前的研究相呼應，在專長生活中學生所面臨的壓力包括同儕競爭、受傷的困擾、生理發育的壓力、課業的壓力等（黃文成，2012）。綜合前述研究結果文獻分析對比發現，專長學生感受與家長期望之間存在矛盾性，學生普遍感受到來自家長的高期望壓力，但家長多數認為他們在尊重孩子的學習發展。學生與家長之間的期望差異可能源於溝通不足，這些研究表明，家長在支持孩子的同時，也需要更進一步地了解孩子的真實需求和感受。

二、專長學生的因應策略

在美術、音樂、體育領域壓力因應來自「才能與學業的啟發和情緒壓力的因應」主要策略為才能和學業問題的解惑、用積極調適來轉移情緒和消極處理來逃避困難等。專長學生在面對才能和學業問題時，積極尋求有經驗的人幫助。同時，對於學業問題，主動尋找學習資源。呼應了先前研究中所提到才能和學業策略，包括增加練習、參與相關領域活動、閱讀專業書籍以及進行自我省思等方式（王麗雁，2015；Cornett & Urhan, 2021）。此外，學生透過體能運動、短暫時間的放空和朋友的陪伴和家人的支持，來轉移情緒方式等因應。與先前研究中提到的身體活躍方式、積極的娛樂活動，以及與親友共度休閒時光等策略相呼應 (Alexopoulou et al., 2019；Park & Kim, 2018)。對於在研究結果發現，一位體育專長學生曾有使用美工刀，造成身體的負面傷害。這種消極的處理行為與過去研究中呼應到，過度壓力的刺激會引發非適應性傷害 (Schäfer et al., 2017)。綜合前述研究結果分析對比發現，在不同專長的學生需要不同的支持和指導，並未充分支持明確區分不同專長學生所需的具體支持類型，在未來研究應進一步深入探討各專長領域學生在壓力因應過程中所需的具體支持類型，以便提供更具實證依據的建議。

三、專長學生的家庭支持策略

在美術、音樂和體育專長在家庭方面，來自「家長提供強大的後援和支出」支持策略，主要給予正向情感連結、投入學習所需的物質環境等。為孩子提供安全感、尊重孩子的選擇安排和給予充分休息的時間等。與先前研究指出，在培養專長的孩子時，家長會根據孩子的個性和需求，建立一個有助於自主發展和情感支持的環境 (Garn et al., 2012)。另外，在家長的支持研究策略中，提供放鬆練習、冥想、娛樂活動，以及休閒時光等 (Alexopoulou et al., 2019; Park & Kim, 2018)。此外，願意提供適合的外部學習環境，包括必要的器材和訓練費用。在不同專長領域的研究中，發現家長在運動投入上的時間和金錢支出、以及在學音樂方面的成本等因素，都是對孩子專長發展的重要支持（李洋、李金為，2021；周碩政，2019；林大森、陳世昌，2022）。綜合前述研究結果文獻分析對比發現，學生希望能夠在一個支持性的環境中學習，家長則更關心孩子的未來發展和學業成績。強調了在專長環境過程中，滿足學生、家長不同需求的重要性，

四、專長指導老師的輔導策略

在美術、音樂和體育專長的指導老師中，運用多種策略來幫助學生發展才能，這些策略源自於「探索才能的發展」。這些策略包括通過術科課程和比賽經驗，老師幫助學生了解自身在專長領域的強項和侷限性，這些方法呼應了探索學生特質、發展專長優勢和生涯目標的研究（江學瀅，2021；陳勇祥，2021）。此外，老師邀請學長姐和家長分享經歷，呼應先前研究應避免過度強調比賽成績和考試，來創造符合孩子性向的環境（王若雯，2016；鄭渝錦，2020；Kao, 2012）。老師提供專長表現機會，呼應先前研究安排多元職業試探和探索課程（劉佳杰等，2017）。同時，老師幫助學生建立自信心和提高自我價值，協助學生管理負面情感。呼應之前研究指出，與專業合作、發展個人、團體和家庭治療的諮詢中心，

以及心理學家了解影響有天賦孩子學習動機的重要性 (Alexopoulou et al., 2019；Sangma et al., 2018）。專長輔導策略應設計情緒和心理課程，呼應研究讓學生了解正向與負向情緒，並教授減少焦慮和壓力的技巧 (Cornett & Urhan, 2021)。綜合前述研究結果分析對比發現，在不同專長的學生需要不同的支持和指導，並未充分支持明確區分不同專長學生所需的具體支持類型，可以在未來研究應進一步深入探討各專長領域學生在壓力因應過程中所需的具體支持類型，以便提供更具實證依據的建議。

伍、結論與建議

本研究旨在探討特殊專長學生的壓力來源及其因應策略，並分析家庭支持和指導老師對學生輔導的調適作用。通過質性取向的深度訪談研究法，主要發現幾點重要結論：

一、結論

(一)專長學生的壓力來源

特殊專長學生面臨的壓力主要來自於才能和學業表現未達到自身及師長的期望、學業難度的增加、學習時間分配不足以及才能和學業之間的競爭。這些壓力源進一步引發了學生在面對家長要求和表現不佳時的負面情緒和反應。

(二)專長學生的壓力因應

特殊專長學生採取的壓力因應策略主要包括：尋求才能與學業問題的解決方案、積極調適以轉移情緒、以及消極逃避困難的方法。有效的因應策略有助於學生更好地管理學業和才能之間的壓力。

(三)專長學生的家庭支持策略

家庭在支持特殊專長學生時，通常提供強大的後援，包括正向情感連

結和物質支持。家長的情感支持、安全感和學習資源的供應對學生的才能發展起著至關重要的作用。

(四)指導老師的輔導因應

指導老師通過提供突破專長才能的策略、積極心理輔導及專長發展的影響，幫助學生克服學業和才能上的挑戰。這些策略不僅有助於學生找到合適的未來規劃，還能延續有效的輔導策略並分享成功經驗。

二、建議

根據研究的發現，提出以下幾點實務上的建議，針對學生、學校和家庭三方面，以及未來研究的方向。

(一)實務上的建議

1. 學生方面

提供心情檢測和健康服務專線，協助學生隨時檢視並自我調節情緒，特別是在競爭和比賽焦慮的情境中。以及增加產業和學界交流機會，以擴展專長學生的視野和職涯規劃。

2. 學校方面

根據專長需求提供經費補助，擴充相關的設施和資源。在專長現有學校體系中補足專長老師編制，注重專業發展和指導的培訓，確保教學能力的延續。並促進專業和社區資源的整合，建立專業跨校合作，創建更多元的學習環境。

3. 家庭方面

促進學生、家長和老師之間的有效溝通，實際了解孩子的需求和壓力。提供適當的休閒活動時間，確保孩子在學習之外有充分的休息。積極參與學校的教育推動，了解學校對專長發展的方向及支持和資源。

三、未來的研究

根據研究的結果，提出以下幾點限制及未來研究方向的說明：

(一)對象限制

擴大樣本規模，由於本研究受訪者主要為新竹地區的學校，為了提高研究結果的外推性，未來的研究可以考慮擴大樣本規模，納入來自不同地區的專長班學生，以確保研究結果的廣泛性和代表性。

(二)時間限制

採用更靈活的訪談安排，由於家長和老師會因家庭和工作時間因素無法接受訪談。未來的研究可以考慮更多元的訪談安排，例如：搭配視訊工具進行訪談，以彌補時間限制並獲得更豐富的研究資料。

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A Study on Stress and Coping among Talented Students in Junior High Schools

Yu-Lin Chen* Fong-Ching Chang**

Abstract

Objectives: Recent educational reforms emphasize the development of students based on their talents and interests. However, statistical surveys show a decline in high school specialty program admissions, increasing competition among junior high school students with specialized skills. This study explores the stress sources and coping strategies of these students, providing insights into how students with different specialties manage stress.

Methods: Qualitative in-depth interviews were conducted with nine students (art, music, and physical education) in Hsinchu, along with their parents and instructors, totaling 21 participants.

Results: The primary stress sources are lagging academic and talent performance, insufficient time allocation, and unmet expectations from themselves and instructors. Some students adopt proactive coping strategies, while others resort to avoidance. Parents and instructors play key roles in providing emotional and practical support.

Conclusions: Parental expectations and poor academic performance are major stressors. Effective coping strategies, family support, and instructor guidance are vital for balancing academic and talent pressures and future planning.

Key words: counseling, family support, stress coping, talented students

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Doubt and Distrust: Determinants of COVID-19 Vaccine Hesitancy in Nigeria From a Qualitative Perspective

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Abstract

Objectives: This research aimed to understand the determinants of COVID-19 vaccine hesitancy in Nigeria, as well as understand the decision-making process behind the choice to vaccinate or not.

Methods: This research employed a qualitative research methodology, utilizing semi-structured interviews. Eighteen participants were selected using a purposive sampling procedure.

Results: The determinants of COVID-19 vaccine hesitancy identified in Nigeria were Doubt-based determinants: (1) Doubt in the vaccine, manufacturers and available vaccine knowledge, (2) Distrust and dissatisfaction in the government, and (3) Doubt in COVID-19's existence, (4) Perceptions and beliefs-based determinants and (5) Situational determinants.

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For the decision-making process, three pathways were identified: The Hesitant - Vaccinated Pathway, The Hesitant - Unvaccinated Pathway and The Willing - Hesitant - Unvaccinated Pathway.

Conclusions: Doubt was found to be a prominent determinant. Determinants were not limited to socioeconomic status, or education level.

Key Words: COVID-19, doubt, Nigeria, trust, vaccine hesitancy

1. Introduction

Vaccine hesitancy has always been a constant in the history of vaccinations, and with COVID-19, it was no different (Pennington, 2021). The World Health Organization's SAGE group defined vaccine hesitancy as 'delay in acceptance or refusal of vaccines despite availability of vaccination services (MacDonald & SAGE Working Group on Vaccine Hesitancy, 2015). Additional to the definition proffered by WHO, vaccine hesitancy is also the situation where the vaccine is taken but with hesitance and concern (Salmon et al., 2015). Summarily, this means vaccine hesitancy is not just the delay in the uptake of vaccines or refusal to take vaccines when they are available, but it also encompasses the acceptance of a vaccine while having concerns about it, portraying a decision made with hesitance.

The COVID-19 pandemic has claimed over 7 million lives worldwide, and the number of cases thus far have been a staggering 774,954,393 (*COVID-19 Cases | WHO COVID-19 Dashboard*, 2024; *COVID-19 Deaths | WHO COVID-19 Dashboard*, 2024). Nigeria, where this research was situated has had a little over 267,000 Covid-19 cases (*COVID-19 Cases | WHO COVID-19 Dashboard*, 2024). Nigeria has recorded about 3200 deaths, similar to countries like Cambodia, Botswana and Malawi that all recorded between 2800 to 3100 deaths (*COVID-19 Deaths | WHO COVID-19 Dashboard*, 2024).

Lots of research exists about vaccine hesitancy concerning several diseases. For instance, in 2019, in Sudan, a community-based cross-sectional study was done to understand how vaccine hesitancy influences the uptake of the MMR vaccine (Sabahelzain et al., 2022). Additionally, a cross sectional study in a hospital in Uganda showed that of a population size of 385 pregnant women, 74% of them were Hepatitis B vaccine (HBV) hesitant (Afolabi et al., 2022).

Despite its reported effectiveness, COVID-19 vaccines have also received resistance for a myriad of reasons. Previous research has highlighted some factors that affect vaccination decision such as age, COVID-19 knowledge, education, trust, residence, fear, family influence, rumors (Amuzie et al., 2021; Hubach et al., 2022; Ilesanmi et al., 2021; Kabagenyi et al., 2022; Lau et al., 2022; Mann et al., 2022; Mubarak et al., 2022; Ojewale & Mukumbang, 2023; Okafor et al., 2021; Schneider-Kamp, 2022). Nigeria is no stranger to COVID-19 vaccine hesitancy. Out of a population of over 216 million people, only 81.3 million (39%) have received full dosage of the COVID-19 vaccine (*COVID-19 Vaccines | WHO COVID-19 Dashboard*, 2023). This is considered low when compared to other vaccinations in Nigeria such as the measles vaccination which has hovered between 50% to 60% in recent years (Olufadewa et al., 2024). Despite the availability of the COVID-19 vaccines in Nigeria, there has been refusal to vaccinate. There is lack of sufficient research on COVID-19 vaccine hesitancy in Nigeria as majority of the existing research utilized quantitative approaches. Some of these quantitative studies include, but not limited to a cross-sectional online questionnaire-based study that pinpointed sociodemographic factors as predictors of COVID-19 vaccine hesitancy as healthcare workers who were younger had significant association with vaccine hesitancy (Amuzie et al., 2021). Another study done in Southern Nigeria noted distrust in the government as a barrier to vaccination (Ilikannu et al., 2022). Previous research has only scratched the surface of this issue.

