



Validation and effect of demographic variables on perceived quality of life by adolescents



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ABSTRACT

The objectives of the current study were to examine the psychometric properties of the WHOQOL-BREF (English and Hindi language) on Indian adolescents and to explore the role of demographic variables on quality of life. Data from 1327 students, aged 11–21 years was collected with mean age = 15.36 years (SD = 1.42 years). The results of validation indicated that English and Hindi version of WHOQOL-BREF was a moderate model fit. Overall quality of life and satisfaction with health both predicted the various domains of quality of life, thus demonstrating acceptable predictive validity. Results of multivariate analysis demonstrated that adolescents differed significantly on demographic variables. Adolescents who attended private school possessed significantly better quality of life (overall), physical health, psychological well-being and environmental conditions as compared to adolescents who attended government school. Rural adolescents had significantly higher perceived quality of life (overall), physical health, psychological well-being, social relationships and environmental conditions as compared to urban adolescents.

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1. Introduction

World Health Organization (1996) defined quality of life as “individuals’ perceptions of their position in life in context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns”. The definition focuses on the respondent’s “perceived” quality of life that reflects the multidimensional nature of quality of life. WHO developed an instrument WHOQOL with an aim to extend the dimension of health measurement beyond traditional health indicators, to have a universal instrument to assess quality of life cross-culturally and to promote a holistic approach to health and health care. The original WHOQOL is a 100 item instrument that was developed with 15 international field centers (Power et al., 1999). Later on a brief version of the WHOQOL (WHOQOL-BREF) was developed since WHOQOL was deemed too lengthy for practical purposes. WHOQOL-BREF was introduced in a generic English language and later translated into multiple languages (WHO, 1996; Skevington, 2001). WHOQOL-BREF has been validated internationally and is widely premeditated in cross-cultural studies (Skevington et al., 2004).

WHOQOL-BREF focuses on the adult or aging population primarily with age group over 18 years old (Skevington, 2002). WHOQOL-BREF is psychometrically valid and reliable instrument for evaluating the quality of life of Brazilian speaking depressed outpatients (Berlim et al., 2005), adult Dutch psychiatric outpatients (Trompenaars et al., 2005) and healthy Iranian population (Nedjat et al., 2008).

Few researches have adapted the WHOQOL-BREF for adolescents (Chen et al., 2006). Adolescence is a transitional phase between dependent childhood and independent adulthood. Adolescents experience numerous transitions that shape their cognition, emotion and behavior (Ben-Zur, 2003) that is characterized by multiple simultaneously occurring and interwoven changes (Frydenberg, 1997). Adolescents as a category are not homogeneous, but are diverse in terms of gender, class, age, experiences, understandings, aspirations and risk (Wyn and White, 1997). Studying adolescents’ quality of life would facilitate researchers and clinical practitioners to help adolescents with acute or chronic dysfunctions following stressful event, long-term survivors with emerging problems and adolescents who are at risk to develop psychological difficulties (Eiser and Morse, 2001).

WHOQOL-BREF is adapted in different cultures. The original four factor solution, internal reliability, factorial validity and construct validity (after deletion of two items) was confirmed on early adolescence in Taiwan children (Chen et al., 2006). WHOQOL-BREF was translated and validated in Bangla (native language of

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Bangladesh) demonstrating acceptable test–retest reliability and discriminant validity (Izutsu et al., 2005). Similarly, WHOQOL-BREF is established to be a reliable and valid instrument for health professionals in the assessment of quality of life of college going Thai youth (Li et al., 2009).

Indian researchers too have extensively employed the WHOQOL-BREF scale to assess various age groups and pathological samples. Saxena et al. (1998) validated the field trial version of WHOQOL-BREF in Hindi and reported that it was a good alternative to the WHOQOL-100. The scale also showed good discriminant validity, content validity and test–retest reliability. WHOQOL-BREF, Hindi demonstrated acceptable CFI (0.90). In a study on quality of life of HIV/AIDS patients, it was reported that education, income, occupation, family support and clinical categories of patients was associated with quality of life (Wig et al., 2006). Agnihotri et al. (2010) validated WHOQOL-BREF for Indian adolescents. They reported that the scale demonstrated acceptable internal consistency ($\alpha = 0.87$) and validity (content, predictive and construct). The content validity was established by assessing item domain correlations and construct was established by cross-domain correlations. “How satisfied are you with your sex life?” was modified to “How satisfied are you with the respect you receive from others?” to make it culturally relevant for adolescents. However, the study did not measure the construct validity via confirmatory factor analysis after modifying the item. Hence, the current paper aims to fulfill this gap.

