

Gula-Kubiszewska Halina, Dębska Urszula, Kalwa Małgorzata, Starościk Wojciech. A health training as a lifestyle element in the time of globalization. Studies of training participants in the context of selected psychological indices. *Journal of Health Sciences*. 2014;4(13):116-129. ISSN 1429-9623 / 2300-665X.

<http://journal.rsw.edu.pl/index.php/JHS/article/view/2014%3B4%2811%29%3A116-129>

<http://ojs.ukw.edu.pl/index.php/johs/article/view/2014%3B4%2811%29%3A116-129>

<https://pbn.nauka.gov.pl/works/509915>

DOI: 10.5281/zenodo.13260

<http://dx.doi.org/10.5281/zenodo.13260>

The former journal has had 5 points in Ministry of Science and Higher Education of Poland parametric evaluation. Part B item 1107. (17.12.2013).

© The Author (s) 2014;

This article is published with open access at Licensee Open Journal Systems of Radom University in Radom, Poland

Open Access. This article is distributed under the terms of the Creative Commons Attribution Noncommercial License which permits any noncommercial use, distribution, and reproduction in any medium, provided the original author(s) and source are credited. This is an open access article licensed under the terms of the Creative Commons Attribution Non Commercial License

(<http://creativecommons.org/licenses/by-nc/3.0/>) which permits unrestricted, non commercial use, distribution and reproduction in any medium, provided the work is properly cited.

This is an open access article licensed under the terms of the Creative Commons Attribution Non Commercial License (<http://creativecommons.org/licenses/by-nc/3.0/>) which permits unrestricted, non commercial use, distribution and reproduction in any medium, provided the work is properly cited.

Conflict of interest: None declared. Received: 10.09.2014. Revised 15.09.2014. Accepted: 04.11.2014.

A health training as a lifestyle element in the time of globalization. Studies of training participants in the context of selected psychological indices

Halina Gula-Kubiszewska¹⁾, Urszula Dębska²⁾, Małgorzata Kalwa¹⁾,
Wojciech Starościk¹⁾

¹⁾University School of Physical Education in Wrocław

²⁾Department of Psychology, University of Wrocław

Keywords: health training, health control placement, I corporeal, coherence, globalization

Abstract:

Times of globalization are characterized by an increased dynamic of changes, including first of all domains of ecology, economy, politics and also social and cultural areas. Unification of technology and culture as well as lifestyles, consumption models and health behaviours too are observed. Forced increased personal care about one's health, increasing possibilities of aiding health, e.g. through participating in specially prepared health training forms, taking care of figures by attending fashionable fitness and aerobic classes, fitness centres, performance sports, running etc.

Our survey comprised 37 health training participants and it was conducted at the AWF in Wrocław in 2013/2014. Assumed general objectives of training were: strengthening postural muscles, control over spine stabilizing techniques and also many intermediate goals. Moreover, the subjects set themselves personal goals of participation in training. The subjects were diagnosed in the context of selected psychological variables. The research was aimed at an initial determination of a psychological profile of participants in a long-term voluntary health training session. I-corporeal was diagnosed (attributional identity aspect), locus of health control, sense of coherence and global

self-esteem¹. Methods: health training session by M. Kałwa; questionnaires: MHLC, SOC-29, SES, Attributional Identity.

It can be observed: the training was mostly attended by persons with a higher index of 'I'-corporeal, higher BMI; they are satisfied with their figures and physicality. There are dependency between quality of life in the sphere of social integration; higher results in controllability and more possibilities to manage and influence their activities - more satisfied with lives in an area of activity: satisfaction and productivity.

In order to obtain more justified results it would be advisable to carry out similar research on a greater population.

Introduction

A globalization process that we have been witnessing nowadays results in the creation of a global society (Kempny, 1998) which is unified in many areas such as technology and culture, lifestyles², and models of consumption. More and more people worldwide have similar life styles, search for similar goods, services and values, have similar eating habits, clothes and forms of spending their free time. Changes that occur with their number, variability and the pace of life contribute to uncertainty and unpredictability as well as to the increase in numerous stressors. They also enforce specific behaviours which are not always good for human health (WHO, 2002). One of the most characteristic features here is a sedentary lifestyle with its adverse effect on personal figure and health (Miller, Rutkowski, Mrowska, 2007; Nowak, 2008; Pańczyk 2012)³.

Good physical and mental well-being in childhood to a large extent influences the health condition of people at later stages of their lives (Cierpiałowska, Sęk, 2006). Health is one of the values that is changing its place in a hierarchy from a purely instrumental one (Dębska, Guła-Kubiszewska, Bielawska, Starościak, 2008?). The area of health undergoes numerous unification transformations⁴. For many people many physical activities are becoming a basis of another lifestyle (Woynarowska 1993)⁵.

Physical activity as (desired or actual) element of lifestyle of contemporary man

¹ The research also comprised other psychological aspects, e.g. coping with stress and quality of life; results to follow in subsequent articles.

² Lifestyle – a manner of functioning of man in everyday life. It is manifested in a mode of work, play, relaxation and recuperation of strength (Wolański, 1977). It depends on many factors such as living conditions, an environment, social norms, personal values, attitudes, knowledge and beliefs (Woynarowska 1993).