Vaccine hesitancy is a public health issue and only serves as a barrier to the implementation of public health interventions and promotion. This study aims to carry out implementation research on the COVID-19 vaccination intervention in Nigeria, to understand the determinants of vaccine hesitancy, and how vaccination decisions are made.

This study aimed to pinpoint the determinants of COVID-19 vaccine

hesitancy in Nigeria and understand the decision-making process that leads to the choice to accept the vaccine or not.

2. Methods

2.1 Setting

Nigeria, located in West Africa, is the most populous country in Africa, divided into 36 states and six geo-political regions, namely, South-West, South-South and South-East, North Central, North-East and North-West. This research was carried out across three of the regions: South-South, South-East and South-West, where internet coverage is highest with the South-West having the highest concentration of internet users, followed by the South-South region (Nigeria, n.d.). Internet coverage is relevant to this research because the call for participants was made via the internet, as well as the interviews. To facilitate the research, it was considered suitable to work with the selected regions due to the higher concentration of internet users and spread of internet.

The definition of urban, semi-urban and rural is country-specific. In the Nigerian context, an urban area is an area with a population size of ≥ 20,000 people, and one that possesses basic social and physical infrastructure, and has been designated so through legal or administrative instruments (Ofem, 2012). A rural area in Nigeria is usually an area with less development than an urban area. Urban areas in Nigeria usually refer to cities, suburbs and towns. They have more development in terms of access to infrastructure and connectivity like airports, ports, railways, housing, roads etc. Rural areas usually do not have much development in terms of infrastructure. Semi-urban areas in Nigeria are in between urban and rural areas. They are more developed and have more population than rural areas but less developed than urban areas, with less population than urban areas. Additionally, access to mobile phones is very

similar in urban and rural areas but access to internet in the urban population (68%) is almost double that of the rural population (36%) (Wambugu & Social and Economic Statistics team, Food and Agriculture Organization of the United Nations, n.d.).

2.2 Participants and Recruitment

Eighteen participants, purposively selected participated in this study. This research utilized a combination of purposive and snowball sampling methods. These participants were distributed across the South-South, South-East and South-West regions in a ratio of 9:5:4. Participants were between the age range of 24-67, and cut across different demographics, consisting of different genders, marital statuses and have different careers. The selection of participants took place from June 2023 to September 2023. The call for participants was made on social media platforms Twitter, WhatsApp, Instagram and through word of mouth. Participants were also asked to spread the word. In a google form attached to the 'Call for Participants', participants were given the opportunity to fill in their contact information (Email address, WhatsApp or Telegram number), their age, region of residence, if they wanted to participate in the research and any questions or comments they had. Appointments were arranged with participants who answered the call and fit the following criteria:

I. Residence in any of the South-South, South-East and South-West regions of Nigeria since February 2020 (or before) till the time of the interview
II. Between the ages of 20 to 80.

The names of participants have been changed and they are identified with fake names.

2.3 Data Collection

Semi-structured Interviews were carried out online using the participants

preferred mode of communication and utilizing a prepared interview guide (Supplementary file 1). All participants opted for WhatsApp. While the interviews were in video format, they were all audio recorded. Participants' informed and verbal consent was obtained at the start of the interview. The interviews ran concurrently with the call for participants, from June 2023 to September 2023. Interviews were held one to two times, and a few participants were contacted subsequently when additional information was sought. Interviews lasted between 40 minutes to 1 hour, 10 minutes.

The eighteen participants consisted of elderly people, young parents, employed adults, university students, unmarried and young adults. Interviews were concluded when data saturation was reached, and no new information was being received.

2.4 Data Analysis

Interviews were audio recorded and transcribed, anonymized, checked and edited, then coded. NVivo QSR International Version 22 was utilized for data management. Data was read and analyzed using an inductive approach and thematically analyzed. Analysis was qualitative descriptive. The interview questions that addressed the research questions were noted as coding nodes at the start of the research. Then, as data was read repeatedly, new and recurring codes were identified. New and emerging themes were gotten through repeatedly reading the transcripts and getting new information. Data was then grouped together based on their similarity, to form clusters systematically. After which, comparisons were made and themes drawn out. The codes were drawn up by one researcher and discussions and conclusions as well as checking the codes was done by the two researchers. The pathways that every participant followed was subsequently mapped out to show their decision making trajectories.

Table 1

Characteristics of Participants

Characteristics		n=18
Gender	Male	10
	Female	8
Age	21-30	12
	31-40	2
	41-50	-
	51-60	2
	61-70	2
Education	Higher National Degree (HND)	1
	Bachelor Degree	14
	Master Degree	2
	PhD	1
Current place of residence	Rural	2
	Semi-urban	2
	Urban	14
Region of Residence	South-East	4
	South-West	5
	South-South	9
Vaccination status	Fully vaccinated (FV)	5
	Partially vaccinated (PV)	2
	Unvaccinated (UV)	11

Note:

Higher National Degree: It is a degree program that is completed in five years at a polytechnic and includes an industrial placement. This is a pathway some people opt for instead of going to the university.

Urban: Developed area, referring to cities, suburbs and towns. More development in terms of access to infrastructure and connectivity like airports, ports, railways, housing, roads etc.

Semi-urban area: Less development than urban area, more development than rural area.

Rural area: Less development than an urban area.

Fully vaccinated (FV): Participants who had taken complete (two) doses of the vaccine.

Partially vaccinated (PV): Participants who had taken one dose of the vaccine, and had no plans to follow up with the second.

Unvaccinated (UV): Participants who had not taken the vaccine.

Table 2

Participant ID	Gender	Age	Education	Residence	Marital Status	Region	Vaccination status
01 Binta	Female	30	BSc	Urban	Divorced	SE	UV
02 Tayo	Male	28	BSc	Urban	Single	SW	FV
03 Layefa	Female	53	BSc	Semi-urban	Married	SS	UV
04 Sambo	Male	29	BSc	Urban	Single	SW	UV
05 Emeka	Male	25	Master	Urban	Single	SE	FV
06 Obatare	Male	24	BSc	Urban	Single	SS	PV
07 Eloho	Female	62	BSc	Urban	Married	SS	FV
08 Bolu	Female	25	BSc	Urban	Single	SW	UV
09 Uloma	Female	28	Bsc	Urban	Single	SS	PV
10 Ladipo	Male	33	HND	Urban	Single	SS	FV
11 Tobore	Male	24	BSc	Semi-urban	Single	SS	UV
12 Emuobor	Male	29	BSc	Rural	Single	SS	UV
13 Okoro	Male	27	BSc	Urban	Single	SE	UV
14 Tejiri	Male	67	PhD	Urban	Married	SS	UV
15 Efe	Female	57	Master	Urban	Widow	SS	FV
16 Tolani	Female	26	BSc	Urban	Single	SW	UV
17 Oluchi	Female	29	BSc	Urban	Married	SW	UV
18 Obinna	Male	32	BSc	Urban	Single	SE	UV

Note:

Fully vaccinated (FV): Participants who had taken complete (two) doses of the vaccine.

Partially vaccinated (PV): Participants who had taken one dose of the vaccine, and had no plans to follow up with the second.

Unvaccinated (UV): Participants who had not taken the vaccine.

2.5 Ethical Statement

This research was approved by the Hualien Tzu Chi Hospital Health Research Ethics Committee, Taiwan (IRB 112-127-B) and National Health Research Ethics Committee, Federal Ministry of Health, Nigeria (NHREC/01/01/2007). The participants were informed of the purpose of

the study and given all relevant information. Participants' informed consent was given orally at the start of the interview, as well as permission to record interviews. To ensure transparency and prevent misrepresentation, questions were repeated, and answers were also repeated to participants, to ensure there was no miscommunication.

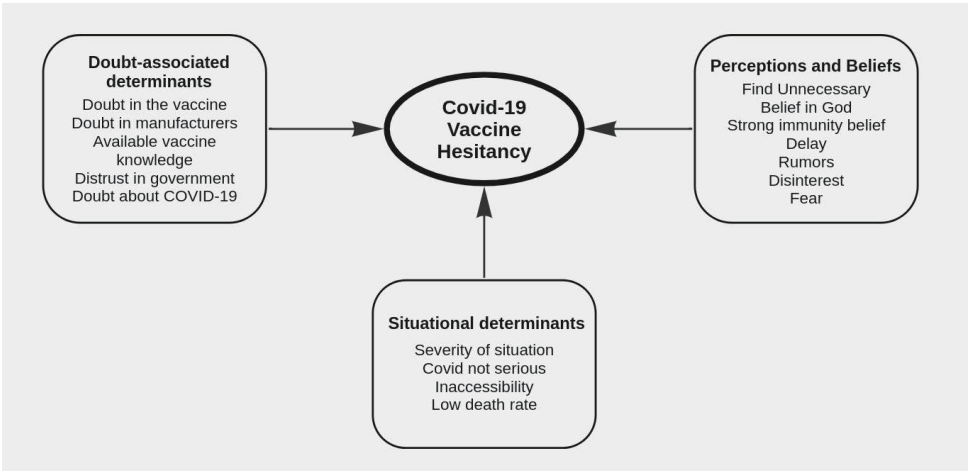
3. Results

3.1 Reasons for Vaccine Refusal/Vaccine Hesitancy

The determinants of COVID-19 vaccine hesitancy found in our research were classified under three themes: Doubt-associated determinants, Situational determinants, and Perceptions and beliefs. Several participants were found to fall across different themes. Of the eighteen participants in this study, all but two were initially vaccine hesitant. Among the sixteen that were vaccine hesitant at the start of the vaccination program in Nigeria, seven have been vaccinated.

Figure 1

Determinants of COVID-19 Vaccine Hesitancy in Nigeria



Note: Figure 1 shows the determinants of COVID-19 vaccine hesitancy as identified in this research.

Doubt-associated Determinants

Among the doubts highlighted by participants that fell in this theme were doubts about the vaccines' safety, manufacturers, and the existing vaccine knowledge, distrust and dissatisfaction in the Nigerian government, and doubt in the existence of COVID-19 itself.

> *There was some rush regarding finding a solution to it in the development of the vaccines. One party wants to outshine the other to come up with a solution so quickly – Sambo (29M, UV)*

> *It's still in the testing phase, I don't want to endanger myself… I don't have that conviction that it's really stable to use for everybody, it depends on your immune system – Tobore (24M, UV)*

There was a lack of confidence in the vaccine, voiced by four participants, and a doubt in its reliability.

> *...I didn't find the vaccine quite reliable and effective…. My understanding of a vaccine is that once you are vaccinated… you don't need to have any fear regarding that virus or disease again… So, at the end of the day, you find out that even these people who took this preventive measure and all of these still have cases. So how else do you want to convince a layman like me that the vaccine is effective? It's supposed to be preventive, right?... I didn't see any logic… – Sambo (29M, UV)*

> *...I didn't doubt the efficacy of the vaccine after the work that Pfizer and the rest brought. But my major concern is that, when there is an issue of*

vaccines, where it is imported from… I am in the health care team... I know that global things like this… the source could be contaminated and so many things could have happened. That was the major reason why I didn't really… – Tejiri (67M, UV)

The adverse side effects of the vaccines that some participants observed from those around them and afar strengthened their hesitant stance.

A colleague of mine took the vaccine, after three days… the place had swollen, she was very sick. So I told her not to take the second vaccine. She didn't take the second vaccine... It was what influenced me most… – Layefa (53F, UV)

The fact that there were numerous vaccines available also fueled these doubts, alongside the contrasting information some participants received.

…there were so many controversies concerning the vaccine. Today the US is saying this, tomorrow China has released their own… Russia has released their own. So there was no concrete…. Okay, yes, this vaccine now, it's 90% efficient and it works, so let's go with this. Everybody is endorsing theirs… something was… not really adding up.. So there were so many things and I felt like because of that, it wasn't really necessary… I think that was the core reason I didn't want to embark on it. But if they had said, okay, this vaccine is what works, it's been endorsed by NAFDAC, every other country is using it, that's what it is. Then I think maybe I probably would have gone for it. – Emuobor (29M, UV)

Dissatisfaction in the government's efforts and distrust in the government

were also prominent reasons for not vaccinating. This distrust stemmed from situations preceding the pandemic, connected to the political situation in the country, and for some, this distrust was compounded by the government's actions during the pandemic.

