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QUALITY OF LIFE DETERMINANTS IN CHILDREN AND YOUTH: CONSEQUENCES FOR SOCIO-EDUCATIONAL INTERVENTION

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Abstract

Quality of life is a multidimensional construct. The study of its determinants in early age groups constitutes a starting point for socio-educational lines of action definition. This study aims to analyse the levels of perceived quality of life in Portuguese children and youth and to compare them according to sociodemographic, anthropometric, family and health variables, in order to understand the consequences for socio-educational practice. 354 Portuguese children and adolescents with a mean age of 12.21 ± 2.92 participated in this ex post facto study. The Portuguese version of KINDL (Ferreira, Almeida, Pisco & Cavalheiro, 2006) was used to evaluate the quality of life and a sociodemographic questionnaire to assess the other variables. The non-parametric analyses were run in SPSS-IBM24, assuming the 95% confidence level. Adequate levels of quality of life were found (92.00±12.23). Encouraging results were found ($p \leq .05$) in the youngest, except in the family subscale; from the coastal area, in self-concept and family; and from rural areas in total. Body mass index and perceived health were, respectively, negatively and positively related ($p \leq .05$) to physical well-being and self-concept. Father's qualifications were associated with self-concept (rho=.15, p =.011). The identification of factors with relevance in the quality of life of children and youngsters will allow the definition of socio-educational intervention guidelines adjusted to the specificities of different groups of the population.

Keywords: Quality of life, children, youth, determinants, socio-educational intervention.

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1. Introduction

The interest in the study of quality of life in early age groups is recent. In fact, the investment in the analysis of this dimension in adult life remains very evident in the literature. However, this growing interest in the study of quality of life in earlier age groups focuses mainly on the understanding of their relevance in relation to health issues, due to the increase in childhood obesity and associated chronic diseases which has preoccupied the scientific community in general (Ferreira et al., 2006). Changes in the lifestyle have led to the increase of health problems in earlier age groups. In fact, early adoption of healthy nutritional and physical activity habits may strongly improve their future quality of life (Roura, Milà-Villarroel, Lucía Pareja, & Adot Caballero, 2016) and with consequences for physical and psychological well-being, self-esteem, relationships with peers and family, and school integration.

In this context, to access the perception of the subjects about their life is fundamental, insofar as this construct of quality of life refers to the evaluation that the individual makes of his living conditions. It is a comprehensive concept that includes dimensions other than health already mentioned in the previous paragraph (Pereira, Teixeira, & Santos, 2012). In children and adolescents, this self-assessment has for a long time been based on adapted instruments of the adult population, not sensitive to the specificities of this developmental stage (Ferreira et al., 2006). On the other hand, the evaluation of the perspective of the adults surrounding the child (parents, teachers or health professionals) may prove insufficient as the children's responses about their life tend to be different from adults (Ravens-Sieberer, Karow, Barthel, & Klasen, 2014). Indeed, "for children and adolescents, well-being can mean how much their desires and expectations approach their realities" (Ferreira et al., 2006, p. 126), which will certainly be addressing developmental issues very different from adults. The studies indicate that the perceptions of the young are influenced by different factors that must be analyzed in an ecological perspective, that is, it is fundamental to take into account characteristics of the child, family and other contexts. Gaspar, Matos, Ribeiro and Leal (2006) point out, for example, some determinants present in the literature related to the characteristics of the individual, family and other life contexts of the youth with relevance in their lower level of quality of life: low socioeconomic status, parent's psychopathology, lack of social support, stressful life events, child behavior problems, among others.