³ More than 50% of adults in Poland lead sedentary lifestyles and only 25-30% of the Polish population systematically engage in healthy physical activity (Drygas et al. 2005).

⁴ Ways of understanding and models of behaviours begin to resemble one another. On the one hand, we can observe a forceful movement towards increased personal care about one's own health and assuming responsibility for it, while on the other hand there are more and more possibilities of supporting health and prevention, e.g. by taking part in specially prepared health training, fashionable aerobic and fitness classes, performance sports, running etc.

⁵ An offer to participate in various programs, forms of health training or other types of classes is more and more often addressed also to elderly and working people. It is aimed at improving the fitness and health of the persons who are exposed to adverse effects of enforced working conditions. Also, the fitness, health and independence of aging people is important here.

Physical activity facilitates health and well-being (DiLorenzo et al. 1999; Ransford et al. 1996)⁶. The efficacy of physical activity is greater when combined with a lifestyle (Wolański, 1977). A significant limitation in physical activity threatens the proper functioning, adaptive abilities and man's health (Miller, Rutkowski, Mrowska, 2007; Pańczyk, 2012). It also contributes to the development of many civilization diseases such as atherosclerosis, coronary artery disease, hypertension, overweight and obesity⁷ or even depression. It also causes disorders of various body functions, cardiovascular (Klecha et al., 2007), respiratory, skeletal, neuromuscular systems as well as water-electrolyte, energy metabolism, homeostasis and blood coagulation processes (WHO, 2002)⁸.

To the greatest extent, the development and health is conditioned by environmental influences and a life style (Wolański, 1977)⁹. The research on man's life style shows that the European postmodern culture imitates American models of massive consumption culture (Melosik, 1999; Bauman, 1991; Kołakowski, 2000; Pańczyk, Warchoń, 2008; Pańczyk, 2012).

One of the most important components of a healthy life style is regular physical activity (Drabik 1996). Systematic physical activity for the whole life constitutes an efficient way of delaying involution changes of the body and as a consequence infirmities of old age. It also supports cognitive functioning and has an impact on a higher sense of quality of life (Bielawska, Dębska, 2006; Dębska, Ułaszewska-Żuk, 2004?; Dębska, Guła-Kubiszewska, Bielawska, Starościak, 2008; Gajos et al., 2014; Guła-Kubiszewska, 2001; Jopkiewicz, 2001; Reznier, 2001).

A mass phenomenon of man's physical inactivity results, among other things, from a postmodern consumption civilisation. Consumerism leads to excessive instrumentation of the body and as such it stresses material life values (fashion for an attractive young body and appearance, artificial beautification of the body, plastic surgeries). Physical passiveness is a symbol of postmodern comfort, pseudo-comfort of fullness and warmth as well as immobility (cosmetic, pharmacological, medical and psychotherapeutic treatments), which is in opposition to effort and fatigue (Baudrillard, 1976; Krawczyk, 1998; Łobożewicz, 1988; Melosik, 1998, 1999, Pańczyk, Warchoń, 2008).

A health model is a leading direction in changing a passive lifestyle to an active type. It is perceived as showing the greatest possibilities of influencing the society's health condition (Kuński 2003). Physical activity connected with health prevention stands the biggest chance of developing in the 21st century. There are numerous sources in the literature of the subject that indicate a necessity to use training programs,

⁶ In many therapies movement has long been used as an element supporting treatment and improvement of the body and spirit (Dykeik, 2001; Ossowski, 1999).

⁷ According to WHO, among one billion obese persons worldwide at least 30 million are characterised by clinical obesity (Shaw et al. 2006).

⁸ All over the world experts emphasize adverse effects of civilization transformations to the health of children. A passive model of spending free time by the youngest results from their parents' negligence and a lack of family models as regards active leisure as well as motivation to practise games and motor activities (Vincente-Rodriquez et al., 2008).

⁹ WHO reports that health depends on a life style in 55%, upon an environment in 20-22% and genetic factors in 15-18%; the remaining several percent is an impact of health education and health care (Pańczyk, Warchoń 2008).

particularly in the fight against over-weight and obesity (Łobożewicz, 1988; Melosik, 1999; Miller, Rutkowski, Mrowska, 2007; Nowak, 2008) and eliminating various spine ailments (Nowak, 2008; Pańczyk, 2012; Pańczyk, Warchoń, 2008; Shaw, Gennat, O'Rourke, Del Mar, 2006). These programs are also used for prevention of collapses and osteoporosis (Nowak, 2008; Pańczyk, 2012) as well as improvement of personal comfort and quality of life (Dębska, Ułaszewska-Żuk, 2004; Dębska, Guła-Kubiszewska, Bielawska, Starościak, 2008).

An imperative of our times is the need to search for various training programs in the fight against civilization diseases and to specify optimal external loads in the context of an effective dose of physical effort and to determine a possible negative influence of given loads on psychophysical health condition. Results of the research that has been carried out over recent years confirm that appropriate physical training taken up independently of age causes certain adaptation changes in the body and a significant factor of these changes is the frequency of the undertaken effort (Kałamacka, 2005; Kałwa, Kosendiak A., Kosendiak J. (2008); Klecha, Bacior, Styczkiewicz, Kawecka-Jaszcz, 2007; Kołakowski, 2000; Krawczyk Z. et al., 1988).