> *...I was not happy with the government. I felt the government would have not given us something good. Because if they really wanted to help the people, there were palliatives given during the COVID. At the peak of COVID-19, palliatives were given but, you wouldn't believe, these guys stored them in big warehouses… It was during the EndSARS protests that the youths broke into some of the warehouses and made away with the palliatives… So I was believing that if COVID-19 vaccine was real, these ones in the government would not share it and they were never people-oriented... I think many people died of hunger and then since there were food and other palliatives to give to these ones to keep them from hunger and the government never did, how do we trust the fact that they spent a lot of money to bring in the vaccine and to help the people live? You could have just helped them in the first place by giving them food. And you are not, also you are giving us vaccines, so there was no confidence in what they are doing. – Okoro (27M, UV)*

> *I believe some of them thought that the vaccine is more of... maybe their own there is better than the one they gave us here… Theirs is effective… They were now saying, you know, maybe our country has gone to go and get the one that has not finished. They don't trust the vaccine.. – Emeka (25M, FV)*

> *I think when the virus was so rampant, you know they were active. Then*

when the vaccines came about, it was as if everybody stopped talking about it. Nobody was actually… trying to persuade us to go and take it… They were just like, the vaccine has come, everybody just... So, I didn't believe, I don't know. – Bolu (25F, UV)

Doubt in COVID-19's existence was mentioned recurrently.

I don't believe in the existence of the COVID-19 and I don't believe in the vaccine. If I don't believe in the existence of COVID, you want me to believe in the vaccine? I know of malaria, so I believe in the vaccine. Typhoid, I believe... I know of those ones, but COVID, no. I don't believe in it…. – Layefa (53F, UV)

Perceptions and Beliefs

Several perceptions and beliefs were brought up under this theme. Four participants deemed vaccination unnecessary and saw no reason to vaccinate. Additional to this perception was 'Confidence in one's body immunity'. One participant, Tobore shied away from vaccinating because of the novelty of COVID-19. Another voiced his dislike for syringes.

I was not sick, as at the time the vaccine came. I have a very strong immune system and I don't have to go for it… Yes, I am very strong. I hit the gym. – Okoro (27M, UV)

As far as it concerns me, I don't need that vaccine for my immunity, that was the thing on which I really did not take the vaccine. – Tejiri (67M, UV)

Religion also played a role for some participants like Okoro who, alongside believing in his body's immunity, voiced his belief in God's protection.

I am a firm believer of God and so I believe God was taking care of me and secondly, I was strong then just like now so I felt I didn't need the vaccine. – Okoro (27M, UV)

Rumors, the notions and stances of others also played a big role in the decision to not vaccinate for some participants.

...I used to be a very strong person… I don't follow trends in a lot of things but then I could say, because I'm being sincere to myself, I was influenced by the media, by what people were saying about the vaccine and that also gave me a lot of notions not to take the vaccine, apart from the fact that the government never did well. – Okoro (27M, UV)

Situational Determinants

When compared to other countries, the situation in Nigeria was not perceived as serious, likewise COVID-19 itself.

The number of death cases which we witnessed in other countries never happened in Nigeria. That is the number one reason... I don't have anybody close to me or anybody who I can point to that I say, yes, I lost this person during COVID, but I know people died due to it. That one is true… Many people died… – Obinna (32M, UV)

Others had this understanding that COVID-19 is just like malaria for us, it

will come and it will go. – Uloma (28F, PV)

Inaccessibility of the vaccines also contributed to these situational determinants. Inaccessibility in our research refers to ease of vaccination (not accessible easily and poor coordination) and cost of vaccination. These factors had a dissuading impact on vaccination. Some participants reported that at the start of vaccination, the vaccines were expensive in some places. Participants described not being able to get the vaccine easily due to difficulty in finding vaccination sites, delays and shortages.

I actually registered to take the vaccine, sincerely, at a point… you register online, you choose your choice of primary care center, all of that. I was supposed to get a notification, giving me a date and time when I would go for my vaccination and I did that in 2021. Up till this moment I have not gotten a text to come for vaccination… – Sambo (29M, UV)

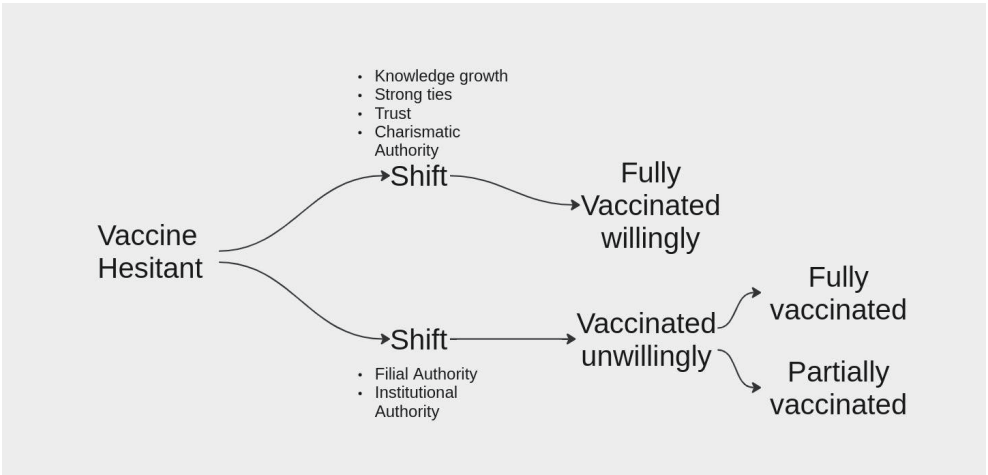
3.2 Vaccine Decision Making Pathways

Three vaccine decision making pathways were identified in our research. These pathways explain vaccine decision making from the initial stance of vaccine hesitancy leading up to the final decision and current stance of participants, as well as the reasons for their shifts to the decision to vaccinate. These pathways have helped understand the COVID-19 vaccine decision-making process. Seven participants had been vaccinated at the time of interviews.

The Hesitant-Vaccinated Pathway

Seven participants followed this pathway.

Figure 2
The Hesitant-Vaccinated Pathway



Vaccinated willingly. Eloho, Emeka, Tayo and Efe went through shifts that caused their initial stance to change and they accepted the vaccines willingly. Emeka's shift was brought about by seeing people around him vaccinate without issues. He also chose to trust his cousins who informed him that their vaccination was without side effects. Despite opposition, he opted to take the vaccine.

> *I didn't believe them. At first, I was just like, let me be sure… I discussed with her (his mother) and a lot of my friends. We talked about it, we joked about it. But when I wanted to take the vaccine, some of them were saying, no, no, don't go and take… I said, I should go and take this… because I don't know… At first she said no, why would I go and hurt myself? Then I had to educate her… My mother believes that people should do what they want to, provided it's their choice and they are ready to take the consequences of their actions. – Emeka (25M, FV)*

While at first, Tayo opted to delay and paid no attention to the vaccines,

the experience of the people he knew, his trust in his parents as well as the knowledge he gained caused his shift to a willing and vaccinated position. Efe, who was not interested and was hesitant to take the vaccine, opted to take it first when she saw someone who she held in high esteem get vaccinated (Charismatic Authority). And she also decided to protect herself after gaining knowledge.

> *Before it came, I said I was not going to take it, because of the information… If it's health information, it's me. But COVID time, they didn't believe me. But other times, I am highly relied upon. It's me that everybody would call, complain to first, but COVID time, everybody had their personal view. They were looking at me, whether I was going to die… But I said, nothing will happen to me. And I won, at least nothing happened to me.. – Efe (57F, FV)*

Vaccinated Unwillingly. Uloma, Ladipo and Obatare followed this pathway, with the reason for their shift being Authority. Uloma and Ladipo were compelled by institutional authority and Obatare was compelled by filial authority. While Uloma's stance has shifted slightly, with her believing the vaccine is effective for some people, Ladipo and Obatare still consider the vaccine unnecessary. Uloma and Obatare are partially vaccinated, with no plans to complete their doses.

> *A hundred and one percent, yes, I do think they are effective… For me, I don't subscribe to the vaccine. I still wouldn't have taken the vaccine. But generally, yes, I'm sure there are those that have benefited from the vaccine… I trust the immunity of my body. I'm sure they'll be proud of me right now. – Uloma (28F, PV)*

In Ladipo's opinion, the vaccine did nothing for him.

The colleague of mine we lost in the vessel took a vaccine and still, he got infected with the COVID virus… I think it's more of your own immune system and not really the vaccine because we saw a lot of people that took the vaccine and they died, first, second and even booster dose… So someone that his or her immune system is already bad, it's easy for that person to die if infected with the COVID virus… I don't believe in COVID-19 vaccine… In my own confined space, my personal life, I take my own decisions myself… If I had a chance, I wouldn't have taken it. I've already taken it, so no regrets. Anything that wants to happen can happen. – Ladipo (33M, FV)

Unlike his parents, Obatare does not believe that COVID-19 exists.

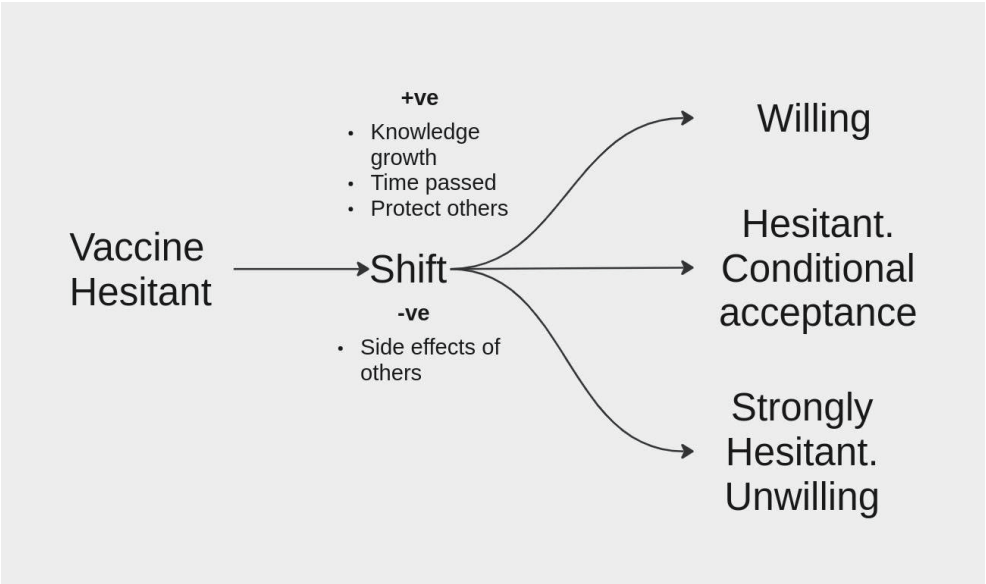
I don't think they had experience but we are different people (referring to his parents) … I did not see anyone with COVID-19. I literally did not see any single person that had COVID-19. And people will just have a normal common cold, and… immediately in their head, their brain has already registered, I can't taste any more, and it's COVID-19... – Obatare (24M, PV)

The Hesitant-Unvaccinated Pathway

This pathway explored the decision-making process of nine participants who had not vaccinated and were unwilling to. Over time, positive and negative shifts played a role in their trajectories. One has moved to the point of willingness, six to the point of hesitancy, but conditional acceptance, and two are still strongly hesitant.

Figure 3

The Hesitant-Unvaccinated Pathway



Note: Figure 3 shows the hesitant-unvaccinated pathway, detailing the reasons for the positive and negative shifts. +ve indicates positive shifts and –ve indicates negative shifts.

Willing. Binta started off distrusting the vaccine, and was swayed by the notions of others. But as she gained knowledge, she made a positive shift to vaccinate.

> *I just came back from training on Tuesday. They talked about it religiously, and currently with the knowledge I have gotten, I will plan towards it because currently we don't have it in the office, but once it arrives, with the knowledge I have now, I will... – Binta (30F, UV)*

When asked about her parents who are against her vaccinating, she noted:

> *...Literally all my life I've always done everything, even when I say no, at*

times, I still have to tilt... Definitely they'll be against it, but I'm not going to tell them before taking the vaccine now. It's my life, it's my body. So, yeah.

Hesitant. Conditional Acceptance. These participants encountered factors that caused a shift in their stance. They are still hesitant and are only willing to vaccinate under certain conditions. So, while they will not go seeking for the vaccines, they will vaccinate under those conditions.

Okoro was strongly unwilling, and even considered himself anti-vaccine, as he also discouraged others. He became less rigid as he learned more. He noted previously, it had been easy to discourage people since they were already skeptical. He is willing to vaccinate only if necessary.

As time passed, I understood that yes, there was COVID-19 and secondly people are not dying, we are not seeing dead bodies on the road as we expected to see as a result of taking the vaccines… since some people actually took the vaccine, I believe it's safe and I was also beginning to reconsider that since I've taken other vaccines. I've also attended conferences here in Nigeria where a lot of elaborations were made to clear the air about what the vaccines really were and how safe it was to the system... Knowledge happened and I believe I can take it now. – Okoro (27M, UV)

Tobore, Emuobor and Bolu also followed the journey that led to conditional acceptance. Emuobor is more open to vaccinating so as to protect those around him, only if the pandemic worsens. He has no regret that he has not taken the vaccine as he found it unnecessary.