In fact, literature points out several determinants associated with quality of life. However, about the importance of sociodemographic variables, regarding quality of life in children and youth, the studies indicate results that not always match. In the studies of Gaspar et al. (2006) and Guedes (2013), the latter with asthmatic children and adolescents, gender was identified as one of the variables with influence on quality of life, with male participants presenting higher levels. Gordia, Silva, Quadros and Campos (2010) corroborate these results, emphasizing that female adolescents present a higher risk of perceiving negative quality of life in terms of emotional well-being. However, Barata (2016) and Coimbra (2014) did not find differences in perceived quality of life according to gender. Barata (2016) in his study stresses that age accounts for 23% of quality of life, being children less than or equal to 12 years and adolescents aged 15 years or more, who tend to perceive their quality of life as reasonable. However, the influence of age is not always consensual in studies. Guedes (2013) and Coimbra (2014) do not verify any relevance of this variable in the quality of life of children and youth. There are few studies on the influence of the area of residence on quality of life in childhood and youth, with published works focusing mainly on health

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issues and the influence of urban zones, which present living conditions based on excessive levels of pollution (Figueiredo, 2015). For example, this author notes that 50% of the children living in these areas are exposed to tobacco smoke. The author enhanced, however, that although the effects of these agents on health were known, it was not possible to establish in his study a statistically significant relationship between exposure to tobacco smoke and children's quality of life with regard to their physical well-being.

In addition to these sociodemographic variables, it is essential to take into account aspects of family life, since it is within this context that the children/youth develop. In this sense, the characteristics of the relatives, more specifically of their parents, contribute to their development and, consequently, also to the quality of life (Gaspar et al., 2006). Most of the studies, focusing on family variables and their negative influence on children's quality of life, explore issues associated with poor parental support, violence and dysfunction in the family, among other factors such as low socioeconomic status. In the analysis of socio-economic status, elements such as the level of education of parents and their professions are essential. In this sense, Perosa, Amato, Rugolo, Ferrari and Oliveira (2013), in a study with asthmatic children, found a significant and positive association between mother level of education and the children's quality of life index. We also know that situations of poverty and dysfunctionality in families are often associated to households constituted of many elements of different generations living in unfit conditions of comfort and hygiene (Silva, 2013). In this sense, Gaspar et al. (2006) point the negative influence of these family characteristics on the quality of life of the younger ones. In fact, according to these authors, poverty constitutes a risk factor for the child's physical, emotional and social well-being (dimensions that are part of the quality of life construct). The authors add that, associated with the low socioeconomic status are aspects such as unemployment, low levels of parent's education, living in problematic areas, households with many elements, among others. However, Coimbra (2014) does not verify any influence of the socioeconomic level on the quality of life perceived by children and youth.

The analysis of variables related to the health and lifestyle of children and adolescents, is traditionally the central nucleus of the exploration of quality of life determinants. Despite the importance of the Body Mass Index as an objective indicator of health and the relevance of health in quality of life, there are studies that do not verify any tendency of association between these variables (e.g. Guedes, 2013). However, other researchers point out a higher risk of negative evaluation of quality of life, especially in emotional well-being, in overweight adolescents (e.g. Gordia et al., 2010). An active lifestyle in childhood and youth has shown to be significant in terms of quality of life. In Guedes's (2013) study, with asthmatic children and youth, the involvement of students in extracurricular sports activities had a positive impact on the quality of life, specifically with regard to physical health. Gordia et al. (2010) also verified a higher risk of perceived negative quality of life in terms of emotional well-being in less active/more sedentary adolescents. Most studies on quality of life focus on health objective aspects such as the existence of diseases. However, according to Gaspar et al. (2006), research and intervention in the area of health-related quality of life, includes the evaluation of the perception of subjects about their quality of life. In this sense, the subjective evaluation of health status is also fundamental in the study of this variable. The authors point out innumerable factors influencing perceived quality of life related to subjective health: self-concept, social support, parental education, coping styles, optimism, among others. In fact, in the definition of the quality-of-life construct, which we have presented previously and that

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meets consensus in the scientific community, the importance of this subjective experience is included (more than the objective evaluation of the living conditions), being fundamental to know the description that the individual does about what he/she feels for his life.