What should dominate in pro-health physical activity is an organized form of health training, not spontaneous or occasional physical recreation. A subjective sense of quality of life depends, among other things, on such behavioural factors as health and mobility as well as physical well-being (Guszkowska, Kozdroń, 2009). Physical activity in the elderly¹⁰ contributes to the improvement of physical health (it increases vigour and vitality) and mental, i.e. in the emotional sphere (improvement of the mood, reduction of anxiety and depression, improving quality of life) (Dębska, Bielawska, 2003; Guszkowska, Kozdroń, 2009; Kałwa et al. 2010?) and cognitive (Dębska, Ułaszewska-Żuk, 2004)¹¹.

According to demographic forecast, the future Polish society dominated by people at the pre-retirement and retirement age shall be a serious burden to the state due to their poor physical fitness. Hence a need to intensify actions aimed at improving the health condition and quality of life of the aging society (Szukalski, 2011; Wieczorowska, Tobis, 2008; Ozaki, Uchiyama, Tagaya, et al., 2007).

Psychological context of pro-health behaviors

¹⁰ Research on elderly persons carried out at the beginning of the 21st century showed that 52% of the subjects were physically active. They pursued the following forms: everyday physical exercises, walks, gardening and cycling. Every third subject consciously looked after their eating habits appropriate for the age (32%), they underwent medical treatments and abstained from stimulants. Forms of active sport playing constituted only signal behaviours of the respondents (Bielawska, Dębska, 2003). Later research (2008) showed that 55% of Poles admitted that they had not exercised physically at all. According to research conducted five years later, the population of physically inactive persons grew by another 4% (Czapiński, Panek, 2013). Forecast for the year 2030 assumes the growth of this phenomenon up to 63% of the adult population (Ptak-Chmielewska, 2004; Raport KPMG, 2012).

¹¹ WHO recommends physical activity in prevention of chronic non-infectious diseases to people aged 18–64, i.e. a minimum of 150 minutes a week of moderate aerobic physical activity or a minimum of 75 minutes a week of intensive aerobic physical activity; activity up to 300 minutes per week gives additional health benefits (2004).

In a bio-psychological (holistic) model, which is based on the general systems theory, it is assumed that biological functioning, health or disease are conditioned, apart from biological factors, also by psychological and social ones (Sheridan, Radmacher, 1998, p. 6). Health is a process that is conditioned by multiple factors (Heszen, Sęk, 2008; Schwarzer, 1997). Each of the aforementioned areas participates in experiencing a sense of being healthy. Intervention on one level or in one part of the system may significantly influence the other components (Sheridan, Radmacher, 1998, p. 43). This explains how difficult it is to keep health on a constant level of functioning (Głowacka, 2000).

The process of regulation which is disturbed by an impact of internal or external factors has a dynamic character (Dolińska-Zygmunt, 2001, p. 13). In a processual aspect, health is defined as ‘a process resulting from mutual influences of resources that man has at his disposal to preserve health and everyday life requirements /.../’ (Sęk, 1997, p. 51). This process is connected with changing a lifestyle to another type, the one that will facilitate regaining balance.

In theory, undertaking activities aimed at implementing a selected pro-health lifestyle can be considered in the aspect of health promotion. It is based on a strategy aimed at stimulating general involvement in health problems, achieving a full and satisfying life and a growth in social awareness of health as an imperative value (Sęk, 1997, p. 49; in: Dolińska-Zygmunt, 2001, p.17). Lalond’s health fields (1978) is one of the concepts of health promotion that takes into account a given lifestyle. According to this model, the health area is shaped by the biology of man, environment, lifestyle and health care organization. The lifestyle constitutes circa 53% of the whole (Opatz, 1985; Sadowski, 1995; in: Dolińska-Zygmunt, 2001, p. 18).

Accepting and realizing the particular health lifestyle requires the awareness of an individual, knowledge as well as skill training and behaviours which are conducive to health¹². Complex cognitive, volitional, decision-making and executive/behavioural activeness takes part in this process. The observed individual differences comprise, among other things, the following aspects: a health potential, frame of mind, efficiency and physical fitness of the body, situational and habitual conditions, readiness to make choices and take up activity aimed at health and well-being. Psychological and subjective factors play a particular role here, for example, the awareness of personal responsibility and undertaken activity, evaluating health, a sense of identity, the so called resources – locus of health control, self-image and self-esteem, a sense of coherence, a sense of self-efficacy and ways of coping with stress (Bielawska, Dębska, 2006; Dębska, Bielawska, 2003; Dębska, 2009; Dębska et al., 2008abc; Dolińska-Zygmunt, 2000; Juczyński, 2001; Schwarzer, 1997; Sęk, 2006; Zalewska, 1997).

We can observe a change in evaluating health – from a subordinate value it becomes a superior one (Dębska, 2011; Dębska, Guła-Kubiszewska, Starościak, 2008b)¹³.

¹² Health promoting behaviours are all forms of intentional activity taken up by healthy persons (considering themselves as such) which are aimed at strengthening (protection) and increasing a health potential (Dolińska-Zygmunt, 2001, p. 35).