Strongly Hesitant. Unwilling. Tejiri and Layefa have no interest in the

vaccine. Tejiri believes COVID-19 is real but does not have confidence in the vaccines. Layefa had a negative shift which reinforced her stance when someone she knew got sick after vaccinating.

Like Layefa, Tolani does not believe that COVID-19 exists. She opined that if COVID-19 existed in other parts of the world, it never existed in Nigeria. Despite conversations she had with her parents who tried to convince her (after they vaccinated), her mind was made up. According to her, the only person who could have convinced her was an uncle she respected. This brings in filial authority, as a drive behind Tolani' s vaccination if she had gotten it.

> *That's my uncle… he is the only person in my house that my parents can report me to. So, at that point, he called me too. But… we were not within reach. There was nothing he could do. So, he told me, 'What if you need the card tomorrow?' I told him, 'Sir, I've heard you'. And that was just the end of the story… Not fear. Let me say it's just respect. – Tolani (26F, UV)*

When asked how she would feel if the pandemic got worse and if she heard of the death of someone she knows from COVID-19, she said:

> *I will just believe it's another strategy from the government just like the first one… There's still no way I can believe that it's COVID. Even if the person died, it's just the person's time to die…*

Oluchi, who worked in the hospital, was also not interested in vaccinating. She had no confidence in the vaccines and the negative notions of people around her also affected her. Oluchi was surrounded by health practitioners who had vaccinated, and those that did not vaccinate. Her mother was against her children vaccinating while her sister was an advocate for vaccination. Regarding her

mother, Oluchi stated:

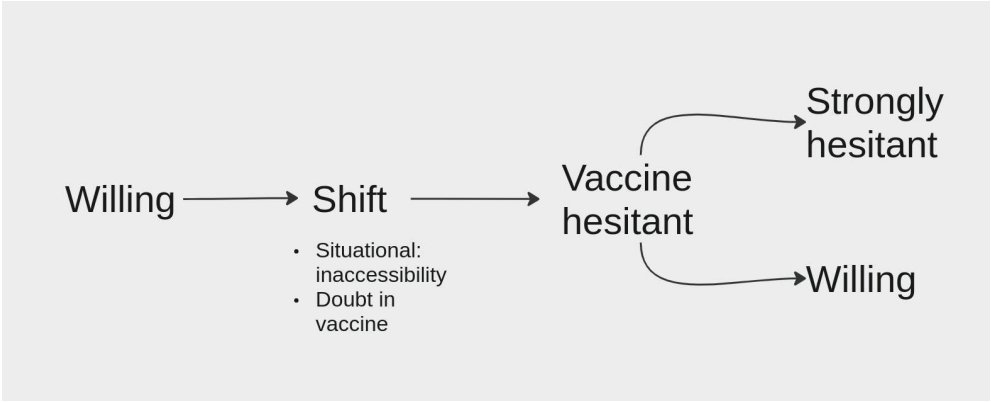
> *And even though I wanted to take it, and she had said no, her choice doesn't really influence my decision, you know, concerning the COVID vaccine. – Oluchi (29F, UV)*

The Willing-Hesitant-Unvaccinated Pathway

The two participants in this pathway, Sambo and Obinna were willing to vaccinate initially, but several shifts occurred, discouraging them. Currently, Obinna is willing and Sambo is strongly hesitant and refuses to vaccinate, except under certain conditions.

Figure 4

The Willing-Hesitant-Unvaccinated Pathway



Note: The figure shows the willing-hesitant-unvaccinated pathway which discusses two participants who were initially willing, then moved to hesitancy.

Inaccessibility was the common string between Sambo and Obinna. Being unable to access the COVID-19 vaccine had a negative toll on their decisions to vaccinate.

I would have taken it because in the beginning I was actually interested in taking it until it dragged on and I just saw it as a waste of time. I just lost interest… The inaccessibility also was a contributory factor because at the point that I was contemplating on whether to take it or not, if it was actually made available to me at that point, I would have just given it a trial. – Sambo (29M, UV)

Sambo's shift was also caused by his doubt in the vaccine's reliability. There was also his perception regarding syringes.

The only thing someone can tell me that would make me want to vaccinate is if I have to leave the border of this country, and it's compulsory, then I would… Except, okay maybe not here, somewhere else that people have actually proven this vaccine if you take it… it's not the usual one you heard about like the one that people have taken it and still got infected actually and I can see that.. they weren't infected… I'll feel okay, I can trust this particular one, let me give it a try…. apart from that… if there are publications or research that have been conducted that can actually validate the fact that this vaccine does not have any side effects, I may want to try… – Sambo (29M, UV)

When asked about what he would have done if he had wanted to vaccinate and his family tried to prevent him, he stated:

"...I don't care what anybody has to say. At the end of the day, it's my life…"

For Obinna, he trusts the government and health agencies. His only obstacle was getting the vaccines. It was not easy for him to access them. He convinced

others to vaccinate. Regarding his religious leader's influence:

> *…he is a man who I confide in, who has given us a lot of reliable information. He is not just any type of religious leader, he is not one who will just cloud the mind of his followers under the influence of religion… And if he had said that we should not take the vaccine, it would have been difficult because I have known him for a very long time. But thank God during that period he said, this thing is just like other pandemics. We should take precautionary measures, take the vaccine and go about our normal activities… Due to the exposure and the research I have done now, I will go ahead and take it, because he is not a medical personnel. – Obinna (32M, UV)*

When asked if he would take the vaccine now if he had the chance, his response was:

> *"Definitely I will."*

Table 3

Reasons for Positive Shift

Reasons for Positive Shift	Comments
Institutional Authority	*"…in my own organization, I know some people who took the undertaking not to take the vaccine. But, weeks later, the pressure got so intense, it was almost 'take the vaccine or lose your job'. Nothing was said, but the handwriting was clear. So, at that point, we were left with no other option..." – Uloma (28F, PV)*

(continued)

Table 3. (continued)

Filial Authority	*"I think in an African home, you really have no choice. They told me I should take the vaccine, and I did. This one was like a mandatory thing." – Obatare (24M, PV)*
Charismatic Authority	*"So my MD, a medical doctor and a consultant, he was the one first to be vaccinated. When I saw that he did not decline, I said, for him to agree to take it, he must have reviewed it…. I respect intelligence, so I said let me go ahead to take it." – Efe (57F, FV)*
Knowledge and Self Preservation	*"So I asked a lot of questions, what about those of us who are on routine drugs, like BP drugs? Or those who are diabetic, is it good for that? And they lectured… the reason that made me take the vaccine is that I didn't want to be infected and didn't want to die… " – Eloho (62F, FV)*
Trust and Strong Ties	*"I have some people that have taken it that are close to me. I asked them… they didn't give me that bad impression..." – Emeka (25M, FV)* *"People I know that took the vaccines. That was more like a major effect on my decision." – Tayo (28M, FV)*

4. Discussion

Our findings showed that the determinants of vaccine hesitancy in Nigeria spanned three themes: Doubt-associated, perceptions and beliefs and situational determinants, with doubt being most prominent.

4.1 Comparison with Existing Literature

Previous research reported concerns about the safety of the COVID-19 vaccine and fear of side effects, agreeing with our research where participants identified hearing about and seeing others experience the side effects as a discouraging factor as well as an encouraging factor, depending on the experience. Rumors also played a role in the decision to vaccinate and have been seen in previous studies, such as the Zwawua & Kor (Zwawua & Kor, 2023) study which highlighted 'Fear of receiving the devil's mark'. Belief in God was also identified as a perception-based determinant in our research.

Contrary to previous findings like that of Hubach et al. (Hubach et. al., 2022), our research did not identify limited COVID-19 knowledge as a determinant of vaccine hesitancy, as more than half of our participants stated that COVID-19 knowledge was abundantly available to almost everyone. However, our study found limited knowledge about the vaccines to be a situational determinant. This is in line with previous research (Ilesanmi et al., 2021). Highlighting severity of the COVID-19 situation in Nigeria as a situational determinant, our study agreed with previous research done in Nigeria (Zwawua & Kor, 2023).

Previous study done regarding COVID-19 vaccine in 2023, also identified vaccine accessibility and affordability issues as factors influencing decision to vaccinate (Iwuagwu et al., 2023). Availability of vaccines and ease of accessibility can encourage immediate vaccination. As seen from the decision making trajectory of the participants in the Willing-Hesitant-Unvaccinated pathway, when the vaccines were not easily accessible, it deterred vaccination.

4.2 Doubt and Distrust

Doubt was a prominent and recurring determinant found in this research. We

found that doubt was associated with the vaccines, manufacturers of the vaccine, knowledge regarding the vaccine, the Nigerian government and COVID-19's existence, and in social relationships.

Previous research identified concerns over insufficient testing of vaccines for safety and perceived vaccine ineffectiveness (Ojewale & Mukumbang, 2023). Distrust in manufacturers, vaccines and the associated lack of confidence in the vaccines was also found in some past studies (Ilesanmi et al., 2021; Ogueji & Okoloba, 2022; Osuagwu et al., 2022). In tandem with previous research (Iwuagwu et al., 2023; Ogueji & Okoloba, 2022), our research also identified distrust and dissatisfaction in the government. Distrust in the government and the system was driven by past antecedents. Some people are unwilling to accept the vaccines as the government is in charge of the process.

Another concern associated with doubt-associated determinants raised by a couple of participants in our study not seen in previous COVID-19 related research was the availability of multiple COVID-19 vaccines. Multiple options led to confusion and distrust in the vaccines, and a state of uncertainty with participants wondering if there were ulterior motives. Doubt in COVID-19's existence was also a new finding of our research, as well as personal beliefs bordering on confidence in one's own immunity and the vaccine deemed unnecessary.

For some participants, they did not believe COVID-19 existed, for others, it existed but not in Nigeria, and there were those who felt COVID-19 in Nigeria was exaggerated and not a true representation. The minds of some of those who doubt COVID-19's existence are quite firm and most stated nothing can change their opinion, like Obatare. Doubt in COVID-19's existence stemmed from distrust with the government, effectiveness of malaria medication for COVID-19 treatment in some cases, having no encounter with COVID-19 patients, and similarity of the symptoms to malaria symptoms.

Our research has shown that Doubt and lack of trust has proven to be very important in the decision to vaccinate. Doubt proved to be an overarching theme in this research, highlighted by participants who focused on it so strongly. The Nigerian atmosphere is one that has led participants to be disillusioned with the Nigerian government, and this also encompasses a doubt in the manufacturers of the vaccine, and the existence of the COVID-19 pandemic itself. This research has shown how relevant the presence of trust is and the consequences when trust is gone and doubt settles in.

4.3 Reasons for Shift

For many who vaccinated willingly, it was done in a bid to protect themselves, among other reasons. This desire to protect oneself was after gaining knowledge about the vaccines. Everyone in the Hesitant-Vaccinated pathway that vaccinated willingly mentioned this as one of the reasons that led to their shift to vaccinate. While seven participants in our study had vaccinated, three of them vaccinated unwillingly, a decision forced by authority, bringing to the fore the impact authority plays in decision making. Worthy of note is the fact that two of those forced to vaccinate were only partially vaccinated, showing that when the external force was removed, they reverted to their initial stance.

Filial authority in the form of family influence has been identified in a previous study by Lau et al. (2022), which identified family influence as having a great influence on the decision to vaccinate, and the influence of friends having a lesser impact. Filial authority arose in this research, identified by one participant. This participant was living with his parents and had been compelled by them to vaccinate.

4.4 Family Influence and Trust

Our research showed how family did not have a major role in the decision to

vaccinate. Discussions with seven participants highlighted this. Asides the filial authority reported by one participant, this study did not find that family had a strong influence on the decision-making process of vaccination. While a couple of participants such as Eloho and Tayo, vaccinated after getting advice from trusted family members (with existing delay period), more participants made the decision by themselves even after discussions with their family.

'It's my life, it's my body' was a phrase stated by several participants, who opted to vaccinate and not vaccinate respectively. For some of these participants like Emeka and Tolani, they ignored their family's concerns or encouragements, regarding vaccination, with Emeka vaccinating and Tolani not vaccinating. It is important to note that the only participant that actually gave into the compelling filial authority of his parents was a participant still dependent on his parents. Some participants who were parents also mentioned that they did not pressure their children to vaccinate or otherwise, but let them make their decisions.

Efe stated that while she was usually the go-to person in her family for health matters, she was not trusted for COVID matters, putting forward again how doubt played a big role in COVID decisions. Some participants also opined how the vaccination decision was a different case, with their minds already made up. This shows that family influence was not considered important in the case of COVID-19, unlike other decisions. COVID-19 vaccination was seen as an individual choice, involving one's health and body. Among the reasons for this were: COVID-19 being a health issue and changing the dynamics of trust, strong mindsets and beliefs, the thought that the other party is not educated enough on the issue, COVID-19 being novel.