In addition to the study of the influence of these variables in an isolated way, it is fundamental, according to Gaspar et al. (2006), to understand the interaction between sociodemographic dimensions (e.g. age, gender and socioeconomic status, as we highlighted earlier), intrapersonal factors (personality traits such as extroversion, internal control locus or self-concept, the latter considered an inherent dimension of the quality of life in some instruments) and the well-being and quality of life. Indeed, in measuring the quality of life of children/youth, the evaluation of dimensions such as self-concept and self-esteem is frequent. Throughout the development, self-concept evolves as children/youth are progressively able to self-perceive and evaluate themselves in different domains: school aspects, social acceptance, appearance and physical competence, among others (Veiga, & Leite, 2016). These are also important dimensions to be taken into account in the evaluation of quality of life in these age groups and that relate to each other and to other variables (for example, according to the authors we have mentioned, there are gender and socioeconomic level differences with regard to children's self-perceptions). The dimension of interpersonal relationships also plays an important role in the assessment of quality of life. In fact, the relationship with the peers is fundamental for the social development of the child/youth, in addition to the relations with the family (already mentioned above). According to Gaspar et al. (2006), the friendship contributes not only to the psychosocial adjustment of the child, but also to school adaptation, emotional well-being, among other aspects of human life. These domains of emotional well-being and school adjustment are also dimensions frequently assessed when the quality of life perceived in children/youth is measured. Finally, we recall the relevance of physical well-being, as previously mentioned, also in the evaluation of the quality of life. We will then see, in the description of the instrument used in the study developed in this paper, these dimensions included in the construct of quality of life.

The study of the quality of life in these age groups allows, therefore, to outline strategies for specific groups of children and youth, in the scope of prevention and improvement, after identification of their biopsychosocial determinants. These strategies should address the need for a multidisciplinary intervention, so that in this context the role of health, psychology and social work professionals is fundamental. In fact, quality of life is a construct studied in different areas, from health, sociology, economics, politics to psychology. In this context, socio-educational intervention presents itself as a privileged area that ensures children and youth an adequate physical, mental and social development. In fact, one of the most recent professionals in the context of social work, especially in the European context, is the social educator. The socio-educational intervention of this professional aims the promotion of quality of life and well-being (Timóteo, & Bertão, 2012). These authors defend that developing well-being will have repercussions on the social inclusion of individuals, especially groups in situations of vulnerability, including children and youth. Hence, the author emphasizes the role of these professionals as a complement to the response of the formal health and education services. In order to develop socio-educational strategies, is crucial to identify specificities in groups that determine the definition of distinct lines of action.

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2. Problem Statement

In the recent decades, the well-being of children and youth have become a constant concern in public discourse and in political debates worldwide. Public organizations, such as UNICEF and others, developed indicators of quality of life in order to monitor the situation of the children around the world. Health, education, safety, economic, as well as behaviour problems, are factors pertaining to the quality of life of the children and youth (Alanen, 2010). In fact, quality of life is a multidimensional construct. Hence, the study of its determinants in early age groups constitutes a starting point for socio-educational lines of action definition, relevant in promoting physical and psychosocial well-being of future generations. In this context, social work intervention, particularly socio-educational practice, is a privileged field of action, according to Timóteo e Bertão (2012). These authors argue that people have the responsibility of change behaviours in order to improve their living conditions and in this sense the social educator is a professional with an important role in empowering individuals in order to promote their autonomy and well-being.

3. Research Questions

The research questions that guided this study were:

How do children and youth assess their quality of life?

Are there differences in quality of life due to sociodemographic, anthropometric, family or health variables?

4. Purpose of the Study

In order to analyse the levels of perceived quality of life in Portuguese children and youth and to compare them according to sociodemographic, anthropometric, family and health variables, we developed this study, hoping also to understand its consequences for the socio-educational practice.

5. Research Methods

This is a quantitative study with an ex post facto design.

5.1. Participants

A total of 354 children (57.8%, from 6 to 12 years) and youth (42.2%, from 13 to 17 years old) participated in this study, with a mean age of 12.21 ± 2.92, 58.5% female, mostly attending the 2nd and 3rd school cycles (28.3% and 28.9%, respectively). Most of the participants lived inland (75.3%), both in urban (n = 128) and in rural areas (n = 180).