¹³ Persons who perceive health as a superior value are more consequent in activating and maintaining health behaviours. Research confirms that persons with internal locus of control are definitely more often physically active, they use stimulants less frequently and are more liked by others. Inner containment that

Another theoretical context of studies on conditions of health activeness is provided by *Psychology of Exercise*. This is a field of study in applied sciences that focuses on psychological conditions of taking up and continuing exercises and other forms of physical activity. It seeks reasons, motives and explanations why people take up numerous physical exercises (Gavin, Seguin, McBrearty, 2006). We are witnessing a growing demand for participation in various forms of health training, exercises, fitness training etc. and at the same time an increased possibility of putting this demand into practice. The subjects at different ages show positive changes, e.g. people with various diseases such as cardiological disorders, post-traumatic stress, Alzheimer, fibromyalgia or even a tumor.

Persons who are aware of being responsible and capable of keeping good psychophysical condition and health to a certain extent take up specified actions more frequently, for instance, getting involved in one of the forms of physical activity. The self-image in the case of these subjects is more positive, namely they control their activities, they are open to others, thus they are more cheerful, do not feel lonely or experience emptiness. Their social reception is more positive because they are more independent and less expecting. Those who do not personally take up any pro-health activities devolving responsibility for what happens to them on chance are negatively received by their surroundings, they are more pretentious and dissatisfied (Dębska, Bielawska, 2003). As research shows, persons who exercise systematically experience changes not only in the physical sphere but also in emotional, cognitive and social ones; moreover, they are characterized by a more positive mood, a lowered level of stress and anxiety and satisfaction from one's own activeness and life (Dębska, Guła-Kubiszewska, Starościk, 2008; Gavin, 2005; Penedo, Dahn, 2005). There is a noticeable growth in self-acceptance in the researched women (Clone, Smith, Gugh, 2005). An improvement in the functioning of verbal memory and recalling things from the past was observed in the elderly persons (Woo, Sharps, 2003). Changes observed in the case of people who work too much and become overworked show that the people who exercise are characterized by lower absence from work and greater awareness of pro-health behaviours (Ur, 2001). People who exercise became better leaders of groups, they are more efficient, consequent and with greater initiative (McDowell-Larsen, Kearney, Campbell, 2002).

Other subjective conditions that predispose the subjects to participate in health training are the following: I-corporeal as it is perceived by an individual, self-esteem, a sense of coherence and locus of health control. These variables were used in the initial characteristic of the female subjects participating in health training.

I-corporeal constitutes a mental representation of one's own body and the attitudes towards it. For contemporary people I-corporeal plays a particular role. What can be observed nowadays is the so called cultural and social trend that ascribes a dominant role to the human body, external appearance and even glorification of this sphere (Kubacka-Jasiecka, 2008). There is a widespread cult of the body and everlasting youthfulness. I-corporeal constitutes only one aspect of identity (unity) of a human being – apart from I-psychological and I-social. While a natural interest in the corporeal sphere and looking after it harmonizes with taking care of other spheres and it is

increases with age is conducive towards pro-health activities (Dębska, Bielawska, 2003).

balanced with them, we must admit that the excessive investment of care, strength and interest in I-corporeal leads to the so called processes of embodying I. It may pose a danger to the balance of individual identity, it constitutes a risk of behavioural disorders and in extreme cases a threat to survival of a given person (Kowalik, 2003; Kubacka-Jasiecka, 2008, p. 185n).

Life experiences result in the well-formed self-esteem of an individual. It constitutes the way persons think about themselves, their attitudes towards their own I and consequently the general mood, emotions and an attitude to tasks that a person faces (Dzwonkowska, Lachowicz-Tabaczek, Łaguna, 2008). Rosenberg understands self-esteem as a type of an attitude towards oneself (Rosenberg, 1965). It is formed at a relatively early stage of development and it increases along with age. Its basis is subject to gradual and slow changes (Rosenberg, 1989). A global self-esteem influences partial assessments and emotions connected with evaluating oneself, in particular a specific assessment of one's own physical fitness (Wojciszke, Baryła, 2005). Persons with high self-esteems are more extrovert than persons with low self-esteems (Halamanandaris, Power, 1997); they are more likely to engage in activities and meet challenges (Bandura, 1986). They are characterized by internal locus of control and a stronger conviction about their own efficiency (Dzwonkowska, Lachowicz-Tabaczek, Łaguna, 2008). A high self-esteem fosters health and greater resistance, while a low self-esteem even with positive experiences is more associated with incidence of numerous diseases and lower resistance (Brown, Siegel, 1988; Brown, McGill, 1989; Oleś, 2003).

A sense of coherence may play a particular role in taking care of health and everyday health activeness in a salutogenic aspect (focused on health). It is one of generalized resistance resources which is a relatively constant feature (Antonovsky, 1971). It is expressed in reasonableness which is evaluated by an emotional attitude towards stimuli that an individual encounters. This belief shows that it is worth getting involved in a given situation and fighting for something (Koniarek, Dudek, Makowska, 1993). Resources help with coping with stress – they are conducive to work out and activate appropriate strategies of actions (Koniarek, Dudek, Makowska, 1993). A higher sense of coherence is combined with a higher ability to cope with stressors (Koniarek, Dudek, Makowska, 1993, p. 492). A stronger sense of coherence is connected with a higher probability of well-being and health (Koniarek, Dudek, Makowska, 1993, p. 494) and an even higher probability of treating new situations as challenges.

Own research

Examined persons and methods

Survey was taken by 37 **health training** participants (35-65 years old), conducted at AWF in Wroclaw in 2013/14 from October 2013 till June 2014.