4.5 Limitations

Recall bias was one of the limitations of this research as some of our participants could not recall clearly all conversations they had at the start of

the pandemic. Another limitation of our research is the lack of diversity in the participants' level of education. The call for participants was done online, and the lowest level of education of the participants in this research was the Higher National degree. The perspectives of people not on the internet was unfortunately not as easily gotten. We acknowledge that exempting people not on the internet could have resulted in bias. Additionally, considering most of our data was collected from participants in urban areas, we admit that this could have also been a source of bias.

Despite this, our research still had a heterogenous group of participants, a strength, as this study included participants in varying age groups, marital statuses, vaccination statuses and at different stages in their lives, leading to rich perspectives.

4.6 Implications for Policy and Practice

This research has been relevant in showing that public health initiatives to increase vaccination uptake should not take a one-size-fits-all approach as there are many reasons people choose not to vaccinate and otherwise. While authority was a main reason participants vaccinated, this research also showed that once the authoritative body is removed, there was a pattern of not following up with completing vaccinations. If the goal is to increase uptake of vaccinations, authority, while seemingly an effective solution, is one that takes away freewill and serves as a temporary solution. Interventions to address knowledge gaps should be designed, and these interventions should not be generic, but rather customized to target doubts and rumors. As our research showed, some participants changed their attitudes when exposed to more knowledge regarding COVID-19 and the vaccines. This shows how relevant it is to incorporate proper knowledge dissemination in tackling vaccine hesitancy, not just for COVID-19, but other diseases. While there are other determinants of vaccine hesitancy,

increasing spread of knowledge would definitely serve to tackle hesitancy rooted in ignorance and improve attitude. Government could seek to provide knowledge through different channels to prevent misinformation and disinformation.

Doubt, a key determinant identified in this research has several root causes and while the current pandemic under discussion is COVID-19, it is daunting to imagine future situations. The government needs to rebuild and regain trust of the masses, an action that will not be easy as the grave distrust is as a result of a compilation of different actions over the years, for instance, the government hoarding COVID-19 palliatives, which is a tip of the iceberg. And there are some people who have very strong opinions regarding the vaccines, and refuse to vaccinate because that is their mindset. Effective program of interventions should be encompassing to address each and every one of these determinants, considering context as well. This research informs public health policymakers and is relevant in tackling vaccine hesitancy in Nigeria.

5. Conclusion

It is very crucial to understand that the determinants identified in our research were not limited to socioeconomic status, or education level, as this in-depth research has shown that vaccine hesitancy goes beyond these demographic parameters.

Doubt in COVID-19's existence is a new finding which stood out in this research. As found in the course of this research, there are participants who are completely doubtful of COVID's existence and even if there is a resurgence, they will be doubtful and not vaccinate. This goes down to the distrust in government and systems. Distrust in the government and all associated with them, in this case, the vaccines and their actions surrounding the COVID-19 pandemic was strongly highlighted.

Family influence was found to not be a major determinant, despite the collectivist society Nigeria is. This has shown that the choice to make decisions as a unit varies depending on the decision being made. Additionally, the Willing-Hesitant-Unvaccinated pathway showed how a reverse trajectory can take place as participants moved from a willing stance to a hesitant stance. This showed that when conditions are unfavorable, vaccine hesitancy can also plant roots. It is interesting to note that the two participants who followed this pathway have different current stances, with the participant who fully trusts the government still willing to vaccinate, showing how individual mindsets, beliefs, trust and context plays a role.

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Declaration of interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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Supplementary File 1

Interview Guide

Demographic data will be collected, consisting of age, gender, occupation, level of education, place of residence

Setting the background. Finding out stance about the pandemic.

- What do you know about the Covid-19 pandemic?
- What do you think about it?
- What did you think about the safety guidelines that were recommended? Did you follow them? Why/Why not? What do you do to protect yourself?

What are the influencers? Factors that influence uptake?

- Do you use social media? Which do you use most?
- If you needed to confirm an information about a health issue, where do you go to? Newspaper? The news? Websites? Social media?
- Think of the government' s communication during the pandemic. In your opinion, has it been good? What do you think of the government and the pandemic?

Thoughts/Opinions about the vaccines:
Trust, Efficacy, Uptake or not? Feasibility

- In your opinion, are vaccinations effective generally?
- Do you know there are vaccines against Covid-19?
- Have you taken the Covid vaccine? How many doses? Which? What are some reasons you did not accept/accepted the vaccine?
- Have you heard any rumors about the vaccines? What did you think of them?
- Why do you feel differently about this vaccine?

How do the opinions of those close matter? (Bonds and connections, Strong ties)

- When you are confused about a decision, who is the first person you think to consult? Why do you trust this person?
- What kind of friends do you have? What do you talk about?

- Do you discuss Covid-19 and vaccinations with your friends/family? Do you share the same thoughts?
- Have those close to you taken the vaccine? Have you heard of anyone that had side effects of the vaccine/Did you see anybody? Tell me about it.
- Those you know who have taken the vaccine, what did they say about it?
- How did you make the decision to vaccinate?
- Tell me about those you consulted when you found out about the vaccine. Did you contact your religious leader?

How do the opinions of those distant matter? (Weak ties)

- When you are sick, do you go to the doctor or you treat yourself at home?
- Do you trust that your friends would be honest than someone you are not close to?
- Where have you gotten more information about Covid-19? From those you are close to or those you are not close to?
- When you hear those you are not close to talk about covid vaccination, does it urge you to get vaccinated too?
- Do you communicate often with people outside your close circle about the pandemic?
- Have you had a different opinion with someone regarding the pandemic? How did it change your mind?

Decision making process and conflict

- Who has authority in the family? Tell me about the person your family holds in high esteem? Whose words are always believed?
- Tell me about your relationship with your parents. Do you do everything they say? What about your siblings? Do you argue often?
- When disputes or disagreements occur in your family or friend group, how are they resolved?
- Regarding the decision to vaccinate, the discussions that have taken place within your family, are they similar to other discussions that have been made about other decisions? What is different?
- Who are the members of your family that have the same thoughts regarding vaccination? Tell me about them

懷疑與不信任：從質性角度探討奈及利亞COVID-19疫苗猶豫的決定因素

Avwerosuoghene Onobrakpeya* 許良因**

摘要

目的：本研究旨在探討奈及利亞民眾對 COVID-19 疫苗猶豫的決定因素，並分析他們在接種COVID-19疫苗過程中的決策方式。

方法：本研究採用質性研究方法，透過半結構式訪談，受訪者共有十八位。

結果：研究結果顯示，奈及利亞民眾對 COVID-19 疫苗的猶豫主要來自懷疑與不信任，其表現於以下幾方面：(1) 對疫苗、製造商及現有疫苗知識的懷疑，(2) 對政府的不滿與不信任，(3) 對 COVID-19 疫情是否在的懷疑，(4) 基於個人感知和信念的決策，以及 (5) 特定情境下的決定因素。此外，受訪者的決策過程呈現出三種不同的路徑：(1) 猶豫後決定接種疫苗，(2) 猶豫後選擇不接種疫苗，(3) 起初願意接種但經過猶豫後最終未接種疫苗。

結論：本研究發現，懷疑與不信任是奈及利亞民眾對 COVID-19 疫苗猶豫的主要決定因素。值得注意的是，這種疫苗猶豫的現象並不限於特定社會經濟地位或教育程度的人。

關鍵詞：COVID-19、懷疑、奈及利亞、信任、疫苗猶豫

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國小學童健康素養及復原力研究

簡子明* 胡益進**

摘要

目標：學童之健康素養及心理健康皆是我國對學生健康促進過程中重要的一環，其中復原力更是學生自我調適不可或缺的能力，本研究旨在探討臺灣國小高年級學童健康素養及復原力之現況，並分析學童健康素養與學童復原力之影響關係。

方法：本研究為橫斷式研究，以臺灣國小高年級學童為目標族群，採用方便取樣抽取北、中、南地區之五、六年級在學學童，共198名研究對象，並以自擬結構式問卷進行資料蒐集，最後以SPSS統計套裝軟體進行各項統計分析，描述性統計以次數、百分比、平均值、單題平均數及標準差進行分析與呈現，推論統計以單因子變異數分析、獨立樣本t檢定、皮爾森積差相關分析及線性迴歸分析進行分析。

結果：研究結果呈現學童整體健康素養（Mean＝96.42）及整體復原力（Mean＝87.57）表現中等以上。學童整體康素養及復原力不會因為背景變項而有顯著差異，但10歲學童於健康素養量表之「正向人際互動」分向度

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（p<.05）及復原力量表之「情緒調節」分向度（p<.05）表現較佳；男學童於復原力量表之「希望與樂觀」分向度（p<.05）表現較佳。學童健康素養與復原力達顯著正相關（r＝.786, p<.01）。學童背景變項及健康素養預測復原力的回歸模式中，健康素養達統計上顯著水準（p<.001）。

結論：依據研究結果建議未來於教育實務上規劃提升正向人際互動與情緒調節之課程，以緩解學童隨年齡成長於正向人際互動與情緒調節表現的落差，為有需要之學童提供協助與支持，加以促進學童健康素養及復原力的提升。

關鍵詞：國小學童、健康素養、復原力

壹、前言

在促進健康的過程中，健康素養（Health literacy）的提升為不可或缺的一環，健康素養的重要性，早在21世紀初已開始在國際間被廣泛討論（李育姍，2014），更在經歷新冠肺炎疫情時期後，人們為了保護自身、家人及社會的健康，深刻體會到具備健康素養之重要性及迫切性（陳立奇，2020）。藉由健康素養的提升，能促進個人的健康行為、增加醫療服務的有效利用、減少醫療成本、縮短健康不平等（蔡慈儀等，2010），不僅建立個人的身心健康，還能營造社會的健康福祉。

關於健康素養的相關研究相當多元，其中心理健康與健康素養的關係是主要的焦點之一，心理健康是全人健康不可分割的一部分 (Nguyen Thai & Nguyen, 2018)。現今的社會面對疫情嚴峻及經濟壓力的困境，生活步調緊湊，使現階段的兒童面臨各種挑戰，包括流行病、自然災害、環境破壞、父母忽視、父母分離等，這些挑戰與環境的變化容易使兒童受到生理與心理因素影響，引起混亂或更大的心理壓力 (Gadari et al., 2022)，尤其經歷過新冠肺炎大流行，研究指出疫情及相關的因應措施對學齡兒童的心理產生了負面影響，包括校園管制、遠距學習、保持社交距離等 (Xu et al., 2022)，學生需要面對社交互動遭到限制、學業耽誤、日常生活變化、社會支持缺乏等巨大變遷，因此出現不同程度的焦慮和抑鬱情緒 (Dhar et al., 2020)。為了因應生活劇變，復原力扮演了重要角色，在發展心理學的觀點中，復原力是當人面對可能產生重大影響的事件或經歷時，做出良好反應並適應的能力 (Xu et al., 2022)，復原力可以減緩公共衛生事件(Ran et al., 2020)、恐怖攻擊 (Zeidner & Kampler, 2020)、癌症 (Mystakidou et al., 2014)、憂鬱症 (Howell et al., 2020) 造成的心理創傷和負面情緒，也能幫助人們在工作環境中面對挑戰與困難 (Xu et al., 2022)。面對未來的變化與挑戰，我們不應該等到出現心理疾

病或精神缺陷時才做出應對措施，更應該提早預防，了解學童自身的復原力，甚至培養正向的思考模式，以利學童面對生活的諸多狀況時可以適當的應對。當學童於兒童時期展現出良好的復原力，亦可作為預測未來正向發展的指標（王琳棻等，2010；Werner, 2005）。

學童之健康素養及心理健康皆是我國對學生健康促進策略所重視的議題（教育部國民及學前教育署，2023；教育部學生事務及特殊教育司，2024），其中復原力是學生在壓力狀態下自我調適不可或缺的能力，涵蓋了人在面對意外事件帶來的變化時恢復和保持心理健康的能力的許多層面，描述當人在遭受嚴重威脅後適應的動態過程 (Tugade & Fredrickson, 2004; Xu et al., 2022)，心理健康會受到個人的健康素養影響，

而復原力則可能是調節兩者之間關連的中介因子 (Xiao et al., 2020)，因此推斷具有良好健康素養的人能擁有更高的復原力，當人具備適應生活逆境的能力時，心理健康狀況也會更好 (Song et al., 2020)，進而降低罹患心理疾病的風險。