With regard to the characteristics of the parents, it was possible to verify a diversity of professional activities in different areas, with only 10.2% of the fathers reporting the 1st school cycle and a similar percentage (9.6%) the higher education level. The remaining were equally distributed by the 2nd and 3rd school cycles and secondary. Concerning mothers, the percentage was lower in the first school cycle (3.7%) and higher in university level (16.7%), showing also a higher percentage in secondary education,

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followed by 3rd school cycle and then the 2nd one. The mean age presented by the fathers was 43.38 ± 6.48 and the mothers' mean age was 40.43 ± 5.69. It should also be noted that the parents had a mean BMI higher than that of the mothers (26.01 ± 2.99 and 24.98 ± 4.37, respectively) and higher than the adjusted limits, while that of the mothers was within normal limits. The majority of households were composed of 3 to 4 individuals (37.7% and 46.4%, respectively).

We explored children and youth health status, and only 6.9% said they had some type of disease (for example, allergies, respiratory or digestive problems). Only 10 participants reported being at the time of data collection on diet, especially to lose weight. Nevertheless, the sample had a mean BMI of 18.83 ± 3.28, a level considered adequate. However, it was observed that on average participants spend about 7 hours a day sitting down during the week and approximately 5 hours ~~a~~ day at the weekend. In general, the participants considered their health to be good (4.34 ± .64, on a scale of 1 to 5).

5.2. Material

One of the instruments most used to access children's and youth's perception of quality of life in general is the KINDL®, initially developed by Bullinger, von Mackensen and Kirchberger (1994), later revised by Ravens-Sieberer, Görtler and Bullinger (2000), in both studies revealing good psychometric qualities, also in the Portuguese version. The version adapted to our population by Ferreira et al. (2006) includes, like the original, 24 items, distributed uniformly across six subscales: physical well-being, emotional well-being, self-esteem, family, friends and school. The items are answered on a Likert scale of 5 points (1 - never to 5 - always), so in the end the maximum score per subscale will be 20 points and the overall quality of life, resulting from the sum of the different dimensions, corresponds to 120. The scores are then converted to a scale of 0 to 100.The instrument also presents a version for parents and an extra subscale that is used in situations of illness and hospitalization of the child/youth. Kiddy-KINDL® is the version for children aged 4-7 years, Kid-KINDL® for the 8-12 years and, finally, Kiddo-KINDL® for youth (Ferreira et al., 2006). In this study, the last two were used.

A questionnaire of general characterization was also completed by their parents, which included sociodemographic, anthropometric, family and health variables.

5.3. Procedures

The instruments were applied with the support of the researcher, and the ethical demands involved in data collection were ensured. Hence, adults responsible for the children and youth signed an informed consent after clarifying the purpose of the study and ensuring the voluntary nature of the participation, as well as the confidentiality and anonymity of the responses. Data collection occurred in December 2016.

Data analysis was run in Statistical Package for Social Sciences - IBM 24, using descriptive and inferential statistics ($p \leq .05$), particularly non-parametric tests (Mann-Whitney and Spearman' rho) due to non-compliance of the normality and homoscedasticity assumptions.

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5.4. Variables

In this study, comparisons were made between groups regarding quality of life (and respective dimensions) as a function of socio-demographic variables, such as age (children *vs*. youth), gender (male *vs*. female) and area of residence (coastal *vs*. inland and urban *vs.* rural). We also explored associations between the quality of life (and their dimensions) and other variables: anthropometric (BMI of the child / youth); family (father's / mother's qualifications and number of household members); and in the context of health-related aspects (health perception and sedentary lifestyle – sitting down time per day).

6. Findings

Descriptive and inferential analysis (t-test) comparing our results with the reference values, by gender and age, presented by the authors of the KINDL® Portuguese version are shown in Table 01.