Assumed general objective of training:

Strengthening postural muscles, control over spine stabilizing techniques, were composed with many intermediate goals. Moreover surveyed people put themselves goals of participation in training.

Main objective: Improvement of physical fitness and mood, condition of the spine, strength and economy of work. Increasing the range of motion in joints. A change in the body composition in favour of an active tissue.

Intermediate objectives (partial): strengthening the postural muscles, improvement in

the symmetry of the spine motion in the frontal plane and bilateral rotation, improvement in the pelvis stability, acquisition of abilities to determine changes in the body efficiency, mastering the skills to offload the particular spine sections in order to eliminate a possible pain, mastering the techniques stabilising the pelvis for the individual application, acquiring the skill of evaluating the spine condition, motivation to do individual exercises or another directional activity, improvement of the body aesthetics, positive change in quality of life, skills of individual choices of an efficient dose of training loads, motor progress manifested in stress tests, (self-control/registration in a training diary).

In survey was used chosen psychological questionnaires:

MHLC-A questionnaire health control placement by K.A. Wallstone, B.S. Wallstone and R. DeVellis adapted by Z. Juczyński (2001), which takes into account the aspect of placing the control inside depending on other people and on accidental events. The assessments are made on six points scale depending on the level of appropriateness for the examined person.

The Sense of Coherence Questionnaire (SOC-29) (Antonovsky, 1987)

The scale consists of 29 questions; the possible answers are evaluated on a scale from 1 to 7 points.

A sense of coherence constitutes a permanent feature, a generalised as well as emotional and cognitive way of viewing the world, which allows perceiving phenomena as understandable (comprehensibility), controllable (manageability) and reasonable (meaningfulness) (Antonovsky, 1984; 1987).

A sense of coherence consists of three elements:

Comprehensibility – is connected with a cognitive aspect of a situation; it conditions the ability to order and structuralize received information;

Manageability – is connected with a sense of managing means and resources by individuals thanks to which they can actively influence a situation;

Meaningfulness – is connected with an emotional attitude to a situation and stimuli which an individual experiences. It is responsible for recognizing the value of getting involved in a given situation, thanks to which a situation can be perceived as a challenge, not as a threat.

The Rosenberg Self-Esteem Scale (SES) (Dzwonkowska, Lachowicz-Tabaczek, Łaguna, 2008).

Self-esteem – a synonym of a conscious attitude towards ‘I’ and emotions connected with my own ‘I’ and connected with cognitive judgments about myself. It is like a subjective evaluation based on perception and self-esteem (Anastasi and Urbina, 1999; Baumeister et al., 2003).

Rosenberg treats self-esteem as a feature or disposition relatively stable in time (Brown, Marschal, 2006; in: Dzwonkowska, Lachowicz-Tabaczek, Łaguna, 2008). As a global assessment, however, it can undergo changes in a shorter or longer perspective (Marsh, Yeung, 1999).

The SES Questionnaire enables diagnosing self-esteem as a state (Cisek, Sedikides, Heart, 2006; Lachowicz-Tabaczek, 2006) and as a feature (Donnellan, Robins, 2003).

The scale consists of 10 statements on which subjects express their opinions. Responses are provided on a scale of 1-4 points (1 – I definitely agree, 2 – I agree, 3 – I don’t agree, 4 – I definitely disagree).

Attributional Identity Questionnaire SBTA (A. Radomska)

The scale is used to measure attributional identity (I-corporeal, I-psychological, I-social) and disintegration of identity in these three areas.

The scale is composed of 60 adjectives referring to the three diagnosed areas of identity. Each subject gives an opinion on each of the adjectives by indicating a degree to which it describes him/her well. The responses are placed on a scale of 1-4 points (1 – it does not describe me at all, 2 – it rather does not describe me, 3 – it quite describes me, 4 – it definitely describes me).

The total score in each sub-scale can range from 20 to 80 points.

Quality of Life Questionnaire Straś-Romanowska, Oleszkowicz, Frąckowiak

The questionnaire includes 60 questions. It comprises four dimensions of well-being: psycho-physical, psycho-social, subjective and metaphysical. Results are in the range from 60 to 240 points. High results start from the level of 180. An internal consistency coefficient for the whole trial is 0,70.

Quality of life Questionnaire R.L. Schalock, K.D. Keith (M. Oleś adapting). It comprises four spheres of functioning: *satisfaction* (a feeling of success, pleasure, presence of family and company); *skill/productivity* (connected with work or attending a school); *a possibility to act/independence* (a feeling of possessing the ability to control activities, making their own decisions on such issues as shopping, medical treatment...); *belonging to the community/integration with the community* (being present in such social groups as the church, theatre, clubs, etc.; participation in meetings and events; a feeling of a positive relationship with other persons; a positive assessment of one's own life).

Questions:

1. What is a mutual arrangement of the particular 'I's' measured by a scale of identity (psychological, social, corporeal)?
2. Are the most reliable subjects characterized by a higher 'I' corporeal?
3. What is locus of health control of the subjects?
4. What is a level of general self-esteem of training participants?
5. What indices of a sense of coherence were achieved by training participants?
6. What is quality of life by training participants?