健康素養及復原力皆被認為是重要的個人資源及社會資產 (Xiao et al., 2020)，不只可以應用在心理健康，更在不同的生活情境中扮演重要的角色，於醫療保健上，具有復原力和充足健康素養的人可以表現出更好的藥物依從性及自我保健行為 (Meraz et al., 2023)，於健康生活上，採用更健康的生活方式，要求更完善的患者權益，並可能為改善社區健康狀況而採取行動，在擁有充足健康素養的基礎下提升個人及社區的復原力 (Kickbusch et al., 2013)，使個人生活及社區環境更加健康。

過去研究表明，健康素養的提升可以增強個人及社區的復原力，兩者之間存在正相關係 (Xiao et al., 2020)，而性別、年齡及家庭等背景因素皆被認為是影響復原力的因素 (Xu et al., 2022)。本研究希望可以重現健康素養與復原力存在正向關係的結果，並由量表之各分向度分析了解目前臺灣之國小學童待加強之處，期望透過本研究更深入了解影響學童健康素養及復原力的相關因素，提供日後針對即將邁入青少年階段的國小

高年級學童健康促進計畫的安排與設計做為參考，以利未來可以透過衛生教育增進健康素養培養學生復原力面對未來的生活逆境，使沒有意識到自身的負面情緒之兒童能及時覺察並有能力正向應對。

貳、研究方法

一、研究對象

(一)研究母群體

本研究之研究母群體為112學年度在學之國小高年級學生，根據教育部112年各教育階段學生數預測報告，112學年度國小五、六年級學生數推估值共有425124人（教育部，2023）。

(二)取樣方法

本研究為橫斷式研究，配合校方意願，採用方便取樣，以班級為抽樣單位，所抽取的班級以全班學生為研究樣本進行調查，分別於臺灣北、中、南、東地區以112學年度在學之國小五、六年級學生為取樣之條件。施測問卷主要採用電子線上問卷，並視校方設備限制提供紙本問卷進行調整，由老師傳送問卷網址連結或發放紙本問卷給予學生並協助填寫「國小學童健康素養量表」及「青少年復原力量表」，若學校無相關設備則寄送紙本問卷請老師教給學生填寫。

(三)樣本

於臺灣北、中、南、東地區共取9所學校，五年級共計5個班級與六年級8個班級進行施測，合計抽取13個班級，刪除重複作答、題項漏答或未完成等無效問卷後，共計198份有效問卷，樣本在學地區及班級分布狀況如表1。

表1

施測學校及班級樣本數一覽表

在學地區	學校名稱	五年級人數	六年級人數	總數
北部	國○實驗國民小學	0	27	27
	雙○國民小學	12	12	24
中部	南○國民小學	20	15	35
	豐○國民小學	0	23	23
南部	大○國民小學	14	0	14
	大○國民小學	0	22	22
	垂○國民小學	14	16	30
東部	新○國民小學	0	13	13
	明○國民小學	6	5	11

二、研究工具

研究工具分為三個部分，第一部分為學童背景問卷，包含學童性別、年齡、家庭組成狀況等，第二部分為國小學童健康素養量表，本研究使用由黃婉瑜於2022年發展之國小學童健康素養量表(附錄一)，共25題，採用李克特氏五點量表計分方式，以1至5分給予「非常不像我」、「不像我」、「有點像我又有點不像我」、「像我」、「非常像我」五個選項進行填答，學生分數越高表示健康素養越好。第三部分為青少年復原力量表(Inventory of adolescent Resilience, IAR)，本研究採用由詹雨臻等於2009年編製之青少年復原力量表(附錄二)，共28題，採用李克特氏四點量表計分方式，以1至4分給予「非常不符合」、「有些不符合」、「有些符合」、「非常符合」四個選項進行填答分數越高表示該學生復原力的維度或整體表現越好。

三、資料處理與分析

將問卷結果整理後，篩選掉重複作答、題項遺漏或未完成等無效問

卷，接著進行資料處理與分析。本研究採用SPSS 24.0統計套裝軟體，進行描述性統計與推論性統計。描述性統計以次數與百分比呈現研究對象之背景變項（性別、年齡、家庭組成狀況）之分佈狀況。以平均值及單題平均數呈現研究對象之健康素養及復原力之集中趨勢，以標準差呈現研究對象之健康素養及復原力之離散程度，並以最大值、最小值呈現研究對象之健康素養及復原力之分佈狀況。推論性統計以單因子變異數分析及獨立樣本t檢定檢驗研究對象之性別、年齡、家庭組成差異於健康素養及復原力是否達統計上顯著差異，探討研究對象之健康素養及復原力是否會隨著背景變項不同而有所差異。以皮爾森積差相關分析健康素養與復原力之關係。再將類別變項進行虛擬編碼後，以線性迴歸分析進行研究對象背景變項及健康素養對復原力之預測力分析。

參、研究結果

一、描述性統計

(一) 學童背景變項分布

為探討國小五、六年級學童的背景變項，包含性別、年齡、家庭組成之分布情形，研究對象之背景變項描述性統計結果如表2。研究對象性別以男性共105人，佔53%；女性則有93人，佔47%；年齡分佈為10歲至12歲，以11歲學童最多，共99人，佔50%；12歲學童為次，共78人，佔39.4%；10歲學童共21人，佔10.6%。家庭組成共分為五類，以核心家戶佔最多數，共105人，佔53%；其次為三代家戶，共57人，佔28.8%；接下來依序為單親家戶19人，佔9.6%；其他家戶12人，佔6.1%；隔代家戶5人，佔2.5%，而其他家戶與隔代家戶人數較少，故於推論統計合併計算並以其他家戶代稱（17人，佔8.6%），改分為四類。

表2

學童背景變項分布情形（n=198）

變項名稱	類別	人數	百分比
性別	男	105	53.0
	女	93	47.0
年齡	10歲	21	10.6
	11歲	99	50.0
	12歲	78	39.4
家庭組成	核心家戶	105	53.0
	單親家戶	19	9.6
	三代家戶	57	28.8
	隔代家戶	5	2.5
	其他家戶	12	6.1

(二) 學童健康素養分布

國小高年級學童之「健康素養整體表現」平均分數為96.35分，中位數為99分，標準差為16.95，單題平均數為3.85，以五分量表而言，國小高年級學童整體健康素養表現中上，詳細內容如表3。

表3

學童健康素養分布情形（n=198）

健康素養量表總分/各分向度	題數	單題平均數	平均數	中位數	最大值	最小值	標準差
健康素養總分	25	3.85	96.35	99	125	29	16.95
自主健康信念	9	4.09	36.89	38	45	9	6.66
排解負面情緒	4	3.27	13.23	13	20	4	4.03
正向人際互動	3	3.94	11.81	12	15	3	2.70
健康行動力	5	4.22	21.08	22	25	5	3.74
健康行為	4	3.37	13.49	14	20	5	3.27

(三) 學童復原力分布

國小高年級學童之「復原力表現情形」平均分數為87.57分，中位數為89分，標準差為14.83，單題平均數為3.13，以四分量表而言，國小高年級學童整體復原力表現中上，詳細內容如表4。

表4

學童復原力分布情形（n=198）

復原力量表 總分/各分向度	題數	單題 平均數	平均數	中位數	最大值	最小值	標準差
復原力總分	28	3.13	87.57	89	112	31	14.83
問題解決與認知成熟	10	3.12	31.21	32	40	10	5.82
希望與樂觀	6	3.11	18.66	19	24	6	3.67
同理心與人際互動	9	3.25	29.22	30	36	9	5.13
情緒調節	3	2.83	8.48	9	12	3	2.27

二、推論性統計

(一)研究對象背景變項與健康素養分析

為檢驗不同性別研究對象之健康素養是否存在差異，經獨立樣本t檢定分析，如表5，不同性別學童健康素養表現未達顯著差異（t=-.85，p=.398）。

表5

不同性別學童健康素養之差異（n=198）

健康素養 總分/分向度	性別	人數	單題 平均數	平均數	標準差	t	p
自主健康信念	男	105	4.15	37.02	7.01	-.555	.580
	女	93	4.05	36.47	6.79		
排解負面情緒	男	105	3.32	13.29	4.39	-.211	.833
	女	93	3.22	13.16	3.82		

（續下表）

表5 （續）

正向人際互動	男	105	4.03	12.13	2.72	-1.397	.164
	女	93	3.84	11.60	2.61		
健康行動力	男	105	4.24	21.02	4.18	-.114	.909
	女	93	4.19	20.96	3.35		
健康行為	男	105	3.49	13.95	3.25	-1.854	.065
	女	93	3.24	13.11	3.14		
總分	男	105	3.91	97.41	18.35	-.848	.398
	女	93	3.79	95.30	16.41		

為檢驗不同年齡研究對象之健康素養是否存在差異，經單因子變異數分析 (ANOVA)，如表6，不同年齡學童健康素養表現未達顯著差異（F=1.040，p=.335），但於「正向人際互動」表現達顯著差異（F=4.179，p=.017），10歲學童高於較年長之學童。

表6

不同年齡學童健康素養之差異（n=198）

健康素養總分/分向度	年齡	人數	單題平均數	平均數	標準差	F	p	事後比較 Tukey HSD 檢定
自主健康信念	10歲	21	4.30	38.71	6.50	.945	.390	
	11歲	99	4.07	36.58	6.45			
	12歲	78	4.07	36.47	7.52			
排解負面情緒	10歲	21	3.42	13.67	4.50			
	11歲	99	3.25	13.12	4.12	.151	.860	
	12歲	78	3.25	13.24	4.07			
正向人際互動	10歲	21	4.44	13.33	1.71			
	11歲	99	3.88	11.52	2.73	4.179	.017	10>11
	12歲	78	3.88	11.96	2.71			

（續下表）

表6 （續）

健康行動力	10歲	21	4.20	21.00	3.46		
	11歲	99	4.21	20.95	4.10	.012	.988
	12歲	78	4.22	21.04	3.53		
健康行為	10歲	21	3.70	14.81	3.39		
	11歲	99	3.34	13.49	3.13	1.840	.162
	12歲	78	3.33	13.34	3.25		
總分	10歲	21	4.06	101.52	17.18		
	11歲	99	3.83	95.51	17.14	1.040	.355
	12歲	78	3.83	96.21	17.91		

為檢驗不同家庭組成學童之健康素養是否存在差異，經單因子變異數分析 (ANOVA)，如表7，不同家庭組成學童健康素養表現未達顯著差異（F= .523，p= .667）。

表7

不同家庭組成學童健康素養之差異（n=198）

健康素養 總分/分向度	家庭 組成	人數	單題 平均數	平均數	標準差	F	p
自主健康信念	核心	105	4.14	36.94	6.91	.454	.715
	單親	19	4.16	37.42	7.04		
	三代	57	4.01	36.04	6.99		
	其他	17	4.05	36.44	6.36		
排解負面情緒	核心	105	3.27	13.30	4.11	1.053	.370
	單親	19	3.60	13.89	4.36		
	三代	57	3.21	12.91	4.03		
	其他	17	3.05	12.19	4.23		
正向人際互動	核心	105	3.85	11.60	2.87	1.003	.393
	單親	19	4.18	12.47	2.41		
	三代	57	4.02	12.07	2.58		
	其他	17	3.89	11.69	2.36		

（續下表）

表7 （續）

健康行動力	核心	105	4.26	21.18	3.56	1.447	.230
	單親	19	4.32	21.37	4.13		
	三代	57	4.20	20.95	3.85		
	其他	17	3.86	19.31	4.79		
健康行為	核心	105	3.44	13.82	3.16	.625	.600
	單親	19	3.30	13.74	4.24		
	三代	57	3.27	13.00	3.14		
	其他	17	3.39	13.56	2.66		
總分	核心	105	3.88	96.84	17.05	.523	.667
	單親	19	3.97	98.89	19.75		
	三代	57	3.80	94.96	17.83		
	其他	17	3.73	93.19	16.12		

(二) 研究對象背景變項與健康素養分析

為檢驗不同性別學童之復原力是否存在差異，經獨立樣本t檢定分析，如表8，不同性別學童健康素養表現未達顯著差異（t=-1.131，p=.259），但在量表的分向度得分中，「希望與樂觀」男性平均分數高於女性並達顯著差異（t=-2.253，p=.025）。

表8

不同性別學童復原力之差異（n=198）

復原力 總分/分向度	性別	人數	單題 平均數	平均數	標準差	t	p
問題解決與 認知成熟	男	105	3.20	32.03	5.74	-1.637	.103
	女	93	3.04	30.67	5.95		
希望與樂觀	男	105	3.22	19.63	5.51	-2.253	.025
	女	93	2.99	18.11	3.68		
同理心與 人際互動	男	105	3.22	28.83	5.46	.912	.363
	女	93	3.28	29.52	5.10		