Table 01. Statistics (by gender and age) - comparative analysis with the original study

Global Quality of Life and its Dimensions	Children[1] (8-12 years)		Youth[1] (13-16 years)		Children (8-12 years)		Youth (13-17 years)	
	Female M (*SD*)	Male M (*SD*)	Female M (*SD*)	Male M (*SD*)	Female M(*SD*)	Male M(*SD*)	Female M (*SD*)	Male M(*SD*)
Physical well-being (PWB)	80.62 (15.69)	80.62 (16.95)	69.14 (18.74)	75.00 (10.94)	82.77 (11.78)	83.10 (15.17)	75.58** (14.27)	79.62* (13.37)
Emotional well-being (EWB)	87.81 (9.40)	86.56 (9.78)	78.91 (13.48)	82.42 (11.68)	86.07 (15.06)	89.08 (13.22)	81.21 (13.34)	83.49 (17.42)
Self-esteem (SE)	55.62 (20.16)	68.75 (19.24)	50.78 (20.26)	51.95 (18.78)	70.22** (17.13)	69.40 (14.60)	66.53** (14.94)	66.98** (14.22)
Family	78.34 (10.03)	79.06 (13.79)	73.05 (24.44)	78.98 (16.59)	83.21** (11.07)	82.22** (11.87)	80.16** (16.82)	82.92 (15.52)
Friends	85.31 (13.64)	79.06 (15.61)	79.30 (9.96)	80.86 (14.52	88.35* (13.19)	88.32** (13.37)	77.82 (14.66)	76.73* (14.31)
School	71.25 (17.84)	69.69 (22.05)	50.00 (13.31)	53.12 (21.77)	64.69** (13.56)	66.25** (15.89)	59.47** (15.92)	61.52** (15.34)
Total	76.51 (8.91)	77.29 (8.78)	66.86 (8.75)	70.38 (9.21)	77.97 (10.49)	78.50 (10.13)	73.05** (8.61)	75.25** (10.56)

[1] Reference values for the Portuguese population by Ferreira, Almeida, Pisco and Cavalheiro (2006).
*p≤.05 ** p≤.01

Adequate levels of quality of life were found in the total sample (M=92.00±12.23). In our children sample we found: higher self-esteem values in female; higher levels in family and friends dimensions in both genders; and worst results in both boys and girls in school. In the youth, we found in our study better results in female and male in physical well-being, self-esteem school and global quality of life; higher levels in family subscale in female; and lower results in friends dimension in males.

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In the inferential analysis (Table 02), there were encouraging results ($p \leq .05$): i) in the youngest, except in the family subscale; ii) from the coastal area, in self-concept and family; iii) and from rural areas in total. In the context of sociodemographic variables, gender was not relevant for quality of life.

Table 02. Group comparisons - sociodemographic variables

		PWB	EWB	SE	Family	Friends	School	Total
Age	*U*	11226.50	11102.50	12923.00	14580.00	7739.50	11668.00	6832.50
	p	.000	.000	.032	.795	.000	.000	.000
Gender	*U*	14215.00	13907.00	14867.00	14549.00	14510.50	13989.50	9722.00
	p	.396	.237	.942	.734	.727	.310	.266
Inland/Coastal	*U*	7683.00	7569.50	6948.50	6897.00	7882.00	7706.50	5578.00
	p	.404	.310	.047	.043	.601	.426	.353
Urban/Rural	*U*	10788.50	10538.50	10933.00	10011.00	9905.00	11285.00	6678.50
	p	.426	.258	.624	.107	.074	.981	.013

Finally, we explored variable associations (Table 03) analyzing anthropometric, specially BMI, health-related and lifestyle variables (subjective health and sedentary life – sitting down time at week and weekend).

BMI and perceived health were, respectively, negatively and positively related ($p \leq .05$) to physical well-being and self-esteem. Health perception was also positively related ($p \leq .05$) to the total of quality of life. In these health-related variables we found no significant associations between quality of life and a sedentary life style.

In what refers to the family variables only the qualifications of the father turned out to be statistically significant and were positively associated with self-concept (r_s=.15, $p \leq .05$).