Results

With regard to attendance (regularity of participation in training):

Table 1. Average results in sub-scales as regards attendance at training

Numerous attendance (above 50%)			Numerous attendance (lower 50%)		
	Average			Average	
SES	2,6	1,08	SES	2,8	0,90
MHLC internal placement of control	28	2,48	MHLC internal placement of control	26	3,09
MHLC health decided by	18	5,60	MHLC health decided by	18	6,17

accidental events			accidental events		
MHLC external placement of control	17	7,83	MHLC external placement of control	21	4,07
SOC 29 comprehensibility	2,3	0,45	SOC 29 comprehensibility	2	0,37
SOC 29 manageability	2,6	0,51	SOC 29 manageability	2,6	0,50
SOC 29 meaningfulness	2,4	0,51	SOC 29 meaningfulness	2,7	0,49
I corporeal	2,31	1,31	I corporeal	2,35	5,22
I psychological	2,07	1,14	I psychological	2	2,93
I social	2,15	1,11	I social	2,43	3,34
BMI	25	3,49	BMI	24	3,48
Quality of life – psycho-physical	54,54	3,31	Quality of life – psycho-physical	55,27	5,30
psycho-social	52,38	3,78	psycho-social	54,53	5,32
subjective	50,62	4,61	subjective	51,33	4,20
metaphysical	51,08	4,68	metaphysical	51,27	4,27
satisfaction	24,15	1,28	satisfaction	23,13	2,09
productivity	21,85	3,95	productivity	23,5	2,19
independence	28,54	1,98	independence	28,56	1,21
integration	20,15	3,98	integration	21,5	4,23

Observed significant correlations:

1. Persons with a higher BMI index achieved significantly higher results in sub-scale 'I'-corporeal ($t=2,134$; $df = 17$, $p= 0.04$)
2. A higher result in sub-scale 'I'-corporeal correlates with higher results in psycho-physical subscale of quality of life ($t=1,267$; $df=20$; $p=0.04$)
3. Higher results in subscale of meaningfulness means higher results in subscale 'I'-social $r=0.68$; $p=0.05$. These persons significantly higher assessed quality of their life in subjective subscale ($r=0.48$; $p=0.05$) and possibilities of acting ($r=0,61$, $p=0.05$)
4. Higher results in subscale of controllability correlated with higher results in subscales of satisfaction and productivity ($r=0.46$; $p=0.05$)
5. Persons with better attendance in classes significantly lower evaluate quality of their life in the sphere of integration ($r=-0.48$; $p=0.05$)
6. The remaining researched dependencies are not statistically significant.

Discussion of results:

The long-term free of charge training was attended by persons on a voluntary basis. It was interesting to note what sort of features had the people who sought such a possibility of improving their health. According to literature reports, women turn out to be less eager to engage in regular physical activity (Pańczyk, 2002); with age they accept passive lifestyles more often (Zawadzka, 1993), however, these results are

relatively old! We are observing a change in this tendency, i.e. physical activity of women is on the increase. It is therefore worth noticing that the proposed training (voluntary and free) was attended by 99% of women!

It can be observed that the training was mostly attended by persons with a higher index of 'I'-corporeal, more concentrated on their own bodies; they are characterized by a higher BMI. Hence it is possible that the training has become for them a chance to lose some subjectively felt weight. However, a higher result in psycho-physical subscale of quality of life leads to the conclusion that they are satisfied with their figures and physicality. So the training rather reinforces their feeling of satisfaction from this sphere. The result showing a dependency between quality of life in the sphere of social integration and attendance in training would suggest that participation in training is for them an occasion to make social contacts and to integrate with others. The training participants, who are characterized by more understanding for everyday functioning, establish more positive social relationships and are more satisfied from their lives in a subjective area. The persons who had higher results in controllability and had more possibilities to manage and influence their activities are more satisfied with their lives in an area of activity: satisfaction and productivity. As research reports show, persons at various ages define a goal of physical recreation slightly differently, i.e. starting from the improvement of figures in the case of the youngest, maintaining good fitness with middle aged people and finishing with rather undetermined goals at late adulthood. This aspect of the results shall be discussed in the next article.

Implication

The research group was not large enough and poorly diversified; it is certain that similar training forms are attended by special persons with determined needs and particular mental features e.g. more resourceful, determined, and aware of goals that they want to achieve.

We can conclude that people who apply for participation in similar health programs belong to a group of so called satisfied with their lives as these who are dissatisfied most frequently remain in the sphere of 'complaining' with no chance 'to actively take their own life in their hands'.

In order to obtain more justified results it would be advisable to carry out similar research on a greater population.

References

1. Antonovsky A. (1971). Twenty-five years later: A limited study of the sequel of the concentration camp experience. *Social Psychiatry*, 6, s.186-193.
2. Baudrillard J. (2001). *Rozmowy przed końcem*, Wydawnictwo SiT, Warszawa.
3. Bauman Z. (1991). *Socjologia i ponowoczesność (W:) Racjonalność współczesności. Między filozofią a socjologią* [red. H. Kozakiewicz, E. Mokrzycki, M., H. Siemek]. PWN, Warszawa.
4. Cierpiałowska, Sęk (2006). *Zdrowie i zaburzenia z perspektywy rozwojowej i procesualnej. Próba integracji podejścia salutogenetycznego i patogenetycznego*.
5. Czapiński J., Panek T. (2013). *Diagnoza społeczna. Warunki i jakość życia Polaków*. Rada Monitoringu Społecznego Contemporary Economics, 7,