（續下表）

表8 （續）

情緒調節	男	105	2.84	8.62	2.35	-.998	.319
	女	93	2.81	8.29	2.27		
總分	男	105	3.17	89.10	16.47	-1.131	.259
	女	93	3.08	86.58	14.72		

為檢驗不同年齡學童之復原力是否存在差異，經單因子變異數分析(ANOVA)，如表9，不同年齡學童復原力表現未達顯著差異（F=1.040，p=.335），但在量表的分向度得分中，於「情緒調節」表現達顯著差異（F=3.481，p=.033），10歲學童高於較年長之學童，尤其於第8題「當別人嘲笑我的時候，我能不予理會。」10歲學童平均分數高於較年長之學童最多。

表9

不同年齡學童復原力之差異（n=198）

復原力 總分/分向度	年齡	人數	單題 平均數	平均數	標準差	F	p	事後比較 Tukey HSD 檢定
問題解決與認知成熟	10歲	21	3.20	32.00	5.82			
	11歲	99	3.11	31.25	5.94	.140	.870	
	12歲	78	3.11	31.40	5.84			
希望與樂觀	10歲	21	3.29	19.71	3.18			
	11歲	99	3.17	19.22	3.57	.809	.447	
	12歲	78	3.06	18.51	6.27			
同理心與人際互動	10歲	21	3.29	29.57	4.91			
	11歲	99	3.23	29.01	5.37	.107	.899	
	12歲	78	3.25	29.22	5.36			
情緒調節	10歲	21	3.02	9.05	2.38			
	11歲	99	2.68	8.04	2.22	3.481	.033	10>11
	12歲	78	2.95	8.85	2.34			
總分	10歲	21	3.23	90.33	14.99			
	11歲	99	3.11	86.81	15.08	.586	.557	
	12歲	78	3.13	88.68	16.66			

為檢驗不同家庭組成研究對象之復原力是否存在差異，經單因子變異數分析 (ANOVA)，如表10，不同家庭組成學童復原力表現未達顯著差異（F=.212，p=.888）。

表10

不同家庭組成學童復原力之差異（n=198）

復原力 總分/分向度	家庭 組成	人數	單題 平均數	平均數	標準差	t	p
問題解決與認知成熟	核心	105	3.13	31.30	5.90	.040	.989
	單親	19	3.09	30.85	6.15		
	三代	57	3.13	31.27	5.90		
	其他	17	3.10	31.00	5.50		
希望與樂觀	核心	105	3.12	18.71	5.68	.670	.571
	單親	19	3.26	19.55	4.70		
	三代	57	3.08	18.46	3.22		
	其他	17	2.99	17.94	2.79		
同理心與人際互動	核心	105	3.27	29.39	5.27	.466	.706
	單親	19	3.32	29.85	4.85		
	三代	57	3.22	29.02	5.62		
	其他	17	3.11	28.00	4.69		
情緒調節	核心	105	2.80	8.40	2.30	.337	.799
	單親	19	2.88	8.65	2.32		
	三代	57	2.89	8.67	2.43		
	其他	17	2.71	8.13	2.25		
總分	核心	105	3.13	87.87	16.31	.212	.888
	單親	19	3.18	90.11	16.52		
	三代	57	3.12	87.44	14.76		
	其他	17	3.04	85.06	13.97		

經皮爾森積差相關分析，分析學童健康素養及復原力之關係結果如表11，學童健康素養與復原力達統計上顯著高度正相關(r=.786, p<.01)，顯示學童健康素養表現越好，復原力表現亦佳。

表11

學童健康素養各分向度與復原力各分向度之關係（n=198）

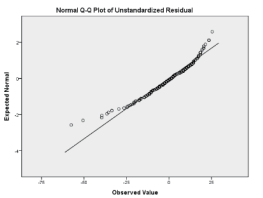
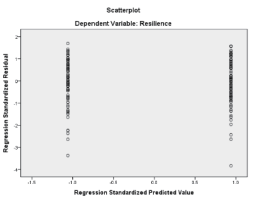
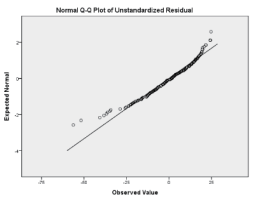
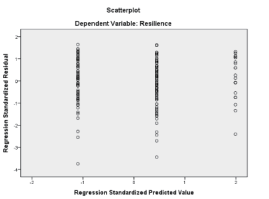
	復原力總分	問題解決與認知成熟	希望與樂觀	同理心與人際互動	情緒調節
健康素養總分	.786**	.761**	.571**	.750**	.503**
自主健康信念	.764**	.766**	.503**	.750**	.476**
排解負面情緒	.572**	.533**	.444**	.534**	.382**
正向人際互動	.629**	.609**	.479**	.592**	.373**
健康行動力	.654**	.605**	.497**	.635**	.417**
健康行為	.599**	.582**	.463**	.531**	.412**

**: p<.01

經殘差診斷及共線性診斷驗證後，學童背景變項（性別、年齡、家庭組成）及健康素養符合線性回歸之前提假設，如12，並且學童背景變項（性別、年齡、家庭組成）無共線性之問題，如13。

表12

學童背景變項及健康素養殘差診斷結果（n=198）

變項名稱	常態機率圖	殘差圖	Durbin-Watson檢定
性別			1.922>DU
年齡			1.936>DU

（續下表）

表12 （續）

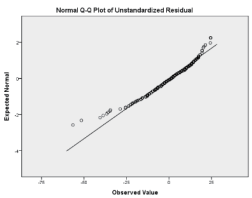
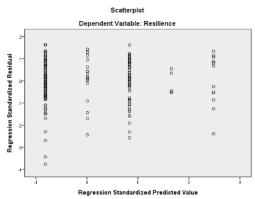
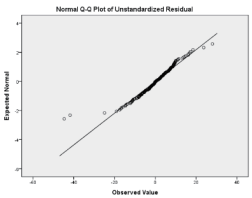
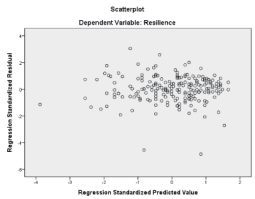
家庭組成			1.936>DU
健康素養			2.015>DU

表13

學童背景變項共線性診斷結果（n=198）

變項名稱	容忍度	變異數膨脹係數
性別	.973	1.018
年齡	.982	1.019
家庭組成	.984	1.016
健康素養	.982	1.029

分析結果顯示以學童背景變項（性別、年齡、家庭組成）及健康素養預測復原力的回歸模式達統計上顯著水準（F=78.092，p<.001），且背景變項及健康素養可以預測復原力之解釋力為61%，如表14。

背景變項中性別、年齡、家庭組成的p值皆大於0.05，接受虛無假說，健康素養的t統計值為17.542，p值小於0.001，拒絕虛無假說，可知健康素養對於復原力有顯著的影響。

表14

學童背景變項預測復原力之多元線性回歸分析（n=198）

變項名稱	B	β	t	p
性別	.345	.012	.259	.796
年齡	.570	.025	.557	.578
家庭組成	.293	.021	.471	.639
健康素養	.689	.788	17.542	<.001

R squared=.618
Adjusted R Square=.610
F=78.092, p<.001

肆、討論

依據研究結果進一步分析討論並與國內外文獻進行比較：

學童健康素養分布與過去研究中探討臺灣國小高年級健康素養之結果亦可見相似結果，雖然使用不同問卷、施測範圍不同，但國小高年級學童之健康素養程度皆為中上（黃婉瑜，2022；Shih et al., 2016）。且於各分向度分析中，以「排解負面情緒」之單題平均數最低(Mean=3.27，SD=1.01)，與過去研究結果相同，顯現國小學童在健康素養的表現中「排解負面情緒」是當前最需加強的能力，其中本研究學生於第17題「不開心時，我會將心事告訴老師」表現最差 (Mean=2.60，SD=1.38)，而當學童面對負面情緒時，若教師能提供資訊、工具、情感或評估等相應的支持，可以增強教師與學生的關係，也能使學生提高尋求教師幫助與討論自己的負面情緒的可能性 (Lei et al., 2018)，可見具支持性的師生關係對於增強學生排解負面情緒的能力至關重要。

學童復原力分布於各分向度分析中以單題平均數以「情緒調節」的單題平均數最低 (Mean=2.83，SD=0.75)，其中學生於第8題「當別人嘲笑我的時候，我能不予理會。」表現最差 (Mean=2.71，SD=0.98)，與過

去研究結果相同(詹雨臻等，2009)，顯現無論是國小學童抑或是國中之青少年，「情緒調節」的能力特質皆需加強培養，其中本研究對象於第8題「當別人嘲笑我的時候，我能不予理會。」表現最差 (Mean=2.71，SD=0.98)，嘲笑屬於言語霸凌的範疇，過去調查發現以臺灣而言國小受言語霸凌的狀況最為常見，面對嘲笑大多學童會表現攻擊與抗爭態度，或是退縮迴避，且學童間的言語攻擊因未有具體傷害痕跡，容易忽略受害者心理上實際的創傷(沈玉翎，2014)，因此教導學童人際衝突處理方式於情緒調節相當重要。

不同性別學童健康素養表現未達顯著差異(t=-.85，p=.398)。與過去針對國小學童健康素養的研究結果不同(黃婉瑜，2022；劉潔心等，2014)，於各分向度分析中，以「健康行為」單題平均數之得分差距最大，推測與健康教育內容及方式有關，健康教育的教學內容貼近生活，有不少技能實作與互動式課程，而男性學童在動手操作、活動參與及視覺學習方面表現較好 (Lin et al., 2021)，可能會使男性學童在健康素養表現更佳，尤其是「健康行為」等實際操作。

不同年齡學童健康素養表現未達顯著差異(F=1.040，p=.335)，但於「正向人際互動」表現達顯著差異(F=4.179，p=.017)，10歲學童高於較年長之學童，其中以第22題「我有很多朋友。」10歲學童平均分數高於較年長之學童最多，對應過去研究推論隨著學童成長，更追求獨立自主，可能減少學童整體人際互動表現(林佩玟，2021)。

不同家庭組成學童健康素養表現未達顯著差異(F= .523，p= .667)，與過去研究結果相同(游惠禎，2014)。各種家庭組成於各分向度之單題平均數表現各有優異，其中「排解負面情緒」單題平均數差距最大，尤其於第18題「不開心時，我會將心事告訴其他人。」單親家戶學童平均分數高於其他學童最多；核心家戶於「健康行為」分向度之單題平均數最高，其中以第4題「我每天運動30分鐘。」之平均分數高於其他學童最多，不同家庭組成型態可能因為家庭社會資本、父母教育程度、家庭生活習慣

等多重因素影響學童之健康素養表現（陳信仁，2013；游惠禎，2014），使不同家庭組成型態於健康素養之各分向度表現各有優異，而非單一家庭組成型態之整體健康素養表現較佳。

不同性別學童健康素養表現未達顯著差異（t=-1.131，p=.259），但在量表的分向度得分中，「希望與樂觀」男性平均分數高於女性並達顯著差異（t=-2.253，p=.025），其中以第18題「我能用幽默的方式看待嚴肅的事情。」男性學童平均分數高於女性學童最多，推測男學童復原力較佳的原因與學童面對困境時抱持正向思考的方式有關，為因應社會期待培養出獨立解決問題的習慣，面對問題比起朝不好的結果想像，更著重於如何以正向思考模式解決問題（王琳棻等，2010；辛昱融，2020；沈家綺、連倖誼，2022）。

不同年齡學童復原力表現未達顯著差異（F=1.040，p=.335），但在量表的分向度得分中，於「情緒調節」表現達顯著差異（F=3.481，p=.033），10歲學童高於較年長之學童，尤其於第8題「當別人嘲笑我的時候，我能不予理會。」10歲學童平均分數高於較年長之學童最多，但於第4題「當別人惹我生氣時，我能控制自己的情緒。」為12歲學童表現最佳，可以看見在學校更加重視學生情緒調節的能力的培養的教育下（沈家綺、連倖誼，2022），學生在控制情緒爆發的能力表現有逐漸進步，相較之下仍缺乏面對生活情境與人際互動帶來壓力時自我調適的能力（沈家綺、連倖誼，2022；Southwick et al., 2014），日後學校教育應以教導學生如何紓解壓力為教學方向，以助於避免造成復原力隨著年齡增長而降低的狀況(She et al., 2020; Yu et al., 2011)。

不同家庭組成學童復原力表現未達顯著差異（F=.212，p=.888），於量表之各分向度表現各有優異，推測國小高年級學童的復原力與依附關係彼此相關（蘇靖雯，2023），即便單親家戶在資源較核心家戶及三代家戶少的狀況下，若家長能與學童維持良好的依附關係，亦能有較佳之復原力表現，雖然本研究結果並未觀察出不同家庭組成復原力之顯著差