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Table 03. Variable associations – anthropometric, health and family dimensions

	Spearman's rho	PWB	EWB	SE	Family	Friends	School	Total
BMI	r_s	-.136*	-.070	-.162*	.026	-.125	-.110	-.121
	N	240	240	240	240	239	240	184
Health perception	r_s	.168**	.083	.173**	.015	.087	.004	.188**
	N	350	350	349	348	348	349	291
Siting time at week	r_s	-.057	-.007	.006	.047	.029	-.021	.026
	N	333	333	332	331	331	332	279
Siting time at weekend	r_s	-.029	.002	-.001	.090	-.024	-.086	-.023
	N	330	330	329	328	328	329	276
Father's education	r_s	.002	-.068	.149*	.017	.096	.112	.070
	N	292	292	291	290	290	291	243
Mother's education	r_s	-.025	-.047	.105	-.025	.074	.081	.033
	N	345	345	344	343	343	344	289
Household members	*rs*	-.028	-.083	-.142	-.147	-.097	-.092	-.012
	N	138	138	138	138	137	138	81

*$p \leq .05$ ** $p \leq .01$*

7. Conclusion

In our study, we verified the relevant contribution of some determinants to the quality of life of children and youth. Regarding socio-demographic variables, age was relevant (as in the study of Barata in 2016), in turn, gender, similar to what happened in Barata (2016) and Coimbra (2014), was not relevant. Concerning the area of residence, given the lack of studies and the results that we found (higher values in the participants of the coastal area in the self-concept and family and from the rural regions in the total quality of life), it seems appropriate to continue to develop studies such as of Figueiredo (2015) that allow exploring the relevance of some factors that characterize different regions of the country in terms of the quality of life in childhood and youth. Contrary to the study of Perosa et al. (2013), we found a significant association of quality of life with the qualifications of the father and not of the mother. In addition, the number of household members was not relevant, although the literature points to this dimension as a risk factor, along with the socioeconomic level of the family (although not relevant in the Coimbra study in 2014). Finally, in the variables related to health, participants with higher BMI had lower results in physical and emotional well-being (the latter result similar to the study of Gordia et al. in 2010). The sedentary lifestyle in our sample did not show a difference in quality of life, contrary to what was observed in the studies of Guedes (2013) and Gordia et al. (2010), although the authors explored other variables within the active lifestyle framework. As Gaspar et al. (2006) mentioned, perceived health is a fundamental element of quality of life, which has proved to be relevant in our sample, as the participants who were more satisfied with their health presented higher levels of physical and emotional well-being, and total quality of life.

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As could been seen, the results found in the literature do not always coincide. Therefore, it is fundamental to continue exploring these and other dimensions, such as: i) crossing these results of self-perception of the children/youth with the parents perception; ii) analyzing the interrelation between the different sociodemographic, health and family variables, which were studied in our work isolated; iii) exploring aspects related to objective health (in the present study, we didn´t do this analysis as we have not balanced groups as to the number of subjects with and without diseases), school aspects (e.g. academic achievement) or the socio-economic level of the parents (although we collected information about the profession, which would allow to classify the socio-economic level, once again it was not possible to establish balanced groups in the number of participants). Hence, the work is assumed to be exploratory considering the limitations already mentioned.

Nevertheless, the results found give us a perspective of the populations that are in a more unfavorable situation and to target strategies of socio-educational intervention that will help to work individual, interpersonal and community variables. The implementation of contextualized intervention programs benefits from the prior identification of the determinants of quality of life and, in this sense, the present study is assumed as a starting point to find ways to deal with the challenges in an appropriate way. In this case, adolescents, from urban areas and of the inland, living in households with lower levels of schooling, overweight and lower health perception, may constitute privileged target groups for intervention at different levels. We suggest: i) development of personal and social skills, promoting increased self-esteem, school integration and improvement of the relationship with peers and families; ii) and strategies for optimizing physical and emotional well-being, such as physical activity and nutritional support, promoting the ability to choose a healthy lifestyle.

The link between scientific research and socio-educational intervention is fundamental. Hence, the identification of determinants of the quality of life of children and youth will help to find intervention guidelines adjusted to the specificities of different groups of the population to find alternatives and ways to deal with the most appropriate challenges in situations where social, economic and environmental factors can be risk factors, in order to increase participation and well-being of children and adolescents. The concept of quality of life evolved from the sensitizing notion to an agent of social and organizational change, and the quest for quality of life is an objective for individuals, but also for professionals, organizations and politicians (Lopes, 2012).

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