1.1. Quality of life, well-being and demographic variables

Well-being and quality of life are interrelated. It can be presumed that an individual who would possess higher quality of life may also possess higher mental well-being. Well-being blends with other concepts such as quality of life, happiness and health acknowledging the social contexts, satisfaction, expectations, socioeconomic conditions and societal values (Diener and Suh, 2000). Psychologists refer to subjective well-being (SWB) as that which captures quality of life, quality of relationships, meanings, achievements and individual values that are rarely acknowledged in health. Well-being has also been related to individual characteristics, such as age, gender, religion, marital status, friendships, residential mobility, income, education, work, leisure activities, biological characteristics, including physical health, beauty, strengths, personality (extroversion or neuroticism), intelligence, sexual preference and assertiveness (Munoz-Sastre, 1999; Cummins, 2000).

Literature has indicated that rural adolescents, compared to urban adolescents, experience more loneliness (O’Grady, 1996), are more family-oriented (Esterman and Delva, 1995), and have smaller peer groups (Woodward, 1990). Elgar et al. (2003) observed that among urban adolescents, males reported more conflict than females. However, among rural adolescents, males and females reported similar levels of conflict. Sharma and Gulati (2012) found that despite living in impoverished conditions, rural adolescents perceive high levels of happiness. They also found that female adolescents perceive more happiness as compared to male adolescents.

Schools are recognized as social systems as agents to enhance mental health (Rowling and Rissel, 2000). Adolescents spend a substantial portion of their time in school. Their experiences in schools not only affect their academic development, but also strongly influence their social, emotional and physical health development, both positively and negatively (Wells, 2000). The schools provide opportunities for adolescents to develop relationally, emotionally, and behaviorally in ways that often have lasting impacts on their lives (Willms, 2004). Elitism, pedagogical practices, and student–teacher relationships are some aspects of the school milieu that may have a significant impact on teenagers’ well being in the school setting (Boulard et al., 2012).

The existing Indian literature on quality of life focused on assessing and validating WHOQOL-BREF on either participants above age 18 years or on clinical populations. The studies lacked to focus on normal population. Even though Agnihotri et al. (2010) studied the psychometric properties for adolescents, their paper lacked to confirm the model. Confirming the model is important especially after modifying items in the questionnaire. Furthermore, the current paper aims to contribute towards documentation of psychometric properties for Hindi and English version of WHOQOL-BREF for Indian adolescents. Demographic details such as gender, types of school (government vs. private) and place of residence (urban vs. rural) are likely to affect the perceived quality of life. Hence, the current paper aims to fulfill these gaps in empirical research.

2. Method

2.1. Participants

The sample consisted of a total of 1327 adolescents. Out of the 1327 participants, there were 815 (61.4%) males and 512 (38.6%) were females. The age range was 11–21 years with mean as 15.36 years (SD = 1.42 years). The demographic profile of the participants is given in Table 1.

2.2. Measures

The study employed WHOQOL-BREF (WHOQOL-BREF, 1996) a 5 point Likert type rating scale with 26 items. The scale measures four domains namely; *Domain 1: Physical* (7 items) (activities of daily living, dependence on medicinal substances and medical aid, energy and fatigue, mobility, pain and discomfort, sleep and rest and work capacity), *Domain 2: Psychological well-being* (6 items) (bodily image and appearance, negative and positive feelings, self esteem, spirituality/religion/personal beliefs and thinking, learning, memory and concentration), *Domain 3: Social relationships* (3 items) (personal relationships, social support and sexual activity) and *Domain 4: Environmental conditions* (8 items) (financial resources, freedom, physical safety and security, health and social care accessibility and quality, home environment, opportunities for acquiring new information and skills, participation in and opportunities for recreation/leisure, physical environment, transport). There are two global scores: overall quality of life (1 item) and overall satisfaction with health (1 item). The items are dispersed in the scale across four domains. Domain scores were scaled in a positive direction (higher scores denote better QoL).

Table 1
Demographic profile of adolescents.

	N	%	Missing	Valid
Place of residence		3.8	50	1277
Rural	451	34.0		
Urban	826	62.2		
Type of school		0	0	1327
Government	524	39.5		
Private	803	60.5		
Education		0.5	7	1320
8th standard	163	12.3		
9th standard	52	3.9		
10th standard	315	23.7		
11th standard	572	43.1		
12th standard	218	16.4		
Type of family		6.6	87	1240
Nuclear	730	55.0		
Joint (with grandparents)	321	24.2		
Joint (with uncle and aunt)	185	13.9		
With grandparents and uncle and aunt	4	0.3		

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