異，但能推論家庭關係或是照顧者付出可能補足家庭資源的缺失，家庭關係可能影響學童之復原力。

過去研究中可以看到復原力能作為健康素養影響心理健康的中介因子(Meraz et al., 2023; Song et al., 2023; Xiao et al., 2020)，而本研究更應證了健康素養可以影響並預測復原力。

伍、結論與建議

一、依據研究目的與研究結果提出以下六項結論：

(一)國小高年級學童整體健康素養表現中上

(二)國小高年級學童整體復原力表現中上

(三)不同背景變項學童健康素養差異

國小高年級學童整體健康素養表現不會因為性別、年齡及家庭組成等背景變項而有顯著差異。但能透過單題平均數發現男性學童在健康素養表現更佳，尤其是「健康行為」的實際操作方面；10歲學童於「正向人際互動」表現較佳，相較於較年長之學童更認同自己有很多朋友的正向敘述。

(四)不同背景變項學童復原力差異

國小高年級學童整體復原力表現不會因為性別、年齡及家庭組成等背景變項而有顯著差異。但於復原力量表中「希望與樂觀」分向度男學童表現顯著高於女學童，「情緒調節」方面，10學童更能調適他人嘲笑帶來的負面情緒，且顯著高於11歲學童，而12歲學童更能成熟的克制憤怒情緒爆發。

(五)國小高年級學童健康素養與復原力達顯著正相關

(六)國小高年級學童背景變項及健康素養能有效預測學童復原力

以國小高年級學童之背景變項(性別、年齡、家庭組成)及健康素養

能有效預測學童之復原力，且解釋力為61%，其中學童健康素養對於復原力有顯著的影響。

二、根據研究結果提出以下建議

(一)對教育實務上的建議

1. 規劃提升正向人際互動與情緒調節之課程

本研究結果發現雖然學童整體健康素養及復原力良好，但隨著年齡增長，學童之「正向人際互動」及「情緒調節」之表現略有落差，顯示學童需再加強培養這兩項能力面對未來學習及生活壓力。因此，建議於教育實務上教育工作者可針對這兩項能力的提升設計課程活動及教學策略，例如目前已有不少縣市推動的社會情緒學習 (Social Emotional Learning, SEL) 融入課程，透過社會情緒學習能確實提升學生學習成就、學習動機及幸福感，且學生於人際互動上有顯著改變，但仍較偏重於知識及技能上的表現，缺乏情緒教育的議題（林秀玲，2022），因此教學團隊需再整合相關主題內容，如自我認識、自我管理、人際關係、社會意識和負責任決策等（王為國，2016），提供學生適合的教育以提升學童健康素養及復原力，透過角色扮演、情境模擬、小組活動等多元教學活動，結合與生活貼近的故事情境，吸引學生注意且提供學生充足的實踐機會並鼓勵積極參與。

2. 推展親子共學之健康教育活動，加強學校與家庭合作互動

本研究結果發現隔代家戶之學童健康素養及復原力普遍較其他家庭結構之學童差，而學童健康素養及復原力呈高度正相關，且學童健康素養能有效預測復原力，顯示當學童健康素養越高時，復原力越佳。因此，建議於健康教育課程中透過各健康議題設計親子共學活動，例如，校慶期間於學校舉辦親子互動活動邀請家長共同參與，或是，於家長日舉辦主題式親子講座，提升家長對健康及復原力的認識同時也傳授親子相處技巧，並邀請家長分享與交流。藉由學校積極組織和舉辦親子共學

活動，為家長提供必要的支持和服務，例如心理諮詢、家庭教育指導等，加強學校與家庭的行動結盟，協助需要之學童提高健康素養及復原力，共同促進兒童的健康發展。

3. 加強促進健康素養及復原力之潛在課程

本研究結果發現低年級學生健康素養及復原力之表現較佳，與過去研究結果相同，顯示現行教育仍無法培養學生足夠能力應對隨著年齡增長增加的壓力（吳枚瑛、洪瑞兒，2020；黃婉瑜，2022）。因此，建議除了規劃提升健康素養及復原力的課程之外，應於日常生活中透過師生互動、班級布置等潛在課程加以輔助促進學生之健康素養及復原力的提升。

(二)對未來研究的建議

1. 增加研究變項

本研究發現學童背景變項無法有效預測學童之復原力，而影響復原力的保護因子及風險因子眾多，於本研究未調查之面向無法進行探討。因此，建議未來研究可參考國內外相關文獻，增列其他探討面向，例如學校、社區等環境因素，以更廣泛的了解學童復原力的影響因素。

2. 擴大研究對象

本研究僅以國小高年級學童為研究對象進行施測及探討，並以方便取樣進行抽樣並施測，且於文獻蒐集發現目前臺灣缺乏針對國小高年級健康素養及復原力之全國性調查，較多以地區調查為主，建議未來可將研究對象擴大，同時調查不同地區的各學齡階段，以更清楚的了解臺灣學童之健康素養及復原力的現況與關係。

3. 增加其他研究方法

本研究採用以電子問卷為主的量化調查分析，雖然資料取得方便，但僅能依據研究對象量表得分之統計分析結果及過去研究推斷其健康素養或復原力差異之因素。因此，為求更詳盡的解釋造成學童健康素養與復原力差異之因素，建議未來研究增加質性訪談、焦點團體訪談等質性研

究，以深入探究影響學生健康素養及復原力之相關影響因素，補足量性研究之不足。

4. 採用更嚴謹統一的收案方式

由於研究經費、時間及人力等因素限制，本研究未採取隨機抽樣而是以方便取樣進行問卷調查，並配合學校設備限制分別提供電子線上問卷及紙本問卷，由導師發放問卷，在缺乏研究人員監督的狀況下，致使許多紙本問卷出現許多重複作答、題項漏答或未完成等無效問卷，產生問卷流失的問題，建議未來研究統一選擇一項收案方式，若是以紙本問卷進行收案需有研究人員到場監督以盡量減少問卷流失，且改以隨機抽樣方式取樣以增加研究結果代表性。

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附錄

附錄一

國小學童健康素養量表

題號	因素與題目	非常不像我	不像我	有點像我又有點不像我	像我	非常像我
	自主健康信念					
8	跌倒破皮時，我會處理傷口。					
9	生病時，我會請家人帶我去看醫生。					
10	生病時，我會吃醫生開的藥。					
14	當遇到困難時，我會鼓勵自己。					
15	當遇到困難時，我會想辦法解決。					
16	心情不好時，我會安慰自己。					
20	我會主動關心朋友。					
21	跟朋友有不一樣的想法時，我會有禮貌地說出我的想法。					
23	我的家人很關心我。					
	排解負面情緒					
12	我很少不開心。					
17	不開心時，我會將心事告訴老師					
18	不開心時，我會將心事告訴其他人。					
19	不開心時，我會將心事告訴家人。					
	正向人際互動					
22	我有很多朋友。					
24	我的朋友很關心我。					
25	我很受歡迎。					
	健康行動力					
1	我的身體很健康。					
5	我每天會自己刷牙洗臉。					
6	我每天都睡足8小時。					

11	我每天都很快樂。					
13	我的生活很有趣。					
	健康行為					
2	我不會偏食。					
3	我不吃零食。					
4	我每天運動30分鐘。					
7	我知道怎樣才不會生病。					

附錄二

青少年復原力量表

題號	因素與題目	非常不符合	有些不符合	有些符合	非常符合
	問題解決與認知成熟				
1	我能有計畫地逐步解決問題。				
5	我能針對問題找到有效的解決辦法。				
10	我做事很積極。				
13	我能從錯誤中學習與成長。				
14	遇到困難的時候，我不會輕易放棄。				
17	遇到問題時，我會仔細考慮後果之後再採取行動。				
20	遇到問題時，我能很快的採取適當的行動，以避免自己受到傷害。				
24	遇到困難時，我能找到適當的人(如老師、朋友、專業人士)幫我解決問題。				
27	遇到問題時，我知道哪裡可以找到我需要的幫助。				
28	我勇於面對挫折與困難。				
	希望與樂觀				
2	我是一個樂觀的人。				
6	我是一個活潑開朗的人。				
11	我能使自己快樂。				
15	我能很快地把不愉快的事情忘記。				
18	我能用幽默的方式看待嚴肅的事情。				
21	每當遇到問題時，我會想像問題很快就會被破解。				
	同理心與人際互動				
3	我能尊重別人。				

7	我時常關心與鼓勵別人。				
12	我能讓別人感到溫暖，並願意與我分享心情與感受。				
16	我是一個善解人意的人。				
19	我能友善大方地對待別人。				
22	我能從幫助他人當中獲得喜悅與滿足感。				
23	我能了解別人的感受與想法。				
25	我能耐心聽取別人的意見，並接納別人不同的觀點。				
26	我能用適當的態度和別人溝通與討論。				
	情緒調節				
4	當別人惹我生氣時，我能控制自己的情緒。				
8	當別人嘲笑我的時候，我能不予理會。				
9	我能很快的從生氣的情緒中回到平和的心情。				

A Study on Health Literacy and Resilience of Elementary School Students

Tzu-Ming Chien* Yih-Jin Hu**

Abstract

Objectives: The health literacy and mental health of students are an important part of promoting health, and resilience is an indispensable ability for students to adjust themselves. The purpose of this study was to explore the current status of health literacy and resilience among senior elementary school student in Taiwan, and to analyze the relationship between students' health literacy and resilience.

Methods: This study employed a cross-sectional design targeting senior elementary school students in Taiwan. The participants were selected from fifth- and sixth-grade students in the northern, central, and southern regions of Taiwan through convenience sampling, resulting in a total of 198 students. Data were collected using a self-designed structured questionnaire. Statistical analyses were conducted using the SPSS software package. Descriptive statistics, including frequency, percentage, mean, item mean, and standard deviation, were used for analysis and presentation. Inferential statistics were performed using one-way ANOVA, independent sample t-test, Pearson's product-moment correlation analysis, and linear regression analysis.

Results: The results show that health literacy (Mean=96.42) and resilience (Mean=87.57) of students are above average. Health literacy and resilience of student will not be significantly different due to background variables, but the

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“positive interpersonal interaction” ($p<.05$)of the health literacy scale and the “Emotional Regulation” ($p<.05$)of the resilience scale of 10-year-old students performed better; male students performed better in the “Hope and Optimism” of the resilience scale ($p<.05$). There is a significant positive correlation between student's health literacy and resilience ($r=.786$, $p<.01$). Student's background variables and health literacy can effectively predict their resilience ($F=78.092$, $p<.001$).

Conclusions: Based on the research findings, it is recommended that future educational practices include the development of curricula aimed at enhancing positive interpersonal interactions and emotional regulation. This will help mitigate the decline in students’ performance in these areas as they age. Additionally, it is suggested to provide necessary assistance and support to students in need. These efforts aim to improve students’ health literacy and resilience.

Key words: elementary school student, health literacy, resilience

《健康促進與衛生教育學報》
作者索引

《健康促進與衛生教育學報》稿約

112年8月修訂

一、本學報旨在提升健康促進與衛生教育領域之研究，促使學術間交流。採每半年出版一期，於六月、十二月出刊。凡和健康促進與衛生教育相關之學術論文，且未曾投稿於其他雜誌者，均歡迎投稿，惟凡翻譯、一般文獻評述、實務報導等，恕不接受。**本學報不接受紙本與電子郵件（e-mail）投稿，請利用線上投稿系統：https://ojs.lib.ntnu.edu.tw/index.php/hphejournal/index**。

二、投遞本學報之論文經編審委員會送請專家學者審查通過後予以刊登，文責由作者自負，來稿以未經任何刊物發表者為限。凡經本刊編輯委員會審查通過予以刊登之著作，其著作財產權即讓與本刊，但作者仍保有著作人格權，並保有本著作未來自行集結出版、教學等個人非營利使用之權利，版權屬於本刊，除商得本刊編輯委員會同意外，不得轉載。

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英文：Globetti與Brown (2011) 的研究指出……

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英文：Yen, E. H.-W., & Ferng, J.-W. (2020). A study of sexual knowledge, sexual attitude, and sexual behavior among college students in 2019 and sexual experience survey among 20 year-old college students, 1979-2019. *Journal of Health Promotion and Health Education, 52*, 61-86. http://doi.org/10.3966/207010632020120052003

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英文：American Psychological Association. (2010). *Publication manual of the American Psychological Association* (6th ed.). Author.

三、編輯的書籍

中文：姜逸群、黃雅文（主編）（1992）。*衛生教育與健康促進*。文景。

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四、收錄於書中一章

中文：李思賢、林春秀（2012）。藥物濫用常見的盛行率估計法。載於楊士隆、李思賢（主編），*藥物濫用、毒品與防治*（頁87-100）。五南。

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五、翻譯類書籍

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http://www.he.ntnu.edu.tw/download.php?fcId=2

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