- Warszawa, s. 16-29.
6. Dębska U. (2009). Wellness and pro-health activity by people In the late adulthood (In:) Impact of a lifestyle on wellness and prosperity [ed. K. Turowski] NeuroCentrum, Lublin, p.45-56.
 7. Dębska U. (2011). Wartościowanie zdrowia i aktywność prozdrowotna w kontekście różnic płciowych (W:) Wymiary kobiecości i męskości. Od psychobiologii do kultury [red. B. Bartosz] Eneteia, Warszawa, s. 303-312.
 8. Dębska U., Bielawska I. (2003). Health-promoting activity by aging people. Empirical research (In:) New ideas in sport sciences: current issues and perspectives [ed. W. Starosta, W. Osiński] t. 2, Warszawa-Leszno-Poznań, p.16-19.
 9. Dębska U., Bielawska I. (2006). Health-promoting activity by aging people in self-image and locus control context, Annales Universitatis Mariae Curie-Skłodowska, vpl. LX, Suppl. XVI, Nr 1, 432-436.
 10. Dębska U., Guła-Kubiszewska H, Starościak W. (2008a). Criterion of health and pro-health activities by students and old age people (W:) Higieniczno-środowiskowe uwarunkowania zdrowia [red. I. Jackowska, M. Iskra, A. Borzęcki, K. Sztance] Katedra i Zakład Higieny Uniwersytetu Medycznego w Lublinie, Lublin, s.600-612.
 11. Dębska U., Guła-Kubiszewska H, Starościak W. (2008b). Health activity the old age people in the health valuation and quality of life context. (In:) Impact of a healthy and unhealthy lifestyle on wellness [ed. K. Turowski], NeuroCentrum, Lublin, p.73-82.
 12. Dębska U., Guła-Kubiszewska H, Starościak W. (2008c). The quality of life the old people In the valuations, pro-health activity and locus control context. (In:) Wellness in different phases of life [ed. G. Olchowik] NeuroCentrum, Lublin, p.19-30.
 13. Dębska U., Ułaszewska-Żuk M. (2004). Pro-health activity of elderly people as a way of coping with disability connected with the process of aging of the organism (In:) Epidemiological analysis of selected medical and social problems connected with non-infectious diseases in Poland I. [ed. D. Karwat] Wydawnictwo Akademii Medycznej w Lublinie, Lublin, p.60-67.
 14. Dolińska-Zygmunt G. (2000). Podmiotowe uwarunkowania zachowań promujących zdrowie. Warszawa, PAN.
 15. Drabik J. (1996). Aktywność fizyczna w treningu zdrowotnym osób dorosłych. cz. II, Wydawnictwo Uczelniane AWF w Gdańsku, Gdańsk.
 16. Drygas W., Jegier A., Bednarek-Gejo A., i wsp. (2005). Physical activity as a key factor influencing obesity and metabolic syndrome prevalence in middle-aged men. Long- term prospective study. Przeg. Lek. 62 (supl.3), s. 8-13.
 17. Dzwonkowska I., Lachowicz-Tabaczek K., Łaguna M. (2008). Samoocena i jej pomiar SES. Polska adaptacja skali SES M. Rosenberga. Pracownia Testów Psychologicznych, Warszawa.
 18. Gajos A., Kujawski S., Gajos M., Chatys M., Bogacki P., Ciesielska N., Żukow W. (2014). Wpływ aktywności fizycznej na funkcje poznawcze w podeszłym wieku. Journal of Health Science, 4/8, p.91-100.

