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The effect of parenthood on perceived quality of life in teens

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KEY WORDS
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Objective: To describe the perceived quality of life of teen mothers.
Study design: The Medical Outcomes Survey–Short Form 36, version 2 is a scale that measures a subject's perception of 8 health dimensions. The Medical Outcomes Survey–Short Form 36, version 2 and a demographics survey were completed by women during obstetric or gynecologic visits to a resident continuity clinic. Mean scores were compared between women with children and those without.
Results: There was no significant difference between adults or teens, with or without children, in any health component scale with the exception of social functioning. When compared with the normative population age, all groups in our population scored significantly on physical functioning and role-physical subscales. In addition, teens with children scored lower on the role-emotional subscale.
Conclusion: Perceived quality of life in teen mothers does not appear to be lower than quality of life in teens without children or adult women.

In the United States, the pregnancy rate among teens has seen a decline of 12% to 39% in the 1990s. In Texas the change has been less dramatic, with pregnancy rates decreasing by 15%.[1] Adolescent child-bearing has social and economic consequences for both mother and child that are almost universally viewed as negative.[2] However, little published research exists on the effect of parenthood on perceived quality of life in teens or adults.

The purpose of this study was to compare perceived quality of life in teen mothers with adult mothers using a validated tool and to determine whether parenthood impacted quality of life in either group by comparing with an age-matched group of women without children.

Material and methods

Approval for the project was obtained from the Committee for the Protection of Human Subjects at the University of Texas Health Science Center. Women between the ages of 14 and 24 years who presented for obstetric or gynecologic care at the Department of Obstetrics, Gynecology, and Reproductive Sciences resident continuity clinic at the University of Texas Medical School–Houston were invited to participate in this study between October 2003 and February 2004. An a priori sample size

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Table I The Medical Outcomes Survey - Short Form 36 version 2

Dimension	Health Aspect
Health Component Scale	Item content
Physical Functioning	Degree of limitation of physical activity
Role-Physical	Health related problems with work or daily activity
Bodily Pain	Intensity of pain/extent pain interferes with normal work
General Health	Evaluation of personal health
Vitality	Level of energy/degree of fatigue
Social Functioning	Extent/frequency health problems interfere with social activites
Role-Emotional	Emotional related problems with work or daily activity
Mental Health	Mood assessment
Reported Health Transition	Rating of health now compared to one year ago

determination was not performed. A convenience sample determined by the number of eligible patients willing to participate during the assigned study period was used. Each subject gave informed consent and completed a demographic form assessing age, parity, marital status, level of education, employment status, ethnicity, and living situation. Each participant completed the Medical Outcomes Survey-Short Form 36, version 2 (MOS-SF 36 v2). This form was available in English and Spanish.

The MOS-SF 36 v2 was used to assess perceived quality of life. This survey was derived from the Medical Outcomes Survey, which was designed to assess 40 physical and mental health concepts. The 8 dimensions of health evaluated in the MOS-SF v2 are described in Table I.[3] These dimensions describe several perceived physical and mental aspects of health. The measures are suitable for comparison between patients with chronic health problems and those in the general population because they are not age, disease, or treatment specific. This is a self-administered survey that has been previously administered successfully in persons 14 years old and older.[4,5] Prior studies have verified the reliability and validity of the SF36 for use with medical and general population samples.[4] This survey has been previously utilized in studies of quality of life in pregnant women.[6-8]

The MOS-SF 36 v2 was scored using the procedures outlined in the accompanying manual.[9] Missing data were estimated using the average score across the other completed items in the scale if at least 50% of the items on the scale were answered as indicated in the scoring manual. Each dimension of health was given an absolute score, which was then transformed into a score from 0 to 100, 100 indicating highest perceived health and functional status and 0 indicating the lowest perceived health and functional status. These scale scores were then converted to standardized z-scores for norm-based comparison. Student t test and analysis of variation were used for statistical analysis, and $P < .05$ was considered statistically significant.

The normative group for comparison was taken from a 1998 study of noninstitutionalized subjects sampled from the general population in the United States that included 4032 women over the age of 18 years and 157 women specifically between the ages of 18 and 24 years. The population sampled in the normative comparison group was matched to the U.S. Census data on geographical region, market size, age, income, and household size.[10] The mean scores for subjects in our study were compared with mean scores for females aged 18 to 24 years. There are no published normative data for women under the age of 18 years. Previous studies have utilized these normative data as historical comparisons when describing quality of life and functional status in study populations.[7] Norm-based comparison allows determination of whether a particular group scores above or below the average for the general population. Scores are considered significantly different from the normative population if they differ by more than 1 SD.

Results

One hundred thirty-eight women between the ages of 14 and 24 years who presented for obstetric or gynecologic care enrolled during the study. During the study period, 476 women presented for new visits to our clinic. Of these, 23 were nulliparous teens (aged 14-17 years), 9 were teens with children, 33 were nulliparous adults (between the ages of 18-24 years), and 72 were adults with children. The demographics of the study population are shown in Table II. As anticipated, adults were older and of higher parity than teens. There was no significant difference in age, education, living situation, race, or employment status between teens with children and those without children or between adults with children and those without children. However, teens without children were more likely to be currently enrolled in school than their adolescent counterparts who had children. Adults were more likely to be employed, compared with adolescents, with the greatest percentage of employment seen in adults without children. Few adults had matriculated high school.

The results of the MOS-SF 36 v2 survey in each group of subjects are shown in Table III and compared with comparative data published from normative populations aged 18-24 years.[10] Two respondents left 1 or more items blank, but both answered at least half of the items in a scale. There was no significant difference between adults or teens, with or without children, in any