19. Guła- Kubiszewska H. (2001). Niekonwencjonalne metody zachowania zdrowia- Tai Chi jako strategia pomagania samemu sobie poprzez aktywność ruchową w każdym wieku [W]: Muranow I. Zdrowie- istota, diagnostyka i strategię zdrowotne], Radom, s.376- 383;
20. Guszowska M., Kozdron A. (2009). Wpływ ćwiczeń fizycznych na stany emocjonalne kobiet w starszym wieku, *Gerontologia Polska*, t. 17, 2, s.71- 78.
21. Heszen I., Sęk H. (2008). *Psychologia zdrowia*. PWN, Warszawa.
22. Juczyński Z. (2001). *Narzędzia pomiaru w promocji i psychologii zdrowia*. Pracownia testów Psychologicznych, Warszawa.
23. Kałamacka E.(2005). Bierny styl życia Polaków: kontynuacja przeszłości czy kontradycja? *Annales Universitatis Mariae Curie- Skłodowska Lublin- Polonia*, Vol. LX, Supl. XVI, 180, Sectio D, p. 317- 320.
24. Kempny M. (1998). *Globalizacja*. 9W:) *Encyklopedia socjologii*. Oficyna Naukowa, Warszawa.
25. Klecha A., Bacior B., Styczkiewicz K., Kawecka- Jaszcz K. (2007). Trening fizyczny u chorych w podeszłym wieku z przewlekłą niewydolnością serca, *Choroby Serca i Naczyń*, t. 4, 2, s. 78- 82.
26. Kołakowski L. (2000). *Kultura i fetysze*, PWN, Warszawa.
27. Koniarek J., Dudek B., Makowska Z. (1993). Kwestionariusz Orientacji Życiowej. Adaptacja The sense of Coherence Questionnaire (SOC) A. Antonovsky'ego. *Przegląd Psychologiczny*, t. XXXVI, 4, s. 491-502.
28. Kosendiak J., Kałwa M. , Kosendiak A. (2008). Projekt treningu zdrowotnego dla osób zagrożonych występowaniem chorób cywilizacyjnych. [W:] *Choroby przewlekłe: wybrane zagadnienia*. [red. A. Abramczyk., B. Panaszka] A&A Optimed, Wrocław, s. 379-388.
29. Krawczyk Z. i wsp.(1988). Sport dla wszystkich w społeczeństwach postindustrialnych, *Wychowanie Fizyczne i Sport*, T. 42, 1, s. 21 – 48.
30. Kubacka-Jasiecka D. (2008). Ja cielesne i problematyka identyfikacji z ciałem w kontekście wartości współczesnej kultury I zdrowia (W:) *Psychologia zdrowia*. W poszukiwaniu pozytywnych inspiracji [red. I. Heszen, J. Życińska] *Academica Wydawnictwo SWPS*, Warszawa, p.185-204.
31. Kuński H. (2003). *Trening zdrowotny osób dorosłych*. Poradnik lekarza i trenera. Agencja Wydawnicza MEDSPORTPRESS, Warszawa.
32. Łobożewicz T. (1988). *Turystyka jako forma kultury fizycznej w życiu człowieka*. PTNKF, Warszawa.
33. Melosik Z.(red.) (1999). *Ciało i zdrowie w społeczeństwie konsumpcji*. Toruń- Poznań.
34. Miller E., Rutkowski J., Mrowiska M. (2007). Udział reaktywnych form tlenu w uszkodzeniu mięśni wywołanych hipokinezją. *Merk. Lek.*, 130, s. 314- 317.
35. Nowak P. (2008). Rola treningu rekreacyjno- zdrowotnego na tle wzorów zachowań we współczesnej kulturze [W:] *Wzory kultury somatycznej a styl życia* [red. S. Zagórny] *Studia i Monografie*, Z. 227, *Politechnika Opolska*, Opole, s. 59-70.
36. Ozaki A., Uchiyama M., Tagaya H. (2007). The Japanese Centenarian Study: autonomy was associated with health practices as well as physical status. *J Am Geriatr Soc.*; 55, 95101.

37. Pańczyk W. (2012). Wychowanie fizyczne dla zdrowia. Wydawnictwo Uniwersytetu Rzeszowskiego, Rzeszów.
38. Pańczyk W., Warchoń K. (2008). W kręgu teorii, metodyki i praktyki współczesnego wychowania fizycznego). Wydawnictwo Uniwersytetu Rzeszowskiego, Rzeszów.
39. Ptak-Chmielewska A. (2004). Stan struktura i dynamika ludności polski według prognozy GUS za lata 2003-2030 oraz prognozy ONZ za lata 2000-2050. PAN Sekcja Analiz Demograficznych 9/2004, <http://www.ae.krakow.pl/~demograf/Publikacje/SAD9.pdf>.
40. Raport KPMG (2012). Analiza zmian społeczno-demograficznych oraz wpływu złego odżywiania, niedostatecznej aktywności fizycznej, nałogów i innych czynników ryzyka na rozpowszechnienie oraz koszty cukrzycy i chorób sercowo-naczyniowych w Polsce. Stan obecny i prognoza do 2030 roku. http://zdrowepokolenia.org/data/pdf/raport_kpmg.pdf
41. Shaw K., Gennat H., O'Rourke P., Del Mar C. (2006). Exercise for overweight and obesity. *Cochrane Database Syst. Rev.* (4): CD003817.
42. Sheridan Ch.L., Radmacher S.A. (1998). Psychologia zdrowia. Wyzwanie dla biomedycznego modelu zdrowia. Instytut Psychologii Zdrowia, Warszawa.
43. Szukalski S. M. (2011). Perspektywy rozwoju usług w Polsce w świetle regresu demograficznego i starzenia się społeczeństwa [W]: Nierówności społeczne a wzrost gospodarczy. Modernizacja dla spójności społeczno-ekonomicznej, ZN, Rzeszów, Zeszyt 18, s. 409-418.
44. The World Health Report 2002 (2002). Reducing risks, promoting healthy life. France, Sadag -7000; World Health Organization, p.. 1-177; *Medycyna po dyplomie* (2004), vol. 13/ 9, s. 47-55.
45. Vincente- Rodriguez G., Rey- López J. P., Martin- Matillas M., Moreno L. A., Wärnberg J., Redondo C., Tercedor P., Delgado M.Castillo M., Bueno M., (2008). AVENA Study Group: Television watching, videogames, and excess of body fat in Spanish adolescents: the AVENA study, *Nutrition*, 24/7- 8, s. 654-662.
46. Wieczorowska H., Tobis K. (2008). Zmiany narządowe w procesie starzenia. *Pol. Arch. Med. Wewn.*, 118 (Suppl): 63-69.
47. Wolański N. (1977) *Rozwój biologiczny człowieka*. SiT, Warszawa.
48. Woynarowska B. i wsp. (1993). *Zachowania zdrowotne młodzieży szkolnej w Polsce*. Instytut Matki i Dziecka, Warszawa.